GAINING TRACTION: EXECUTING COSTED IMPLEMENTATION PLANS

EXPERIENCES AND LESSONS FROM TANZANIA

Implementing Tanzania's Costed Implementation Plan for family planning would avert more than

9.7 million

unintended pregnancies,

1.3 million

unsafe abortions, and more than

24,000

maternal deaths between 2010 and 2015.

By 2015, the CIP would also save a total of USD

$529 million

in direct health-care spending

BACKGROUND

Since the London Summit on Family Planning (FP) in 2012, 33 countries have thus far committed to making high-quality, voluntary FP services, information, and supplies more available, acceptable, and affordable for an additional 120 million women and girls in the world's 69 poorest countries by 2020. These commitments evolved into a global partnership known as Family Planning 2020 (FP2020). The Ouagadougou Partnership emerged from a 2011 conference in West Africa, where countries agreed to reach at least 1 million additional women in the region with FP services by 2015. Meeting the commitments will ensure that every woman and every girl has the right, and the means, to shape her own life — to grow, to thrive, and to plan the family she wants.

Costed implementation plans (CIPs) are multi-year action plans that contain detailed resource projections for achieving the goals of a FP program. CIP enables countries to operationalize and monitor progress toward their commitments. Thus far, 16 countries have developed CIPs: Bangladesh, Benin, Burkina Faso, Côte d'Ivoire, Democratic Republic of the Congo, Guinea, Kenya, Mali, Mauritania, Niger, Nigeria, Senegal, Togo, Tanzania, Uganda, and Zambia.

Translating CIPs into action, and ultimately into results, requires a sustained deliberate approach to the execution process throughout the plan. This notion may sound simple and straightforward, but it can be complex. Strategic planners agree that planning seldom fails; it is the implementation that fails. Extensive literature describes the factors that can stall a plan, including lack of buy-in and ownership, unclear lines of responsibility and accountability, lack of dedicated efforts to mobilize resources, inability to recognize and facilitate change processes, poor communication and coordination among stakeholders, and inadequate leadership and management skills to effect execution.

Two years before the London Summit, in March 2010, Tanzania became the first country to launch a CIP. June 2014 marked four years of implementation of its plan, which expires December 2015. This case study report gives an account of the process of translating and sustaining the plan into "action" and "measurable results" —what was done, challenges, and lessons learned. It is based on consultations with stakeholders, conducted in April 2014 to understand the implementation process, and is enriched by reports from performance-monitoring efforts.

The Tanzania experience offers lessons for other countries that are developing and executing CIPs. However, this report is mainly intended to share the execution process rather than document programmatic results of implementation. A report documenting the results achieved in Tanzania will be available at the end of 2015.

FAMILY PLANNING IN TANZANIA

Modern FP services have been available in Tanzania for more than half a century. They were first introduced in the late 1950s by the International Planned Parenthood Federation affiliate Chama cha Uzazi na Malezi Bora Tanzania (UMATI) and then offered as part of the government's maternal and child health program beginning in the early 1970s. The use of modern methods quadrupled in two decades, from 6.6% in 1992 to 27.4% in 2010. The pace of growth has, however, been inconsistent; the annual growth rate was about 1.5 percentage points in the 1990s but dropped to 0.6 during the 2000s. This loss of momentum has been attributed to competing health and development priorities, which diverted resources from FP programming. The population of Tanzania also increased fivefold between the

1950s and 2000s, exerting pressure on available human, financial, and infrastructural resources, hence affecting the country's ability to keep pace with the demand for services. In 2012, the population reached approximately 45 million, with nearly half of the population (46%) being of reproductive age (15-49 years). One of every four women in this age group has an unmet need for contraception. Furthermore, young people (15-24 years) make up 54% of the population of reproductive age in Tanzania, but only 12% use contraceptive methods.

Recognizing inherent challenges to the health and socioeconomic development of the country, in addition to the high rates of maternal mortality and unmet need for contraception, Tanzania set an ambitious goal to reach a 60% contraceptive prevalence rate (CPR) by 2015. This goal was reflected in the *National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (2008-2015),* known as the "One Plan," as part of efforts to operationalize the country's commitments to the Millennium Development Goals. Although the "One Plan" set the direction for FP in Tanzania, it did not provide guidance on how the country would achieve this goal or on the level of resources that would be required.

This gap in information provided the impetus for developing a detailed CIP, now known as the National FP Costed Implementation Program 2010-2015 (NFPCIP).

Hon. Prof. David Mwakyusa, former Minister, MOHSW, cuts the ribbon launching the new Tanzania NFPCIP.

OVERVIEW OF THE NFPCIP

In March 2010, the then Tanzania Minister for Health and Social Welfare, Hon. Prof. David H. Mwakyusa, launched the NFPCIP, which contained five main technical areas (referred to as strategic action areas): contraceptive security, capacity building, service delivery, health systems management, and advocacy. The plan, developed after a yearlong consultative process with a broad group of stakeholders, identified two strategic priorities: contraceptive security and integration of FP into other health services.

Reaching the goal of 60% CPR by 2015 would require an annual growth in CPR of 6 percentage points. This translated to 5.2 million contraceptive users served and an estimated US$235 million mobilized within five years (or US$4.30 per woman of reproductive age per year). Implementing the plan was expected to avert more than 9.7 million unintended pregnancies, 1.3 million unsafe abortions, and more than 24,000 maternal deaths between 2010 and 2015. By 2015, the CIP was also expected to save US$529 million in direct health care spending.

MOVING FROM A PLAN TO SUSTAINED ACTION AND RESULTS

The move from development into execution of the NFPCIP was smooth and immediate, right after the launch in March 2010. It included a brief three-month transition stage, which allowed time to set up for execution. The foundation for this successful transition had already been established during the development of the plan itself, mainly through inclusive and thorough stakeholder engagement, and through intense advocacy to gain political support and visibility of FP in the national development agenda. Furthermore, through the establishment of the National FP Technical Working Group (NFPTWG) in 2008, stakeholders were already resolved to working together to reposition FP; therefore, the NFPCIP represented a joint road map toward a shared vision. The following describes the deliberate joint stakeholder efforts to move the plan into sustained action (and ultimately results) and the lessons learned.

The Power of Country Ownership

Realizing a common mission for a shared vision.
Among FP stakeholders in Tanzania, the launch of the NFPCIP signaled a call for a renewed commitment to repositioning FP. This also meant a shared responsibility, mutual accountability, and well-coordinated work toward a shared vision. On the launch day, March 30, 2010, a Call to Action was released that described the contributions of all key stakeholders, including members of parliament; central, regional, and district government authorities; development partners; civil society organizations (CSOs); nongovernmental organizations; and the private sector. Thereafter, the NFPTWG adopted the mantra *"One vision, One plan,"* aiming to communicate the key principle that the CIP would be a blueprint guiding all partner work plans and activities. In October 2013, during the first National FP Conference, more than 200 stakeholders signed a Declaration of Commitment — another powerful statement following the 2010 Call to Action underscoring renewed vigor and joint commitment to intensify and accelerate efforts to achieve universal access to voluntary FP by 2020.

Hon. President Dr. Jakaya Kikwete delivering Tanzania commitments at the London Summit, July 2012.

Leading by example. Public proclamation of, and action on, the government's commitment was essential in rallying other stakeholders behind the plan. Soon after the CIP launch, the Government of Tanzania (GOT) more than doubled its annual funding for contraceptive commodities, compared with that of the previous five years, to ~US$9.3 million. This funding was channeled through a newly established line item for FP in the national budget, created as a result of considerable advocacy efforts. This bold act also stimulated development partners to increase resources to support FP. By 2012, the Australian Department of Foreign Affairs and Trade (DFAT) and the UK Department for International Development (DFID) joined the U.S. Agency for International Development (USAID) and the United Nations Population Fund (UNFPA) as dominant funders of contraceptive commodities.

Furthermore, since the launch of the plan, senior leadership within the GOT has made multiple public proclamations of the country's commitment to FP. Among the most notable was the Hon. President Dr. Jakaya Kikwete attending the high-profile London Summit, where he made six FP2020 commitments. During the launch of the 2012 national census report, the Hon. Prime Minister Mizengo Pinda recognized the country's rapidly growing population as a challenge to government development efforts, when pressed on the need for citizens to use FP. And in May 2014, President Kikwete once again attested to slow progress in reducing the maternal and newborn mortality as attributed to low use of FP, among other factors, when launching the "Sharpened One Plan." Unlike the original "One Plan," the "Sharpened One Plan" included FP as one of four identified high-impact interventions. Other selected interventions included care at birth, postpartum and postnatal care, commodity security, and accountability and transparency initiatives.

Raising visibility of FP. Low visibility of FP in the health and development agendas was partly attributable to the loss of momentum of the FP program in the early 2000s. Efforts to reposition FP in Tanzania and to develop the NFPCIP were set to reverse this trend. The first year of NFPCIP implementation resulted in several key policy and advocacy gains at the highest levels of the national development agendas. These included the integration of targets to reduce total fertility and population growth rates in the *National Strategy for Growth and Reduction of Poverty II* (MKUKUTA II) and the establishment of a separate FP target (budget line item) in the Ministry of Health and Social Welfare's (MOHSW's) medium-term expenditure framework (MTEF). Efforts were also made to engage the mass media to augment FP coverage, with the goal of placing FP at the center of public and policy dialogues. One key example was the Green Star Campaign, which enhanced public attention to and awareness of FP. The first national FP conference with a theme — "Local Solutions to Local Problems" — was held in Dar es Salaam in 2013 and was attended by more than 500 participants. The theme was yet another testimony to the growing visibility of FP.

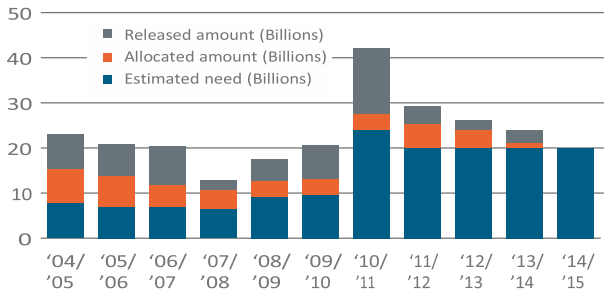
Governance and Coordination: Strengthening Plan Implementation

Clear oversight and accountability roles. To effectively execute the plan, a sound governance structure was needed to clearly define the responsibilities of different actors and ensure accountability. The MOHSW was assigned as the primary steward for the plan, and the national FP coordinator was designated as the focal person to lead, manage, and coordinate implementation. Furthermore, five MOHSW program officers were assigned to each co-lead one of the five CIP technical areas with a designated partner. At this stage of the plan, efforts were also put in place to enhance the capacity and resources of the MOHSW to ensure successful implementation. For instance, staff were seconded to the FP unit to support administrative and logistics efforts, and to support contraceptive security matters.

Coordination mechanisms. With many different actors at play, an inclusive coordination framework to facilitate joint planning, pooling of resources, decision making, and sharing of information and responsibilities was crucial. The NFPTWG was reconfigured to solidify the focus on the NFPCIP. During the development of the NFPCIP, partners with expertise in specific technical areas served in strategy advisory groups. These advisory groups were re-enacted as sub-TWGs, and co-leads (a MOHSW program officer and an implementing partner) were assigned to serve as the lead technical resource persons for their respective technical areas. Furthermore, four task forces (configured similarly to the sub-TWGs) were established to support the following cross-cutting functions: resource mobilization, advocacy coordination, resource and results tracking, and media engagement. To promote information sharing, knowledge management, and coordination among partners, a website was developed, consisting of extranet and

intranet functionalities. The extranet is a source for FP resources, including government approved guidelines, policy documents, and training manuals. The intranet site hosts the Performance monitoring database for the NFPCIP, the e-TrainTracker system for capturing data on provider training, and the e-work plan system for joint planning among partners. Information is shared via general listservs and e-work spaces for the various sub-TWGs and task forces.

Cascading the plan to subnational levels. During the 1990s, the GOT introduced the decentralization by devolution (D by D) policy to transfer fiscal responsibility, power, and authority from the central level to local government authorities (LGAs) to improve the delivery of public goods and services, including health services. In this policy context, accountability and responsibility for the NFPCIP also needed to devolve to the district level. In the beginning, the NFPCIP was focused primarily at the national level (i.e., no specific FP goals or targets were assigned at the regional or district level, and



activities were not aligned to LGAs' mandate for resource allocation). However, it quickly became clear that the NFPCIP needed to be cascaded to the LGA level to ensure that functions, processes, and resources allocated to FP were in line with the plan. To address that need, stakeholders developed a National Package of Essential Family Planning Interventions for the Comprehensive Council Health Plans (2010) to translate the NFPCIP technical areas into activities that could be incorporated into comprehensive council health plans (CCHPs) and LGA budgets (see side bar). High-level advocacy meetings with regional and district leaders were also conducted to raise awareness about the need to increase resource allocations for FP and to ensure that FP was included in the districts' annual CCHPs as well as other development plans.

Resource Mobilization: Key to Successful Plan Implementation

Budget advocacy. After the launch of the NFPCIP, budget advocacy took considerable precedence over other types of advocacy. This was indeed crucial to meet the financial resource requirements of the plan. Local civil society coalitions were formed and given capacity to influence the GOT to

Making Family Planning an Investment Priority for Local Government Authorities

During the development of the NFPCIP, it was clear that considerable resources would be needed to implement activities to achieve the country's goal of 60% CPR by 2015, and that these resources would be needed quickly. Subnational government authorities (i.e., LGAs) represent a key source of funding for the implementation of the NFPCIP through CCHPs. Therefore, the challenge was how to cascade the NFPCIP to the LGAs to ensure that FP was prioritized in district-level budget allocations, among other competing demands.

In 2010, the MOHSW led partners in the development of guidance and procedures to help council health management teams (CHMTs) better plan and budget for FP interventions in their CCHPs. These guidelines, referred to as the National Package of Essential Family Planning Interventions for the CCHPs, were disseminated to approximately 90 of the 169 districts of Tanzania. Additional interventions directed to the districts included intense advocacy with district and regional leaders, technical support to CHMTs during budget preparations, use of champions at national and district levels, and capacity building of CHMTs on the use of FP data for decision making. Annual tracking of the budgets has shown remarkable success in budget allocations for FP. The number of districts including FP in their budgets increased from 26 in 2008 (budgeting 5.7 million Tsh) to 64 in 2013 (budgeting 1.2 billion Tsh).

In July 2011, the MOHSW and the Prime Minister's Office revised the Comprehensive Council Health Planning Guidelines to improve the guidance provided to those involved in CCHP development. Although these revisions provided an opportunity to integrate FP as an appropriate intervention in the priority area of maternal, newborn, and child health, they did not require LGAs to allocate resources for FP. In November 2014, after a series of one-on-one advocacy meetings with top officials and high-level negotiations between the MOHSW and the Prime Minister's Office/Regional Administration and Local Government, a budget directive for inclusion of FP was approved for circulation to all district and municipal councils. Furthermore, to support the budget directive, the Local Government Planning and Reporting Database (PlanRep3) — a computerized tool used by LGAs in planning, budgeting, projecting, and tracking revenue — was revised to include FP as a priority area.

increase resource allocation for FP at both national and district levels. Prior to the NFPCIP, the MTEF had no specific budget line item for FP, and a significant voice to influence the GOT budget in the parliament was lacking. With intense advocacy, a budget line item was created in 2011, and a Parliamentary Family Planning Club was established. Furthermore, in 2010/2011, the GOT more than doubled its annual funding for contraceptive commodities (to ~US$9.3M) compared with that of the previous five years. In fact, the GOT's "own" funding more than doubled, from 0.5 billion Tsh in 2010/2011 to 1.2 billion Tsh in 2011/2012. This initial success was not sustained at first, however; in 2012/2013, the GOT did not allocate any funds for FP because of competing interests among policymakers. However, in fiscal year 2014/2015, the GOT allocated 2 billion Tsh to FP — double the amount set in the previous financial year, and the largest allocation since the budget line for FP was created in 2010.

Donor coordination. With a per capita gross domestic product of US$630 (in 2013), Tanzania operates with limited resources. In the past five years, only 5-7% of Tanzania's gross domestic product has been spent on health expenditures; furthermore, only 1-2% of the health expenditures have been directed to FP. Hence, for the NFPCIP to be implemented, a considerable amount of resources needed to be mobilized from other sources, particularly from development partners. Champions, such as the late Tim Manchester, USAID/ Tanzania's senior FP and reproductive health adviser, helped engage and influence donors to increase resources and redirect them to the plan. This, along with renewed government commitment demonstrated by the budget allocations for FP, generated positive responses from other stakeholders that resulted in stability in the contraceptive pipeline. After the DFAT and DFID joined USAID and UNFPA as major donors in the procurement of contraceptive commodities, they sustained their support to the extent that no stock outs occurred at the national level in 2013 or 2014.

Prioritizing investments. It was imperative that finite resources be directed to the efforts most likely to yield results, without negating the key objective of achieving universal access to FP. Expenditure tracking in the first two years of the plan revealed that most funding was directed to regions with high CPR, and that regions with low CPR had the smallest share of interventions. This observation facilitated a decision to direct resources to the lower-performing regions and districts in the Lake and Western Zones of Tanzania. To ensure equity of resource distribution and maximize results using high-impact and tailor-made interventions, partners developed criteria for site selection that considered a site's CPR level, unmet need, population, and contribution to the national CPR. These efforts informed the FP2020 Action Plan, and subsequently the "Sharpened One Plan," launched in 2014.

Performance Monitoring and Accountability: Keeping Track of the Plan

Monitoring and accounting for results. Soon after the launch of the CIP, a performance-monitoring mechanism was established to track the amount of resources mobilized or expended, progress toward activity implementation, and results against the objectives set forth in the NFPCIP. The design of this mechanism was a joint assignment given to the Monitoring Resource Mobilization, Allocation, Activity Implementation, and Results Task Force established immediately after the CIP launch. The performance-monitoring mechanism was a cyclical "plan-act-assess" process that involved 1) collecting and analyzing quarterly data on resource commitments, resource expenditures, and results achieved in the previous quarter from all implementing stakeholders, including the government; and 2) reviewing data and developing recommendations for future planning. The simple, paper-based Resource, Activity, and Results Tracking Tool was used at the beginning and later replaced by a web-based NFPCIP performance-monitoring database (www.nfpcip.rchs. go.tz). This system now tracks and reports the amount of resources expended, activity implementation, and results against the indicators and targets set forth in the NFPCIP. Service-delivery data are also captured from the health management information system.

Periodic reviews and adjustments. Resource and results data collected on a quarterly basis are shared and discussed in one-day semi-annual FP implementers' meetings, which bring together the government, donors, and implementing partners, including civil society. Decisions and recommendations from these meetings flow into the NFPWTG agendas for follow-up. Thus far, six semi-annual meetings have been convened, dedicated entirely to reviewing CIP progress. Key decisions have been made during these meetings, resulting in considerable shifts in the plan. For example, in 2013, the NFPCIP was updated to re-prioritize strategies and adjust targets based on experiences from the first two years of implementation, update projections as a result of the 2010 demographic and health survey (DHS) and the 2012 population and housing census, and take emerging issues (e.g., FP2020 commitments) into consideration.

Senior leadership engagement in progress review. Stakeholders have strived to continuously engage senior leadership in reviewing progress toward the country's FP goal. Senior leaders within the MOHSW have chaired semi-annual review meetings, and at least two high-level ministerial briefings have been held to discuss FP issues with stakeholders. For example, to kick off the FP2020 process in the country, the then Minister of Health and Social Welfare Dr. Hussein Mwinyi chaired a FP stakeholders meeting in August 2012, when he reiterated the country's commitments from the London Summit and highlighted the government's resolve to prioritize

FP and increase funding for FP. Another meeting that the current Minister of Health and Social Welfare Dr. Seif Rashid chaired took place in July 2014 to take stock of the country's efforts in implementing FP2020.

Secondary school students champion Green Star during the regional launch in Mwanza, Tanzania. (Image courtesy of JHU/TCCP).

REFLECTIONS AND LESSONS LEARNED

Gaining momentum to implement the NFPCIP was a monumental task. FP stakeholders raised the following questions during a debrief session after the March 2010 launch: Where will the money come from? How should we work together? What should we do to make the plan more visible? How will we know we are making progress?

Now, with less than a year left of the plan, several key indicators suggest that the plan's execution has been successful. A review conducted in 2012 by MEASURE Evaluation described Tanzania as showing positive indications of progress toward a repositioned FP program. Specifically, the report showed significant funding for FP, effective stewardship through the NFPTWG (despite being donor-driven), multi-sectoral engagement (as both a strength and a challenge), strong plans and policies related to FP, and use of data for evidence-based decision making. Furthermore, a review conducted in April 2014 to assess implementation emphasized the same general message — that traction has been gained in executing the plan. However, several lessons have also been learned throughout the process. These lessons, described below, will inform and shape the design and execution of the subsequent plan (NFPCIP II, 2016-2020), to be developed toward the end of 2015.

Multi-stakeholder coordination is complex; dedicated and deliberate efforts are key to fostering joint planning and action. In the first year of the NFPCIP, partners were asked to report activity plans and funding commitments for the entire year, with the aim of establishing funding gaps and informing joint planning. However, this was deemed onerous, and some partners lacked information for the entire 12-month period. This reporting requirement was subsequently removed, hindering the ability of partners to proactively plan joint activities and assess resource gaps. Alternatively, at the government's request, month-to-month work plans were instituted. These were primarily activity-driven and helped facilitate organization within the MOHSW's FP unit and assist partners in not competing for the same few staff within the unit. A seconded administrative staff within the unit coordinated the mechanism, but when the secondment period ended, the practice waned. Finally, in 2014, stakeholders agreed to resume joint annual planning, and a FP partners mapping tool was re-introduced. Despite similar reporting challenges, considerable information has been gathered to facilitate planning for the remainder of the plan period. For example, the mapping tool has been instrumental in showing the geographical distribution of resources, as well as areas where there are resource gaps.

As execution gains traction, maintaining a common mission for a shared vision should remain a priority. The NFPCIP requires all parties to be accountable for their efforts — providing resources, conducting activities, delivering products, monitoring, and reporting results — in a timely and efficient manner. However, maintaining a common mission over time can be a challenge, as stakeholders' interests, priorities, and agendas periodically shift; newcomers to the process may not share the common mission; and donor funding and planned priorities may be misaligned, locking the implementing partner in the middle. Although flexibility is needed to accommodate new ideas and initiatives, stakeholders should continue to be encouraged to work toward a common plan for delivering results; otherwise, the purpose of the entire plan becomes defeated. Careful and systematic engagement of stakeholders immensely helps manage shifts in stakeholders' interests, focus, and overall agendas, which in turn sustains a shared vision.

Also, as described earlier, several task forces were established after the NFPCIP was launched, to facilitate coordination within and across different NFPCIP technical areas. To date, these task forces have been at best only moderately active, and some have never gotten off the ground. The groups seem to be active only when reports need to be prepared for semi-annual progress review meetings, but not for their overall intended purpose. Several reasons are contributing to this inactivity, including lack of a clear aim and purpose, meeting fatigue, change in partner co-leads, and a limited number of staff within the FP unit to lead the groups. Nevertheless, these groups are important not only to facilitate coordination and encourage collaboration but also to pay close attention to strategies implemented and results generated. Simply stated, they foster accountability and ensure that different stakeholders working on a specific technical area use common language and messages. Better and efficient ways of engaging these groups with clear goals and deliverables are needed to realize their intended purpose.

Collaboration is instrumental for coordination and efficient use of resources. Tanzanian FP stakeholders are generally a highly collaborative group. In most cases, major tasks are performed jointly, and decision making by consensus is the norm. The NFPWTG has a generally accepted "rule" for approaching key tasks, which involves developing a temporary task force and assigning stakeholder roles ranging from advisory roles to cost sharing. This principle of collaboration has underpinned the complex, multi-faceted coordination involved in delivering the momentous Green Star Campaign in the Lake and Western Zones of Tanzania. For the campaign, multiple partners have synchronously worked to generate demand, deliver services, and conduct advocacy for FP for populations that have long lacked adequate access to these services.

Advocacy pays off, but should be consistent and continuous. Advocacy — a critical intervention in realizing CIP results — should not be approached as a temporary effort or a one-off event. Rather, it should be a continuous and consistent process that goes hand-in-hand with implementation of the plan. This is because decision makers and priorities can change. CIP advocacy efforts have uncovered several key lessons in the area of increasing domestic resources for the plan. For example, despite the government's allocation of resources to FP immediately after the CIP launch, funding for FP has been inconsistent because of competing and shifting priorities, inadequate systems to necessitate allocations, changing leadership, and a general lack of appreciation of the role of FP in enhancing family welfare and socioeconomic development. Since the launch of the NFPCIP, the Tanzania MOHSW has gone through several rounds of leadership, with three different ministers, chief medical officers, and permanent secretaries. Leadership within the Reproductive and Child Health Section (RCHS) has also shifted twice. Although there has been general support for the FP agenda among all leaders, turnover among government officials requires quick orientation of incoming policymakers and reframing of advocacy messages and strategies.

Like earlier advocacy efforts, later efforts focused more on increased resources and less on the policy environment. This was and will continue to be the priority given Tanzania's dependence on donor support for its FP program. However, the same energy and strategies need to be re-directed to foster an enabling policy environment. Granted, there have been notable policy successes since the CIP was introduced, including the formation of the budget line on MTEF, integration of FP into PlanRep3, and expansion of the method mix to include Jadelle, dedicated emergency contraceptives, and CycleBeads. However, other policy agendas remain inadequately addressed by advocacy efforts. These include task shifting, sexual education in the school system, health insurance coverage of FP, and leveraging of private-sector support to FP.

One reason that advocacy efforts have not been entirely successful is that many partners have an inadequate understanding of advocacy, often confusing it with information, education, and communication or with behavior change communication. Furthermore, only a few organizations undertake FP advocacy, and local CSOs are largely absent from these endeavors. To enhance and sustain advocacy efforts, the capacity of the local CSO pool of FP advocates needs to be strengthened, as Tanzania currently has just a handful of local CSOs working in FP advocacy. However, according to the Foundation for Civil Society, there are more than 5,000 CSOs nationwide that could be engaged at multiple levels (national, regional, district, and community) to address various FP advocacy agendas, from political and social accountability to community mobilization, to increase citizen engagement and population support for FP. As the number of engaged CSOs increases, it is imperative that regional and district CSO coalitions be constituted and that their leadership's commitment to FP be sustained. A similar national CSO coalition would be instrumental in tackling the national-level FP agenda while providing support at the community level.

To contribute to socioeconomic development, FP needs to be mainstreamed and institutionalized beyond the health sector. There is no doubt that progress has been made to reposition FP in the past 10 years, but this has been confined to the health sector. It is time to move beyond this sector and build a case for FP as an integral component of all sustainable development. Earlier advocacy efforts succeeded in having FP targets included in MKUKUTA II. Although this represented acknowledgment of FP as a tool for achieving socioeconomic goals, this acknowledgment has yet to be effectively translated into practice. A recent report assessing opportunities for demographic dividend in Tanzania showed that the country needs to aggressively and simultaneously prioritize investments in economic reform, FP, education, health care, and governance to achieve the socioeconomic transformation envisaged in the National Vision 2025 and the Big Results Now initiative. To ensure that FP goals and objectives are appropriately integrated with other health and development initiatives, the development and implementation of the NFPCIP should extend to all other ministries affected by high population growth, such as finance, social welfare, education, and to the Planning Commission. The current Big Results Now plan for health underscores the necessity for the multi-sector NFPCIP II to adopt a broader development agenda and involve a broad spectrum of stakeholders to coordinate activities and resources.

When engaged, and when systems are in place to support engagement, subnational governments become key players in plan execution. Before the NFPCIP, no sound policy directives, guidelines, or tools required districts to allocate resources and therefore to be engaged in advancing national FP goals.

Consequently, most districts were not allocating resources for FP activities in their CCHPs. Now, as a result of joint multi-year advocacy efforts, these requirements are in place. The question is whether this will result in enhanced and sustained district engagement in FP over time, and whether the degree of engagement will match the needs in respective districts. Experiences from district-level advocacy efforts stress the need for sustained advocacy to ensure that FP is fully integrated and budgeted for in CCHPs on a continuous basis, and that districts continuously increase their own financial sources for implementing FP activities beyond donor funding periods. Coupled with written guidelines and directives, consistent technical assistance is needed to help local governments make well-informed, evidence-based decisions related to programming and budgeting for FP. Based on lessons learned from implementing the NFPCIP thus far, it is imperative that the NFPCIP II include district-level goals and targets to facilitate full participation at all levels of the health system and in other sectors. This inevitably also calls for strong coordination mechanisms at the district level.

Donor harmonization has increased resources, but untapped opportunities exist. Because donors will continue to be a major source of financial resources for implementing the NFPCIP, they need to be fully engaged in aligning their programmatic and financial contributions with the NFPCIP. Champions from within the donor community, as well as the government's commitment to FP issues, have helped facilitate donor harmonization and raise the visibility of FP, but there are still untapped opportunities to further enhance donor engagement. The GOT will need to rally donors and partners around the FP agenda, including galvanizing existing efforts and support, to ensure that FP is central to the overall development agenda of donors. The Development Partners Group, an umbrella entity addressing donor support in development cooperation, is an established coordination forum that needs to be further tapped and leveraged to move the FP agenda forward.

A concerted resource mobilization effort must be central to plan execution. One of the great challenges of the NFPCIP continues to be mobilizing adequate resources to meet the five-year plan's performance targets. In fact, for the technical areas of service delivery and capacity building, only about 13% and 22% of targets, respectively, had been mobilized by the end of year 3. Contraceptive security received the largest share of resources, and thus far 50% of the total required resources for this technical area have been mobilized. Although a task force was established at the beginning of the plan to work on resource mobilization, these efforts eventually dwindled with the exception of budget advocacy involving the government. Therefore, there were no dedicated, systematic, and persistent efforts to mobilize resources, such as expanding the donor base or increasing domestic nongovernment resources. Nevertheless, Tanzania did experience an increase in resources, mainly because of internal advocacy and external initiatives such as FP2020. Country-driven efforts need to be in place to expand the donor base and maintain or increase funding levels from current donors. Also, other sustainable financing mechanisms for FP need to be considered, such as exploring health insurance for FP and intensively engaging the private sector as a resource.

Better target resources for maximum impact. The next DHS (2015/2016) will reveal the extent to which FP efforts have reached their various intended beneficiaries, categorized by age, sex, educational background, and geographical location. However, review of performance data indicates that there may have been some missed opportunities to better target use of resources. For example, according to the 2012 census, four of every 10 Tanzanian women of reproductive age (ages 15-49 years) are youth (ages 15-24 years). Moreover, according to the 2010 DHS, only 12% of young people use contraceptive methods, and 23% of women are mothers or pregnant with their first child by the age of 19. Hence, youth need to be the focus of efforts to reduce unmet need and increase FP uptake. Yet interventions focusing on young people account for only 10% of the entire budget estimates of the NFPCIP.

There is also a need to ensure equity while improving resource targeting. The current concentration of resources in the Lake and Western Zones was strategic, as these regions have low rates of FP use and large household sizes. However, to achieve a balance in resource distribution, resources should not simply be shifted from well-performing regions such as Dar es Salaam, Morogoro, and Mbeya to low-performing regions, mainly in the Lake and Western Zones. There are several reasons such a shift should be discouraged. First, the CPR of all regions is below the projected required contribution to the national FP goal. Second, regions such as Dar es Salaam, Mbeya, Kagera, Morogoro, and Dodoma have large populations of women and thus likely have a higher absolute number of women with unmet need than regions where the CPR is low.

Sound government leadership should not be expected without focused attention on addressing capacity issues. Through the MOHSW, the GOT has remained committed to managing the NFPCIP to generate results throughout the execution period. The FP unit, known as the "sleeping giant" within the RCHS in the early 2000s, has awoken. However, the unit's capacity has not matched the pace of FP growth. As more partners have joined the FP movement, the number of staff in the FP unit has dwindled, some retiring and others leaving for other positions, with no replacements for a considerable time. This understaffing has contributed to overwhelmed FP staff, an inability to transfer skills to the MOHSW, and partners' increasing demand for the few available staff. Similarly, as with other government offices, the FP unit is under-resourced and in

need of continued financial support for basic administration and logistics for effective functioning.

Donors have been providing this support for several years, and new staff members have recently been seconded to the unit to lessen the current staff's workload. However, advocacy efforts with top-level MOHSW and government officials is needed to ensure that new staffing and resources for the FP unit are a priority — a move that will further demonstrate commitment toward the country's FP goal. It should also be noted that although this report has described capacity issues only at the MOHSW's central level, similar challenges at subnational levels require action to ensure optimal staffing.

Performance monitoring enhances accountability and attention to results, but there is room for improvement. Continuous monitoring of the plan's resources and results has facilitated stakeholder focus and engagement. For the first time, the GOT has directed more resources toward partners' FP efforts and is better informed to lead and coordinate the program. The performance-monitoring system has also armed the MOHSW with data to identify trends (e.g., activities and resources concentrated in areas of high CPR, gaps in availability of youth-friendly services) that can facilitate decisions about how to revise strategies, reprioritize activities, and refocus investments to address disparities.

Despite these strengths, the performance-monitoring system falls short in several areas. For example, the electronic health information management system captures FP service statistics, but these data are neither available nor accessible to stakeholders. Until this changes, stakeholders will continue to rely on DHS data, which are gathered and analyzed only every five years. Although the web-based system has been more successful than the paper-based system, data collection is still arduous, and inadequate priority is given to reporting among partners. This greatly affects the reliability of the information presented in semi-annual progress reviews. Furthermore, the mechanism that was established to support follow through of actions from progress reviews is flawed. Efforts are under way to improve the system, including revising the functionality of the web-based platform, introducing a CIP dashboard with minimum key performance indicators, and promoting the use of data for decision making.

Some partners do not have the capacity for monitoring and evaluation within their organizations and thus require greater support and training to use the performance-monitoring database for the NFPCIP. In addition, the database captures only FP-related activities conducted by implementing partners. Capturing lower-level data, such as from the activities of LGAs, CHMTs, and community-based organizations, will require capacity strengthening to enforce the use of the system at subnational levels.

CONCLUDING THOUGHTS

Tanzania took a proactive role in developing its CIP before declaring its FP2020 commitments and has stayed on course for the past four years in translating its plan into sustained action. Given the lack of reliable service statistics, Tanzania will need to wait until 2016 to determine whether these enhanced efforts to reposition FP have significantly increased the country's CPR. There are, however, indications that the trend is positive. Nevertheless, the country's experience with CIP execution provides instructive lessons to other countries, in terms of both appreciating the value of having a CIP and understanding the four factors that support effective execution: country ownership, governance and coordination, resource mobilization, and performance monitoring and accountability. As more countries develop their CIPs and move into execution phases, we expect to have richer experiences and lessons to further our understanding of the execution process. In the end, each country will have a unique experience suited to its own context, but these four facilitating factors will remain key elements that need to be in place for successful execution. It remains to be seen whether executing CIPs will lead countries to fulfill their FP2020 commitments and realize their FP goals. However, a CIP will remain critical in providing a formalized road map of how a country intends to reach its FP goal and in providing essential guidance to stakeholders — particularly government, development, and implementing partners — to understand budgetary requirements and prioritize finite resources and efforts to achieve desired results.

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