THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT,
GENDER, ELDERLY AND CHILDREN

TANZANIA

National Family Planning Costed Implementation Plan 2019-2023

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TABLE OF CONTENTS

FIGURES AND TABLES

FOREWORD

As shown by statistics from the 2015–16 Demographic and Health Survey, Tanzania has made impressive gains in reducing child and infant mortality. However, other reproductive health impact indicators such as total fertility, maternal and neonatal mortality, and teenage pregnancy rates remain high. Contraceptive prevalence rates for modern methods across the country have slightly increased but show wide regional variation.

Various policy and guidance documents have called for a continuous emphasis on family planning, including the Tanzania Development Vision 2025, Planning Commission National Development Plan 2016/17–2020/21, the Health Sector Strategic Plan IV (2015–2020), and the National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child, and Adolescent Health in Tanzania (2016–2020), known as One Plan II.

As Tanzania strives to reach middle-income status as expressed in the Tanzania Development Vision 2025, the health sector will play an instrumental role in ensuring that healthy individuals and families are contributing to socio-economic development, in particular by increasing access to family planning services and appropriate information as part of strengthening reproductive health. The development of this National Family Planning Costed Implementation Plan (NFPCIP) 2019–2023 was built on recommendations from the end-of-period review of the NFPCIP 2010–2015. The current NFPCIP takes a more in-depth approach to finding evidence for what works best from national and service delivery data, gaining a better understanding of the regional variations among our communities, and prioritising interventions that will have the greatest impact on modern contraceptive use. It is also informed by Tanzania's revised accelerated FP2020 commitments made in London in July 2017.

Under the ownership and leadership of the Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC) and the President's Office Regional Administration and Local Government (PORALG), the NFPCIP 2019–2023 has been developed to address the gaps and accelerate the gains from the implementation of the NFPCIP 2010–2015. The plan emphasises the following strategic priorities, which will help achieve our objectives of increasing the country's modern contraceptive prevalence rate to 47 percent among married women and 40 percent among all women by 2023:

- **STRATEGIC PRIORITY 1:** Improve uptake of postpartum family planning
- **STRATEGIC PRIORITY 2:** Address social norms that hinder individuals from using contraception to delay, space, or limit births
- **STRATEGIC PRIORITY 3:** Reduce stock outs at facilities
- **STRATEGIC PRIORITY 4:** Increase age-appropriate information about, access to, and use of contraceptives among young people ages 10–24.

Evidence from Tanzania and other countries in sub-Saharan Africa has shown that family planning is a cost-effective intervention that can contribute toward reducing maternal and child mortality and can drive the country's economy so that Tanzania can become a middle-income country by 2025. Recognising this, the MOHCDGEC in collaboration with PORALG are committed to coordinating and supporting the implementation, monitoring, and evaluation of this plan.

It is with this commitment that all development partners and implementing partners at various levels are called upon to use this document for their current and future family planning activities, particularly in support of the country's One Plan II and its annual operational plans and in the preparation, implementation, and monitoring of annual Comprehensive Council Health Plans.

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- Regional Medical Officers and Regional Reproductive and Child Health Coordinators from all regions of the Tanzania mainland; Zonal Reproductive and Child Health Coordinators; and District Medical Officers and District Reproductive and Child Health Coordinators from Ilemela Municipal Council, Nyamagana Municipal Council, Arusha Municipal Council, Arumeru District Council, Mbeya Municipal Council, Mbeya District Council, Kinondoni Municipal Council, Ubungo Municipal Council, Ilala Municipal Council, Kigamboni District Council, and Temeke Municipal Council.
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Prof. Muhammad B. Kambi
Chief Medical officer

ACRONYMS

ADDO	Accredited Drug Dispensing Outlet
CCHP	Comprehensive Council Health Plan
CHMT	Council Health Management Team
CHW	Community Health Worker
CIP	Costed Implementation Plan
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organisation
DFID	Department for International Development
DHIS	District Health Information System
DHS	Demographic and Health Survey
DSW	Deutsche Stiftung Weltbevoelkerung
FP	Family Planning
GOT	Government of Tanzania
JSI	John Snow, Inc.
LARC	Long-acting Reversible Contraception
M&E	Monitoring and Evaluation
mCPR	Modern Contraceptive Prevalence Rate
MNCH	Maternal, Newborn, and Child Health
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly, and Children
MSD	Medical Store Department
NFPCIP	National Family Planning Costed Implementation Plan
NFPTWG	National Family Planning Technical Working Group
PORALG	President's Office Regional Administration and Local Government
PPFP	Postpartum Family Planning
PRINMAT	Private Nurses Midwives Association of Tanzania
RCHS	Reproductive and Child Health Section
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
SAG	Strategic Advisory Group
SBCC	Social and Behavioural Change Communication
SDG	Sustainable Development Goal
TAYARH	Tanzania Youth Adolescent and Reproductive Health
TDHS	Tanzania Demographic and Health Survey
TMA	Total Market Approach
TZS	Tanzanian Shillings
TST	Technical Support Team
UMATI	Chama Cha Uzazi na Malezi Bora Tanzania
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
YFCS	Youth-friendly Contraceptive Services

EXECUTIVE SUMMARY

The Government of Tanzania (GOT) envisions that by 2025 the country will have graduated from a low-income country to a middle-income country with a high level of human development. Inherent in the achievement of the Tanzanian Development Vision 2025 is progress toward achieving the sustainable development goals (SDGs), including SDG 3 (i.e., Good Health and Well-being), which includes targets related to maternal, infant, and child mortality as well as access to sexual and reproductive health services, including family planning (FP). Furthermore, population dynamics—including a country's ability to reap the benefits of the demographic dividend—clearly affect whether and when a country will attain many, if not most, of the SDGs.

Validating the rights of its citizens to SDG 3 and recognising the links between health and development, Tanzania developed its One Plan II (2016–2020) with a clear vision: 'healthy and well-informed Tanzanians with access to quality reproductive, maternal, newborn, child, and adolescent health (RMNCAH) services that are affordable, equitable, and sustainable.' One Plan II articulates that access to quality, rights-based FP services—that is, the ability to choose whether to have children, when to have them, and how many to have—is a critical component of Tanzania's journey toward middle-income status and aims to increase the modern contraceptive prevalence rate (mCPR) among married women to 47 percent.

The National Family Planning Costed Implementation Plan (NFPCIP) 2019–2023 serves as a road map and costing guide for FP stakeholders to contribute toward the FP targets contained in One Plan II and the accelerated FP country commitments made at the London Summit in July 2017.

The goal of the NFPCIP 2019–2023 is to enable women, youth, and couples in Tanzania to achieve their desired fertility intentions through access to high-quality and respectful services as well as appropriate, evidence-based information. In doing so, Tanzania's mCPR among married women is anticipated to increase from 36 percent in 2019 to 47 percent by 2023, and the mCPR among all women to increase from 30 percent in 2019 to 40 percent by 2023. Importantly, the health impacts of this would include averting more than 7 million unintended pregnancies and more than 22,000 maternal deaths, which is approximately 3,442 more deaths averted than if the current mCPR and method mix remain constant. These additional deaths to be averted represent approximately 9 percent of expected maternal deaths in this period.

During the period 2010–2015, the mCPR increased from 27 percent to 32 percent—a noteworthy increase in a short period. However, mCPR varies widely among regions due in part to different beliefs and social norms that hinder utilisation of FP, including early marriage and early sexual debut. For example, several regions in the Western and Lake Zones have mCPRs for married women between 13 percent (Geita) and 18 percent (Mwanza, Kitavi, and Kigoma), considerably lower than the average for the country. Furthermore, there are still women and couples across the country who wish to use contraception but are not doing so and who must be served; unmet need is currently estimated at 22 percent, with figures as high as 29 percent among the poorest married women.

The Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC) and the President's Office Regional Administration and Local Government (PORALG), along with a variety of development partners and civil society organisations, collaborated to develop the NFPCIP 2019–2023 based on local evidence for what works best, using national service delivery data and considering the regional variations among our communities. As a result, this document identifies four strategic priorities that will contribute toward achieving the overall mCPR goal:

- **STRATEGIC PRIORITY 1:** Improve uptake of **postpartum FP** (defined as up to 12 months after birth)
- **STRATEGIC PRIORITY 2:** Address **social norms** that hinder individuals from using contraception to delay, space, or limit births
- **STRATEGIC PRIORITY 3:** Reduce **stock outs** at facilities to offer clients a full range of contraceptive methods
- **STRATEGIC PRIORITY 4:** Increase age-appropriate information about, access to, and use of contraceptives among **young people** ages 10–24.

Activities related to postpartum FP and to young people will be implemented in all regions of the country, while activities related to addressing social norms and reducing stock outs are prioritised for a subset of regions where data indicates they would make the most difference. Regions targeted for activities related to addressing social norms are Dodoma, Arusha, Morogoro, Pwani, Lindi, Mtwara, Ruvuma, Mbeya, Singida, Tabora, Rukwa, Kigoma, Shinyanga, Kagera, Mara, Manyara, Katavi, and Simiyu. Regions targeted for activities focused on reducing contraceptive stock outs are Dodoma, Arusha, Kilimanjaro, Pwani, Dar es Salaam, Mtwara, Ruvuma, Iringa, Tabora, Kagera, Mwanza, Mara, Njombe, and Simiya. Additional activities within the NFPCIP 2019–2023 will help maintain quality services and information and therefore make up a 'maintenance package' to ensure that ground is not lost. These activities will focus on ensuring that there are well-trained staff at various levels of facilities, including staff trained to offer long-acting and reversible contraceptives at dispensaries, and community health workers with the appropriate skills to inform, counsel, and either offer or refer clients as needed for contraceptive methods.

By articulating Tanzania's priorities for FP, the NFPCIP 2019–2023 can guide the government, implementing partners, and donors in their FP investments, particularly at the implementation level through the formulation of annual budgeted Comprehensive Council Health Plans and the Annual Operational Plans from One Plan II at the national level. The total estimated cost of the NFPCIP 2019–2023 is approximately TZS 470 billion. Though the exact amount required to achieve the plan's goal may shift over time, this estimate can serve as an important tool for monitoring and stimulating resource mobilisation.

This document begins with sections providing context on the state of FP globally and in Tanzania, including the important role that Costed Implementation Plans can play in achieving international and national objectives, followed by a summary of the process for developing the NFPCIP 2019–2023. Next, the Results Framework for the NFPCIP 2019–2023 is presented, including the

goal, outcomes, and outputs and a presentation of the cross-cutting strategic priorities. This is followed by high-level indicators; the demographic, health, and economic impacts of achieving the FP targets; high-level cost estimates required to achieve the targets; and projections for the method mix that will inform the One Plan II, its updates, and the One Plan III. The Implementation Framework provides more details regarding the types of activities that can lead to specific outputs and outcomes, organised by thematic areas, which will assist local councils and implementing partners to define activities for the CCHPs. Finally, the document discusses the Monitoring and Coordination Frameworks that are envisioned.

GLOBAL CONTEXT

Evidence demonstrates that family planning (FP) is one of the most effective means for reducing maternal mortality and morbidity and improving infant and child health. For example, it is estimated that one-quarter to one-third of global maternal deaths could be prevented by reducing unintended pregnancies,[1] and that spacing births by about three years is associated with decreased newborn, infant, and child mortality.[2] Furthermore, data show that FP is one of the most cost-effective development interventions, with each dollar spent on FP initiatives on average resulting in savings of US$6 on health, housing, water, and other public services.[3] Therefore, FP directly and indirectly contributes to the Sustainable Development Goals (SDGs), particularly SDG 3, which seeks to 'ensure healthy lives and promote well-being for all at all ages' and SDG 5, which aims to 'achieve gender equality and empower all women and girls.'

Increasingly, analyses also demonstrate that efforts to expand access to contraceptive information and services, which thereby reduce unintended pregnancies, positively contribute to other sectors. Namely, this is by reducing aggregate demand for increasingly scarce food products, reducing the strain on natural resources, reducing harmful environmental waste, increasing children's access to education, and increasing women's participation in the marketplace.[4] At a macro level, one analysis indicates that enhanced contraception and FP use in 27 of 74 low- and middle-income countries (that account for more than 95 percent of maternal and child deaths) could contribute to a demographic dividend exceeding 8 percent of the gross domestic product by 2035.[5]

Despite the huge potential of FP to contribute to development improvements, more than 214 million women in developing countries desire to space or limit pregnancies but are not using contraception.[6] In July 2012, stakeholders from around the world gathered in London to 'mobilise global policy, financing, commodity, and service delivery commitments to support the rights of an additional 120 million women and girls in the world's 69 poorest countries to use contraceptive information, services, and supplies, without coercion or discrimination, by 2020.' This was the birth of the FP2020 collaboration. Among the participating countries was Tanzania, with a delegation led by the former President Honorary Jakaya Kikwete, who presented the country's FP commitments in support of an overall objective to double the number of FP users to 4.2 million by 2020.

Prior to the London Summit, Tanzania had become the first country in sub-Saharan Africa to launch a National Family Planning Costed Implementation Plan (NFPCIP). The purpose behind the NFPCIP was to guide the national FP program to more efficiently achieve the country's reproductive, maternal, newborn, and child health goals as articulated in the One Plan. Soon after, several other countries followed suit and FP2020 began promoting costed implementation plans as a key pillar for national FP programs that also help translate FP commitments into concrete actions.

Since the launch of FP2020 in 2012, the number of commitment-making countries has increased to 41 and an additional 38.8 million women have begun using contraception, representing a 30-percent increase over historical trends in growth.[7] In July 2017, FP stakeholders reunited in London to make new and renewed commitments to address unmet need. Tanzania was among those making renewed commitments, with a continued focus on increasing domestic resource allocation and targeting both interventions to increase access to methods and interventions for specific populations, namely adolescents and youth. These commitments are captured in the NFPCIP 2019–2023 and will be monitored throughout its implementation to inform progress and achievements.

TANZANIA'S FP2020 COMMITMENTS

2012 COMMITMENT: Tanzania is committed to doubling the number of FP users to 4.2 million by 2015 to reach a national CPR of 60%. The government will increase its financial allocation for family planning, while strengthening partnerships to continue implementing the NFPCIP. Additionally, the government will execute a FP2020 Action Plan (2013–2015) to address regional disparities and inequalities through training, capacity building, community-based services, and interventions targeting young people and postpartum women, with a particular focus on the Lake and Western Zones. Through public-private partnerships and training for service providers and local staff, the Government will improve contraceptive commodity security, logistics systems, and the method mix. Strategic communications will be used to address barriers to FP use, through a countrywide campaign carried out at the national and subnational levels.

2017 ACCELERATED COMMITMENTS: By 2020, Tanzania will increase the availability of modern contraceptive methods at all levels of its health system. Specifically, the government will increase its allocation for FP commodities from TZS 14 billion in 2017 to TZS 17 billion by 2020, expand the availability of at least three modern contraceptive methods at primary-level facilities and at least five modern contraceptive methods at secondary- and tertiary-level facilities from 40 percent to 70%, and scale up the number of health facilities providing youth-friendly reproductive health services from 30 percent to 80%.

INTRODUCTION AND RATIONALE

The Government of Tanzania (GOT) envisions that by 2025 the country will have graduated from a low-income country to a middle-income country with a high level of human development.

Inherent in the achievement of the Tanzanian Development Vision 2025 is progress toward achieving the SDGs, including SDG 3 (i.e., Good Health and Well-being), which includes targets related to maternal, infant, and child mortality as well as access to sexual and reproductive health services, including FP. Furthermore, population dynamics—including a country's ability to reap the benefits of the demographic dividend—clearly affect whether and when a country will attain many, if not most, of the SDGs.

In 2010, recognising the health challenges that plagued the country, including high rates of unmet need for contraception and a high maternal mortality rate, Tanzania became the first country in sub-Saharan Africa to launch an NFPCIP. The NFPCIP aimed to guide the national FP program to increase the modern contraceptive prevalence rates (mCPR) among women of reproductive age from 28 percent in 2010 to 60 percent by 2015. This goal was also 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.

The NFPCIP 2019–2023

is designed to enable the country to attain an mCPR of **47%** for married women and **40%** for all women by **2023** by identifying high-impact practices and articulating related activities and associated costs necessary to achieve that goal.

Validating the rights of its citizens to SDG 3 and recognising the links between health and development, Tanzania developed its One Plan II (2016–2020) with a clear vision: 'healthy and well-informed Tanzanians with access to quality reproductive, maternal, newborn, child, and adolescent health (RMNCAH) services that are affordable, equitable, and sustainable.' One Plan II articulates that access to quality, rights-based FP services—that is, the ability to choose whether to have children, when to have them, and how many to have—is a critical component of Tanzania's journey toward middle-income status and aims to increase the mCPR among married women to 45 percent.

During the implementation period of the NFPCIP 2010–2015, the mCPR increased from 27 percent to 32 percent—a noteworthy increase in a short period, but one that fell short of the national goal. Ultimately, Tanzania made substantial strides toward repositioning its FP program. Specific achievements included increased domestic funding levels for FP, effective stewardship through the National FP Technical Working Group (NFPTWG), the development of strong policies and plans for FP, and increased use of data for evidenced-based decision making.[8] Gaps that remained at the end of the implementation period included challenges in adequate commodity distribution to the last miles; inadequate capacity of facility staff to accurately fill report and request forms; forecasting and procurement; a heavy reliance on donors to finance the FP program, including outreach; a continuing critical shortage of trained personnel at all levels (thereby hindering sustainability); a continued reliance on in-service training for FP; and an increasing teenage pregnancy rate.

Therefore, there remains a need for a common vision for FP programming reflecting national and regional needs and a road map for concerted action to accelerate recent gains and to contribute toward achievement of One Plan II, the Tanzania Development Visions 2025, and the SDGs. The NFPCIP 2019–2023 is designed to enable the country to attain an mCPR of 47 percent for married women and 40 percent for all women by 2023 by identifying high-impact practices and articulating related activities and associated costs necessary to achieve that goal. Building upon the successes realised under the NFPCIP 2010–2015, this document serves as a guide for all FP stakeholders (government ministries and sectors, development partners, implementing partners, and the private sector), particularly at the implementation level through the formulation of annual budgeted CCHPs and the annual operational plans from One Plan II at the national level.

The NFPCIP 2019–2023 will be used for the following purposes:

- **To operationalise the country's national FP strategy through development of the annual Reproductive and Child Health Section (RCHS) operational plans, review of One Plan II, and development of One Plan III:** The NFPCIP 2019–2023 articulates Tanzania's priorities for FP, as supported by the One Plan II, and was developed through a consultative process and centered on evidence-based interventions. This unified national approach will guide the government, implementing partners, and donors in their FP investments, particularly at the implementation level through the formulation of annual budgeted CCHPs. In addition, the NFPCIP 2019–2023 monitoring and progress reports will be used to inform the revision of FP content and targets in One Plan II and the development of related content in One Plan III. This approach will ultimately ensure that all FP activities are aligned with the country's needs and will mitigate fragmentation and duplication of efforts.
- **To focus on implementing high-impact practices:** The NFPCIP 2019–2023 outlines several high-impact practices for FP that, if implemented at scale, will accelerate mCPR growth. Using various data sources, the FP Goals Model, variations in regional needs, results of the NFPCIP 2010–2015 end-of-period performance review, and the district health information system 2 (DHIS 2), focus intervention areas were identified and activities were developed that will be implemented nationally and regionally. Focusing on evidence-based interventions where need is the greatest will ensure that limited resources are used to achieve the highest impact.
- **To advocate for and mobilise FP resources:** The NFPCIP 2019–2023 will be the main FP advocacy and resource-mobilisation tool used both domestically and internationally to ensure the success of the FP program. Planned activities and associated costs are clearly outlined in the document, which easily allows the government, donors, and implementing partners to remain abreast of the funding needed to fully execute the FP program, or to determine funding gaps and address them.
- **To monitor progress toward the national goal:** The NFPCIP 2019–2023 will act as a tool to monitor the progress and achievements of FP activities and to ensure that milestones and performance targets are met. It will also help ensure stakeholder coordination and guide any necessary course corrections.

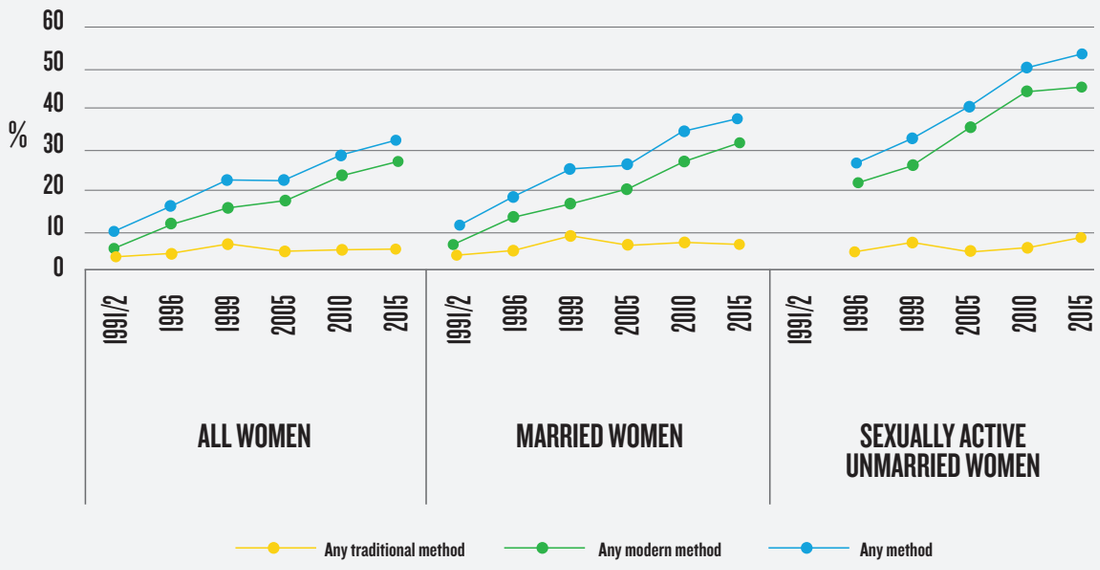
COUNTRY CONTEXT: DEMOGRAPHICS, POPULATION, AND FERTILITY

Contraceptive Prevalence

The rate of modern contraceptive use among women slowly but steadily increased during the decade before implementation of the NFPCIP 2010–2015. According to data from the Tanzania Demographic and Health Survey (TDHS), the mCPR among married women ages 15–49 increased from 16.9 percent in 1999 to 27.4 percent in 2010.[9]

During the NFPCIP 2010–2015, total mCPR among married women ages 15–49 grew by 4.6 percentage points, increasing to 32 percent in 2015. This increase was driven largely by the mCPR in rural areas, which increased by 5.4 percentage points from 2010 to 2015, as compared with the mCPR in urban areas, which increased by less than 1 percentage point during the same period (Figure 1).

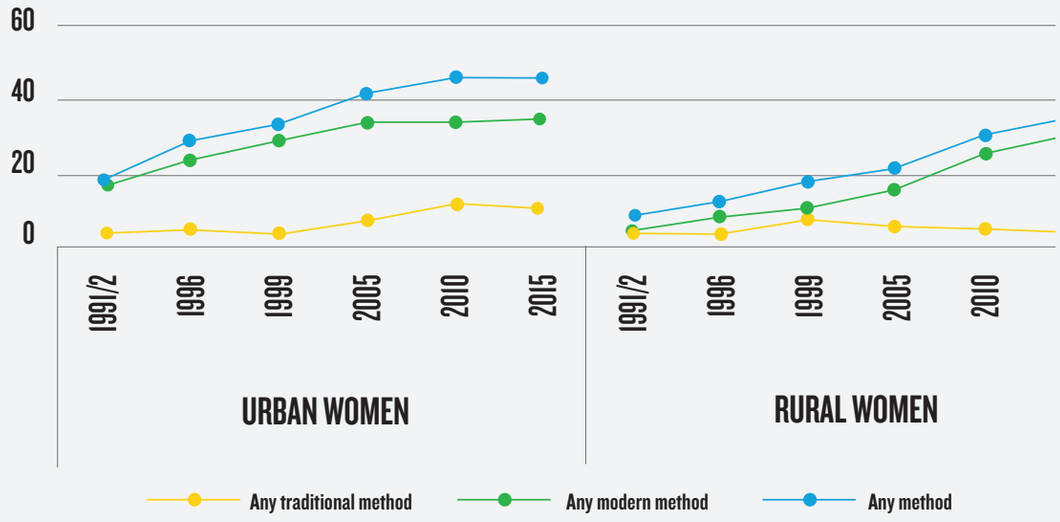
FIGURE 1. Current Use of Contraception among Women Ages 15–49 by Marital Status, 2005–2015



Data reported more recently by FP2020, which uses country service statistics, show a similar trend of increasing mCPR. The estimates show a slow and steady increase in mCPR from 29 percent in 2012 to 32 percent in 2015 to 35 percent in 2017 among married women. (Among all women, mCPR increased from 25 percent in 2012 to 27 percent in 2015 to 29 percent in 2017.)[10]

Disparities in contraceptive use also exist by age, marital status, education, region, and wealth quintile. Modern contraceptive use is highest among currently married women ages 35–39. Women with more education and higher household wealth are more likely to use contraception. Further, contraceptive use is more prevalent among women living in southern regions and is lowest in Zanzibar. Interestingly, data from the TDHS show that urban married women use traditional methods at a rate that is two times higher than that of rural married woman (11 percent versus 4 percent) (Figure 2).[11]

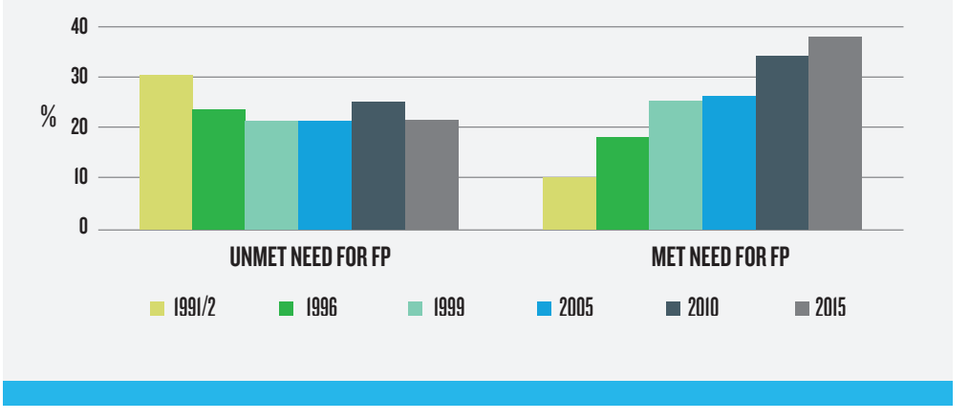
FIGURE 2. Current Use of Contraception Among Urban Versus Rural Married Women Ages 15–49, 2005–2015



Unmet Need and Demand for FP

The 2015–2016 TDHS reports that 22 percent of married women have an unmet need for contraception, defined as wanting to space their births or not wanting to become pregnant, yet not using contraception. Unmet need declines with increasing wealth quintile, from 29 percent among currently married women in the lowest wealth quintile to 17 percent among those in the highest wealth quintile. Furthermore, unmet need declines with increasing level of education, from a high of 27 percent among currently married women with no education to 17 percent among women with a secondary or higher education. Unmet need is highest among regions in the Lake Zone, namely Mara, Mwanza, and Geita.[11]

FIGURE 3. Met and Unmet Need for Family Planning among Married Women Ages 15–49, 2005–2015



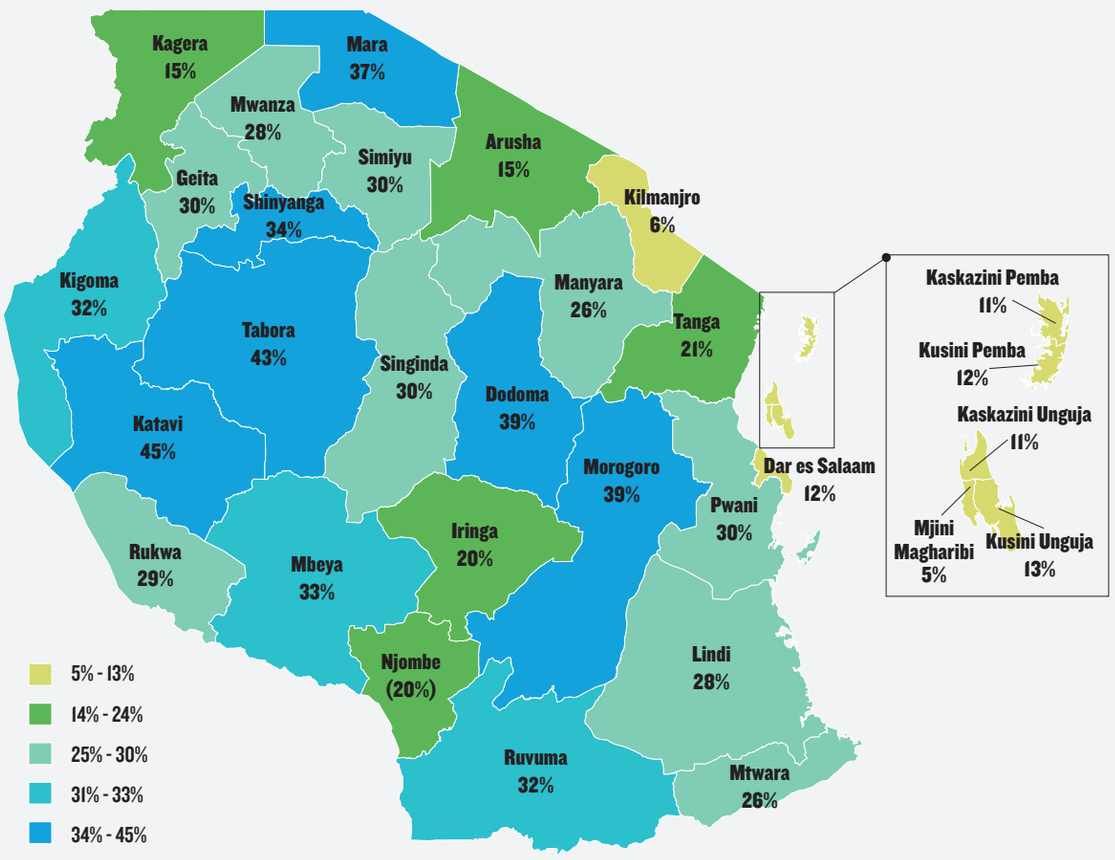
The total demand for contraception in Tanzania is high. Total demand is the combination of met and unmet need (i.e., the total of modern contraceptive users plus the total of those with an unmet need). Currently, approximately six in 10 married women ages 15–49 have a demand for FP: 39 percent want to space births and 22 percent want to limit births, while the remaining 39 percent have no need for FP. As shown in Figure 3, unmet need is higher now than in 2005 (though it has decreased from a peak in 2010), and met need is steadily increasing.

Adolescent Sexual and Reproductive Health

Nationally, pregnancy rates among adolescent women declined slightly between 1999 and 2010, from 26.1 percent to 22.8 percent.[9] This trend was largely driven by a substantial decline in pregnancy rates among urban adolescent women, while pregnancy rates among rural adolescent women remained essentially unchanged during this period.

According to the TDHS, the adolescent pregnancy rate declined from 26 percent in 1999 to 23 percent in 2010 and has subsequently steadily increased to 27 percent in 2015. Rates are 1.7 times higher in rural areas than in urban areas. Furthermore, as might be expected, the percentage of young women who have begun childbearing increases with age: 4 percent of 15-year-olds, 11 percent of 16-year-olds, 23 percent of 17-year-olds, 38 percent of 18-year-olds, and 57 percent of 19-year-olds have begun child-bearing.[11] Further analysis revealed that much of this teenage childbearing happens within marriage; 75 percent of teenagers who have had a child or are currently pregnant are married or cohabitating. There is a high regional disparity in teenage pregnancy rates (Figure 4), especially among adolescents with only a primary level of education.

FIGURE 4. Adolescent Pregnancy Rates by Region, 2010-2015 (from TDHS 2015-2016)



While adolescent pregnancy rates have been increasing, modern contraceptive use among all adolescents declined slightly from 9.4 percent in 2010 to 8.6 percent in 2015. Rates are much lower for married adolescents ages 15–19 than for unmarried sexually active adolescents of the same age (13.3 percent versus 33.1 percent).[9]

According to a national survey on child marriage,[12] almost two out of five girls in Tanzania marry before their 18th birthday, and rates of early marriage are higher in rural and poorer communities than in urban and richer ones. Early marriage accelerates population growth (as women tend to have children earlier), decreases women's educational attainment and labor force earnings, and reduces a country's overall national earnings. Importantly, child marriage can lead to poorer health outcomes for women and children; the literature suggests that the maternal morbidity and mortality rate is higher for adolescent women ages 15–19 than for women ages 20–24 in many countries, though not Tanzania, because of childbirth-related complications.[13] In a landmark decision, the High Court of Tanzania ruled in July 2016 that the Law of Marriages Act be revised to eliminate inequality between the minimum ages of marriage for boys and girls. The former act allowed girls to marry at age 14 with the consent of the court and at age 15 with the consent of their

parents. The amendment set the minimum age for marriage at 18 years for both boys and girls; however, the law has not officially been changed, and much remains to be done at the grassroots level to change community attitudes and practices around early marriage.

In addition to the potential for unplanned pregnancy and early marriage, many adolescent girls and young women in Tanzania experience violence. Among Tanzanian girls ages 15–19, approximately one in five (21.9 percent) had experienced physical violence since age 15, and 11.2 percent reported at least one experience of sexual violence. Among ever-married Tanzania women ages 15–19, one in three have experienced physical or sexual violence in the past 12 months at the hands of a husband or partner.[11]

The DHS measures adolescent pregnancy as the proportion of all women ages 15–19 who have had a live birth or who are currently pregnant. It is important to note that this indicator does not capture the number of adolescent women who have been pregnant but whose pregnancies have ended in miscarriage or abortion. Therefore, the full extent of adolescent pregnancy may be underestimated, given recent estimates of 21 abortions out of every 100 live births among women ages 15–49.[14]

NFPCIP 2019–2023 DEVELOPMENT PROCESS

Situation Analysis

Tanzania began developing its NFPCIP 2019–2023 in mid-2017 with a preparatory phase, namely an end-of-period performance review of the NFPCIP 2010–2015 led by the government and supported by partners. This review aimed to assess the implementation of the NFPCIP 2010–2015, to examine planned targets vis-à-vis outcomes, and to describe the extent to which these achievements may have contributed to national FP goals. More specifically, factors were identified that both facilitated and hindered progress toward achieving FP-related outcomes, actionable recommendations were identified, and considerations were generated to inform the development of the NFPCIP 2019–2023. Results from this assessment were shared at a stakeholders' meeting in Dar es Salaam in May 2017 and provided important background for developing the NFPCIP 2019–2023.

In June 2017, data on key FP indicators, gathered from the national health management information system, were shared with stakeholders at the annual data consensus meeting organised by the Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC). These data, along with data from other key resources such as the DHS (2015–16), the United Nations Population Fund (UNFPA) facility survey (2016), and partner reports, coupled with the results of the NFPCIP 2010–2015 end-of-period performance review, served as the foundation for the NFPCIP 2019–2023 situation analysis.

In July 2017, a technical support team (TST) was established to coordinate the development of the NFPCIP 2019–2023. This small team, headed by the FP Unit of the RCHS of the MOHCDGEC, and with participation from key technical assistance partners, proposed a process for developing the NFPCIP 2019–2023, which was validated by the NFPTWG. Under the direction of the RCHS, strategic advisory groups (SAGs) were established for each of the following result areas, which were also validated by the NFPTWG: enabling environment, demand creation, service

delivery, and commodity security. The service delivery area was further divided into facility, community, and private subareas. Each SAG was co-chaired by an MOHCDGEC representative and an implementing partner representative and was made up of experts from the MOHCDGEC, development partners, and implementing partners who provided critical input throughout the NFPCIP 2019–2023 development process. Additional input was provided by the President's Office Regional Administration and Local Government (PORALG).

Results Formulation

The TST guided the SAGs and Regional Reproductive and Child Health Coordinators through a series of technical consultations that included reviewing the situation analysis and baseline data and conducting a root cause analysis for bottlenecks, as well as articulating a goal and an initial set of intended high-level outcomes. These high-level outcomes were applied to the FP Goals Model—a strategic planning tool that estimates the impact of multiple high-impact practices for FP on the mCPR based on a country's context and global evidence on intervention effectiveness.

The FP Goals Model identified three high-impact practices with the potential to drive national mCPR growth if implemented at scale: increasing use of postpartum FP (PPFP), addressing social norms that hinder FP uptake, and reducing stock outs of contraceptives. The model analysed regional data and thereby indicated which practices should be implemented in which regions to reach the national mCPR goal of 47 percent among married women by 2023. The model also presented data suggesting which practices had likely led to recent gains in mCPR and should, therefore, be maintained during the NFPCIP 2019–2023. Application of the FP Goals Model was a first step in prioritising high-impact practices—a process that continued throughout the rest of the development of the NFPCIP 2019–2023.

Validation meetings, at both the national and regional levels, were held in August and September 2017 to agree on the high-impact practices that the FP Goals Model highlighted and to solicit feedback on whether additional strategic priorities should be added. During regional meetings, district-based stakeholders provided input into the feasibility of implementing activities within the high-impact practices, including specific challenges that they anticipated. The three high-impact practices were agreed upon by all FP stakeholders, with a nearly universal recommendation to also include reaching youth and adolescents with information and services as an important cross-cutting priority.

Outcomes, Outputs, and Activity Planning

After validation of the FP Goals Model, the SAGs met multiple times from October to December 2017 to finalise the CIP outcomes, to identify related outputs, and to plan activities to be implemented within each result area, aligned to the strategic priorities that had been agreed upon. The activity matrices, including detailed subactivities, inputs, and a time line for implementation, were finalised through a series of group and one-on-one consultations with key partners, with oversight by the RCHS. Activities and subactivities were costed using unit costs collected from the Tanzania context. Concurrently, key indicators were prioritised for performance monitoring during the NFPCIP 2019–2023 implementation period. Finally, the RCHS circulated multiple draft versions of the NFPCIP 2019–2023 to key stakeholders and partners before it was finalised.

NFPCIP 2019–2023 RESULTS FRAMEWORK AND STRATEGIC PRIORITIES

The NFPCIP 2019–2023 serves as a road map for FP stakeholders to contribute toward the FP targets contained in One Plan II.

One Plan II Country Vision

The NFPCIP will contribute to the vision of One Plan II: "healthy and well-informed Tanzanians with access to quality RMNCAH services that are affordable, equitable, and sustainable."

NFPCIP 2019–2023 GOAL

The goal of the NFPCIP 2019–2023 is to enable women, youth, and couples in Tanzania to achieve their desired fertility intentions through access to high-quality and respectful services as well as appropriate, evidence-based information. In so doing, Tanzania's mCPR among married women is anticipated to increase from an estimated 36 percent in 2019 to **47 percent** in 2023, and the mCPR among all women will increase from .30 percent in 2019 to **40 percent** in 2023. The goal is the highest level of result for the NFPCIP 2019–2023.

Result Areas

The NFPCIP 2019–2023 will be realised through the implementation of activities aligned to four result areas:

1. Enabling environment
2. Demand creation
3. Service delivery
4. Commodity security

The Results Framework (Figure 5) visualises the causal relationship of outputs to outcomes, leading to the overall goal. Activities will contribute toward specific outputs and outcomes.

Strategic Priorities

The NFPCIP identifies four strategic priorities that should influence how resources are used. The first three strategic priorities were selected for their potential to accelerate growth in the mCPR, as shown by the FP Goals Model (Figure 6). The FP Goals Model identified which high-impact practices should be prioritised at the subnational level based on regional differences and needs (see Annex A for list of strategic priorities per region). By scaling up high-impact practices in the regions with the greatest need, limited resources can be most efficiently utilised to drive impact. While the FP Goals Model did not show that providing comprehensive adolescent and sexual reproductive health services would significantly contribute to growth in the mCPR, stakeholders

felt a strong commitment to address and respect the rights of young people. Furthermore, increasing access to adolescent-friendly contraceptive services is included among Tanzania's FP2020 commitments; therefore, reaching young people ages 10–24 is the fourth strategic priority.

- **STRATEGIC PRIORITY 1: Improve uptake of PPFP** services to ensure healthy birth spacing through a combined effort of improving provision of FP services at the time of delivery and integrating FP services into immunisation and other facility- and community-based RMNCAH services until age 1. This strategic priority links to outputs under two result areas: demand creation (since pregnant and postpartum women must be reached with tailored messages) and service delivery. Due to the high need for and potential high impact of PPFP interventions, activities related to this strategic priority area will be scaled up across all regions.

Within the global FP community, **PPFP is defined as the prevention of unintended pregnancy and closely spaced pregnancies through the first 12 months following childbirth.**[15]

Programming strategies for postpartum family planning, World Health Organization 2013

- **STRATEGIC PRIORITY 2: Address social norms** that hinder individuals from using contraception to delay, space, or limit births through comprehensive community engagement activities in the 18 regions shown to have low demand for FP. This strategic priority includes activities aimed at influencing communal beliefs regarding who should use contraception and when to empower women, youth, and couples to use FP services when they desire. It also involves addressing issues around ideal family size and gender roles.

- **STRATEGIC PRIORITY 3: Reduce stock outs** at districts and facilities to offer clients a full range of contraceptive methods whenever and wherever they are needed, which is particularly important to reduce unmet need. This strategic priority, which is aligned to Tanzania's FP2020 commitments, links to all the outcomes in the commodity security result area; links to an output under the enabling environment result area related to financing; and includes activities related to procurement as well as management and distribution. Activities related to this strategic priority are focused in 14 regions with the highest levels of past stock outs. Continued advocacy for a total market approach (TMA), captured within the commodity security result area, will also help
address stock outs by diversifying procurement and distribution sources.

- **STRATEGIC PRIORITY 4: Reach young people** ages 10–24 in order to increase age-appropriate information about, access to, and use of contraceptives. Given the upward trend in teenage pregnancy and the vast pipeline of future contraceptive users, attention must be paid to equipping young people of various profiles—from very young unmarried adolescents to young married couples and first-time parents—with information and empowering them to seek services when they need them. This strategic priority links to outputs in the enabling environment, demand creation, and service delivery areas and will be applied to all regions.

FIGURE 5. NFPCIP 2019-2023 Results Framework

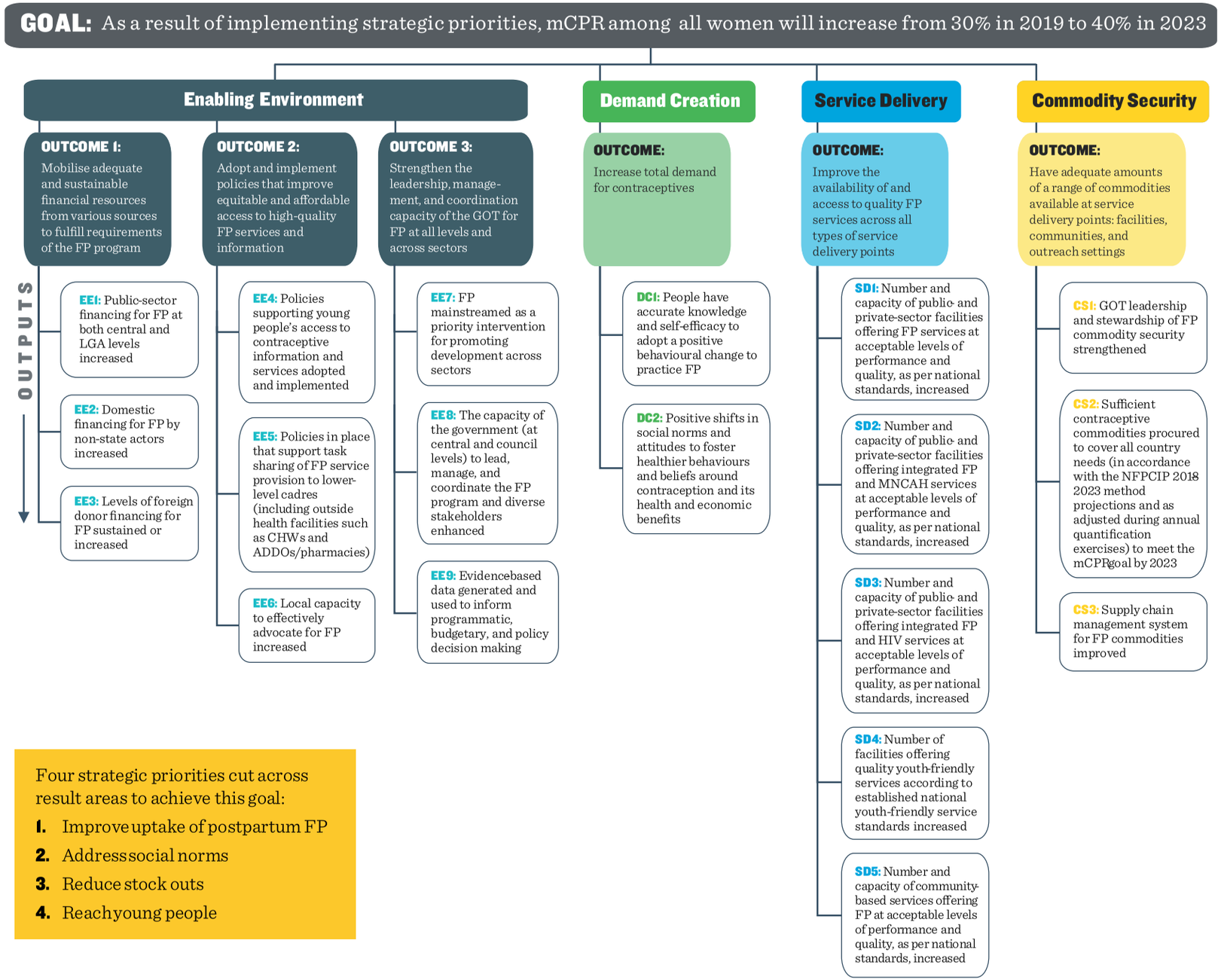


FIGURE 6. Contributions of High-impact Practices to Growth in mCPR, from the FP Goals Model

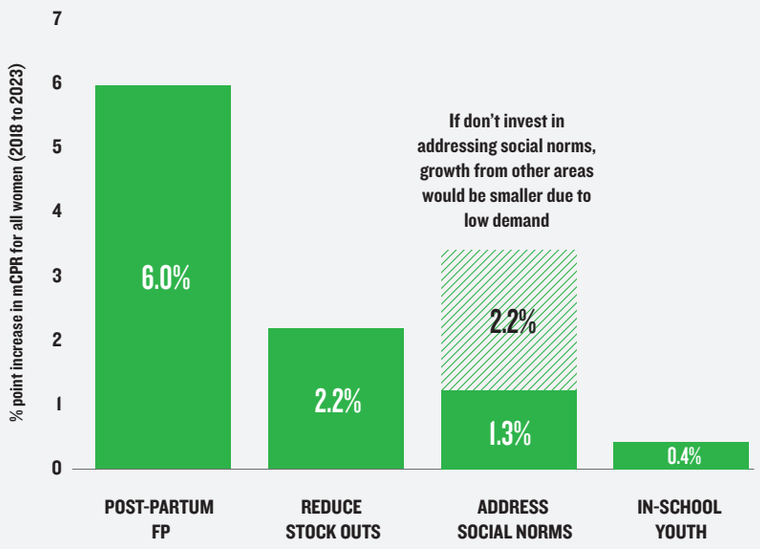


FIGURE 7. Considerations for Identifying Strategic Priorities for the NFPCIP 2019-2023

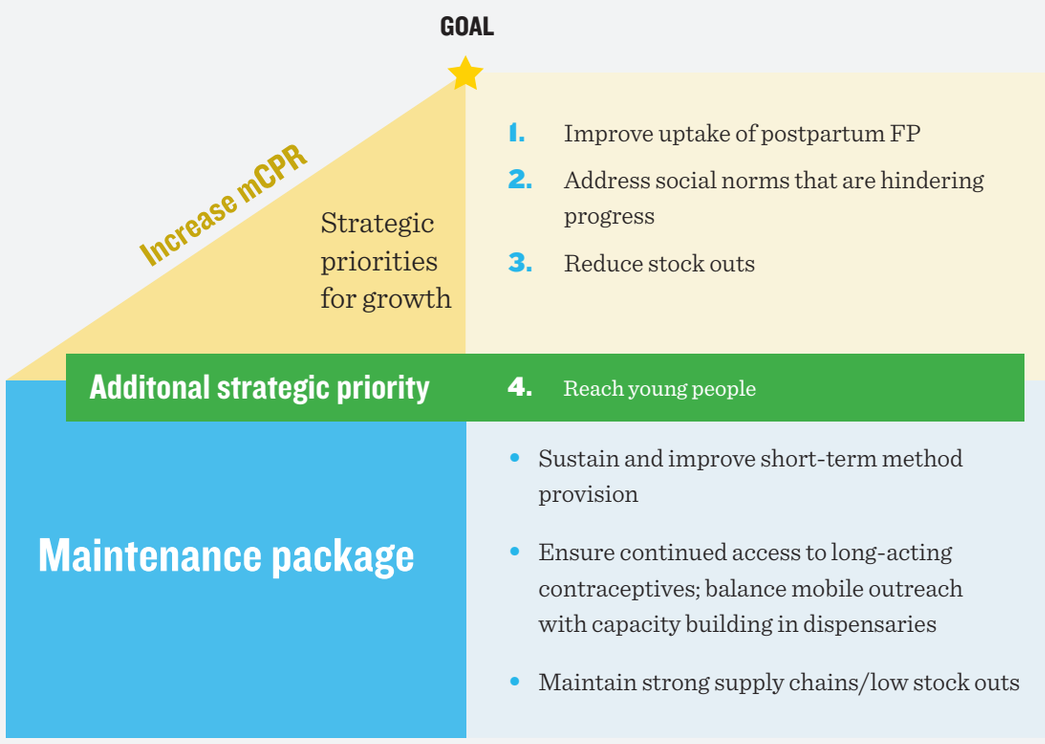
Strategic Priority	Impact on mCPR	FP2020 Commitment or Action Plan	Rights	Equity	Quality
Improve uptake of PPFP	✓		✓	✓	✓
Address social norms	✓	✓	✓	✓	
Reduce stock outs	✓	✓	✓	✓	✓
Reach young people (information and services)		✓	✓	✓	✓

Maintenance Package

In addition to activities that link to strategic priorities, other activities within the NFPCIP 2019–2023 will help maintain quality services and information and therefore make up a 'maintenance package.' This includes supporting critical components of a functioning quality FP program, such as adequate numbers of trained providers, effective supervision systems, and strong supply chains. The maintenance package also aims to further bolster effective practices already in the system and to introduce opportunities for efficient use of resources. In the context of the NFPCIP 2019–2023,

this includes strategies such as ensuring that providers at all levels of the health system are trained to provide a range of methods,* shifting from mobile outreach strategies to building the capacity of providers in dispensaries to offer long-acting reversible contraception (LARC) and strengthening the community health worker platform to bring information and methods closer to clients. Figure 8 represents how the maintenance package and strategic priorities work together to achieve the NFPCIP 2019–2023 mCPR goal. Annex 1 provides information generated by the FP Goals Model identifying which strategic priorities will be implemented across the regions.

FIGURE 8. How Strategic Priorities and a Maintenance Package Collectively Contribute to the NFPCIP 2019–2023 mCPR Goal



As per the Results Framework, the mCPR goal will be achieved by implementing activities that lead to outputs and subsequently outcomes spread across the four result areas. The outcomes will be measured by specific performance targets, listed in Table 1. More information is available under the Performance Monitoring section of this document and will be articulated in the performance monitoring plan.

It is important to note that current projections estimate that the mCPR in Tanzania will grow 1 percent per year (1.1 for married women, 0.9 for all women) based on current trends,[16] but the NFPCIP 2019–2023 requires an annual growth rate of 2 percent to achieve the national goal. Therefore, efforts at accelerating growth are required, and they have been prioritised within this document.

* Two of the three commitments made by the GOT to FP2020 are directly linked to the four strategic priorities. The third commitment—related to expanding access to methods at primary and secondary levels of the health system—is reflected as part of the maintenance package, in that this requires strengthening and improving routine service delivery.

Result Area	Outcome Performance Indicator	Baseline	Target
Enabling Environment			
OUTCOME 1: Adequate and sustainable financial resources mobilized from various sources to fulfil requirements of the family planning programme	Percentage of the annual CIP budget funded by all sources	47% *(Source: NFPCIP 1 end-of-term evaluation)*	>80%
	Percentage of the annual supply plan for contraceptive commodities funded by all sources	78.7% *(Source: RCHS Supply Plan, 2019)*	100%
	Percentage of the annual supply plan for contraceptive commodities funded **(based on disbursements)** by the government	10.5% *(Source: AFP Budget Analysis Report, 2016/2017)*	36%†
OUTCOME 2: Policies that improve equitable and affordable access to high-quality FP services and information adopted and put into place	Examples of cases where policies or directives that support improvements in access and use of FP services are created or implemented.	Some progress in conducive policy, including expansion of method range (Jadelle and ECs), and clear guidelines on adolescent use of methods. Evidence generated to inform policy decisions (e.g. task shifting and private sector engagement), however policies remain unchanged *(Source: NFPCIP 1 end-of-term evaluation)*	Conducive evidence-based policies or directives are enacted to support improvements in accessibility and use of FP services. For example, policies related to task shifting, total market approaches etc.
	National Composite Index on Family Planning (NCIFP)	58 *(Source: Track 20. The National Composite Index for Family Planning (NCIFP) Tanzania 2014 Results, unweighted)*	65

† GoT committed to contribute 17bn by 2020 for contraceptive commodities. Based on the CIP, the cost for commodities in YR 3 (~2020) is TZS 46.9 billion, which therefore a TZS 17bn contribution would be 36%.

Result Area	Outcome Performance Indicator	Baseline	Target
Enabling Environment			
OUTCOME 3: Strengthened leadership, management, and coordination capacity of the GOT at the central and decentralized levels	Demonstrated evidence of enhanced leadership and management capacity over the FP program. For example, annual joint operational plans, consistency in the occurrence of stakeholder coordination meetings, regular use of routine data from DHIS-2 (and other systems) for decision-making, resource mobilization etc.	CIP Execution Cumulative Score = 2.5 *(Source: CIP Execution Checklist, November 2017)* Improvements in collaboration and coordination of implementing partners was observed but appear unstructured to support optimal collective impact. Improvements in data visibility but data use and more regular review of routine data is weak.	CIP Execution Cumulative Score > 2.5. The government adopts and leads a partnership framework that supports a structured collaborative process to facilitate greater collective impact. Improved use of data for decision-making. Regular and consistent review of routine FP data.
Demand Creation			
OUTCOME: Increased Total demand for Contraceptives	Demand for Family Planning (CPR + unmet need)	60.5% total demand married women *(Source: 2015 DHS)* 49% total demand (all women) *(Source: 2015 DHS)*	76% for married women 62% for all women
Service Delivery			
OUTCOME: Improved availability of and access to quality family planning services across all types of service delivery points	Percentage of demand satisfied by modern methods among all women (DHS) (disaggregated by age)	52.9% married women 55% all women *(Source: 2015/16 DHS)*	62% demand satisfied with a modern method for married women 64% demand satisfied by a modern method among all women
	Proportion of women using modern contraceptives at 6 months post-partum.	19% *(Source: 2015/16 DHS)*	55%

Result Area	Outcome Performance Indicator	Baseline	Target
Commodity Security			
OUTCOME: Adequate amounts of a range of commodities available at service delivery points (SDPs) —facility, community, & outreach.	In-Stock rate: Percentage of primary level service delivery points that with at least three modern contraceptive methods on the day of the assessment. (Disaggregated by region)	National: 63.5% *(Source: UNFPA Annual Survey 2016/7)*	Reduce stock outs by 70% in priority regions and 40% in all other Regions
	In-Stock rate: Percentage of secondary/tertiary service delivery points with at least five modern contraceptive methods on the day of the assessment. (Disaggregated by region)	National: 34% *(Source: UNFPA Annual Survey 2016/7)*	

PLAN ALIGNMENT WITH NATIONAL POLICIES AND STRATEGIC PLANS

The NFPCIP 2019–2023 is aligned with other broader and multisectoral national policies and strategies and aims to operationalise their guidance. This alignment should ensure broader support and help to mobilise additional resources from beyond the FP community. Table 2 includes examples of such policies and strategies.

TABLE 2. NFPCIP 2019–2023 Alignment with Other Policies and Strategic Plans

Policy/Strategy Document	Description
The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child, and Adolescent Health in Tanzania (2016–2020)	This strategy aims to increase the mCPR from 27% to 45% by 2020.
National Five-year Development Plan 2016/17–2020/21	This document recognises the unchanging risks of high birth rates in national economic development. It mentions that the relatively high total fertility rate is due, in part, to low usage of modern FP methods.
Tanzania Development Vision 2025	Vision 2025 recognises the reduction in maternal mortality rate and its contribution to a high-quality livelihood for all Tanzanians. The vision's target is to reduce the infant and maternal mortality rates by three-quarters of current levels. Given FP's contribution to reducing infant and maternal mortality, the NFPCIP can contribute toward this vision.
The National Healthy Policy	This policy states that the government will collaborate with the nonprofit sector, the private sector, and international organisations and will continue to provide services to pregnant women, FP clients, and children under 5.
Health Sector Strategic Plan IV (2015–2020)	This plan mentions RMNCAH services as a key area, with a target of achieving a 20% reduction in maternal and neonatal mortality rates in five identified priority regions by 2017–18. It states that the use of modern FP methods will continue to receive high priority, to delay the age of first pregnancy, to space birth, and to limit the number of children to be born, per women's choices. It looks to increase the CPR for married women ages 15–49 from 27.4% to 60% in 2020 and to reduce the adolescent fertility rate for those under 20 from 11.6% to less than 10% in 2020.
National Management Guidelines for Health Sector Response to and Prevention of Gender-based Violence	This guideline notes the links between sexual violence and unintended pregnancy and the importance of the provision of contraception, including emergency contraception, to survivors of gender-based violence.
National Strategy for Growth and Reduction of Poverty 2.0	This strategy states that given the strains placed on available resources by high rates of population growth, effective measures are deployed to promote access to education on reproductive health and an appropriate mix of FP methods.

PROJECTED HEALTH IMPACT OF THE NFPCIP 2019–2023

Table 3 shows that if the mCPR and method mix goals of the NFPCIP 2019–2023 are reached, then Tanzania is expected to avert:[18‡]

- More than 7.1 million unintended pregnancies.
- Nearly 2.8 million abortions, including approximately 2.7 million unsafe abortions.
- More than 22,000 maternal deaths, which is approximately 3,442 more than if the current mCPR and method mix remain constant. These additional deaths to be averted represent approximately 9 percent of expected maternal deaths in this period.
- Almost 11.4 million disability-adjusted life years.
- Approximately TZS 762 billion (US$346 million) in maternal and infant health care costs, since unintended pregnancies carry associated health care costs, including the costs of antenatal and delivery services, postpartum care for the mother, and routine health care for the infant (assuming that all women receive full care for pregnancy, birth, and any adverse outcomes).
    - This is an additional TZS 118.35 billion (US$53.8 million) in health care costs averted compared with the health care costs averted under the current use of FP.
    - By way of comparison, total health expenditures from all sources for child health in 2014–15 equaled TZS 914.27 billion and for reproductive health equaled TZS 484.38 billion.[19§] The expected maternal and infant health care savings per year are an average of 11 percent of the total health care expenditures for child and reproductive health for the 2014–15 year.

TABLE 3. Impact of Reaching the mCPR and Method Mix Goals of the NFPCIP 2019–2023

	Baseline	Year 1	Year 2	Year 3	Year 4	Total
Demographic Impacts						
Unintended pregnancies averted	1,125,906	1,268,231	1,420,032	1,581,551	1,753,027	**7,148,748**
Abortions averted	439,103	494,610	553,813	616,805	683,681	**2,788,012**
Health Impacts						
Unsafe abortions averted	420,460	473,610	530,299	590,617	654,653	**2,669,638**
Maternal deaths averted	3,491	3,932	4,403	4,903	5,435	**22,164**
Economic Impacts						
Maternal and infant healthcare costs averted	120,013,301,235 TZS	135,184,053,698 TZS	151,364,961,887 TZS	168,581,656,561 TZS	186,859,768,475 TZS	**762,003,741,856 TZS**

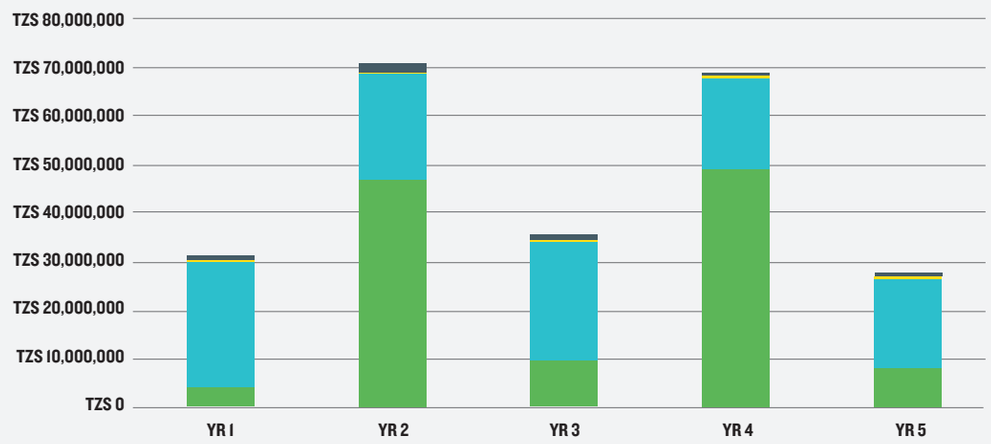
‡ Through the Advance Family Planning project (in collaboration with the MOHCDGEC), Palladium, Johns Hopkins Center for Communication Programs, and partners applied the ImpactNow model in Tanzania.

§ Of note, 44% of this child health spending and 41% of this reproductive health spending was spent by the government.

COST SUMMARY

The total cost of implementing the NFPCIP 2019-2023 for the five-year period is 470,359,184,947 TZS. Figure 9 shows the estimated costs per result area for each year of the NFPCIP 2019–2023. **

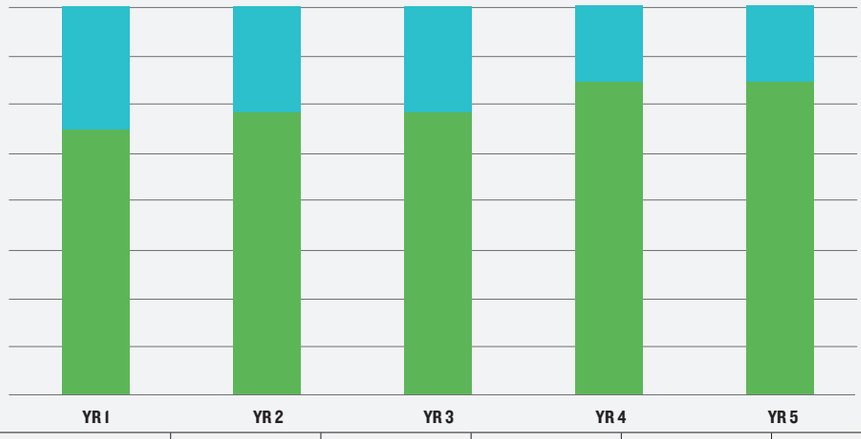
FIGURE 9. Costs by Result Area (TZS)



	YR1	YR 2	YR 3	YR 4	YR 5
Enabling Environment	1,031,960,000	1,626,060,000	1,012,214,150	697,125,146	765,037,479
Commodity Security (activities only)	400,690,000	356,853,750	366,993,819	322,754,889	332,589,862
Service Delivery	25,628,982,159	21,973,872144	24,407,366,088	18,684,658,004	18,613,555,228
Demand Creation	4,372,731,440	46,921,395,726	9,801,597,325	49,272,905,951	8,048,276,671

The majority of the costs to be incurred as part of commodity security are related to the purchase of commodities and consummables. Figure 9 shows only the cost of implementing the CS activities. Figure 10 illustrates the annual costs for CS activities and for commodities and consummables.

FIGURE 10. CS Cost By Activities and Commodities/Consumables



	YR1	YR 2	YR 3	YR 4	YR 5
Commodity Security (Activities)	403,090,000	356,853,750	366,993,819	322,754,889	332,589,862
Commodity Security (Commodities and Consumables)	37,859,311,070	42,260,581,827	46,910,837,249	51,782,085,746	56,902,349,164

** Costs for the NFPCIP 2019-2023 were identified using the methodology outlined in the CIP Costing Tool (http://www.healthpolicyplus.com/pubs.cfm?get=2101-3212). Unit costs for commodities and consumables were identified based on similar methodology used in 'Adding It Up: Investing in Contraception and Maternal and Newborn Health, 2017' (https://www.guttmacher.org/sites/default/files/report_pdf/adding-it-up-2017-estimation-methodology.pdf). Unit costs were abstracted from the UNFPA Reproductive Health Interchange database (https://www.unfpaprocurement.org/about-thedata). The unit cost data in the UNFPA database include the total landed cost for the commodity (unit price, shipping, insurance, any related test, fees, etc.).

METHOD MIX AND COMMODITY PROJECTIONS

Figure 10 shows the modern method mix and total number of users for each year of the NFPCIP 2019–2023.

FIGURE 11. Method Mix and Total Contraceptive Users

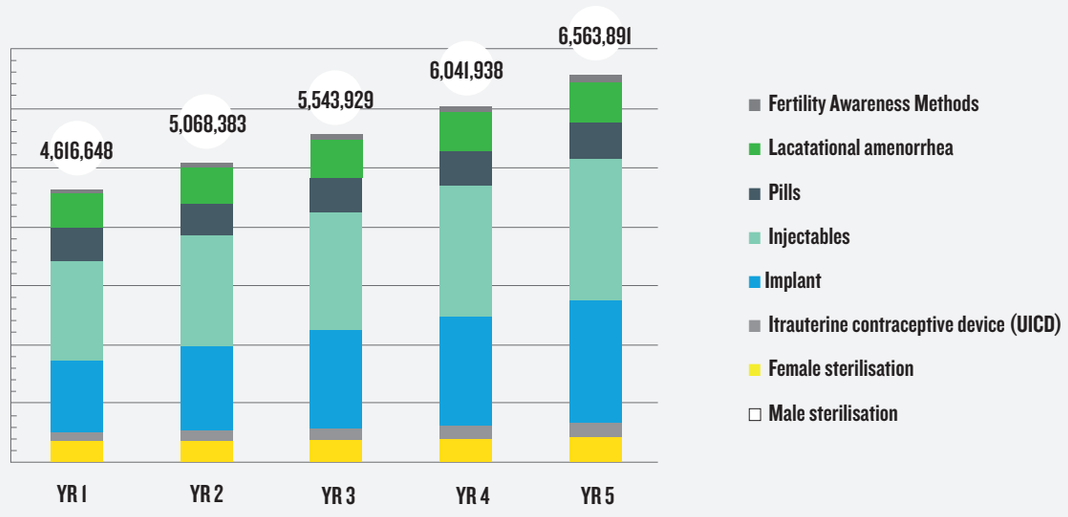


Figure 11 shows the total modern method mix, summed to 100 percent, for all women for each year of the NFPCIP 2019–2023.

FIGURE 12. Total Modern Method Mix, All Women

METHOD	YR 1	YR 2	YR 3	YR 4	YR 5
Male sterilisation	0.2%	0.2%	0.2%	0.2%	0.2%
Female sterilisation	7.6%	7.2%	6.8%	6.4%	6.1%
Intrauterine contraceptive devices	3.0%	3.1%	3.2%	3.3%	3.4%
Implants	26.6%	28.2%	29.6%	30.9%	32.1%
Injectables	36.5%	36.5%	36.5%	36.5%	36.5%
Pills	12.2%	11.4%	10.7%	10.1%	9.5%
Male condoms	11.7%	11.0%	10.4%	9.9%	9.4%
Female condoms	0.1%	0.1%	0.1%	0.0%	0.0%
Emergency Contraception	0.1%	0.1%	0.1%	0.1%	0.00%
Lactational Amenorrhea Method	1.0%	0.9%	0.9%	0.8%	0.8%
Fertility Awareness Methods	1.0%	1.3%	1.5%	1.8%	2.0%

IMPLEMENTATION FRAMEWORK

Each result area will be achieved by implementing activities at the national and regional levels that align to the strategic priorities and address problems identified during the situation analysis. Annex 2 associates activities within each result area with the different strategic priorities, while Annex 3 is a detailed listing of activities and subactivities to be implemented with specific targets, inputs, timing, and cost information included.

Main Gaps in Enabling Environment (from situation analysis)

- Decrease in GOT financing over the years
- Lack of diversified funding mechanisms (e.g., Global Financing Facility and health insurance schemes)
- FP not considered a multisectoral issue
- Task shifting FP not allowed by health policy

Enabling Environment

Creating a conducive environment for the national FP program to succeed is essential for Tanzania to realise its commitments made for FP2020, as well as to achieve larger health and development goals. An enabling environment for a countrywide FP program requires a minimum of three characteristics: 1) adequate financial resources; 2) supportive policies; and 3) good governance, management, and accountability.

Tanzania had a successful FP program during the 1990s, but the program started losing its momentum starting in 2000. A few documented factors that contributed to this slowed momentum were decentralisation and integration of health programs, donor shifting of FP funding from targeted geographic programs to basket funding, and multiple competing priorities (e.g., HIV, malaria, infant mortality).[20] Efforts to reposition FP in Tanzania started after 2002 with the goals of ensuring that FP remained a development priority and increasing political and financial commitment to the national FP program. A programmatic situational analysis conducted for the NFPCIP 2010–2015 end-of-period performance review and in preparation for this NFPCIP indicated gains made as well as remaining challenges across the three subcomponents of the enabling environment. This informed the identification of the three outcomes in this result area: increased financing from both domestic and external sources (Outcome EE1); improved policies to increase access to and widen coverage of FP services sustained (Outcome EE2); and stronger leadership, governance, coordination, and accountability at all levels and across sectors (Outcome EE3). Given the supportive role that an enabling environment plays in achieving an effective and efficient FP program, **the set of activities outlined in this result area support all of the NFPCIP 2019–2023 strategic priorities.**

FINANCING: During the NFPCIP 2010–2015, advocacy efforts resulted in several 'wins,' including a government budget line item for contraceptive commodities, increased FP allocations from the government (though fluctuations were experienced in the amount of funding released), and an increasing number of districts or councils allocating funds for FP in their CCHPs. In addition, international donor funding increased, and in 2016, one of the private health insurance companies, AAR, integrated FP services into its insurance benefit package. **Outcome EE1** builds upon these gains to further increase domestic financing, in line with FP2020 commitments, and to expand private funding.

POLICY/LEGAL: The GOT recognises the contribution of RMNCAH, including FP, to national development and has included improving maternal and child health services in several policies and strategies, such as One Plan II, the National Strategy for Growth and Reduction of Poverty II, and the National Five-year Development Plan 2016/17–2020/21. Further, Tanzania has made global commitments supportive of FP via FP2020 to increase the availability of modern contraceptive methods at all levels of the health system. Despite the strong commitments, operationalising these policies and guidelines and involving other ministries has proven challenging. Activities within **Outcome EE2** focus on strengthening policies in support of strategic priority 4—related to comprehensive sexuality education and in-school health programs—as well as cross-cutting aspects of the maintenance package, such as strengthening the community health program via task sharing.

GOVERNANCE/MANAGEMENT/COORDINATION/ACCOUNTABILITY: Tanzania has benefited from dedicated leaders who are supportive of FP and committed staff throughout the government. However, frequent leadership changes at all levels of the government can shift priorities from sustained support of FP. Furthermore, there has been limited engagement of government actors outside of the MOHCDGEC, in which the RCHS faces human resource limitations, and staff managing FP activities are often overburdened. Collectively, these factors can challenge strong leadership and coordination of the FP program within and across sectors. Activities within **Outcome EE3** focus on positioning FP as a multisectoral endeavor and building the capacity of the MOHCDGEC to guide and coordinate application of the NFPCIP 2019–2023 using data to inform decision making.

OUTCOME 1: Mobilise adequate and sustainable financial resources from various sources to fulfill requirements of the FP program

OUTPUT EE1: Public-sector financing for FP at both central and local government authority levels increased

The activities under this outcome will focus on supporting coordinated and sustained advocacy efforts to ensure that financial resources from government sources—both central and local government authority levels—are adequately and consistently mobilised, and that timely disbursements are made to implement annual activities in the national FP program. Historical budget analyses will be conducted, synthesised, and distributed to different government entities at both the central level (e.g., the Policy and Planning Unit of the MOHCDGEC, PORALG, Ministry of Finance) and the regional level (e.g., via zonal reproductive and child health coordinators, reproductive health management teams, district health management teams) to stimulate dialogue and support advocacy efforts to increase budgeting for FP, particularly for contraceptive commodities. Current and new innovative funding mechanisms implemented in Tanzania, such as Global Financing Facility and the National Health Insurance Fund, will be explored as additional means to finance components of the FP program. Leveraging advocacy aimed at adopting and implementing a TMA, efforts will include providers within the National Health Insurance Fund scheme.

OUTPUT EE2: Domestic financing for FP by non-state actors increased

Tanzania has registered a considerable number of private health insurance companies to cater to the health needs of its growing and economically diverse population. Despite this proliferation of health insurance companies, the coverage for FP is either low or nonexistent. The NFPCIP 2019–2023 recognises this as an opportunity. This outcome will focus on mobilising and engaging

private health insurance companies to provide coverage for FP services as part of their health insurance package. This will include making the business case to private health insurance companies, building on efforts begun under the NFPCIP 2010–2015, and hopefully using the National Health Insurance Fund as an incentive and example. Meetings will be held with technical and management staff in private health insurance companies to present the business case and to include private enterprises that purchase insurance policies and can advocate for the inclusion of FP in those policies. If successful, this initiative may increase the number of users covered by private insurance who receive FP services under their plans. However, many FP users currently source products and services in the private sector without using insurance, suggesting that expanded access to FP products and services through private clinics and commercial outlets would be a very effective way to leverage non-state financing for FP in Tanzania (see Service Delivery thematic area).

OUTPUT EE3: Levels of foreign donor financing for FP sustained or increased

To complement efforts to mobilise adequate resources from the government and the private sector, current and potential development partners and other external supporters will be continuously engaged to sustain or increase their levels of FP financing for the planned NFPCIP 2019–2023 activities. To achieve this, efforts will focus on including FP as part of the agenda in the reproductive and child health development partners meetings, including annual RCHS meetings, and on facilitating participation of current and potential FP development partners in the annual platforms of civil society organisations (CSOs) to learn about FP needs that require sustained support.

OUTCOME 2: Adopt and implement policies that improve equitable and affordable access to high-quality FP services and information

OUTPUT EE4: Policies supporting young people's access to contraceptive information and services adopted and implemented

One of the strategic priorities of the NFPCIP 2019–2023 is increasing age-appropriate information about, access to, and use of contraceptives among adolescents and youth ages 10–24. This priority is, in part, dependent on another strategic priority focused on addressing social norms that hinder individuals from using contraception to space or limit births. Both of these strategic priorities require action to improve the enabling environment. To address the staggering teen pregnancy rate of 27 percent, Tanzania aims to improve and adopt policies that facilitate adolescent and youth access to contraceptive information and services. Stakeholders identified two opportunities to reach in-school youth: 1) reviewing and rolling out an evidence-based national comprehensive sexual education curriculum to ensure that the content on contraception is strong and evidence-based and 2) revising the National School Health Programme guidelines and strategy to include FP information. Additionally, efforts will be undertaken to engage diverse stakeholders from across sectors to review evidence and best practices for reducing teenage pregnancy, obtain sector-specific commitments on key priority actions for reducing teenage pregnancy, and monitor progress from sectoral efforts through semi-annual meetings. These activities will also focus on out-of-school youth as well as strategies to delay first pregnancy and encourage birth spacing among young married adolescents. These interventions will be aligned with the broader context of the National Adolescent Health and Development Strategy 2019–2022, which places positive health outcomes for youth and adolescents as one of the key factors for realising the demographic dividend agenda in Tanzania.

OUTPUT EE5: Policies in place that support task sharing of FP service provision to lower-level cadres (including outside health facilities such as community health workers [CHWs] and accredited drug dispensing outlets [ADDOs]/pharmacies)

Sharing and shifting tasks from higher-level to lower-level cadres of workers is recognized globally to optimise the health system, given a critical shortage of skilled health workers.[21] To improve the FP service delivery capacity in this constrained human resource setting, planned interventions under this outcome will be implemented as per the recent Policy Guide on Task Sharing (2015), which allows various health cadres including CHWs and ADDO shopkeepers to promote and provide FP services at the primary level of the health system, relieving the burden at higher levels of health care facilities. There is already an established FP task-sharing task force that continues to share proven evidence-based practices gathered from both within and outside the country. This evidence will help provide policy advice to the MOHCDGEC and other key decision makers to allow implementation of additional task-shifting options outside of the health facility. The FP Goals Model has illustrated that the contribution of CHWs to the FP program is currently limited by the narrow range of methods they are permitted to provide, but that they could contribute more with an expanded method mix, if included in the national policy task-sharing guidance.

OUTPUT EE6: Local capacity to effectively advocate for FP increased

Interventions under this outcome focus on ensuring that there is sustained and coordinated advocacy efforts for supporting the national FP program, recognising that both civil society and other sectors beyond health can play an important role in advocating for supportive FP policies. Building on recent efforts undertaken in the country, technical support will be given to CSOs to build their capacity to effectively advocate for implementation of the strategic priorities of the NFPCIP 2019–2023, to support additional resources for the national FP program, and to hold the government accountable to its FP commitments. Specific activities include identifying well-positioned CSOs, training them in advocacy techniques, supporting their own resource mobilisation and advocacy plans, and facilitating knowledge exchanges. In addition, evidence-based advocacy packages with targeted messages for different audiences, such as the contribution of FP in the demographic dividend agenda in Tanzania or analyses of budgets, expenditures, and savings, will be developed and disseminated to identified champions for use in their advocacy work at various sectors and levels. Again, this will help bolster other activities within this result area and across other result areas of the NFPCIP 2019–2023.

OUTCOME 3: Strengthen the leadership, management, and coordination capacity of the GOT for FP at all levels and across sectors

OUTPUT EE7: FP mainstreamed as a priority intervention for promoting development across sectors

Tanzania aims to engage diverse sectors, such as education, agriculture, environment, and health and youth, to promote and position FP as a cost-effective development intervention to drive national economic growth. As such, efforts will be made to operationalise FP within the current five-year development plan by updating indicators in annual development plans and budgets. Efforts will also be made to conduct advocacy so that those indicators are also included in the Five-year Development Plan 2021–2026 and eventually tracked as part of five-year development plan monitoring. A coalition of potential FP champions will be established among high-level government officials from diverse ministries, and the coalition will be supported to advocate

for ministerial department agencies to prioritise and raise the visibility of FP interventions within their sectoral plans. These advocacy efforts will be aligned with ongoing work by various stakeholders promoting the potential of the demographic dividend, and will be supported through advocacy materials developed under output EE6. Efforts will be made to operationalise FP interventions through annual development plans of relevant ministerial sectors, which will subsequently be tracked, and progress will be shared and discussed through a multisectoral platform. This platform will convene once a year as a dedicated session of the semi-annual FP implementers meeting and will help support output EE4, specifically, and the strategic priority focused on increasing access to and use of FP information and services among adolescents and youth, more broadly. Efforts will also be made to orient mass media outlets to the evidence of FP's contribution to social and economic development so that they can include better coverage of the topic in their media programs targeting various audiences, thereby also contributing to the strategic priority focused on shifting social norms in support of FP.

OUTPUT EE8: The capacity of the government (at central and council levels) to lead, manage, and coordinate the FP program and diverse stakeholders enhanced

Strong leadership and management are essential for executing a high-quality FP program. Activities under this outcome will focus on identifying gaps and weaknesses in the current managerial and coordination capacity of the FP program at all levels, and establishing standardised approaches for improving FP program management and coordination at the national and subnational levels. Sustained efforts will be dedicated to strengthening the monthly NFPTWG meetings and continuing semi-annual FP meetings to allow FP stakeholders to collectively monitor and improve implementation of the NFPCIP 2019–2023.

OUTPUT EE9: Evidence-based data generated and used to inform programmatic, budgetary, and policy decision making

Interventions will focus on addressing current challenges related to the availability of quality FP data in the DHIS and the health management information system, known locally as *mfumo wa taarifa za uendeshaji wa huduma za afya* (MTUHA). Improvements in those systems will include capturing PPFP and postabortion data and building the capacity of council health data teams to enter, access, and analyse FP data for broader programmatic decision making. Central MOHCDGEC staff will also receive training in these areas.

Demand Creation

In Tanzania, though knowledge of contraceptive methods is almost universal,[11] data show that social norms and beliefs as well as myths and misconceptions around FP hinder use of contraceptive methods.[22,23] Additionally, a desire for large families persists, as the mean ideal number of children hovers around five (i.e., 4.7 for women and 5.1 for men).[11] Other contributors to low demand include experienced or perceived method-related side effects, cultural and religious ties that serve as barriers (e.g., a persistent attitude that contraception and sex are taboo topics that should not be discussed openly), and partner opposition to FP use.[22,24]

During the NFPCIP 2010–2015, two SBCC campaigns rolled out: Jiamini and the relaunch of the Green Star Campaign, which emphasised FP, empowered women to initiate and continue use of modern FP methods, and encouraged male support of FP. However, since those two campaigns ended, the country has not developed a new national SBCC strategy to guide demand-creation activities. Furthermore, despite the wide reach of past communications campaigns, demand-

generation interventions were not segmented to address the needs of various audiences (e.g., youth, male, female, urban, rural, educated, uneducated) at various points in the life cycle (e.g., unmarried, married with no children, postpartum).

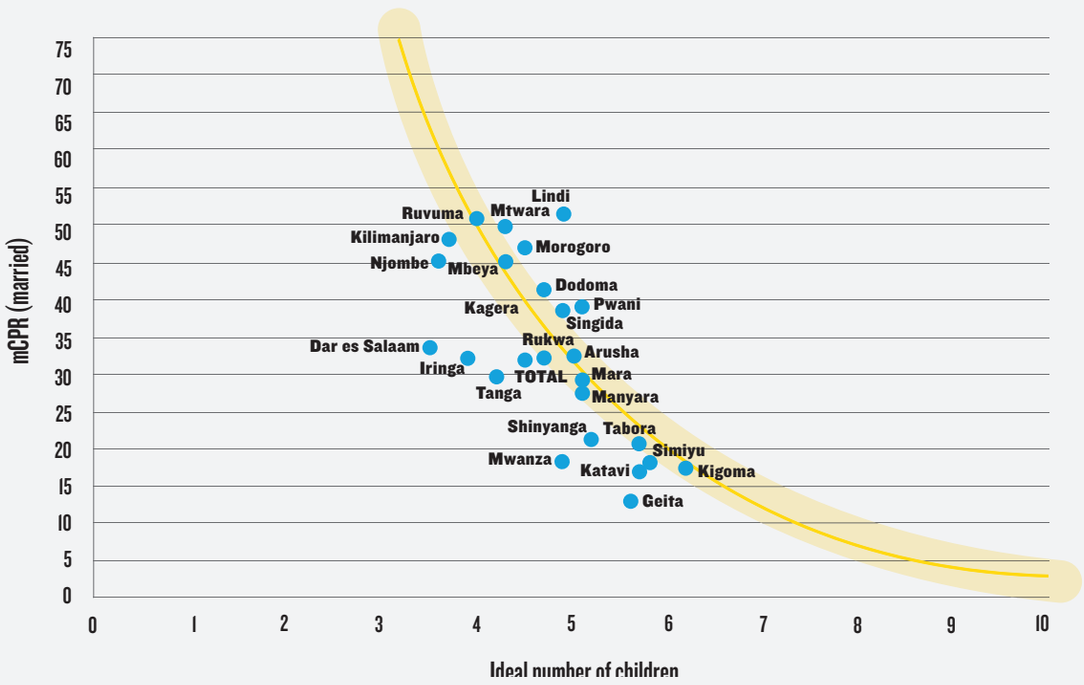
Main Gaps in Demand Creation (from situation analysis)

- Absence of national FP social and behavioural change communication (SBCC) strategy
- SBCC efforts not targeted in terms of gender, age, life cycle, or geographical location
- Insufficient use of commercial marketing approaches
- Low levels of community involvement to support SBCC

The FP Goals Model identified regions in which demand-creation activities, specifically those focused on shifting social norms toward support of FP use, would have maximum impact on growth in the mCPR. Analyses using the actual mCPR and mean ideal number of children help to project maximum potential mCPR if current sociocultural factors, such as norms and beliefs around fertility, remain the same. This is called the maximum prevalence demand curve (Figure 12).[25] The gap between the curve and where a region sits in relation to the curve is called the 'potential use gap.' In regions where the gap is small or modest, future mCPR growth may be limited without further changes in demand; there is likely a need to prioritise interventions that address underlying social norms. In regions where the gap is large, there is likely room for further mCPR growth from investments to improve and expand FP service delivery. This exercise identified 18 regions that would benefit the most from demand-creation activities focused on shifting social norms.

Activities within this result area aim to achieve one outcome-level result—increased total demand for contraceptives—via two outputs: one focused on increased FP knowledge and self-efficacy of individuals to effect positive behaviour change in support of FP use (Output DC1) and one focused on achieving a shift in norms held within communities that are supportive of FP use (Output DC2). Demand-creation strategies will be tailored for different audiences according to age, marital status, sex, geographic area, and other characteristics to ensure that the priority audience groups are reached, with specific attention paid to postpartum women (and influencers such as men, partners, and mothers-in-law) and young people, in support of strategic priorities. Activities within this result area will be informed and supported by those in other strategic areas, to strengthen quality and avoid duplication of efforts.

FIGURE 13. Tanzania Maximum Prevalence Demand Curve by Region



OUTCOME: Increase total demand for contraceptives

OUTPUT DC1: People have accurate knowledge and self-efficacy to adopt a positive behavioural change to practice FP

The NFPCIP 2019–2023 acknowledges the need for tailored communication materials and varied communication channels to reach individuals with FP information. Activities include adapting and harmonising existing SBCC materials or developing and testing new materials (as needed, based on gaps identified by the FP SBCC stakeholders). These materials may include flyers, posters, and booklets to reach the different target audiences, particularly postpartum women and youth, with appropriate information. The messages will focus on providing accurate and relevant information about FP methods, promoting the availability of FP services, and promoting the importance of healthy timing and spacing of births. They will also ensure that communities are aware of their rights related to accessing FP services and selecting the methods most appropriate for them. Cost efficiencies will be sought when disseminating materials to the 18 priority regions, leveraging planned meetings, trainings, and events to get materials out into communities. A similar approach will be followed to develop tailored messages to diffuse via local and national radio and television and through existing and new digital health platforms such as m4RH. Activities to raise awareness and knowledge will also target different service delivery points with many postpartum women, such as labor wards and immunisation clinics.

The NFPCIP 2019–2023 also recognises that CHWs offer an important platform for reaching individuals with information that can lead to positive behaviour change. Although CHWs cannot offer many FP methods, they can offer general FP and method-specific information to clients as trusted members of the community, thus complementing what current and potential clients may receive through print, mass, and digital media. Therefore, activities under this outcome will focus on equipping CHWs with enhanced and improved knowledge and skills related to offering FP information, making referrals (including to private for-profit facilities, nonprofit facilities, pharmacies, and ADDOs in addition to public facilities), mobilising clients for outreach activities, and supporting and tracking FP users.

OUTPUT DC2: Positive shifts in social norms and attitudes to foster healthier behaviours and beliefs around contraception and its health and economic benefits

Given that the FP Goals Model identified improving social norms related to FP as a major contributor to future mCPR growth, specific attention will be paid to identifying and subsequently addressing and shifting social norms. The foundation activity will be an assessment to identify social norms that currently impede FP use in the priority 18 regions, the findings of which will inform subsequent activities in this and other outputs. Specifically, findings will be shared with SBCC and FP stakeholders, including regional technical representatives, who are involved in adapting and developing key communications materials (in output DC1), and they will be used to update the guide for integrated health messages. Developed messages will be tailored to address specific norms relevant for the specific regions and groups, including messages targeted to health care providers to normalise FP services for all age groups. The messages and tools will be integrated into community-sensitisation activities run by CHWs and shared with local FP champions. CHWs who underwent the government's one-year training for CHWs, and who will be identified through mapping conducted under the service delivery thematic area, will receive refresher training and support to conduct community-mobilisation activities using updated content to change social norms and attitudes (i.e., module 1 of the FP refresher training curriculum). A message development guide and tailored messages will be part of the service delivery supervision conducted monthly by nearby health facilities. Also, in collaboration with a media consultant, messages that address social norms will be developed for local radio, while messages that address 'shared' norms (across regions) will also be aired through national radio. Finally, concerted efforts will be made within MOHCDGEC to consistently link the FP Subunit of the RCHS with the Health Communication Subunit of the Health Promotion Section for better coordinated activities.

Service Delivery

The Tanzanian health system is made up of the public sector and the private sector, which includes for-profit or commercial facilities and entities (e.g., pharmaceutical companies and distributors), not-for-profit facilities and organisations, faith-based organisations, private maternity homes for maternal, newborn and child health (MNCH) and FP services, private pharmacies, unregistered drug shops and ADDOs, and traditional practitioners. The MOHCDGEC and the PORALG are jointly responsible for the delivery of public health services: the MOHCDGEC has overall responsibility for health services and provides technical guidance to organisations involved in service delivery, while the PORALG is responsible for managing and administering public services at the council level (i.e., in districts and municipalities).

Main Gaps in Service Delivery (from situation analysis)

- Limited provider capacity for LARC at the dispensary level
- Limited integration of FP into other services, including MNCH
- Minimal implementation of a TMA
- Limited task-shifting approaches for FP service provision

Maximising access to quality services was a fundamental priority of the NFPCIP 2010–2015. When the plan was developed, FP provision through the facility-based system had been negatively affected by a lack of adequate and qualified providers, inadequate and irregular supply of commodities, and poor infrastructure, among other weaknesses. Further, other channels, such as community-based provision, were limited to a few geographical areas of the country. Private-sector provision was minimal, although an increasing trend was seen. During the NFPCIP 2010–2015, activities were designed to target these service delivery weaknesses in the FP program. Despite achievements, several gaps remained, as identified by the NFPCIP 2010–2015 end-of-period performance review.

The improved ability of public, private, and faith-based service delivery points to deliver accessible and high-quality contraceptive services to clients is the outcome for this result area. Activities within this result area aim to address persistent gaps and to ensure that all FP service delivery points fulfill client demand irrespective of age in a timely and respectful manner, offering services using a rights-based approach to men and women of reproductive age, including postpartum women and youth. For example, the use of contraception in the postpartum period has remained low and unchanged over the past 10 years. Six months after having a birth, only 18.6 percent of women are using a modern contraceptive method,[5] and numbers vary across regions. Given the high fertility rates in Tanzania, many women of reproductive age give birth each year, presenting a large potential need for postpartum services.

Activities support both the maintenance package—specifically in Outputs SD1 and SD5—and strategic priorities 1 (postpartum women) and 4 (adolescents and youth). Specifically, health providers will be targeted for capacity-building activities with the focus on PPFP service delivery (i.e., immediate postpartum provision of FP as well as integration of FP counseling into antenatal care, postnatal care, postabortion care, and well-child/immunisation services) and LARC at all levels to gradually shift away from a reliance on costly mobile outreach services. Guidelines, standard operating procedures, and training materials will be updated to ensure quality FP information and services. Finally, the FP program will equip graduating cadres of CHWs with skills to counsel clients in contraceptive methods suited to their needs and to offer specific

methods in accordance with current policy. Special efforts will be made to integrate the private sector into national FP program activities at all levels; thus, the private sector is not represented via a separate output.

OUTCOME: Improve the availability of and access to quality FP services across all types of service delivery points

OUTPUT SDI: Number and capacity of public- and private-sector facilities offering FP services at acceptable levels of performance and quality, as per national standards, increased

Activities within this output are focused on strengthening core components of quality FP service delivery in both public and private health facilities to ensure that past gains are maintained, while looking for ways to increase efficiencies and effectiveness (see the maintenance package described earlier in this document). All efforts will target both public and private sectors, to the extent possible. Stakeholders recognised that capacity-building efforts are essential to maintaining the necessary number of trained FP staff but are also resource-intensive. Thus, they sought to identify ways to integrate them into preservice curricula to build sustainability or to use more efficient in-service training techniques such as on-the-job training, and to focus on key technical areas requiring updated skills. Efforts will continue to include human resource mapping of both public and private sectors on an annual basis to inform the annual training plan, and the online training tracker will be updated and used to monitor the extent to which planned training needs are being met. Preservice curricula for different cadres, including assistant medical officers and nurse-midwives, will be updated to strengthen their FP content, particularly related to PPFP, youth-friendly contraceptive services (YFCS), and rights-based high-quality FP services. These materials will be shared with private training institutions, including faith-based hospitals with nursing programs. In-service trainings will also be planned to ensure access to a broad method mix at all levels. Partner-led mobile outreach that provides increased access to LARC services will be conducted in the first three years in 10 regions with lower access to LARC services at the facility level. During that time, capacity-building efforts will focus on providers at the dispensary level so that the outreach strategy can gradually shift to health center-led services—a more sustainable, long-term approach to meeting clients' needs. On-the-job training will be utilised to minimise the time that providers are off-site, and trainers will be sought from both the public and private sectors (e.g., Private Nurses Midwives Association of Tanzania [PRINMAT]). In addition, opportunities should be explored to adapt training curricula, formats, and time frames to the needs of the private sector, such as by utilising e-learning and conducting sessions after business hours.

Zonal and district-level health teams will be supported to conduct quarterly supportive supervision, as per the national guidelines and standards, in all FP delivery points. In private facilities, supportive supervision will be conducted jointly with facility owners and management and with MOHCDGEC staff. Procurement of necessary equipment and supplies as well as FP job aids (updated to include additional information related to PPFP and adolescent sexual and reproductive health) for both trainings and service delivery purposes is also planned.

OUTPUT SD2: Number and capacity of public- and private-sector facilities offering integrated FP and RMNCAH services at acceptable levels of performance and quality, as per national standards, increased

To achieve this output, multiple interventions will be implemented to reach women across the continuum of care from antenatal care through delivery, postnatal care, and immunisation visits, as well as in in postabortion care settings. Evidence indicates that uptake of FP is greater when services are offered in the same place at the same time, with the feasibility of doing so in multiple service delivery settings. As a foundational step, the national FP operational guidelines and standards will be revised to incorporate these different models of FP and RMNCAH integration. They will also articulate specific job roles and responsibilities for staff sitting in different maternal and child health units of health facilities. The revised guidelines and standards will be disseminated during zonal meetings, during which reproductive health management teams and council health management teams (CHMTs) will develop action plans to orient facility-based staff on the FP and RMNCAH integration models and requirements within their zones of responsibility.

Training needs will be identified through the mapping conducted under Output SD1. The pool of PPFP trainers will be expanded to ensure that each region has at least four trainers to meet the identified training needs and that trainers from the private sector are included. These trainers will, in turn, train labor and delivery personnel in PPFP service provision. Providers stationed in antenatal and postnatal care, including those who participate in immunisation services, will be trained on PPFP service provision including FP counseling and referral for FP services. With strong, routine immunisation outreach services in the country, this is an important opportunity to increase access to FP services through integrated immunisation and FP services. As part of the revised operational guidelines and standards, facilities will be asked to ensure that at least one provider qualified to counsel on FP and offer short-acting methods accompanies each immunisation outreach activity. Referrals, mainly for LARC and permanent methods, will be made to nearby health facilities. FP services will continue to be an important part of comprehensive postabortion care, and postabortion care providers will continue to be supported through supportive supervision to maintain their FP counseling and FP service provision skills.

OUTPUT SD3: Number and capacity of public- and private-sector facilities offering integrated FP and HIV services at acceptable levels of performance and quality, as per national standards, increased

Integrating FP into HIV services is an important component of increasing access to FP services among people living with HIV who wish to space births or limit conception. Stakeholders in Tanzania recognise the potential of FP to help reduce the overall HIV burden. As such, modest investments will be made to complement efforts already underway and funded by other government units, partners, and donors. The focus will be on updating the National Operational Guideline for Integrating MNCH/HIV/AIDS Services 2012 to incorporate current recommendations and best practices, and on developing standard operational tools for integrated services. Providers who deliver care and treatment clinic services will be equipped with knowledge and skills to offer comprehensive FP counseling and provision of FP methods. Depending on the care and treatment clinic setting, if space is a challenge, clients will be referred to the FP Service Unit. Additionally, once evidence from the ECHO trial is available, in-service training materials will be updated to reflect current knowledge on interactions between the injectable depot medroxyprogesterone acetate and HIV.

OUTPUT SD4: Number of facilities offering quality youth-friendly services according to established national youth-friendly service standards increased

Reflecting strategic priority 4, activities in this output focus on improving services for young people at both the facility and community levels. First, an assessment will be conducted with youth of different profiles (e.g., different age groups, married versus unmarried, in- versus out-of-school) to collect information regarding barriers they face in accessing contraceptive services. Findings will be shared with CHMTs and facility managers as part of advocacy to prioritise funding for structural changes, including infrastructure improvements to ensure privacy and confidentiality, changes in hours of service, and signage to publicise facilities that have undertaken efforts to become adolescent-friendly. Facilities will be identified for improvement and for training needs via routine supervision. In collaboration with the Adolescent and Reproductive Health Unit, at least one trainer per region will be trained in YFCS. At least two providers per facility across the country will be trained to offer contraceptive services to youth without bias or barriers; these trainings will also include private facilities or pharmacies and ADDOs that youth are likely to frequent. In addition, operators of the youth-focused toll-free help line will also be trained in YFCS. In addition to showing visible signs that identify them as meeting requirements for YFCS, facilities will be included in a YFCS directory that can be disseminated through FP stakeholder meetings, trainings, and zonal meetings and through the toll-free help line.

Efforts will also be made to reach young people with services outside of facilities, including outreach from facilities to places where youth gather frequently (e.g., youth clubs, youth corners). The quality of YFCS offered by both facility- and community-based providers will be assessed during routine supportive supervision visits conducted under Output SD1.

OUTPUT SD5: Number and capacity of community-based services offering FP at acceptable levels of performance and quality, as per national standards, increased

While the range of contraceptives that can be provided at the community level is limited, CHWs have a unique opportunity to provide potential clients with information and support to move them from thinking to action, either by offering short-acting methods or referring them for long-acting and permanent methods. Similarly, CHWs have an important role to play in providing services to specific populations, including postpartum women, adolescents, and youth. For the period of the NFPCIP 2019–2023, community-based FP services will be strengthened to ensure quality of care as well as coordination and alignment between the community and health facilities. CHWs will be trained and dispersed throughout all regions, but there will be an increased focus on CHW support and supervision in the 18 regions where demand-creation activities are needed to increase the mCPR, thus efficiently leveraging the role of CHWs for both supply and demand. In the remaining regions, CHWs will be deployed to maintain the current level of service provision to ensure that recent mCPR gains are not lost.

CHWs will be identified through a mapping activity and will then receive refresher training that provides updated skills and content focused on PPFP and YFCS that emphasise free and informed choice. The FP program will participate and contribute in the review of a formalised CHW curriculum to ensure inclusion of adequate FP skills building within the curriculum. The CHWs will be responsible for raising awareness of FP services, including among pregnant women so that they are ready to begin a method postpartum, and for providing community-based FP services as per guidelines.

Commodity Security

Contraceptive commodity security exists when supportive national policies are in place, adequate funding is available for commodity procurement, logistics management systems are functioning, and the FP supply chain results in the timely and adequate supply of contraceptives to both service providers and clients. Although progress has been made in Tanzania to ensure that a range of contraceptive commodities are available at the central and zonal medical store department (MSD) warehouses, inadequate and inconsistent funding for commodities and inefficiencies in the logistics and supply chain management system result in stock outs. Regional progress has remained uneven, and public and private health facilities often experience interrupted supplies of commodities.

Reducing stock outs was identified as strategic priority 3, given its potential to increase the mCPR and given the importance of a range of available methods to ensure that clients' rights are respected and fulfilled. Activities in this result area will be geared toward improving correct and timely forecasting, quantification, procurement, and supply chain management capacity at various levels including the central MSD, the Logistics Management Unit of the MSD at the zonal MSD office, the PORALG (responsible for overseeing implementation at the council and district levels), the Directorate of Pharmaceuticals Section of the MOHCDGEC, and the FP Unit of the MOHCDGEC. The vision is for GOT entities to build their capacity and demonstrated commitment to lead in all aspects of commodity security. Technical support will also be directed to regions where facilities experience frequent stock outs of commodities, as per results of the FP Goals Model. This support will aim to identify and address specific challenges for stock outs, while simultaneously sustaining and improving commodity availability in regions that have experienced less-frequent commodity stock outs. Finally, necessary commodities and equipment will be procured to meet projected needs (Table 4). Continuous advocacy for a TMA will also be pursued and will influence various activities within this thematic area (e.g., by balancing the proportion of commodities that should be procured for public-sector consumption against the anticipated consumption from the private sector).

Main Gaps in Commodity Security (from situation analysis)

- Decrease in GOT financing over the years
- Forecasting difficulties due to challenges in acquiring service utilisation data
- More providers needing training on the integrated logistics system

The activities under this result area will be implemented in line with initiatives to improve national holistic supply chain management as stipulated in the national CIP for supply chain management of the MOHCDGEC. Furthermore, to ensure increased access to affordable contraceptive commodities for all segments of the population in need, efforts will be made to solicit buy-in from high-level government decision makers, relevant agencies, and other key stakeholders for creating a conducive environment for a TMA for contraceptives commodities in the country.

TABLE 4. Projected Required Quantities of Contraceptive Commodities for All Women

METHOD	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
Intrauterine contraceptive devices	44,343	49,431	54,826	60,434	66,339
Implants	514,913	585,463	660,241	738,475	820,899
Injectables	6,741,605	7,399,597	8,092,245	8,817,581	9,577,761
Pills	7,315,784	7,509,613	7,705,606	7,900,935	8,096,867
Male condoms	53,074,294	54,850,461	56,667,533	58,505,489	60,374,284
Female condoms	477,434	406,708	330,443	248,342	160,318
Emergency contraception	103,167	94,859	85,829	76,023	65,436
CycleBeads	917,039	1,304,311	1,716,585	2,153,990	2,617,433

OUTCOME: Have adequate amounts of a range of commodities available at service delivery points: facilities, communities, and outreach settings

OUTPUT CS1: GOT leadership and stewardship of FP commodity security strengthened

Under this output, planned activities intend to increase and strengthen GOT ownership and leadership in undertaking contraceptive security-related functions at various levels to enable the availability, accessibility, and affordability of a wide range of quality contraceptive methods to meet the needs of all clients. This will be addressed through supporting the FP Unit of the RCHS with skilled staff to properly coordinate and undertake contraceptive security-related core functions while identifying key functions that other staff within the FP Unit (and within the RCHS) should fulfill related to contraceptive security. Activities are also planned to regularly bring together key government agencies, specifically the RCHS, MSD, and Pharmaceuticals Supplies Section to better coordinate functions and roles in support of contraceptives security; these could be expanded to include private-sector representation as well. Finally, activities are planned to operationalise recommendations included in the TMA assessment report, including establishing a working group, developing an implementation plan, and monitoring progress through regular meetings.

OUTPUT CS2: Sufficient contraceptive commodities procured to cover all country needs (in accordance with the NFPCIP 2019–2023 method projections and as adjusted during annual quantification exercises) to meet the mCPR goal by 2023

The availability of sustainable and consistent, adequate funding for procurement of contraceptive commodities in a timely manner is essential for meeting the FP program goals of Tanzania for the next five years. While advocacy to ensure sufficient financing for commodities is represented in the enabling environment result area, this output will focus on accurate and timely procurement, based on high-quality data and well-conducted quantification, to meet program needs. Support will be given to make sure that proper and accurate forecasting inform routine commodity quantification exercises and that all key stakeholders are involved in the exercises. The support will also make sure that procurement plans are shared with all relevant GOT departments and relevant donors for timely funding, ordering, and shipping of the needed commodities for both public and private health sectors.

Recognising that private-sector commodity data have not been sufficiently incorporated into the logistics management information system, an assessment will be conducted to estimate the market share that is truly private-sector versus socially marketed. Equipped with better data, the quantification exercises will take into account market segmentation and thus better estimate requirements for the public sector.

OUTPUT CS3: Supply chain management system for FP commodities improved

While acknowledging that the challenges related to the supply chain system are vast and beyond the auspices of the national FP program to address, this plan intends to improve management of the supply chain to ensure that contraceptive commodity supply plans are regularly monitored, that possible supply disruptions are identified, and that agreed-upon actions are implemented to avert disruptions. Special focus will be geared toward addressing supply chain management problems facing regions where many facilities experience persistent stock outs of contraceptives commodities. These regions have been identified by the FP Goals Model and will also be identified based on persistent problems in filling out report and request forms. Joint quarterly supervision visits from the FP Unit, CHMTs, the MSD, and staff from the Logistics Management Unit will serve to build the skills in these regions and ensure that all related logistics management system reporting tools and materials at the facility level are available and that providers can use them accurately.

RESOURCE MOBILISATION FRAMEWORK

The successful execution of the NFPCIP 2019–2023 will require optimal levels of financial resources mobilised in a sustained manner. This plan envisages mobilising increased resources by advocating for 1) increased government allocations and eventual disbursements; 2) domestic resource mobilisation from non-state actors, including inclusion of FP in health insurance; and 3) sustained or increased levels of funding from foreign sources, including development partners and through the Global Financing Facility mechanism. A financial and program gap analysis will be conducted on an annual basis to inform resource allocation and mobilisation efforts. During development of the NFPCIP 2019–2023, the TST collected data from implementing partners to inform the financial and program gap analysis for 2019 (the first year of this plan). This exercise provided information on current investment allocations for FP against CIP priorities, geographical mapping, and areas that are under- or overfunded. Parallel to the launch of the NFPCIP 2019–2023, a sub-working group will be established to steer and coordinate multi-stakeholder efforts focused on resource mobilisation and financing for FP.

PERFORMANCE MONITORING

Measuring performance of the CIP over time generates important information to guide strategic investments, operational planning, and coordination. Similar to performance monitoring efforts during the NFPCIP 2010–2015, this plan will be routinely monitored using data from various sources and systems. The goal is to ascertain progress toward results articulated in the plan. Alongside the development of the NFPCIP 2019–2023, the TST prepared for future performance monitoring of the plan. Specifically, during the results-formulation stage in November 2017, the TST worked with each SAG to identify results that were critical to regularly monitoring

performance. These are referred to as key results. Subsequently, the TST worked with the Monitoring and Evaluation (M&E) Unit of the MOHCDEC and representatives from different organisations working on M&E to review key performance indicators based on performance targets already included in the NFPCIP 2019–2023. The key results, key performance indicators, and performance targets will be fed into an online CIP performance monitoring database. This same database, which was used to collect and analyse performance monitoring of the NFPCIP 2010–2015, will be upgraded during the first two quarters of the NFPCIP 2019–2023.

The MOHCDEC has assigned an M&E officer, who is also the appointed Track20 M&E officer, to manage the NFPCIP 2019–2023 performance monitoring process. Data to inform progress will be collected on a quarterly basis from available data sources, including the DHIS 2, partner reports, the e-logistics management information system, TrainTracker, and other sources. This data will be fed into the CIP performance monitoring database to generate status reports in the form of a dashboard. Twice a year, status reports will be shared during FP semi-annual stakeholder meetings. The SAGs will continue to play an important role, including reviewing performance data on respective thematic areas, identifying challenges and lessons learned, and providing recommendations. Once a year, during data consensus workshop meetings organised by Track20, stakeholders will review data to assess progress over a one-year period. Recommendations from the review will inform realignment of technical strategic priorities and resource allocation.

COORDINATION FRAMEWORK

Given the diversity and multitude of stakeholders required to guide the implementation of activities outlined in the NFPCIP 2019–2023, coordination of resources and activities will be of paramount importance. Stakeholders implicated in this work include the MOHCDGEC, PORALG, MSD, Ministry of Finance, Ministry of Education, Ministry of Youth, parliamentarians, development partners, CSOs and nongovernmental organisations, and the private health sector. Though stakeholders will play distinct roles, including providing general leadership (i.e., the MOHCDGEC and PORALG), maintaining an efficient logistics system (i.e., the MSD), allocating and disbursing funds for FP (i.e., the Ministry of Finance), providing financial resources and technical expertise (i.e., development partners), and finally implementing activities across the strategic priorities to achieve the national mCPR goal (i.e., CSOs and nongovernmental organisations), a clear and active coordination framework is necessary to prevent duplication of efforts, enhance efficient use of resources, track progress and results, facilitate knowledge sharing and collaboration, and promote accountability for results.

At the central level, over the past 10 years, the RCHS of the MOHCDGEC has benefitted from an active and diligent technical working group for its FP Unit. Meeting monthly, this technical working group serves as an advisory arm of the FP Unit of the MOHCDGEC and consists of implementing partners and representatives from the donor community with expertise in FP programming. Besides its advisory function, the NFPTWG continues to be instrumental in identifying and addressing implementation issues, sharing lessons learned, and promoting transparency between actors in the FP field. Given that FP falls under the umbrella of reproductive, maternal, neonatal, and child health programs, it will continue to be an important agenda topic within the broader technical working group in this area for the RCHS of the MOHCDGEC.

At the local government level, particularly at regional and council or district levels, the coordination mandate will continue to lie within the reproductive health management teams and CHMTs through the regional reproductive health coordinators and district reproductive and child health coordinators who play a key role in coordinating diverse implementing partners at these levels. Efforts will continue to strengthen working relationship with zonal reproductive health coordinators as an important link between the regional and district reproductive and child health coordinators and the RCHS of the MOHCDGEC.

Within the MOHCDGEC, coordination between FP and other relevant health departments such as human resources, health promotion, quality assurance, and the specific disease control programs will continue to follow the established management structure of the MOHCDGEC. This structure is under the guidance of the permanent secretary and the chief medical officer through the director of preventive services. Importantly, for smooth implementation of this plan countrywide, deliberate efforts will be made to strengthen the working relationship with PORALG, which is responsible for supervising, employing, and deploying all government health care workers, and for managing their performance at regional and district or council levels.

Other existing forums and platforms, such as the annual reproductive and child health coordinator meetings and the semi-annual FP implementer meetings, will continue to play an important role in guiding implementation. They will also serve as an avenue for sharing information on progress across different stakeholders and will promote accountability for results from all partners, implementing facilities, and community-based FP interventions.

Additional actors that will contribute to the NFCIP 2019–2023 include other government ministries and sectors, such as the Ministry of Education and the Ministry of Youth, that will work to deliver a multisectoral approach to FP and parliamentarians who will advocate for FP issues both in their respective districts and at the national level. Finally, the private sector will play an important role in achieving the national FP goal, as the government alone cannot meet the growing demand for service provision and commodities.

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ANNEXES

ANNEX 1

Strategic Priorities by Region per FP Goals Model Application

NFPCIP 2019-2023 Strategic Priorities				
	Postpartum FP	**Reduce stock outs**	**Address Social Norms**	**Adolescents and Youth**
# Regions with intense scale up	25	14	18	25
Dodoma	s	s	s	s
Arusha	s	s	s	s
Kilimanjaro	s	s	m	s
Tanga	s	m	m	s
Morogoro	s	m	s	s
Pwani	s	s	s	s
Dar Es Salaam	s	s	m	s
Lindi	s	m	s	s
Mtwara	s	s	s	s
Ruvuma	s	s	s	s
Iringa	s	s	m	s
Mbeya	s	m	s	s
Singida	s	m	s	s
Tabora	s	s	s	s
Rukwa	s	m	s	s
Kigoma	s	m	s	s
Shinyanga	s	m	s	s
Kagera	s	s	s	s
Mwanza	s	s	m	s
Mara	s	s	s	s
Manyara	s	m	s	s
Njombe	s	s	m	s
Katavi	s	m	s	s
Simiyu	s	s	s	s
Geita	s	m	m	s

m = maintain current status

s = intense scale up

ANNEX 2

Regional mCPR Annex

	Impact by Strategic Priority					Total increase		Change in mCPR (all women)		
	Post-partum FP	Stock out reductions	Addressing social norms	Indirect impact of demand*	Youth: in-school SRH	Total Increase	Avg annal %pt increase	mCPR (DHS 2015/16)	Starting mCPR (adjsuted to 2019)	Goal mCPR (2023)
Tanzania	6.0%	2.2%	1.3%	2.2%	0.4%	9.9%	2.0%	27.1%	30.2%	40.1%
By region										
Dodoma	4.1%	2.9%	1.4%	2.8%	0.3%	8.7%	1.7%	35.4%	38.5%	47.2%
Arusha	5.1%	2.9%	1.6%	1.6%	0.4%	9.9%	2.0%	26.1%	29.1%	39.0%
Kilimanjaro	1.7%	1.7%	n/a	0.0%	0.3%	3.8%	0.6%	33.8%	36.9%	40.6%
Tanga	5.7%	0.4%	n/a	0.0%	0.2%	6.2%	1.0%	21.6%	24.6%	30.8%
Morogoro	3.5%	1.3%	1.2%	1.2%	0.4%	6.4%	1.1%	40.5%	43.6%	50.0%
Pwani	4.1%	3.0%	0.9%	3.2%	0.6%	8.7%	1.4%	33.9%	37.0%	45.6%
Dar Es Salaam	3.5%	4.0%	n/a	0.0%	0.4%	7.9%	1.3%	28.6%	31.6%	39.5%
Lindi	1.9%	0.6%	0.6%	0.6%	0.3%	3.4%	0.6%	47.9%	51.0%	54.3%
Mtwara	1.7%	2.1%	0.6%	0.5%	0.3%	4.7%	0.8%	47.1%	50.1%	54.8%
Ruvuma	2.3%	1.8%	1.0%	0.9%	0.4%	5.5%	0.9%	46.3%	49.3%	54.9%
Iringa	3.8%	4.7%	n/a	0.0%	0.9%	9.4%	1.6%	27.0%	30.1%	39.5%
Mbeya	2.6%	n/a	1.5%	1.5%	0.6%	4.6%	0.8%	37.2%	40.3%	44.9%
Singida	6.2%	0.8%	1.3%	2.0%	0.4%	8.7%	1.4%	31.3%	34.3%	43.0%
Tabora	12.7%	2.1%	2.9%	10.2%	0.1%	17.9%	3.0%	20.2%	23.3%	41.2%
Rukwa	9.4%	0.7%	1.9%	5.1%	0.3%	12.2%	2.0%	27.3%	30.4%	42.6%
Kigoma	12.8%	0.6%	2.4%	5.1%	0.3%	16.0%	2.7%	13.7%	16.7%	32.8%
Shinyanga	10.4%	1.2%	1.0%	1.1%	0.3%	12.8%	2.1%	20.0%	23.0%	35.9%
Kagera	4.3%	2.5%	1.4%	2.4%	0.3%	8.5%	1.4%	30.9%	34.0%	42.5%
Mwanza	11.1%	1.0%	n/a	0.0%	0.4%	12.5%	2.1%	16.1%	19.1%	31.6%
Mara	10.2%	2.5%	2.5%	7.8%	0.3%	15.5%	2.6%	26.0%	29.1%	44.5%
Manyara	8.8%	1.1%	1.9%	2.1%	0.5%	12.3%	2.0%	22.7%	25.7%	38.0%
Njombe	4.2%	4.8%	n/a	0.0%	0.3%	9.3%	1.6%	34.5%	37.5%	46.8%
Katavi	13.5%	1.4%	2.9%	7.4%	0.5%	18.3%	3.0%	16.9%	20.0%	38.3%
Simiyu	14.9%	1.8%	1.2%	5.0%	0.2%	18.1%	3.0%	15.4%	18.5%	36.6%
Geita	17.4%	0.4%	n/a	0.0%	0.3%	18.1%	3.0%	10.7%	13.7%	31.8%

*investments in social norms have an indirect impact by increasing demand and therefore allowing other interventions to have a larger impact

ANNEX 3

Result Area Outputs and Activities by Strategic Priority

	PPFP	Social Norms	Stock outs	Youth	Maintain	Other
ENABLING ENVIRONMENT						
OUTPUT EE 1: Public-sector financing for FP at both central and LGA levels increased						
1. Engage relevant Government entities at both central and local government authority (LGA) levels to increase FP funding allocations and ensure timely funding requests and disbursements for contraceptive commodities and other FP program elements	×	×	×	×	×	
2. Conduct advocacy towards RCHS to effect allocations for FP in the GFF funds	×	×	×	×	×	
3. Engage National Health Insurance Fund (NHIF) to ensure FP as part of the national Health Financing Strategy being developed						×
OUTPUT EE 2: Domestic financing for FP by non-state actors increased						
1. Engage private health insurance companies to provide FP coverage in their respective health insurance packages						×
OUTPUT EE 3: Levels of foreign donor financing for FP sustained or increased						
1. Sustain engagement of development partners in enhancing FP support	×	×	×	×	×	
OUTPUT EE 4: Policies supporting young people's access to contraceptive information and services adopted and implemented.						
1. Include strong, evidence-based FP content into Comprehensive Sexuality Education (CSE), currently integrated in national school-based curricula for primary and secondary schools				×		
2. Revise National School Health Programme (NSHP) guidelines and strategy to include FP information				×		
3. Engage key stakeholders across different sectors to participate in efforts towards reducing teenage pregnancy rate				×		
OUTPUT EE 5: Policies in place that support task sharing of FP service provision to lower-level cadres (including outside health facilities such as CHWs and ADDOs/pharmacies)						
1. Conduct dialogue with FP stakeholders to expand the method mix through various outlets using innovative approaches (e.g., pharmacy approves inclusion of DMPA-SC in the national essential medicines list (EML) for public use)					×	
OUTPUT EE 6: Local capacity to effectively advocate for FP increased						
1. Increase engagement of CSOs in FP advocacy and accountability	×	×	×	×	×	
2. Generate and package evidence for diverse FP advocacy purposes (e.g., Demographic Dividend, Impact Model, Budget analysis expenditure data, SGDs)	×	×	×	×	×	

	PPFP	Social Norms	Stock outs	Youth	Maintain	Other
OUTPUT EE 7: FP mainstreamed as a priority intervention for promoting development across all sectors						
1. FP is prioritized and operationalized within 5- year national development plans		×		×		
2. Mainstream FP into different sectors' policies and strategies (e.g., Education, Youth, etc.)		×		×		
3. Establish and actively operate a multi-sectoral coordination platform structure to promote and support FP across different sectors		×		×		
4. Sensitize media outlets to include coverage on FP as an engine for social and economic development as part of planned programming		×		×		
OUTPUT EE 8: The capacity of the government (at central and council levels) to lead, manage, and coordinate the FP program and diverse stakeholders enhanced						
1. Improve Government coordination and support of implementing partners at the national and district level	×	×	×	×	×	
OUTPUT EE 9: Evidence-based data generated and used to inform programmatic, budgetary, and policy decision-making						
1. Improved FP data management at subnational level, including appropriate disaggregation of community-level data in the existing MTUHA and DHIS2	×	×	×	×	×	
2. Capacity of FP unit staff strengthened on information management including data access, analysis, and data presentation for decision-making	×	×	×	×	×	
DEMAND CREATION						
OUTPUT DC 1: People have accurate knowledge and self-efficacy to adopt a positive behavioral change to practice family planning						
1. Finalize FP content in CHW module 1 training package	×	×		×	×	
2. Conduct module 1 Training of CHWs in 18 prioritized regions (per FP Goals)	×	×		×		
3. Conduct FP promotional activities using CHWs targeting 18 prioritized regions. Note: activities will target both individuals (related to this output) and groups/communities (related to Output DC2).	×	×		×		
4. Develop/Harmonise print materials to increase awareness of FP methods and availability of FP services, targeting specific populations, and with rights-based language	×	×		×		
5. Utilize broadcast media to increase awareness of FP methods and availability of FP services, targeting specific populations, and with rights-based language.	×	×		×		
6. Promote FP services and methods via multiple channels to raise community awareness	×	×		×		
OUTPUT DC 2: Positive shifts in social norms and attitudes to foster healthier behaviours and beliefs around contraception and its health and economic benefits						
1. Determine regional and community level barriers to FP uptake and use		×				
2. Update "national FP message guide for champions" to address negative social norms that hamper FP use		×				
3. Develop national and local mass media campaigns to address FP-related social norms and attitudes		×				
4. Strengthen collaboration between the MOH's RCHS unit and the Advocacy Social Behavioural Change (ASBCC) component of the health promotion unit		×				

	PPFP	Social Norms	Stock outs	Youth	Maintain	Other
SERVICE DELIVERY						
OUTPUT SD 1: Number and capacity of public- and private-sector facilities offering FP services at acceptable levels of performance and quality, as per national standards, increased						
1. Review and update FP training plan on an annual basis					×	
2. Strengthen FP preservice education					×	
3. Revise pre-service curriculum for nurses and midwives to include sufficient information regarding PPFP, PACFP and YFCS	×			×		
4. Conduct clinical training on surgical contraception					×	
5. Conduct on the job training (OJT) for comprehensive FP clinical skills.					×	
6. Procure necessary equipment and supplies for training and service delivery needs (beyond contraceptives)					×	
7. Procure equipment and supplies for routine FP service delivery in health facilities					×	
8. Ensure availability of FP job aids					×	
9. Strengthen LARC provision at dispensary level					×	
OUTPUT SD 2: Number and capacity of public- and private-sector facilities offering integrated FP and MNCAH services at acceptable levels of performance and quality, as per national standards, increased						
1. Revise the FP Operational Guidelines and standards to incorporate PPFP into facility and community-based FP integrated service delivery	×					
2. Disseminate revised FP operational guidelines to subnational level	×					
3. Develop need-based training strategy focused on labour and delivery staff (Based on the needs assessment results)	×					
4. Expand the pool of qualified PPFP trainers	×					
5. Train providers from labour and delivery in PPFP	×					
6. Train/orient antenatal care (ANC), post-natal care (PNC) and immunization (IZ) providers to new PPFP procedures and job aids	×					
7. Integrate FP into routine immunization outreach activities to include counselling, provision and referral for FP	×					
8. Support providers to offer FP as part of PAC	×					
OUTPUT SD 3: Number and capacity of public- and private-sector facilities offering integrated FP and HIV services at acceptable levels of performance and quality, as per national standards, increased						
1. Review National Operational Guideline for Integrating MNCH/HIV/AIDS services (NOGI)– 2012 and SOPs to include current evidence and practises.					×	
2. Review and finalize the FP/HIV integration curriculum for CTC health providers					×	

	PPFP	Social Norms	Stock outs	Youth	Maintain	Other
OUTPUT SD 4: Number of facilities offering quality youth-friendly services according to established national youth-friendly service standards increased						
1. Renovate facilities to ensure adequate space & privacy as per youth friendly services guidelines				X		
2. Train providers on youth friendly contraceptive services (YFCS)		X		X		
3. Deliver FP services during convenient hours for youth				X		
4. Promote YFCS facilities to young people.				X		
5. Provision of wide range of methods to youth as per National Guideline				X		
OUTPUT SD 5: Number and capacity of community-based services offering FP at acceptable levels of performance and quality, as per national standards, increased						
1. Conduct trainings of formalized CHWs					X	
2. Contribute to curriculum revision for formalized CHWs to include the FP component for advocacy, promotion, service delivery and referral					X	
COMMODITY SECURITY						
OUTPUT CS 1: GOT leadership and stewardship of FP commodity security strengthened						
1. Second contraceptive security coordinator with CS/SCM skills to FP unit of RCHS			X		X	
2. Build capacity of other staff within FP unit/RCHS on core functions of CS/SCM (focus on commodity quantification, procurement, active management of supply chain, including logistic Information management)			X			
3. Organize routine meetings between Reproductive and child health Section (RCHS), Medical Store Department (MSD) and Directorate of Pharmaceutical Services (DPS) to coordinate and improve contraceptive security core functions			X		X	
4. Garner support from the MoH to adopt and implement a TMA to support CS/SCM in the country						X
OUTPUT CS 2: Sufficient contraceptive commodities procured to cover all country needs (in accordance with the NFPCIP 2019-2023 method projections and as adjusted during annual quantification exercises) to meet the CPR goal by 2023.						
1. Support routine national level quantification exercise			X		X	
2. Include private sector within Commodity Procurement Tables, specifically to disaggregate social marketing from true private sector			X		X	
3. Procure commodities as per projected country method mix and projected mCPR goal by 2023			X		X	
OUTPUT CS 3: Supply chain management system for FP commodities improved						
1. Identify and address capacity needs of facilities with problems in filling R&R forms			X			
2. Provide technical and financial resources support to CHMTs for monitoring and supportive supervision related to CS/CM including early identification of stock status issues			X			
3. Build the capacity of CHMTs and RCHS FP staff to use eLMIS for increasing real time data visibility and use in addressing stock status issues at facility level within the councils			X			
4. Ensure availability of CS/SCM-related materials and documents			X			
# activities:	**23**	**23**	**17**	**27**	**27**	**3**

ANNEX 4

Detailed activity matrices

ENABLING ENVIROMENT									
OUTCOME EE 1: Mobilize adequate and sustainable financial resources from various sources to fulfill requirements of the FP program									
OUTPUT EE 1: Public-sector financing for FP at both central and LGA levels increased									
ACTIVITY 1: Engage relevant Government entities at both central and local government authority (LGA) levels to increase FP funding allocations and ensure timely funding requests and disbursements for contraceptive commodities and other FP program elements					Total Activity Cost (Tsh) 2,206,133,641				
Sub-activity	**Sub-activity level Targets**	**Input**	**Quantity of each input item** *(# needed for each input item)*	**Frequency of each input item** *(# of occurrences for each input item)*	**Timeframe** *(# of times each input occurs for each year)*				
					2019	**2020**	**2021**	**2022**	**2023**
Conduct FP budget analysis to gather evidence on current trend in FP funding needs, allocations, and spending at both national and LGA level	FP budget analysis conducted once per year	Consultant	20 days	Once per year	1	1	1	1	1
Develop policy briefs, PPTs and fact sheets to communicate information from budget analysis (previous sub-activity)	Accompanying policy briefs, PPTs, and fact sheets developed	Consultant	5 days	Once per year	1	1	1	1	1
		Printing	100 policy briefs						
		Printing	100 fact shets						
Conduct meetings with Policy and Planning unit of MoHCDGEC, Ministry of Finance and Planning, Pharmaceutical services section and PORALG to share findings and propose increased budget ceiling and timely disbursements of funding for FP commodities and program needs	Meeting with designated entities held once per year	Conference package (1 day)	1	Annually	1	1	1	1	1
		Half per diems	40 participants						
Conduct meetings with ZRCHCO, Regional Management Teams (RMTs) and District Management Teams (DMTs) to share district level FP budget analysis evidence	Meeting with RMTs and DMTs held at least one per zone per year	Conference package (1 day meeting)	1 meeting per zone	Annually	8	8	8	8	8
		Half per diems	10 participants						
		Full per diems	40 participants						
		Fuel	7 vehicles @ 50 litres						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(# of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
RCHS FP unit staff and FP TWG members participate in annual Council Health Management Teams (CHMTs) planning meetings to influence adequate FP budget increases	RCHS FP unit staff and other members of the FP TWG participate in CHMTs once annually	Per diems	One person supported to attend a meeting in each council (34 councils per year)	Once a year	34	34	34	34	34
		Fuel	20 vehicles @ 50 litres						
		Air tickets	15 roundtrip tickets						
Hold meetings with sample of councillors to strengthen accountability for FP in Direct Facility Financing (DFF) processes.	Meetings with councillors held once a year	Conference package (one-day meeting)	40 participants	Once a year	1	1	1	1	1
		Per diems	25 participants						
		Half per diems	2 participants						
		Fuel	10 vehicles @ 50 litres						
		Local transport	15 participants						
ACTIVITY 2: Conduct advocacy towards RCHS to effect allocations for FP in the GFF funds								**Total Activity Cost (Tsh)**	
								22,887,226	
Compile existing evidence on FP and GFF in the country	Existing evidence on FP and GFF in the country compiled once	Engage consultant	15 days	Once		1			
Hold meeting with GFF country focal team and Development Partners Group-Health to share evidence on the impact of FP on maternal and child death reduction to influence allocation of GFF funds for high impact FP interventions (eg., PPFP, demand creation, contraceptive commodities)	Meeting with the GFF country focal team	Conference package (1 day)	1	Once each In Years 1, 3, and 5	1		1		1
		Half per diems	40 participants						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(# of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
ACTIVITY 3: Engage National Health Insurance Fund (NHIF) to ensure FP as part of the national Health Financing Strategy being developed								**Total Activity Cost (Tsh)**	
								17,950,000	
Conduct meetings with NHIF and MoHCDGEC Policy and Planning Unit to share current evidence to facilitate inclusion of FP in their insurance package and propose required NHIF policy amendment in NHIF health package	Two meetings with MOHCDGEC and NHIF held	Conference package (1 day)	1	Twice during Y1	2				
		Half per diems	20 participants						
Facilitate development of proposed amendment in the NHIF policy	One 5-day workshop conducted	Conference package (5 days)	1	Once		1			
		Full per diems	20 participants						
OUTPUT EE 2: Domestic financing for FP by non-state actors increased									
ACTIVITY 1: Engage private health insurance companies to provide FP coverage in their respective health insurance packages								**Total Activity Cost (Tsh)**	
								17,403,797	
Gather evidence from selected private health insurance companies on FP coverage, develop the business case for private companies to include FP, and identify advocacy entry points	Evidence on FP coverage and advocacy entry points gathered per company and compiled in a report/ presentation	Consultant	15 days	Once	1				
Meet with technical teams from selected private health insurance companies to share evidence on benefits of inclusion of FP in their packages	One 2-day workshop held with 20 representatives from selected private companies	Conference package (2 days; 20 participants)	1	Once	1				
Meet with management of selected private health insurance companies to influence inclusion of FP in their packages	One meeting with management from 5 companies held. (Each company, 10 participants)	Conference package (1 day; 10 participants)	1	Five	5				
Conduct Annual progress meetings with management of the selected company to report progress on inclusion of FP in their insurance package	Annual meetings held with 3 representatives from each company	Conference package	15	Once every year 2, 3, 4, and 5		1	1	1	1

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(# of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
OUTPUT EE 3: Levels of foreign donor financing for FP sustained or increased									
ACTIVITY 1: Sustain engagement of development partners in enhancing FP support								**Total Activity Cost (Tsh)**	
								143,497,768	
Ensure FP is part of the agenda in the RCH development partners meetings	FP is on the agenda at annual RCH development partners meeting	Conference package (1-day, 50 participants)	1	Annually	1	1	1	1	1
		Per diems	20						
Facilitate participation of current and potential FP development partners in CSOs annual and annual platforms to learn about FP needs that require sustained support	Current and potential FP development partners participate in CSOs annual and annual platforms once a year	Conference package (2-day meeting)	1	Annually	1	1	1	1	1
		Per diems	40 participants						
		Half per diems	20 participants						
		Local travel	25 participants						
		Air ticket	15 roundtrip tickets						
OUTCOME EE 2: Adopt and implement policies that improve equitable and affordable access to high-quality FP services and information									
OUTPUT EE 4: Policies supporting young people's access to contraceptive information and services adopted and implemented									
ACTIVITY 1: Include strong, evidence-based FP content into Comprehensive Sexuality Education (CSE), currently integrated in national school-based curricula for primary and secondary schools								**Total Activity Cost (Tsh)**	
								222,179,000	
Engage consultant to review current CSE curricula for primary and secondary schools to include updated FP-related content	Consultant identified and engaged	One consultant	30 days	Once		1			
Conduct stakeholders' workshops to solicit inputs for revision of the current CSE curricula for primary and secondary schools	2 workshops conducted	Conference package (5 days)	1	Twice		2			
		Per diems	30 participants						
		Local transport	20 participants						
		Fuel	4 vehicles @ 50 litres						
		Drivers per diems	4 drivers						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(# of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Draft CSE curricula for primary and secondary schools	CSE curricula drafted	Consultant	Included in 30 days above						
Conduct stakeholders meeting to review the draft CSE curricula for primary and secondary schools with incorporated FP content for final comments	2 meetings conducted	Conference package (2 days)	1	Twice		2			
		Per diems	30 participants						
		Fuel	4 vehicles @ 50 litres						
		Drivers per diems	4 drivers						
Revise and print the CSE curricula for primary and secondary schools	The updated CSE curricula for primary and secondary schools printed	Printing cost primary school curriculum	6000 copies	Once		1			
		Printing cost secondary school curriculum	6000 copies						
Disseminate the updated CSE	Updated CSE dissemination meeting conducted	Conference package (1 day)	1	Once		1			
		Full per diems	25 participants						
		Half per diems	35 participants						
		Fuel	3 vehicles @ 50 litres						
		Drivers per diems	3 drivers						
		Local transport	10 participants						
ACTIVITY 2: Revise National School Health Programme (NSHP) guidelines and strategy to include FP information								**Total Activity Cost (Tsh)**	
								212,533,750	
Engage consultant to review NSHP guidelines and strategy to ensure FP content is included	NSHP guidelines and strategy reviewed by consultant	One consultant	20 days	Once		1			
Conduct stakeholders' workshop to solicit inputs for the revision of NSHP guidelines and strategy	One review workshop conducted	Conference package (5 days)	One workshops	Once		1			
		Per diems	30 participants						
		Fuel	4 vehicles @ 50 litres						
		Local transport	20 participants						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(# of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
NHSP guidelines revised to incorporate FP content		Consultant	Included in 20 days above	Once		1			
Conduct stakeholders meeting to review the draft NSHP guidelines and strategy with incorporated FP content	1 meeting conducted	Conference package (2 days)	1	Once		1			
		Fuel	3 vehicles @ 100 litres						
		Participant per diems	30 participants						
		Drivers per diems	3						
Print the revised NSHP guidelines and strategy	The updated guidelines and strategy printed	Printing cost	6000 copies	Once		1			
Disseminate the updated NSHP guidelines and strategy	One-day dissemination meeting conducted	Conference package (1 day)	1	Once		1			
		Per diems	60 participants						
		Fuel	3 vehicles @100 litters						
		Drivers per diems	3						
ACTIVITY 3: Engage key stakeholders across different sectors to participate in efforts towards reducing teenage pregnancy rate								Total Activity Cost (Tsh)	
								10,200,000	
Compile evidence and best practices on mutisectoral strategies for reducing high teenage pregnancy rate	Evidence and best practices on mutisectoral strategies to reduce high teenage pregnancy rate compiled	Consultant	10 days	Once	1				
Conduct meetings with key stakeholders from multiple sectors to share evidence and solicit commitments on key priority actions for reducing teenage pregnancy	Report documenting commitments produced following meeting	Conference package (1 day)	1	Once	1				
		Half per diems	30 participants						
Track progress in commitment implementation through semi-annual meetings	Progress in commitment implementation tracked and shared twice a year (Conducted via FP semi-annual meeting (output #) and existing ASRH technical working group meeting)	N/A	N/A	Twice a year	2	2	2	2	2

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(# of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
ACTIVITY 1: Conduct dialogue with FP stakeholders to expand the method mix through various outlets using innovative approaches (e.g., pharmacy approves inclusion of DMPA-SC in the national essential medicines list (EML) for public use)								**Total Activity Cost (Tsh)**	
								86,174,038	
Compile existing evidence on safety and acceptability of provision of FP methods through various innovative approaches to increase access to a wide range of methods	Comprehensive evidence on innovative approach compiled	Consultant	20 days	Once	1				
Conduct a meeting to share the compiled evidence and gather recommendations and amendments from stakeholders	Meeting to share evidence conducted	Conference package (1 day)	1	Once	1				
		Half per diems	40 participants						
		Fuel	2 vehicles @ 50 litres						
Conduct meeting with MoH senior management, pharmaceutical board and Tanzania Federal Drug Authority (TFDA) and PORLAG to present evidence, proposed recommendations and secure support for inclusion of amendments in relevant regulations and policies	One meeting conducted	Conference package (1 day)	1	Once	1				
		Half per diems	25 participants						
		Fuel	2 vehicles @ 50 litres						
Facilitate the amendment of regulations and policies based on accepted findings	Regulations and policies are amended through 5-days workshops	Conference package (5 days)	1	Twice during year 2 and 3		2	2		
		Per diems	15 participants						
		Fuel	15 participants						
Disseminate revised regulations and policies to key FP stakeholders	Revised regulations disseminated through meetings	Fuel	3 vehicles @ 50 litres	Twice during year 2 and 3		2	2		
		Conference package (1 day)	1						
		Half Per diems	40 participants						
		Local travel	5 participants						
		Air ticket	2 roundtrip tickets						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(# of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
OUTPUT EE 6: Local capacity to effectively advocate for FP increased									
ACTIVITY 1: Increase engagement of CSOs in FP advocacy and accountability								Total Activity Cost (Tsh)	
								751,648,029	
Carry out a rapid assessment to identify local CSOs with potential for FP advocacy in selected regions of mainland Tanzania	Rapid assessment on local CSOs with the potential for FP advocacy conducted	Consultant	20 days	Once	1				
Conduct FP advocacy training sessions for identified local CSOs	5-days workshops conducted annually	Conference package (5 days)	1	Four times during year 1 and 2	4	4			
		Per diems	30 participants						
		Facilitation fee	2						
		Local travel	20						
		Fuel	2 vehicles @ 100 litters						
		Drivers per diems	2						
		Air ticket	4						
Facilitate development of FP advocacy resource mobilization strategies for trained local CSOs	FP advocacy resource mobilization strategies developed through five 5-days workshops	Conference package (5 days)	1	Five workshops in year 2 and 3		5	5		
		Per diems	50 participants						
		Facilitation/ consultant fee	10 days						
		Local travel	45 participants						
		Air ticket	5 roundtrip tickets						
Conduct annual meetings to share and track progress on the implementation of funded FP advocacy strategies for trained local CSOs	Annual progress sharing meeting conducted	Conference package (1 day)	1	Annually during years 2-5		1	1	1	1
		Per diems	60 participants						
		Local travel	30						
		Fuel	3 vehicles @ 100 litters						
		Drivers per diems	3						
		Air ticket	10						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(# of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
ACTIVITY 2: Generate and package evidence for diverse FP advocacy purposes (e.g., Demographic Dividend, Impact Model, Budget analysis expenditure data, SGDs)								**Total Activity Cost (Tsh)**	
								201,897,104	
Analyse, compile, and package key FP data and messages from various data sources for specific targets into policy briefs, PPTs, fact sheets, and info graphs	Policy briefs, PPTs, fact sheets, and info graphs developed once	Consultant	15 days	Once in year 2 and 4		1		1	
		Printing policy briefs	2000 copies						
		Printing DD fact sheets	2000 copies						
		Printing infographs	2000 copies						
Conduct dissemination workshops to share packaged FP data to key FP stakeholders	Dissemination workshops held twice annually at TWGs, RHMT and CHMT meetings and MDAs meetings (one-day workshop)	Conference package (1 day)	1	Twice a year		2	2	2	2
		Per diems	40 participants						
		Fuel	5 vehicles @ 100 litters						
		Drivers perdiems	5						
		Local travel	25						
OUTCOME EE 3: Strengthen the leadership, management, and coordination capacity of the GOT for FP at all levels and across sectors.									
OUTPUT EE 7: FP mainstreamed as a priority intervention for promoting development across sectors									
ACTIVITY 1: FP is prioritized and operationalized within 5- year national development plans								**Total Activity Cost (Tsh)**	
								37,091,533	
Disseminate 2015-2020 FYDP to relevant ministries	5-year development plan disseminated in collaboration with the PO planning commission	Conference package (2 days)	1	Once	1				
		Half per diems	50 participants						
Meet with PO-PC to engage them on comprehensive inclusion and updating of FP indicators in the Annual Development Plans (ADPs) and budgets	Meeting with the PO-PC held annually	Conference package (1 day)	1	Annually	1	1			
		Half per diems	25 participants						
Engage PO-PC on comprehensive review and inclusion of FP indicators in the 2021-26 FYDP	FP stakeholder participation in relevant PO-PC meetings concerning the 2021-26 FYDP	N/A	N/A	Once during year 2 and 3		1	1		

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(# of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Conduct advocacy meetings with selected Parliamentary committees and associations to solicit their support on comprehensive inclusion of FP indicators in Annual Development Plans and the 2021-26 FYDP	Meetings with selected Parliamentary committee and associations held annually	Conference package (1 day) meeting	30 participants	Once during years 1-3	1	1	1		
		Per diems	25 key members of PM committees and associations						
		Fuel	3 vehicles @ 50 litres						
		Facilitators allowances	2 facilitators						
		Drivers per diems	3 drivers						
		Roundtrip air ticket for facilitators	2						
Track implementation of FP indicators in ADPs and budgets	Support PO-PC to hold annual meetings to share updates tracking FP indicators progress in ADPs and budgets	Conference package (1 day meeting)	1	Annually	1	1	1	1	1
		Half per diems	25 participants						
ACTIVITY 2: Mainstream FP into different sectors' policies and strategies (e.g., Education, Youth, etc.)								**Total Activity Cost (Tsh)**	
								286,093,359	
Conduct an analysis of existing and potential FP champions from MoHCDGEC, PO-RALG, PO-PC, and MOFP	An analysis of existing and potential FP champions conducted once (to update list as needed annually)	Consultant	20 days	Once in year 2 and 4		1		1	
Conduct assessments of status of FP in selected sectors' policies and strategies	One assessment conducted per sector (at least 10 sectors)	Engage consultant firm to assess the status of FP reflected in the selected sectors' strategies and policies.	30 days	Twice	5	5			

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(# of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Hold meetings with identified champions in each MDAs and Parliamentarians to orient them on key FP issues including contraceptive security functions and their roles as FP Champions	Two meetings with identified Champions from MDA and Parliamentarians held	Conference package (2 days)	1	Twice		1		1	
		Full per diems	20 participants						
		Half per diems	20 participants						
		Air ticket	10 roundtrip tickets						
		Drivers per diems	10 drivers						
		Fuel	5 vehicles @ 50 litres						
Share findings with FP stakeholders, FP champions and representatives from selected MDAs for validation and to generate sectoral commitments	Conduct a 1-day workshop with representatives from selected MDAs	Conference package (1 day)	1	Once		1			
		Full per diems	30 participants						
		Half per diems	10 participants						
		Fuel	5 vehicles						
		Drivers per diems	5 drivers						
		Local travel	10						
		Facilitator's per diems	1						
Sectors develop action plans for implementing commitments	Each sector develops an action plan within own resources	N/A	N/A						
Track implementation of sectoral action plans	Progress in commitment implementation tracked and shared twice a year (through existing mechanism, including semi-annual meeting)	N/A	N/A	Twice a year	2	2	2	2	2
ACTIVITY 3: Establish and actively operate a multi-sectoral coordination platform structure to promote and support FP across different sectors								**Total Activity Cost (Tsh)**	
								44,655,976	
Establish a multi-sectoral structure to promote FP across sectors	A mutisectoral structure established with specific ToR	Refreshments (1 day)	30 people	Once	1				

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(# of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Facilitate operations and regular meetings of the structure	A multi-sectoral platform meeting held annually	Conference package (2 days)	1	Annually	1	1	1	1	1
		Half per diems	25 participants						
		Full per diems	5 vehicles @ 50 litres						
		Facilitators per diems	1						
		Fuel	5 vehicles @ 150 litters						
ACTIVITY 4: Sensitize media outlets to include coverage on FP as an engine for social and economic development as part of planned programming								**Total Activity Cost (Tsh)**	
								27,557,938	
Conduct a 1-day sensitization meeting with 15 identified media owners	15 media owners sensitized	Conference package (1 day)	20 participants (15 media owners, 5 FP experts)	Once	1				
Orient journalist/ media reporters on producing articles /airing sessions related to contribution of FP in social and economic developmental issue	3 days' workshop each with 40 journalist	Conference package (3 days)	30 people	One workshop in years 1-3	1	1	1		
		Half perdiems	30 people						
		Facilitators	2						
OUTPUT EE 8: The capacity of the government (at central and council levels) to lead, manage, and coordinate the FP program and diverse stakeholders enhanced									
ACTIVITY 1: Improve Government coordination and support of implementing partners at the national and district level								**Total Activity Cost (Tsh)**	
								338,210,979	
Conduct assessment of the coordination of FP implementing partners at national and council levels	One assessment conducted	Consultant	30 days	Once	1				
Share findings with key FP stakeholders for inputs, validation, and to recommend guidelines and standards for improving coordination	Meeting with stakeholders held to validate the findings and recommend guidelines and standards for improving coordination	Conference package (1 day)	50 participants	Once	1				
		Half per diems	35 participants						
		Full per diems	15						
		Facilitators per diems	1						
		Local travel for facilitators	15						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(# of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Draft guidelines and standards for improved partner coordination, FP based on assessment and stakeholder input	Guidelines and standards drafted	Consultant (time included above)	N/A	Once	1				
Hold meeting to validate the guidelines and standards for FP partner coordination	Meeting held and guidelines and standards validated	Conference package (1 day)	1	Once	1				
		Half per diems	30 participants						
Disseminate the guidelines for FP partner coordination at all levels	One dissemination meeting held	Conference package (1 day)	1	Once	1				
		Half per diems	20 participants						
		Full per diems	30 participants						
		Facilitators per diems	1						
		Fuel	3 vehicles @ 50 litres						
		Local transport	20 participants						
Conduct monthly national FP technical working group meetings	Monthly FP TWG meetings held	Refreshments (1 day)	40 participants	Monthly	12	12	12	12	12
Conduct semi-annual FP stakeholder's meetings	Semi-annual meetings conducted	Conference package (2 days)	1	Twice per year	2	2	2	2	2
		Half per diems	30 participants						
		Full per diems	50 participants						
		Drivers per diems	10 drivers						
		Local travel	30 participants						
		Fuel	10 vehicles @ 200 litres						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(# of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
OUTPUT EE 9: Evidence-based data generated and used to inform programmatic, budgetary, and policy decision making									
ACTIVITY 1: Improved FP data management at subnational level, including appropriate disaggregation of community-level data in the existing MTUHA and DHIS2								Total Activity Cost (Tsh)	
								460,737,198	
Identify gaps related to FP data management in the existing data systems (MTUHA and DHIS2)	Existing FP-related data systems gaps identified and recommendations made	Consultant	10 days	Once every two years	1		1		1
Share the identified gaps and recommendations for improvements during the NFPTWG meetings	Identified gaps shared for approval during the NFPTWG meeting	Refer to TWG meetings 4. 4 a (1.5 sub activity)		Once every two years	1		1		1
Facilitate the inclusion of approved improvements in the MTUHA and DHIS2 systems	Adoption of agreed improvements in MTUHA system and tools facilitated through participation of FP unit staff in routine MTUHA review workshops	Per diems (5 days)	4 people	Once every two years	1		1		1
		Local transport	4 people						
Train council health data teams on improved data systems and overall information management, data sharing and use for decision making within the councils	Council health data teams trained on improved data systems	Conference package (3 days)	30	Every other year (years 1, 3, 5)	8		8		8
		Half per diems	2 participants						
		Full per diems	28 participants						
		Trainers per diems	3						
		Local travel for participants from council	15 participants						
		Fuel	5 vehicles @ 50 litres						
		Drivers per diems	5 drivers						
		Roundtrip air ticket for trainers	3 Roundtrip tickets						
Monitor and evaluate implementation of improved data system and information management at council level	RCHS/FP M&E staff conduct quarterly data auditing at the council levels	Inputs represented under CS Output 3	N/A	Quarterly (10 council visits per quarter)	40	40	40	40	40

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(# of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
ACTIVITY 2: Capacity of FP unit staff strengthened on information management including data access, analysis, and data presentation for decision-making								**Total Activity Cost (Tsh)**	
								49,545,438	
Conduct capacity assessment of selected MoH staff information management including data access, analysis, and presentation for decision making	Capacity assessment conducted	Consultant	20 days	Once	1				
Develop Capacity Development Plans (CDPs) for selected MoH staff	CDPs developed every three years	Consultant	10 days	Twice	1			1	
Conduct training sessions for selected MoH staff	Training sessions conducted once every three years	Conference package (3 days)	1	Twice	1			1	
		Half per diems	10 participants						
		Facilitation fee	1						
		Air ticket for facilitator	2 roundtrip tickets						
Evaluate implementation of CDPs and update as needed	Evaluation report documenting impact of CDPs developed with recommendations for reviewing CDPs	Consultant	15 days	Once				1	

DEMAND CREATION

OUTCOME DC 1: Increase total demand for contraceptives

OUTPUT DC 1: People have accurate knowledge and self-efficacy to adopt a positive behavioral change to practice FP

ACTIVITY 1: Finalize FP content in CHW module 1 training package

Total Activity Cost (Tsh): 419,000,000

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Hold a finalisation meeting for FP content in CHW module 1 training package	Module 1 package in place	Conference package (5 days)	1	Once	1				
	1 meeting	Per diems	15 people						
Print the Module 1 package for CHWs	8,000 Module 1 packages printed	8,000 copies (one for each CHW) Designing and Printing costs	8000	Once	1				
Print the Module 1 package for stakeholders and government officials	2000 Module 1 packages printed	2,000 copies Designing and Printing costs	2000	Once	1				
Dissemination of Module 1 package for CHWs	Module 1 package disseminated during CHW trainings	Cost covered under CHW trainings (see next activity)	Through 270 workshops (18 Regions, 15 workshops per region)	Annually		60	150	60	

ACTIVITY 2: Conduct module 1 Training of CHWs in 18 prioritized regions (per FP Goals)

Total Activity Cost (Tsh): 3,781,378,238

Train CHWs Trainers through a 5-day TOT	2 TOT workshops held	Conference package (5 days)	1	Twice		1	1		
		Participant per diems	36 participants						
		Trainers per diems	3 facilitators						
		Participants transport region	36						
		Trainers transport region	3						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Conduct refresher Training for CHWs on Module 1 Package	270 training workshops held for CHWs using Module 1	Conference package (5 days)	270 workshops (18 Regions, 15 workshops per region)	Annually		60	150	60	
		Trainers per diems	540 trainers						
		CHWs per diems	8000 CHWs						
		Trainers transport within the region	540						
Conduct supportive supervision of CHWs		Covered under Service Delivery Output 5	N/A	Monthly		12	12	12	12
ACTIVITY 3: Conduct FP promotional activities using CHWs targeting 18 prioritized regions. Note: activities will target both individuals (related to this output) and groups/communities (related to Output DC2).								**Total Activity Cost (Tsh)**	
								79,459,025,059	
Support CHWs to conduct continuous FP promotional activities in the 18 priority regions.	8000 CHWs conduct monthly activities	CHWs allowances	8000 CHWs	Monthly during years 2-5		12	12	12	12
ACTIVITY 4: Develop/Harmonise print materials to increase awareness of FP methods and availability of FP services, targeting specific populations, and with rights-based language								**Total Activity Cost (Tsh)**	
								144,860,143	
Hold a meeting to agree on the target groups, messages and materials that need to be harmonised/ developed	Target groups, messages, and materials to be harmonised/developed are agreed upon.	Conference package (1 day)	1	Once	1				
		Per diems	25 participants						
		Consultant	30 days						
Conduct a meeting to harmonise existing materials and develop new, targeted resources (eg for youth, postpartum women, etc.)	1 meeting held to harmonise or develop FP materials and ensure they address specific groups	Conference package (5 days)	1	Once	1				
		Per diems	35 participants						
		Transportation region allowances	18 participants						
Materials drafted for pre-testing	Draft materials ready for pre-testing	Consultant	Included in 30 days above	Once	1				
Pre- test materials in selected regions	Harmonised materials pretested in selected regions	Travel cost from Dar to 8 selected regions	8	Once		1			
		Per diems (10 days)	8 people						
		Transport (within the region)	8 people						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Conduct a meeting to finalise materials based on feedback from pre-test	A meeting held to finalise promotional materials	Conference package (5 days)	1	Once		1			
		Per diems	15 people						
		Transportation	15 people						
Printing of the promotional materials	Promotional materials printed	Design and printing of fliers	200,000 copies of fliers	Annually		200,000	200,000	200,000	200,000
		Design and printing of banners	200,000 copies of banners	Twice		200,000		200,000	
		Design and printing of comic books	500,000 comic books			500,000		500,000	
		Design and printing of posters	100,000 copies of posters			100,000		100,000	
Disseminate promotional materials	Disseminate promotional materials Promotional materials available to the communities	Dissemination will be integrated into FP meetings and trainings including FPTWG, CHMTs meetings, Health Facility meetings and CHWs trainings and supportive supervision visits.	N/A	Continuous		x	x	x	x
ACTIVITY 5: Utilize broadcast media to increase awareness of FP methods and availability of FP services, targeting specific populations, and with rights-based language.								**Total Activity Cost (Tsh)**	
								17,450,492,608	
Hold a meeting to agree on the themes of broadcast radio, TV-based and mHealth targeted messages to be developed	Agreement on the themes of broadcast radio, mhealth, TV -based and mHealth targeted messages to be developed	Conference package (1 day)	1	Once	1				
	1 meeting	Transport	25 participants						
		Per diems	25 participants						
		Media Consultant	30 days						
Consultant drafts targeted TV and radio messages	Targeted radio and TV messages developed	Consultant	Included in 30 days above	Once	1				

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Hold a meeting to review and finalize broadcast radio and TV messages	Targeted radio and TV messages reviewed and finalized	Conference package (2 days)	1	Twice	1			1	
		Per diems	20 participants						
Record developed radio and TV messages	Targeted radio and TV messages reviewed and recorded	Recording costs	Media consultant	Twice	1			1	
Pre-test recorded radio and TV messages	Targeted radio and TV messages pretested in selected 8 regions	Travel costs to the regions	4 people (MOH representative, 2 partners representatives and media consultant)	Twice		1		1	
		Per diem 20 days	4 People						
		Venue – at community level	8						
		Transport allowance – within the district for 20 people	20 participants						
Conduct a meeting to finalize radio and TV messages based on feedback from pre-test	2 meetings conducted to finalises radio and TV messages	Conference package (5 days)	1	Twice		1		1	
		Per diems	20 participants						
Hire a consultant to harmonize and draft mHealth messages	Consultant is hired	Consultant	20 days	Once	1				
Conduct a meeting to review and finalize existing mhealth messages and develop new resources (eg YFCS, PPFP etc.)	1 meeting held to review and finalize FP materials and ensure they address specific groups (PP women, young people etc)	Conference package (2 days)	1	Once	1				
		Per diems	15 participants						
		Transportation	15 participants						
		Communication allowances	15 participants						
Pre- test harmonised materials in selected regions	Harmonised materials pretested in selected regions	Travel Dar to selected regions	3 participants	Once	1				
		Per diem (10 days)	3 participants						
		Transportation within the region	3 participants						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Conduct a meeting to finalise harmonised materials based on feedback from pre testing	A meeting held to finalise promotional materials	Conference package (5 days)	1	Once	1				
		Per diems	15 participants						
		Communication allowances	15 participants						
ACTIVITY 6: Promote FP services and methods via multiple channels to raise community awareness								**Total Activity Cost (Tsh)**	
								37,960,000	
Promote FP services through RMNCH mHealth channels	FP messages promoted via text messages and social media channels	Text messages airtime		Monthly	12	12	12	12	12
		Technology partner/ company	1 company						
		Social media staff salary	1 staff						
Promote existing FP services through national toll-free helpline	FP services are promoted through national toll-free helpline	Helpline counsellors allowance	8 helpline counsellors	Annually	365	365	365	365	365
Promote FP services through national and local radio stations	4 National and 5 local radio stations are promoting FP services (3 days a week three times a day)	6 month-package for national radio spots (to air 3 days a week three times a day)	4	Annually	2	2	2	2	2
		6 month-package for local radio spots (to air 3 days a week three times a day)	5						
FP services are promoted via TV spots	3 TV stations promote FP services (3 days a week three times a day)	6 month-package to air TV spot, 3 days a week, 3 times a day	3	Annually	2	2	2	2	2
OUTPUT DC 2: Positive shifts in social norms and attitudes to foster healthier behaviors and beliefs around contraception and its health and economic benefits									
ACTIVITY 1: Determine regional and community level barriers to FP uptake and use								**Total Activity Cost (Tsh)**	
								16,344,301,500	
Assess community level and regional social norms that prevent FP use	Assessment report on social norms in place	Consultant fee	40 days	Once	1				
	Regional travel to selected 8 regions	8 regions	3 people						
	Per diem	20 days	3 people						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Print report on community- and region- specific social norms that prevent FP use	Community reports on social norms printed	Printing costs	2,000 copies	Once	1				
Dissemination of the social norms report.	Social norms report disseminated	Dissemination will be integrated into other activities such as CHWs trainings and supportive supervision visits and meetings with champions	N/A	Continuous	x	x	x		
ACTIVITY 2: Update "guide for integrated health messages" to address negative social norms that hamper FP use								**Total Activity Cost (Tsh)**	
								313,700,000	
Consultation meeting held with partners and RCHCos to identify gaps in the national message guide and update based on results from social norms assessment	Report outlining recommended changes to integrated health messages guide drafted	Conference package (2 days in Dar)	1	Once	1				
		Consultant	30 days						
		Per diems	30						
		Regional Travel	8 RCHCos						
Update the message guide per recommendations from the meeting	Message guide updated	Consultant (included in 30 days above)	N/A	Once	1				
Conduct a meeting to review and validate the updated message guide	Meeting to review and validate the updated guide conducted	Conference package (2 day)	1	Once	1				
		Per diems	20 participants						
		Regional Travel	8 RCHCos						
Print copies of the integrated health message guide that addresses social norms and attitudes	Integrated health message guide printed	Printing costs	9000	Once	1				
Orient Community Champions on addressing FP norms and attitudes	Community Champions oriented on addressing FP norms and attitudes	Conference Package (3 days)	1	Once	5				
		Facilitator fee	2 facilitators						
		Per diem	90 Champions						
		Regional Travel	2 facilitators						
		Regional Travel	60 Champions						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Dissemination of integrated health message guide for champions	FP message guide for champions disseminated	Will be disseminated through Champions trainings (preceding activity and as part of Output EE7)	N/A	Continuous	x	x	x	x	x
ACTIVITY 3: Develop national and local mass media campaigns to address FP-related social norms and attitudes								**Total Activity Cost (Tsh)**	
								461,143,491	
Hold a series of meetings to agree on the themes per target groups and develop draft content based on the results of social norms report	Themes of the local media campaign identified and developed	Conference package (5 days)	Five zonal level meetings	Twice	5		5		
		Regional travel	150 participants						
		Per diem	150 participants						
Work with media consultant to develop content specific to certain zones/regions and targets including...	Media content addressing social norms developed	Media consultant	20 days	Twice	1		1		
Hold a meeting to review and validate the final media content	Final media content validated	Conference package (1 day)	Five zonal level meetings	Twice	1			1	
		Per diem	75 people						
		Regional travel	75 people						
		Half Per diem	10 participants						
Air mass media campaigns through local radios to address social norms and attitudes	Messages to address social norms aired in local radio on a weekly basis	6-month package for radio spots aired	18 regions	Twice	2	2	2	2	2
		3 spots/day, 2 days per week	18 local radios						
Air social norms messaged through national radios to address universal social norms and attitudes	Messages to address universal social norms aired in national radios	6-month package for radio spots aired	3 national radios	Twice	2	2	2	2	2
		3 spots/day, 2 days per week							
ACTIVITY 4: Strengthen collaboration between the MOH's RCHS unit and the Advocacy Social Behavioural Change (ASBCC) component of the health promotion unit								**Total Activity Cost (Tsh)**	
								5,046,075	
Convene meetings between the FP and ASBCC units to discuss issues related to FP demand creation strategies, activities and messages.	Quarterly meetings held between RCHS-FP Unit and MOH Health promotion – ASBCC	Refreshments for 30 people	1	Quarterly	4	4	4	4	4

SERVICE DELIVERY

OUTCOME SD 1: Improve the availability of and access to quality FP services across all types of service delivery points

OUTPUT SD 1: Number and capacity of public- and private-sector facilities offering FP services at acceptable levels of performance and quality, as per national standards, increased

ACTIVITY 1: Review and update FP training plan on an annual basis

Total Activity Cost (Tsh)
142,940,598

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Conduct mapping of FP service providers' (both public and private) training coverage, levels, and gaps across units within facilities and by type of FP training (comprehensive, PPFP, etc)	Mapping assessment conducted annually to verify those sites that have big difference with training tracker average	Air time (75,000)	26 RCHCos	Annually	1	1	1	1	1
		Per diems (10 regions, 5 days per region)	2						
		Transport (RCH central staff to 10 regions)	2						
Gap analysis based on mapping exercise conducted and fed into revised annual training plan.	Training Plan reviewed and updated annually via 1 meeting	Conference package (5 days, Dar)	1	Annually	1	1	1	1	1
		Half per diem	15 participants						
	Validation held with additional RCHS staff to finalize Training Plan	Conference package (3 days)	1	Annually	1	1	1	1	1
		Half per diem	15 participants						
Update online training tracker based on HR mapping results	Train tracker updated annually to incorporate results from HR mapping	Refreshments (3 days)	1	Annually	1	1	1	1	1
	1 in-house meeting	Half per diem	8 participants						
Dissemination of the FP training strategy	Annual Training Plan shared with FP stakeholders (both public and private) through TWG meeting and RCHS website at least once a year			Annually	1	1	1	1	1

ACTIVITY 2: Strengthen FP preservice education

Total Activity Cost (Tsh)
272,697,008

Stakeholder sensitization meeting to update the pre-service training curriculum	Plan for updating pre-service training drafted	Conference package (1 day)	1	Once	1				
	1 meeting	Refreshments/and or lunch	20 participants						
		Per diems	20 participants						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Update FP AMO training package (pre-service tutors FP package)	Updated FP-pre-service package for medical institutions.	Conference package (5 days)	1	Once					
	1 workshop	Per diems	15 participants						
		Transport	15 participants						
Print updated version of the FP AMOs pre-service tutors FP package	Updated version of the FP AMOs pre-service tutors package printed	Printing costs	300 copies	Once	1				
Conduct orientation training for tutors from 5 AMOs Medical institutions on FP package	5 Medical institutions have at least 4 tutors oriented on FP	Workshop/conference package (2 weeks)	1	Once		1			
		Facilitators fee	4						
		Participants per diems	20 participants						
		Transport regional	12 participants						
		Roundtrip air ticket	8 participants						
Conduct post orientation supportive follow-up of oriented Medical institutions tutors	Tutors from 5 Medical institutions receive at least one supportive supervision visit each year	Per diems	2 supervisors	5 visits per year from year 2		5	5	5	5
		Fuel	2 vehicles (150 litres/car)						
		Roundtrip air ticket	2 supervisors						
ACTIVITY 3: Revise pre-service curriculum for nurses and midwives to include sufficient information regarding PPFP, PACFP and YFCS								Total Activity Cost (Tsh)	
								88,816,250	
Hold a meeting with relevant stakeholders to garner buy-in to revise pre-service curriculum for nurses and midwives	Relevant stakeholders agree on revising pre-service curriculum for nurses	Conference Package (2 days)	1	Once		1			
	1 meeting	Per diem	30 participants						
Conduct workshop to revise pre-service curriculum for nurses and midwives	Revised pre-service curriculum includes sufficient information on PPFP and YFCS	Conference package (5 days)	1	Once		1			
	1 workshop	Per diem	25 participants						
		Travel	25 participants						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Print updated version of the revised pre-service curriculum for nurses and midwives	Updated preservice printed	Printing costs	2,000 copies	Once		1			
ACTIVITY 4: Conduct clinical training on surgical contraception								**Total Activity Cost (Tsh)**	
								1,032,928,341	
Conduct 14-day permanent methods training	416 Providers from 26 Regions trained on surgical contraception. (26 workshops held, 1 workshop/region, 16 providers/region, 3 trainers per workshop)	Conference package (14 days)	26	5 – 6 workshops per year	5	6	5	5	5
		Vasectomy Kits	52						
		Minilap kits	52						
		Participants per diems	416						
		Trainers per diems	3						
		Participants' transport (Local transport regional)	416						
		Trainers Transport (Local transport regional)	3						
ACTIVITY 5: Conduct on the job training (OJT) for comprehensive FP clinical skills.								**Total Activity Cost (Tsh)**	
								23,116,854,008	
Identification of facilities that need OJT for comprehensive FP clinical skills using supervision reports	OJT needs identified through supervision reports	Covered under supervision costs		Quarterly	4	4	4	4	4
Conduct on the job training for comprehensive FP clinical skills in 6000 facilities	12,000 providers trained (2 per facility) on comprehensive FP clinical skills through on the job training	21-day onsite training	1	Annually	1200 facilities	1200 facilities	1200 facilities	1200 facilities	1200 facilities
		Trainer per diem	1						
		Trainees half per diem	2 trainees						
		Local regional transport	2 trainers						
Conduct post-training supervision of trained providers	Post-training follow-up for 12,000 trained providers conducted in 26 regions	Bus Travel	2 supervisors	Annually	5	5	5	6	5
		Per diems (10 day stay)	2 supervisors						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Conduct on the job training for permanent FP methods for clinical officers and AMOs	9817 providers have been trained on permanent FP methods through on the job training in 26 regions (5 days training- 20 trainees per class, 4 per council, 167 councils)	21-day onsite training (5 days)	1	Annually	1965 providers	1965 providers	1965 providers	1965 providers	1957 providers
		Trainer per diems	2 trainers						
		Trainees half per diems	5 trainees						
		Local Transport (trainers within the region)	2 trainers						
Conduct Clinical training for onsite FP clinical mentors/ preceptors	167 Councils have trained clinical mentors/preceptors (660) (5 days training- 20 mentors per class, 4 per council, 167 councils)	Regional conference package (5 days)	1 workshop	Annually Y1 & Y2	16 workshops	17 workshops			
		Trainer per diems	3						
		Trainees per diems	20 trainees						
		Transport within the region (trainers)	3						
		Regional Transport Participants	20						
		Per diem participants	20						
Support trained clinical mentors to conduct mentorship activities	Clinical mentorship activities conducted on a quarterly basis	Half per diem (5 days per quarter)	668 mentors	Quarterly	4	4	4	4	4
Joint supportive (from national to regional) supervision to the 26 regions and districts semi – annually	26 regions receive joint supportive supervision visits twice per year (14 days supervision)	Fuel	26 regions	Semi Annually	2	2	2	2	2
		National staff full per diem	6						
		National to regional travel	6						
		Regional staff half per diem	6						
		Regional to facility travel	12						
		District staff half per diem	3						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item (# needed for each input item)	Frequency of each input item (# of occurrences for each input item)	Timeframe (Write the # of times each input occurs for each year)				
					2019	2020	2021	2022	2023
Quarterly joint supportive supervision visits from 167 Councils to facilities (including private)	4,000 facilities receive quarterly joint supportive visits from Council staff (1 day per facility)	Fuel (Councils to facilities)	4000 visits	Quarterly	4	4	4	4	4
		Half per diem	3 people/Council						
ACTIVITY 6: Procure necessary equipment and supplies for training and service delivery needs (beyond contraceptives)								**Total Activity Cost (Tsh)**	
								7,653,385,732	
Procurement of training materials for practicum sites	Training materials procured for 104 practicum sites nationwide	Pelvic model	2/site	Twice	52	52			
		Mama U	1/site						
		Madam zoo	1/site						
		Penile model	1/site						
		IUCD Kits	2/site						
		Supplies							
		Disposable speculum	400000						
		Scissors	10000						
		Tenaculum	10000						
		Ringed forceps	10000						
		Needle disposable	400000						
		Metal cup 4 x 4's	6000						
ACTIVITY 7: Procure equipment and supplies for routine FP service delivery in health facilities								**Total Activity Cost (Tsh)**	
								8,366,550,000	
Procurement of PPIUD kits for 3000 facilities	Each facility has at least 2 PPIUD kits (lasts for 2-3 years)	PPIUD kits	6,000	Twice	6000		6000		
Procurement of Minilap kits for 2000 facilities	Each facility has at least 2 minilap kits (from health centre level)	Minilap kits	4,000	Twice	4000		4000		
Procurement of IUCD kits for 3000 facilities	Each facility has at least 2 IUCD kits	IUCD kits	6,000	Twice	6000		6000		
ACTIVITY 8: Ensure availability of FP job aids								**Total Activity Cost (Tsh)**	
								169,889,653	
Review of comprehensive FP job aids	Comprehensive FP job aids revised	Workshop/Conference package (1 week)	2	Twice	2			2	
	2 review workshops	Per diems	20 participants						
		Travel	20 participants						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Printing of FP job aids – 2 per facility	Comprehensive job aids printed for all facilities	Design costs	1	Twice	1			1	
		Printing costs	7500 copies	Twice					
Dissemination /Distribution of comprehensive FP job aids	3000 facilities have updated comprehensive FP job aids	Distribution – through trainings and partners		Continuous	x	x	x	x	x
ACTIVITY 9: Strengthen LARC provision at dispensary level								**Total Activity Cost (Tsh)**	
								4,265,073,375	
Conduct LARC training targeting providers at dispensary level through OJT	6000 providers at dispensary level facilities trained on LARC through OJT	Covered under OJT above	3000 dispensaries/ 2 providers per dispensary	Continuous	1200 providers	1200 providers	1200 providers	1200 providers	1200 providers
Conduct health centre led outreach services to provide LARCs at dispensaries	Health centre led monthly outreach conducted to 3000 dispensary facilities	Half per diem	2 health providers	Monthly	1000	2000	3000	3000	3000
		Fuel– 2 days per month	1 car per facility – 100 litters each						
Conduct mobile outreach activities to complement dispensary level LARC outreach	Quarterly outreach events conducted in 12 regions First 3 years as a transition to dispensary led outreach	Outreach activities (2 weeks per region)	12	Quarterly	4	4	4		
		Per diems	2 Providers						
		Transport	2 Providers						
Conduct joint supervision (CHMT and partners) to monitor partner led outreach activities	Supportive supervision conducted to monitor partner led outreach activities in 72 districts of 12 regions	Sample of 1 outreach per council per quarter 1-day visit	72 districts	Quarterly	4	4	4		
		Half per diem	3 people						
		Travel	3 people						
OUTPUT SD 2: Number and capacity of public- and private-sector facilities offering integrated FP and MNCAH services at acceptable levels of performance and quality, as per national standards, increased									
ACTIVITY 1: Revise the FP Operational Guidelines and standards to incorporate PPFP into facility and community-based FP integrated service delivery								**Total Activity Cost (Tsh)**	
								96,000,000	
Conduct a workshop to update the FP operational Guidelines and Standards	Inputs for updating FP Operational Guidelines and Standards obtained	Conference Package (3 days)	1	Once	1				
		Per diem	25 participants						
		Consultant fee	40 days						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Conduct a workshop to finalise the updated FP operational Guidelines and Standards	FP Operational Guidelines and Standards finalised 1 workshop	Conference Package (3 days)	1	Once	1				
		Per diem	25 people						
Conduct a workshop to validate the updated FP operational Guidelines and Standards	FP Operational Guidelines and Standards validated 1 workshop	Conference Package (1 day)	1	Once	1				
		Per diem	25 people						
Print updated FP Operational Guidelines and Standards	FP Operational Guidelines and Standards printed	Printing costs	30000 copies	Once	1				
ACTIVITY 2: Disseminate revised FP operational guidelines to subnational level								**Total Activity Cost (Tsh)**	
								3,751,368,821	
Hold zonal meetings with members of RHMTs and CHMTs and select representative from private hospitals to orient on FP operational guidelines and to develop action plans for disseminating to facility level	8 zonal meetings held at which representatives from RHMTs and CHMTs developed action plans for orienting facility-based staff to new PPFP operational guidelines	Conference package (1 day)	1	Once per year zone during Y1	8				
		Per diem for RHMT members	24						
		Per diem for CHMT members	32						
		Travel regional costs RHMTs and CHMTs	66						
CHMTs orient facility managers/in-charges on FP operational guidelines and how to develop action plans for disseminating to facility level	167 district meetings held to orient facility managers and facility in-charges	Meeting venue	167	Annually in Years 1 & 2	100	67			
		Per diems	35 people/district						
		Travel – within the district	35						
Facility managers/in charges to orient health providers on FP operational guidelines and to develop action plans	Health providers from 3000 facilities have been oriented on FP operational guidelines and developed actions plan	To be included as an agenda of the regular facility meetings.	3000 facilities	Annually in Years 1 & 2	2000	1000			

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Develop and disseminate a national one- hour powerpoint and fact sheet for PPFP orientation to be used by partners	Meeting held to develop a PPT and fact sheet for PPFP	Conference package (1 day)	1	Once	1				
		Per diem	8 People						
	National one- hour powerpoint and fact sheet for PPFP orientation developed	Printing costs	200 copies fact sheet	Once	1				
Integrate comprehensive job aids and FP guidelines and standards into FP counselling training	FP Counselling curriculum and comprehensive FP curriculum include PPFP operational guidelines	No cost		Continuous	x	x	x	x	x
ACTIVITY 3: Develop need-based training strategy focused on labour and delivery staff (Based on the needs assessment results)								**Total Activity Cost (Tsh)**	
								0	
Identification of gaps for PPFP training among providers in labor/delivery at all levels (link to activity in Output SD 1)	Annual report on the list of provider capacity needs for PPFP at all levels (hospital, HC and dispensary) (would be included in report that is target for activities in SD 1) Total 5 reports			Annually	1	1	1	1	1
ACTIVITY 4: Expand the pool of qualified PPFP trainers								**Total Activity Cost (Tsh)**	
								536,075,950	
Conduct ToT workshops to train 112 additional PPFP trainers	7 TOTs held to train 112 trainers across all regions to ensure each region have at least 4 trainers Base unit: One workshop = 4 regions and 16 participants total	Conference/workshop package (11 days)	1 workshops	Once	7				
		Participants per diems	16 participants per workshop						
		Trainers per diems	4 trainers						
		Travel participants Regions	16 participants						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Conduct post training follow-up at 6 weeks after training to certify newly trained PPFP trainers	Follow-up visit at 6 weeks after training conducted in all regions for newly trained PPFP trainers Base unit: Zone	Senior trainer per diem (10 days)	8 trainers	Once	8 zones				
		Fuel	8 Vehicles – 100 litres each						
		Drivers per diem (10 days)	8						
		Travel costs to regions (senior trainers)	8						
Conduct a 2nd follow-up visit to certify 33% of newly trained PPFP trainers	Second follow-up visit after training conducted for 33% of newly trained PPFP trainers (34 trainers visited)	Senior trainer per diem (10 days)	8 trainers	Once	4 zones				
		Fuel	8 vehicles – 100 litres each						
		Driver per diem (10 days)	8						
		Travel costs to regions (Senior trainers)	8						
Refresher training for all previously trained PPFP trainers	112 PPFP trainers receive refresher training	Conference package (6 days)	1 workshop	Five times during Y4				5	
		Trainers per diem	4						
		Participants per diem	20 participants						
		Travel to the regions (trainers)	4						
		Travel to the regions (Participants)	20 participants						
ACTIVITY 5: Train providers from labour and delivery in PPFP								**Total Activity Cost (Tsh)**	
								20,751,951,792	
Hold 12-day training workshops for labour and delivery providers using PPFP curriculum	Workshops held to train 6000 providers on PPFP provision	Conference package (11 days)	1	75 workshops per year	75	75	75	75	75
		Participant per diems	16						
		Trainers per diems	4						
		Trainers travel costs to the regions	4						
		Participants travel costs to the regions	16						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Conduct post training follow-up 6 weeks after training	100% of newly trained providers receive at least 1 follow up visit at 6 weeks from trainer Assumption: 1 trainer per zone will need 15 days to conduct post-training follow-up in their zone . Total of 1200 providers to receive the visits per year.	Senior trainer per diem (15 days)	8	Annually	1	1	1	1	1
		Fuel	8 vehicles @100 litres						
		Driver per diems (15 days)	8						
		Travel costs to regions (senior trainers)	8						
Conduct post training follow-up 6 weeks after training *cont.*	33% of those newly trained receive a 2nd follow-up visit Assumption: 1 trainer per zone will need 8 days to conduct 2nd post-training follow-up in their zone. 33% of 1,200 providers = 396 per year.	Senior trainer per diem (8 days)	8	Annually	1	1	1	1	1
		Fuel	8 vehicles @100 litres						
		Drivers per diems (8 days)	8						
		Travel costs to regions (Senior trainer)	8						
Conduct refresher training for newly trained PPFP providers after 2 years	3,600 trained providers receive refresher training (1,200 each year receive refresher training 2 years post-training)	Conference package (6 days)	1 training	75 trainings each year in years 3,4,5			75	75	75
		Participants per diem	20						
		Trainers per diem	2						
		Participants travel region	20						
		Trainers travel region	2						
ACTIVITY 6: Train/orient antenatal care (ANC), post-natal care (PNC) and immunization (IZ) providers to new PPFP procedures and job aids								**Total Activity Cost (Tsh)**	
								0	
ANC, PNC and IZ providers are skilled to provide PPFP services	Facility-based staff from 3000 facilities oriented to job aids (2 staff per facility)	No additional inputs—conducted as part of FP supervision visits budget	3000	Continuous	x	x	x	x	x

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
ACTIVITY 7: Integrate FP into routine immunization outreach activities to include counselling, provision and referral for FP								**Total Activity Cost (Tsh)**	
								0	
Facilities organize immunization outreach activities with a provider trained to counsel and offer FP as part of the outreach team	3000 facilities integrate FP counselling, provision and referral into monthly immunization outreach activities	No additional cost—assume that provision of FP is integrated into routine immunization outreach activities which are included in district/council or facility budgets	3000 facilities	Continuous	1000 facilities	2000 facilities			
ACTIVITY 8: Support providers to offer FP as part of PAC								**Total Activity Cost (Tsh)**	
								0	
PAC providers have adequate FP skills.	3000 facilities offer FP services as part of PAC	Through supportive supervision in Output SD 1.	3000 facilities	Continuous	x	x	x	x	x
OUTPUT SD 3: Number and capacity of public- and private-sector facilities offering integrated FP and HIV services at acceptable levels of performance and quality, as per national standards, increased									
ACTIVITY 1: Review National Operational Guideline for Integrating MNCH/HIV/AIDS services (NOGI)– 2012 and SOPs to include current evidence and practises.								**Total Activity Cost (Tsh)**	
								222,298,000	
Review NOGI 2019 to identify gaps and areas of improvement	Consultant to review NOGI and come up with proposed areas for revision	Consultancy fee	40 days	Once	1				
Conduct a meeting to agree on the areas of improvement	Areas for NOGI's revision identified	Conference Package (5 days)	1	Once	1				
		Per diems	30 participants						
Conduct a meeting to validate the revised NOGI	Meeting held and revised NOGI validated.	Conference Package (3 days)	1	Once		1			
		Per diems	30 participants						
Print revised NOGI	Revised NOGI printed	Printing costs	15,000 copies	Once		1			
Disseminate NOGI to FP/HIV stakeholders	Dissemination meeting conducted with participation from HIV and MCH stakeholders 1 meeting	Conference Package (1 day)	1	Once		1			
		Transport ZRCHCos	8						
		Per diems	30 participants						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
ACTIVITY 2: Review and finalize the FP/HIV integration curriculum for CTC health providers								**Total Activity Cost (Tsh)**	
								784,949,356	
Hold workshop with key stakeholders to review the FP/HIV integration curriculum	1 workshop held to review and finalize FP/CTC curriculum	Conference package (5 days)	1	Once		1			
		Consultant fee	30 days						
		Per diem	15 participants						
		Regional transport	5						
Hold workshop with key stakeholders to validate the FP/HIV integration curriculum	1 workshop held to validate FP/CTC curriculum	Conference package (1 day)	1	Once		1			
		Participant per diem	30 participants						
		Transport region	8						
Print revised FP/CTC curriculum	Revised FP/CTC curriculum printed	Design costs	1	Once		1000			
		Printing costs	1000 copies						
Conduct FP/HIV integration training for CTC providers	500 CTC providers trained on FP/CTC curriculum	Conference/workshop package (9 days)	1	25 workshops during Y2-Y4		5	10	10	
		Trainers per diems	2						
		Participant per diems	20						
		Trainers travel region	2						
		Participants Travel to regional	20						
OUTPUT SD 4: Number of facilities offering quality youth-friendly services according to established national youth-friendly service standards increased									
ACTIVITY 1: Renovate facilities to ensure adequate space & privacy as per youth friendly services guidelines								**Total Activity Cost (Tsh)**	
								0	
Conduct analyses of facility infrastructure needs during supervision visits	Facility infrastructure needs report completed	Costs covered under supportive supervision (Ref to activity Output SD 1)		Quarterly	4	4	4	4	4

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Advocate to CHMTs and facility managers to allocate funds to implement needed renovations in facilities	Advocacy meetings with CHMTs and facility managers to fund needed renovations in facilities	Cost covered under Output EE 1 activity related to meetings with CHMTs to influence adequate FP budget increases		Continuous	x	x	x	x	x
ACTIVITY 2: Train providers on youth friendly contraceptive services (YFCS)								**Total Activity Cost (Tsh)**	
								17,414,383,592	
Liaise with Adolescent and Reproductive Health Unit to train one National YFCS trainers from each region, 26 in total	26 National YSFC Trainers trained and available 1 workshop	Conference package (7 days)	1	Once	1				
		Trainers per diems	3						
		Participants per diems	26						
		Trainers transport region	3						
		Participants transport region	26						
Liaise with ARH department to conduct YFCS training to health providers (both public and private)	2 providers per facility have been trained on YFCS (6000 facilities/ 12000 providers)	Conference/workshop package (7 days)	1	96 workshops per year	96	96	96	96	96
		Trainers per diem	3						
		Participant per diems	25						
		Participants transport region	25						
		Trainers Transport region	3						
ACTIVITY 3: Deliver FP services during convenient hours for youth								**Total Activity Cost (Tsh)**	
								22,500,000	
Assessment conducted on available YFCS and preferable time/day for young people (disaggregated by profile—eg in/out of school) to attend FP clinic	Report generated detailing convenient hours for youth service delivery	Consultant	30 days	Once	1				

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Disseminate assessment report to facility managers and providers through partners and CHMTs.	6000 facilities receive YFCS service delivery assessment report	Disseminated during regular facility visits, eg. supervisions and meetings		Continuous	x	x	x	x	x
ACTIVITY 4: Promote YFCS services to young people								**Total Activity Cost (Tsh)**	
								50,405,739	
Design and print a youth friendly contraceptive services sign board to promote FP services at the facility level	Sign boards designed and printed	Designer fee	10 days	Once		1			
		Sign board printing	8,000 copies of sign board						
Disseminate YCFS sign board to facilities	6000 facilities receive signboards (at least one per facility)	Disseminate through YSCF trainings (Ref activity 3.4.2) and supportive supervision visits (Ref activity 3.1.5.)							
In addition to YFCS sign boards, facilities clearly display hours of YFCS services	6000 facilities displaying hours of service	No cost	Continuous		x	x	x	x	x
YFCS facilities/service delivery points display FP rights-based information	6000 facilities display FP rights-based information	No cost	Continuous		x	x	x	x	x
Develop a national YFCS directory for referral services	National YFCS directory developed	Airtime	8 RCHCos	Annually	1	1	1	1	1
		Airtime	1 RCHS						
Incorporate a directory of youth-friendly service facilities into toll-free helpline databases	YFCS directory incorporated into toll-free helpline	No cost		Once per year	1	1	1	1	1
Train toll-free helpline counselors on YFCS	375 councelors trained on YFCS services	Conference Package (3 days)	1	Three times per year	3	3	3	3	3
		Trainers per diems	3						
		Trainers transportation within the region	3						
		Participants half per diem	25 people						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
ACTIVITY 5: Provision of wide range of methods to youth as per National Guideline								Total Activity Cost (Tsh)	
								302,764,523	
YFCS facilities conduct monthly targeted outreach to youth (eg. visit youth clubs, or provide services at youth corners) with information and services	4000 YFCS facilities conduct monthly outreach targeting youth	Half Per diem for 2 providers	2	Monthly	12	12	12	12	12
		Fuel	1 Car @ 50 litres						
		Drivers half per diem within the district	1						
Promote partnerships and coordination with other stakeholders (NGOs, faith-based organizations [FBOs], private sector) to provide YFCS outreach	Each region convenes 1-day meeting once per year	Conference package (1 day)	1	26 annually (1 per region)	26	26	26	26	26
		Per diem	15 stakeholders						
Conduct supportive supervision to trained YFCS provides	Supportive supervision to trained YFCS providers conducted	Covered under the facility supportive supervision (Ref Output SD 1)		Quarterly	4	4	4	4	4
OUTPUT SD 5: Number and capacity of community-based services offering FP at acceptable levels of performance and quality, as per national standards, increased									
ACTIVITY 1: Conduct trainings of formalized CHWs								Total Activity Cost (Tsh)	
								23,240,549,855	
Mapping of formalised CHWs workers	List of formalised CHWs developed	Consultant fee	5 days	Once	1				
Print FP package for CHWs refresher training	CHW packages printed	Printing costs	10,000 copies	Once	1				
Disseminate the FP package for CHWs during CHWs training	FP package for CHWs disseminated to CHWs	Combined in CHWs training costs	8000 copies	Three times	2800	2800	2400		
Conduct a refresher training on FP to formalised CHWs	8000 Formalised CHWs receive FP refresher training 400 workshops held	District level conference package (5 days)	1	During Y1-Y3	134	134	132		
		CHW per diems	20 per workshop						
Procure CHWs equipment	All districts procure and distribute equipment for CHWs in their catchment area	Umbrella Rain boots Bags	8,000 CHWs	Once per year	1	1	1	1	1

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Facilitate health providers at facility level to conduct monthly supportive supervision of CHWs	4000 facilities conduct monthly supervision visits of formalized CHWs within their catchment area	Half per diem (once per week)	4000 health providers	Once/month	12	12	12	12	12
		Airtime	4000 health providers						
ACTIVITY 2: Contribute to curriculum revision for formalized CHWs to include the FP component for advocacy, promotion, service delivery and referral								**Total Activity Cost (Tsh)**	
								14,375,000	
Conduct a meeting with FP stakeholders to elicit revisions to update FP content in CHW curriculum	Meeting conducted with FP stakeholders to updated FP content in CHW curriculum	Refreshments (1 day)	1	Once	1				
		Half per diem	8						
		Full per diem	12						
		Transportation (roundtrip air ticket)- Dodoma	12						
Conduct a follow-up meeting with Health Promotion Section and NACTE to ensure revisions are captured	Meeting conducted to finalize revisions to FP content	Refreshments (1 day)	1	Once	1				
		Half per diem	8						
		Full per diem	7						
		Transportation (roundtrip air ticket)- Dodoma	7						
Participate in the formal CHWs curriculum revision meetings to ensure FP component is included	3 participants representing FP program	Per diem	3 people	Once		1			

COMMODITY SECURITY

OUTCOME CS 1: Have adequate amounts of a range of commodities available at service delivery points: facilities, communities, and outreach settings

OUTPUT CS 1: GOT leadership and stewardship of FP commodity security strengthened

ACTIVITY 1: Second contraceptive security coordinator with CS/SCM skills to FP unit of RCHS

Total Activity Cost (Tsh)
152,730,000

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item (# needed for each input item)	Frequency of each input item (# of occurrences for each input item)	Timeframe (Write the # of times each input occurs for each year)				
					2019	2020	2021	2022	2023
Assist RCHS to develop job description for the seconded staff	Job description for seconded contraceptive security coordinator developed and approved	Advert cost	3 adverts	Once	1				
Recruit additional pharmacist to assist on SC/SCM functions	One pharmacist recruited and seconded to RCHS FP unit	Salary (annual)	Three	Once per year	1	1	1		
		Laptop	One	Once					

ACTIVITY 2: Build capacity of other staff within FP unit/RCHS on core functions of CS/SCM (focus on commodity quantification, procurement, active management of supply chain, including logistic Information management

Total Activity Cost (Tsh)
32,180,000

Conduct an assessment to identify gaps in undertaking core functions of CS/SCM within FP unit/RCHS	An assessment conducted, gaps identified and documented	Consultant	10 days	Once	1				
Develop Capacity-building plan based on the identified gaps	Capacity-building plan developed	Consultant	5 days	Once	1				
One-day meeting to disseminate the plan to key stakeholders to solicit support	One high level meeting held to engage donors, government and key stakeholders to sustainably address CS capacity gaps at RCHS	Conference package	1	Once	1				
		Per diems	20 participants						
		Consultant	3 days						
Develop SOPs for specific functions related to CS/SCM for staff within FP unit/RCHS	SOPs developed	Consultant	10 days	Once	1				
Disseminate the SOPs for inputs and validation to the members of the TWG meeting	Refers to TWG meeting (under output EE 4.4 a sub activity 1.4)	N/A		Once	1				

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Train/Orient FP/RCHS staff on SOPs for specific CS/SCM functions including active management of supply chain including stock status	FP/RCHS staff trained/ oriented on SOPs for specific CS/SCM functions	Conference package (5-days meeting)	5 days	Once	1				
		Full per diems	10 participants						
		Fuel for vehicle (Dodoma-Morogoro)	2 Vehicles @ 100 Litres						
		Drivers per diems	2						
ACTIVITY 3: Organize routine meetings between Reproductive and child health Section (RCHS), Medical Store Department (MSD) and Directorate of Pharmaceutical Services (DPS) to coordinate and improve contraceptive security core functions								**Total Activity Cost (Tsh)**	
								5,046,075	
Conduct quarterly Contraceptive security meeting with high level participation of leadership from key responsible government units	Contraceptive security meetings held quarterly	Refreshments (half-day meeting)	30 participants	Four times per year	4	4	4	4	4
ACTIVITY 4: Garner support from the MoH to adopt and implement a TMA to support CS/SCM in the country								**Total Activity Cost (Tsh)**	
								21,156,063	
Conduct advocacy meeting to get buy in from relevant MoH Agencies (TFDA, Pharmaceutical Section) to adopt a TMA in the country	Advocacy meetings held with relevant government ministries and agencies	Local per diems	5 participants	Twice	2				
		Consultant/ facilitator	1						
		Conference package (1 day meeting)	1						
		Per diems	25 participants						
		Fuel for vehicle (Dar to Dodoma)	3 vehicles @ 100 Litters						
		Drivers per diems	3						
		Local transport	20 participants						
Establish TMA working group to endorse and steer the implementation of TMA plan	TMA working group established with specific ToR	Conference package (1 day)	1	Once	1				
		Half per diems	40 participants						
Develop TMA implementation plan based on the TMA assessment report (UNFPA report) and outcomes of the advocacy meetings	TMA implementation plan developed, including advocacy activities	Refreshments	30 participants	Once		1			

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Disseminate the TMA implementation plan to stakeholders	TMA implementation plan disseminated 1 meeting	Refreshments	25 participants	Once		1			
Hold quarterly TMA working group meeting to provide guidance and monitor the implementation of TMA plan	Quarterly TMA working group meetings held and action points are tracked	Refreshments	25 participants	Four times a year	4	4	4	4	4
OUTPUT CS 2: Sufficient contraceptive commodities procured to cover all country needs (in accordance with the NFPCIP 2019–2023 method projections and as adjusted during annual quantification exercises) to meet the mCPR goal by 2023									
ACTIVITY I: Support routine national level quantification exercise								Total Activity Cost (Tsh) 254,391,562	
Conduct FP data analysis workshop for commodity quantification	Data analysis workshop conducted for FP commodity quantification	Conference package (1 day)	1	Once every other year		1		1	
		Per diems (2 days, including travel)	40 participants						
		Fuel for vehicle	5 vehicles @ 50 litters						
		Drivers per diems	5						
		Local travel	10 participants from Dar to Bagamoyo to Dar						
Conduct national quantification workshop to develop quantification plan	Annual quantification plan developed taking into consideration a total market approach (public, private and social marketing)	Local travel	5 participants Dar-Bagamoyo to Dar	Once every other year		1		1	
		Conference package (7 days)	1						
		Per diems	30 participants						
		Fuel for vehicle	5 vehicles @ 50 litters						
		Drivers per diems	5						
Organize meeting to disseminate and validate the quantification plan	Quantification plan validated and disseminated	Conference package (1 day)	1	Once every two years		1		1	
		Half per diems	30 participants						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Conduct resource mobilization meeting with government and key donors to meet procurement needs based on quantification exercise	Annual commodity procurement plans developed by Government and respective partners cover quantification plan requirements at 100%	Conference package (1 day)	1	Once a year	1	1	1	1	1
		Half per diems	40 participants						
Conduct semi-annual quantification review meetings	Quantification review meeting held semi-annually	Conference package (4 days)	1	Twice a year	2	2	2	2	2
		Half per diems	30 participants						
ACTIVITY 2: Include private sector within Commodity Procurement Tables, specifically to disaggregate social marketing from true private sector								**Total Activity Cost (Tsh)**	
								41,787,812	
Conduct an assessment to identify the market share (% of FP commodities) within private sector that is social marketing (vs true private sector brand)	Desk assessment conducted annually; results shared with quantification committee members and with FP unit	Consultant	5 days	Once a year	1	1	1	1	1
Disseminate the findings from the assessment to stakeholders	Assessment findings shared with stakeholders	Conference package (1 day)	1	Once a year	1	1	1	1	1
	1 meeting	Half per diems	30 participants						
ACTIVITY 3: Procure commodities as per projected country method mix and projected mCPR goal by 2023								**Total Activity Cost (Tsh)**	
								0	
Government and donors procure contraceptive methods in line with quantification plans (see previous activity in this output)	Contraceptives commodities procured by type of methods	Contraceptives Taxes and fees	See table in CIP narrative						
OUTPUT CS 3: Supply chain management system for FP commodities improved									
ACTIVITY 1: Identify and address capacity needs of facilities with problems in filling R&R forms								**Total Activity Cost (Tsh)**	
								77,599,172	
Conduct quarterly mapping based on trends of electronic logistical data on RR rejections from facilities within the councils	Facilities with RR rejection mapped quarterly	Seconded RCHS staff time	N/A	Quarterly	4	4	4	4	4
Conduct in-depth assessment in sample of facilities with high rejection rates to better understand the problems and capacity gaps	Assessment conducted	Consultant	20 days	Once every two years	1		1		1

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
Conduct workshop to develop targeted capacity building plans to improve data quality, accountability and governance based on the identified key weakness	Targeted capacity building plans to address reporting issues for identified facilities developed	Conference package (10 people)	5 days	Once after every two years	1		1		1
		Perdiems	10 people						
		Local travel	10 people						
		Facilitators	2						
Conduct targeted capacity-building through joint supportive supervision of LMU, CHMTS to identified facilities with poor performance	Facilities identified with problems provided with targeted capacity building to address R&R reporting issues on a quarterly basis	Conducted as part of next activity below		Four times per year	4	4	4	4	4
ACTIVITY 2: Provide technical and financial resources support to CHMTs for monitoring and supportive supervision related to CS/ CM including early identification of stock status issues								**Total Activity Cost (Tsh)**	
								217,822,254	
Conduct quarterly supportive supervision to monitor stock reporting, management, storage at facility level in collaboration Zonal LMU, RHMT and MSD and RCHS/ FP unit	Quarterly joint supportive supervision conducted to identified facilities with RR reporting issues	Supervision allowances (within zone/ region)	10 people (14 days visits)	Four times per year	4	4	4	4	4
		Per diems (from Dar)	10 people						
		Fuel	2 vehicles @ 300 Litters						
Conduct routine data quality assessments to sample of facilities within districts (those identified by FP Goals)	DQA conducted quarterly	Per diems	3 people (15 days per quarter)	Four times per year	4	4	4	4	4
		Fuel	2 Vehicles @ 300 Litters						
		Air ticket (go and return)	3						
ACTIVITY 3: Build the capacity of CHMTs and RCHS FP staff to use eLMIS for increasing real time data visibility and use in addressing stock status issues at facility level within the councils								**Total Activity Cost (Tsh)**	
								823,161,169	
Conduct refresher training to orient CHMTs on the use of eLMIS	CHMTs oriented on the use of eLMIS	Conference package (2 day meeting)	16 meetings each (27 participants)	4 meetings in a year (year 1,2,3 and 4)	4	4	4	4	
		Half per diems	6 Participants						
		Full per diems	11 Participants						
		Fuel	2 vehicles @ 50 litters						
		Drivers per diems	2						

Sub-activity	Sub-activity level Targets	Input	Quantity of each input item *(# needed for each input item)*	Frequency of each input item *(# of occurrences for each input item)*	Timeframe *(Write the # of times each input occurs for each year)*				
					2019	2020	2021	2022	2023
ACTIVITY 4: Ensure availability of CS/SCM-related materials and documents								**Total Activity Cost (Tsh)**	
								25,000,000	
Provide sufficient R&R forms to facilities	Sufficient R&R forms provided to facilities	Print R&R forms	50,000 RR forms printed annually	50,000 copies	Once a year	50,000	50,000	50,000	50,000