The United Republic of Tanzania
Ministry of Health and Social Welfare

NATIONAL COSTED OPERATIONAL PLAN FOR STRENGTHENING COMMUNITY-BASED FAMILY PLANNING SERVICES AT SCALE

July 2014–June 2020

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TABLE OF CONTENTS

ACRONYMS

ADDO	Accredited Drug Dispensing Outlet
AFP	Advance Family Planning
APC	Advancing Partners and Communities
CBFP	Community-based Family Planning
CBD	Community-based Distributor
CBHP	Community-based Health Program
CCHP	Comprehensive Council Health Plan
CHMT	Council Health Management Team
CHW	Community Health Worker
COP-CBFP	Costed Operational Plan for Community-based Family Planning
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
DMPA	Depot-medroxyprogesterone Acetate
DSW	Deutsche Stiftung Weltbevoelkerung
FBO	Faith-based Organization
FP	Family Planning
GIZ	Gesellschaft für Internationale Zusammenarbeit
GoT	Government of Tanzania
HMIS	Health Management Information System
LAM	Lactational Amennorrhea Method
LAPM	Long-acting and Permanent Method
LGA	Local Government Authority
MDG	Millennium Development Goal
MMAM	Mpango wa Maendeleo wa Afya ya Msingi (aka PHSDP)
MNCH	Maternal, Newborn and Child Health
MOHSW	Ministry of Health and Social Welfare
NFPCIP	National Family Planning Costed Implementation Program
NGO	Nongovernmental Organization
PROGRESS	Program Research for Strengthening Services
PSI	Population Services International
QA/QI	Quality Assurance/Quality Improvement
RCH	Reproductive and Child Health
RCHS	Reproductive and Child Health Section
SBCC	Social and Behavior Change Communication
SDM	Standard Days Method
SRH	Sexual and Reproductive Health
TCCP	Tanzania Capacity and Communication Project
T-MARC	Tanzania Marketing and Communications
UMATI	Chama Cha Uzazi na Malezi Bora Tanzania
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
VICOBA	Village Community Banks
WHO	World Health Organization

FOREWORD

The Government of Tanzania (GoT) aspires and is committed to ensuring that all persons, despite their age, marital status, or disabilities, are able to fulfill their right to decide freely and responsibly the number and spacing of their children. Investing in family planning is a priority for Tanzania given its unparalleled contribution to the nation's health and social development goals. In affirmation of family planning as a national priority, on July 11, 2012, His Excellency, President of the United Republic of Tanzania, Dr. Jakaya Mrisho Kikwete, attended the high-profile London Summit on Family Planning and made six commitments expected to double the number of family planning users by 2015. In 2010, the Ministry of Health and Social Welfare (MOHSW) launched the National Family Planning Costed Implementation Program (NFPCIP) to increase the contraceptive prevalence rate to 60 percent by 2015. The NFPCIP was developed in recognition of the need to revitalize and reinvigorate the national family planning program, which was losing momentum from gains observed in the 1990s. By 2010, good progress had been made, and the CPR had caught up with that from the 1990s; annual growth between 2004-2005 and 2010 was 1.5 percent, and modern method use reached 27.4 percent by 2010. Nevertheless, an even higher increase in annual growth, of 4.8 percent, is demanded for the country to meet its goals by 2015. Furthermore, unmet need for family planning is on the rise, increasing from 21.8 percent in 2004-2005 to 25 percent in 2010. The country is also experiencing a high level of population growth, with a population of 44 million as of 2012.

Implementing effective approaches that enable all women and men of reproductive age to be reached with quality family planning services is key to fulfilling Tanzania's commitment and FP goals. Community-based family planning (CBFP) is acknowledged as one of the key approaches that contributed to the gains observed during the 1990s, but its performance has considerably weakened alongside the slowdown experienced by the entire family planning program. Many CBFP programs closed during that time because of a lack of resources and a shifting of attention toward other health issues. As such, the contribution of CBFP as a source of modern contraceptives gradually declined, from 2.5 percent of women citing community health workers as their source of supply in 1999 to 0.5 percent in 2010. On the other hand, investments in the private sector, especially drug shops, have been fruitful in complementing the faltering CBFP program. Drug shops as a source of supply for modern contraceptives tripled from 3.2 percent in 1996 to 11.1 percent in 2010, as the program for accredited drug dispensing outlets expanded nationwide.

This operational plan serves to expand on Strategic Result 2 of the NFPCIP: Integrated community-based services increased and expanded. It provides a more comprehensive plan, linked to an in-depth review and analysis of key issues and challenges concerning CBFP services, to enable a community-based platform to be a viable approach for increasing access to quality services in a sustainable manner. The MOHSW recommends that the activities stipulated in this operational plan be implemented in line with the new policy guidelines for the community-based health program. The operational plan is designed to be implemented by all stakeholders in public and private sectors, non-governmental organizations, faith-based organizations, community-based organizations, and other partners at all levels. To facilitate implementation, the MOHSW plans to revise and update associated tools and reference materials for managing community-based reproductive and child health activities at all levels. To realize the intended results, resource mobilization and monitoring and evaluation will be integral to implementing this operational plan. The MOHSW further emphasizes that coordination at all levels will be crucial to ensure effectiveness and that this coordination will be a shared responsibility among the Ministry's Reproductive and Child Health Section, reproductive health management teams, council health management teams, and local government authorities at ward and village levels.

The MOHSW believes that this operational plan will guide all stakeholders in the community-based health program to achieve the important task of bringing quality contraceptive services closer to the people who need them, and in turn realizing the nation's goal. Let us now, and in the years ahead, join efforts and ensure that the plan is translated into concrete, focused, and sustained action.

Dr. Donan W. Mmbando
Permanent Secretary

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The Ministry of Health and Social Welfare (MOHSW) would like to express its sincere appreciation and gratitude to the many implementing and development partners who worked under the leadership of the Reproductive and Child Health Section to develop the National Costed Operational Plan for Strengthening Community-based Family Planning Services at Scale, July 2014–June 2020.

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Finally, the MOHSW would like to acknowledge the Reproductive and Child Health Section for leading the development of this plan, the coordination of all stakeholders engaged in the development of this document, and the contributions of regional and district representatives to the plan.

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Ag. Chief Medical Officer

1

INTRODUCTION

1.1 Purpose

This National Costed Operational Plan for Strengthening Community-based Family Planning Services at Scale, July 2014-July 2020 (COP-CBFP) has been developed in recognition of the need to revitalize and scale-up quality community-based family planning (CBFP) services to increase access to family planning (FP) and enable people to attain their desired number of children and determine the spacing of their pregnancies. Tanzania aims to increase the contraceptive prevalence rate (CPR) among all women of reproductive age, from 28.8 percent in 2010 to 60 percent by 2015, and fulfill the nation's six commitments from the London Summit on Family Planning by 2020. Measurements of CPR in the upcoming 2015 Demographic and Health Survey (DHS) will inform future projections for CPR growth by 2020, and thus a potentially revised CPR goal for 2020.

In April 2014, the Ministry of Health and Social Welfare (MOHSW) issued policy guidelines for its community-based health program (CBHP) aimed at supporting measures to establish national community-based health services offered by a formalized cadre of community health workers (CHWs) at the community level. CBFP is one of the key components of the comprehensive package of health interventions to be offered under community-based health services. Specifically, CBFP services are FP services provided beyond the health facilities by CHWs selected by community members based on selection criteria guided by national guidelines. In line with the policy guidelines for community-based health services, FP service providers within communities provide health education, counseling, and mobilization toward positive behavior change and service utilization; directly provide or refer for contraceptive methods; and support effective use of contraceptives to avoid unintended pregnancies. Service delivery platforms at the community level can take many forms, including household-to-household visits by CHWs, accredited drug dispensing outlets (ADDOs), and other community structures deemed feasible and effective in providing quality FP services. Excluded are outreach services that are categorized under facility-based services and discussed elsewhere in the national outreach guidelines FP.

The COP-CBFP provides clear guidance on:

- Priority interventions, which when fully implemented in a systematic and coordinated manner will strengthen and scale up FP services through community-based health care platforms nationwide.
- Required resources (i.e., financial, human, technical, and equipment) to achieve intended outputs, outcomes, and strategic results.
- Performance targets and indicators to monitor progress and evaluate results.

1.2 Alignment with Policy and Guidance Documents

Investments in this operational plan are part of a larger government effort to make high-quality contraceptive services more equitable and accessible to women and men throughout Tanzania. As such, the plan reflects the operational activities to be implemented and interprets the principles, priorities, and policy guidance outlined in the pertinent directives and programs of the Government of Tanzania (GoT), as shown in Table 1.

Table 1: Alignment of the COP-CBFP with government policies and strategies

Policy/Strategy document	Alignment with COP-CBFP
The National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008–2015 (also known as the One Plan); The Sharpened One Plan 2014–2015	The Sharpened One Plan (2014–2015) describes accelerated actions up to 2015 for Millennium Development Goals (MDGs) and outlines key prioritized interventions for 2016 to 2020. Offering information and services through the CBFP platform is an overarching approach to scale up the number of FP users by 2015 in the Lake and Western Zones to create demand and bring services closer to the communities. The COP-CBFP identifies the resources needed to implement the priority interventions described in the plan. Furthermore, all regions in the Lake and Western Zones are included in the 15 priority regions, which also represent the regions for investment priority under the COP-CBFP (Section 3.1).
National Community-based Health Program Policy Guidelines (2014)	The CBHP policy guidelines provide a coordinated, integrated framework that enables local government authorities (LGAs) to put in place sound community health practice that extend the benefits of the MOHSW's primary health services development program —Mpango wa Maendeleo wa Afya ya Msingi (MMAM) — beyond first-line health facilities. By 2025, the CBHP expects to have an adequate number of community-based health workers trained and effectively operational nationwide. FP is recognized as one of the essential health interventions for primary health care and, hence, for CHWs to provide. This COP-CBFP builds upon the CBHP policy guidelines by identifying specific interventions that need to be implemented in the context of the CBHC platform to address issues related to quality FP service provision.

National Family Planning Costed Implementation Program (July 2013 update)	Strengthening CBFP services is Strategic Result 2: Integrated community-based services increased and expanded of the NFPCIP, which clearly defines costed strategic actions to be implemented to achieve the national goal of 60 percent CPR by 2015. The COP-CBFP provides a more comprehensive plan, linked to an in-depth review and analysis of key issues and challenges, to enable the community-based platform to be a viable approach for increasing access to quality services in a sustainable manner.
National Family Planning Guidelines and Standards (2013)	The FP guidelines and standards provide explicit directives on the operational rules, regulations, guidelines, and administrative norms governing FP services and programs and the minimum acceptable levels of performance and expectations for service delivery and program implementation at the community and health facility levels. Implementation of the COP-CBFP follows the directives and standards described in the FP guidelines and standards, which also define the FP services and methods that CHWs and ADDO dispensers can offer and describes how FP services should be integrated with other health services.
National Family Planning Research Agenda (2013)	The national FP research agenda summarizes recent evidence on the status of FP services in Tanzania and the perceived priorities for future research as discussed among key stakeholders. The COP-CBFP includes cost estimates for conducting research to answer several key research questions identified in the research agenda as pertaining to CBFP programs and services.
National Operational Guidelines for Integration of Maternal, Newborn, Child Health, and HIV/AIDS Services (2013)	The national operational guidelines for integrating maternal, newborn, and child health (MNCH) and HIV/AIDS services are meant to help stakeholders determine the appropriate MNCH and HIV/AIDS services to integrate. They are also meant to help stakeholders plan, implement, monitor, and evaluate the integrated services. The community-based platform is recognized as one of the service delivery levels for integrating MNCH and HIV/AIDS services. The COP-CBFP outlines the activities to be implemented to translate the guidelines for integration into results in the context of revisions or updates to the national guidelines and standards for CBFP featuring integrated service delivery. Furthermore, the revised selection criteria and recruitment strategy for CHWs will follow the CBHP policy guidelines for moving from vertical to horizontal programming.
FP2020 Commitments (2012)	In July 2012, the GoT joined the FP2020 initiative and made six commitments that require robust community-based services. The COP-CBFP accounts for activities to be implemented to fulfill commitment # 5 (to strengthen community-based services as one of the important platforms for expanding access to quality services) and commitment # 6 (which involves building community and leadership capacity to support FP through mobilization and education campaigns following the Green Star re-launch).

The Primary Health Care Strengthening Programme	THE COP-CBFP is in sync with the MOHSW's primary health services development program — MMAM — which aims to accelerate the provision of primary health care. Essentially, the operational plan draws on the MMAM directives to establish the overall direction and vision for CBFP. It also strives to coordinate the efforts and resources of various public and private, national, regional, district, local, and international development partners who must collaborate to ensure that communities can provide appropriate high-quality FP services to all Tanzanians, regardless of where they live.

1.3 Intended Audience

This document is intended for stakeholders who (or aim to) design, fund, implement, monitor, and evaluate CBFP services in Tanzania. These include officials from the GoT, development partners, and implementing partners such as nongovernmental organizations (NGOs), civil society organizations (CSOs), faith-based organizations (FBOs), and the private sector at all levels of the health system. These stakeholders also include advocacy groups, professional associations, academic institutions, and other CBFP collaborators.

1.4 Development Process

This COP-CBFP was developed collaboratively by a task force that included members of the Reproductive and Child Health Section (RCHS) of the MOHSW, implementing partners, and development partners. Its development followed a five-step process, starting with engagement of consultants to conduct a situational analysis to identify key issues and challenges. Consultants reviewed literature and gathered qualitative information from stakeholders to document the existing situation, experiences, and practices related to CBFP. Issues identified in the literature review were discussed during workshops with various stakeholders from all levels of the GoT (i.e., zonal, regional, district, facility, and community levels). These discussions involved various techniques and processes such as problem trees, issue prioritization, and intervention development. The information was then analyzed to identify themes and develop recommendations, which were shared with stakeholders during a series of technical workshops. The workshop participants organized the issues by themes, prioritized them, ranked them using criteria that reflected their level of significance, analyzed them to identify the root causes of problems and challenges, and finally discussed the feasibility of potential solutions. The final recommendations were reflected in the strategies and activities included in this COP-CBFP. The final step included generating cost estimates for each of the activities and developing performance monitoring indicators.

2

BACKGROUND

2.1 Overview of Family Planning in Tanzania

A continuing high rate of population growth is presenting major challenges to social and economic development in Tanzania. At the current rate of growth of 2.7 percent annually, the 2012 census projects that Tanzania's population will exceed 60 million by 2025. This will put increased strain on already overstretched health and education services, infrastructure, food supply, and the environment. Early initiation of childbearing and a high rate of fertility are the principal factors contributing to this rapid population growth, which also has detrimental effects on the health of women and children. Tanzania has among the highest rates of maternal and child deaths in the world. Gender issues play an important role, both in affecting access to health and economic resources for women and in limiting the roles women can play in the country's social and economic development. Early childbearing usually curtails educational attainment for girls and constrains women's economic productivity. FP has, for several decades, been well documented as a key strategy to promote social and economic development and to improve the health of women and their children. It is a requisite intervention for enabling the country to achieve its Vision 2025 goal of achieving high-quality livelihoods for its people and developing a strong and competitive economy.

In the early 1990s, during the "golden age" of FP in Tanzania, the prevalence of modern method use more than doubled; it increased from 6.6 percent in 1992 to 13.3 percent in 1996, growing an average of 1.5 percentage points per year. Beginning in 2000, however, the increase in prevalence dropped to 0.6 percentage points per year, with contraceptive prevalence for all methods among married women of reproductive age reaching only 26.4 percent by the time of the DHS in 2004/2005. The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008–2015 (One Plan) has set a goal to increase the CPR to 60 percent by 2015. In 2010, the MOHSW launched the NFPCIP for 2010–2015 to guide efforts to reposition and reinvigorate access to and use of FP services in Tanzania. The NFPCIP represents a renewed commitment to FP and a re-invigorated program that will require a substantial investment of resources to achieve the One Plan goal. The

NFPCIP was updated in 2013 to document progress toward the initial goals and targets, take into account new demographic data, and incorporate FP2020 commitments made at the London Summit on FP in July 2012. Furthermore, the One Plan was recently reviewed to develop a set of interventions that became known as the Sharpened One Plan (2014–2015). As the countdown to 2015 nears, FP is featured prominently in this Sharpened One Plan as a priority strategy for accelerating short-term change to meet MDG 5 goals.

Efforts to improve FP access are reflected in increases in the CPR. According to DHS data, the use of modern methods among married women was at 27.4 percent in 2010, up from 20 percent in 2004. However, although CPR increased, the unmet need for FP also increased, to 25.3 percent. Maternal mortality decreased, but is still unacceptably high at 454 deaths per 100,000 live births. The country's development is also not keeping pace with the population growth; the 2012 census showed that since 2002, the population has increased by 10 million people, up to 44 million.

Tanzania has set a target of raising the CPR from the current 28.8 percent for all methods to 60 percent by 2015 and reaching more than 5.2 million new users by 2020. Given current trends in the annual growth rate of the CPR, it will be a challenge for the country to achieve this goal. If using a realistic estimation of CPR growth at 1.5 percentage points a year, the country is projected to achieve its goal by 2030. If the goal is maintained to 60 percent CPR by 2020, then the CPR will need to grow 3.98 percentage points for each of the five years between 2015 and 2020. To achieve the country's goals, FP services must be accessible in rural communities where the majority of the population lives, and community-based services will be key.

2.2 Overview of Community-based Family Planning

Since Tanzania's independence, the GoT has underscored the need to expand health services in rural areas through a variety of outlets. Several malaria prevention, tuberculosis treatment, and HIV prevention programs have used community-based interventions to improve access to health services. The community-based approach, also known as community-based distribution (CBD), has also been used to improve access to FP services. CBD for FP was introduced in Tanzania in the 1980s in programs organized by Chama Cha Uzazi na Malezi Bora Tanzania (UMATI) with support from Pathfinder International. Through home visits, CBD agents been very instrumental in counselling and recruiting clients for FP services, educating the community about the benefits of FP and about all method choices, providing method-specific counselling on oral contraceptives and condoms, and letting people know where to get more information about other methods. CBD agents are also responsible for the initiation and re-supply oral contraceptives and condoms and the referral of clients for other FP methods and services at the facility level.

CBD has increased community awareness of FP and improved geographical coverage for FP services. The expanded reproductive and child health (RCH) services that resulted from the International Conference on Population and Development have also increased the potential scope of community-based programs, requiring additional programs and providers to meet the demand. The Strategy for Reproductive Health and Child Survival (1997-2001) guided implementation of integrated RCH services, establishing community-based RCH interventions to complement clinic-based services.

Tanzania acknowledges the pivotal role that CHWs play in accelerating the attainment of MDGs 4, 5, and 6. MDG 4 aims to reduce the under-five mortality rate by two-thirds, whereas MDG 5 aims to reduce the maternal mortality ratio by three-quarters by 2015. The objective of MDG 6 is to halt and begin to reverse the spread of HIV/AIDS by 2015 (Tanzania MDG Report, 2010). Expansion of FP services, both generally and through community-based efforts, is essential for achieving these and other MDG goals.

Despite the potential offered by community-based programs, multiple factors have hindered the realization of universal, nationwide access to well-integrated, high-quality primary care at the community level. Pilot CBD programs that were sponsored by development partners and focused in a single technical area expanded until alternative strategies and mechanisms for administration and funding were explored to improve access, quality, and sustainability; at that point, direct financial support to the pilot programs (which were vertical or non-integrated) declined. Decentralization by the process of devolution now requires that communities, through LGAs, assume responsibility for providing health care services for their citizens, as the MOHSW has withdrawn from direct service provision at the district and municipal levels. LGAs are responsible for assessing local needs, developing plans to address the needs, requesting funds from the central authority, and managing implementation of their plans. The GoT expects that these practices will contribute to health equity and facilitate service delivery reforms that re-organize health services around people's needs.

With the development of the national CBHP policy guidelines in 2014, the GoT is closing the policy gaps and formally empowering communities to take responsibility for identifying, analyzing, prioritizing, and addressing challenges at the local level. These policy guidelines give communities authority and control over resources, management, and ownership for health and development activities. The policy supports long-range efforts to integrate trained CHWs into the national health workforce to ensure the availability, efficacy, and organizational sustainability of this cadre. Embedding CHWs within the health care system will alleviate the service-provision burden on facility-based providers and foster informed self-care and home-based care.

This operational plan describes how existing human and other resources for CBD will be used to improve access to FP while the GoT works to fully develop the structures needed to support the ultimate goal of fully integrating community-based services.

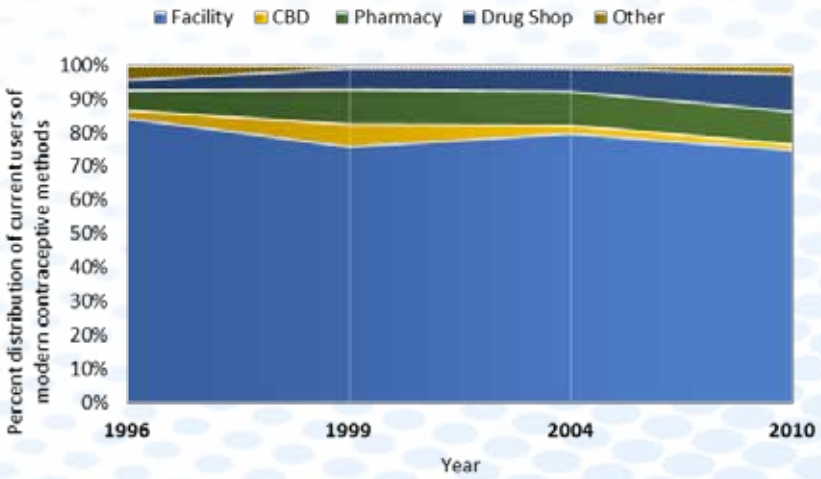
2.3 Key Issues and Challenges

Since the CBD approach to FP services was introduced in Tanzania in the 1980s, it has been acknowledged as an essential component of a holistic FP program. It has also been acknowledged as necessary for expanding access and increasing contraceptive prevalence, especially in communities that are not easily reached by facility-based services. For example, the high CPRs in certain regions (e.g., 34 to 45 percent in Mbeya, Lindi, and Tanga) are frequently linked to the important German-assisted CBD program there. However, the contribution of CBD agents as a source of modern contraceptives has been gradually declining over the past 15 years (Figure 1), from 2.5 percent of women citing CBD agents as their source of supply in 1999 to 0.5 percent citing the same in 2010 (DHS, 1996; DHS, 1999; DHS, 2004; DHS, 2005).

This decline began when overall investments in FP in Tanzania started to decrease; this considerably affected the CBD program, which was heavily dependent on NGO and donor funding. Furthermore, according to the 2010 DHS, only 3.7 percent of women who were not using contraception reported to have been visited by a CHW in the past 12 months; this low statistic is albeit a small increase from 2004-2005 when only 2.6 percent of women reported having being visited by a CHW.

On the other hand, drug shops as a source of supply for modern contraceptives, tripled from 3.2 percent in 1996 to 11.1 percent in 2010, overtaking pharmacies. This trend, most likely attributed to the expansion of ADDOs, also calls for assurance that the FP services offered via drug shops meet FP guidelines and standards.

Figure 1: Source of Modern Contraceptives, 1996-2010



A situational analysis of Tanzania's current CBFP program was conducted to inform the development of this operational plan. The analysis identified key issues and challenges to explain the decline in contraceptive provision by CBD agents and provide a basis for determining what can be done to turn the tide around. It was guided by EngenderHealth's SEED™ Assessment Guide for Family Planning Programming (2011) and thus organized under three categories: supply, demand, and enabling environment. The supply category was further broken down into six sub-categories as guided by the World Health Organization's (WHO's) Health System Building Blocks (WHO, 2007). The results of the situational analysis are described below by category and sub-category.

2.3.1 Category I: Supply

1) Service Delivery

Service delivery refers to the availability of CBFP services; the organization of CBFP service delivery, including community structures, integration of services, and referral; quality assurance; and community participation in CBFP. To contribute to the national CPR goal, the CBFP program must be strengthened and scaled up. The CBFP program falls short in both the scale and the quality of service delivery. Although a comprehensive mapping exercise of CBFP service quality and coverage was not conducted as part of the situational analysis, geographical coverage of CBFP services is generally acknowledged to be highly limited. Scale-up and long-term sustainability of CBFP services has been largely influenced by the availability of financing, relying heavily on short-term, donor-funded programs; however, there are several anecdotal reports of public-sector support of CBFP services, such as through the Muheza district council.

The current practice of multiple partner-supported vertical community projects, all using community volunteers with no, limited, or exclusive experience with FP tasks, has led to non-coordinated, non- standardized delivery of services. This, in turn, has made it difficult for local councils, facility supervisors, or district RCH coordinators to provide the necessary guidance. Attempts are being made for CBFP providers to follow set standards and move toward an integrated model of service delivery, as outlined in the national CBHP policy guidelines. Integration aims to combine FP with other reproductive health and primary health care activities such as HIV/AIDS, hygiene, and nutrition services, which are currently delivered and managed separately; the goal is to maximize coverage and optimize the use of scarce resources (National Operational Guidelines for Integration, MOHSW, 2012).

The results of the analysis also noted that the CBFP service-delivery platform is currently confined to the traditional model of household visits. This highlights the need to expand and make effective use of existing community structures (e.g., Village Community Banks (VICOBA), women's groups, agricultural extension workers) and to integrate FP with other health services and non-health services to increase awareness, use, and coverage. The use of a wide range of existing structures can facilitate coverage of a wider area and meet the needs of different community groups and facilitates integration of FP in a multi-sectoral environment.

ADDOs, with an expanding network of more than 5,900 regulated drug shops nationwide, are currently licensed to sell condoms and oral contraceptives, including combined progestin-estrogen pills for emergency contraception. ADDOs offer a potentially viable community-based platform for expanding the reach of FP services, especially to rural populations. They are also poised to dispense an expanded range of contraceptive methods, including a dedicated emergency contraceptive product (i.e., Postinor 2) and the injectable depot-medroxyprogesterone acetate (DMPA), and to strengthen referrals to health facilities for long-acting and permanent methods (LAPMs). The situational analysis assessed the current operational context of ADDOs in FP provision to see what needs to be strengthened and how best the ADDO platform can be used to expand FP service provision in the country.

Qualifications of ADDO dispensers vary, but most have some health training as nurse assistants (60 percent), medical attendants (29 percent), and other cadres (11 percent), including registered nurses, nurse midwives, and clinical officers. More than 80 percent have undergone in-service training on FP; however, several areas of FP provision were noted as needing improvement, including counselling, screening for medical eligibility, and managing side effects. Also, the results noted weak documentation of linkages between ADDOs and facilities, and a lack of specific guidance and resources to facilitate referrals for LAPMs. Furthermore, although the shops appeared to be adequate in size to allow for client interaction, few had the essential space to ensure auditory and visual privacy when FP services were offered. Poor keeping of FP records was another challenge observed, due in some cases to lack of tools, lack of time to report, or incorrect entries. Dispensers noted using different types of recording forms for FP, including bin cards, ledgers, purchase forms, and sales record books. The supply of FP commodities was reported as not being reliable, and many dispensers faced transportation problems when seeking to purchase FP commodities from pharmacies. Furthermore, supervision was irregular.

2) Human Resources

Several key issues related to human resources were identified. These included coverage and distribution, recruitment, retention, roles and responsibilities, working environment, remuneration, supervision, competences, and linkages with others in the community and with health facilities.

According to the National Guidelines for Initiating and Managing Community Based Reproductive and Child Health Services (2005), the recommended number of households a CHW should serve is 100 to 150 in an urban setting and 25 to 100 in a rural setting. To date, there has not been a comprehensive mapping study to determine the coverage (i.e., the numbers and distribution) of CHWs providing FP services nationwide; however, it is generally acknowledged that coverage of CBFP services is limited. A small, rapid mapping exercise conducted in 2012 to identify coverage of CBFP interventions supported by partners estimated 3,752 CHWs in Mwanza, Shinyanga, Dar-es-salaam, Arusha, Tanga, Morogoro, Mbeya, and Iringa regions.

Although guidelines and training tools exist for managing CBFP, they were last updated in 2005; hence, they do not feature new evidence-based approaches for improving program performance and effectiveness, lack standards of practice for assessing quality, and do not adequately align with the current needs of the FP program. For example, methods provided by CHWs are limited to oral contraceptives and condoms; however, there may be an opportunity, pending evaluation of feasibility and safety in the local context, to expand the method mix to include natural methods and injectables.

Recruitment and selection of the most appropriate individuals to be CHWs is essential to a well-functioning community health strategy. Although selecting CHWs from local communities is widely accepted and implemented, the communities do not always directly and meaningfully participate in the selection process; this is despite the presence of structures that can facilitate community involvement. Inadequate community involvement and participation in planning and managing CBFP services results in failure to empower communities to take ownership and accountability for the program. It also affects CHW retention.
Evidence on attrition rates of CHWs is lacking, but retention of CHWs is generally acknowledged as being poor, especially when incentives (both monetary and non-monetary) are irregular or absent. For example, all respondents who were CHWs said they are working without any incentives or working tools, such as raincoats, boots, umbrellas, and transport. CHWs also said they lacked career development opportunities and reported an unreliable supply of FP commodities. Despite this difficult working environment, the data indicate that some CHWs serve for a long time, even though general turnover is known to be high. For example, most of CHWs interviewed had served for 3 to 12 years. Stakeholders agreed that a formal approach to retention is needed and that the current incentive mechanism should be revised and improved to focus on increasing motivation and facilitating retention.

Both CHWs and their supervisors need training on the full complement of skills, knowledge, and attitudes needed to deliver high-quality FP services. However, the situational analysis found a great diversity of approaches to, locations for, organization of, and length of training. The roles and responsibilities of CHWs are unclear, limited, and outdated. Furthermore, the training curriculum and associated resources, which were last updated in 2005, need to be updated and aligned with the new CBHP policy guidelines.

CHWs are supervised by staff from the RCH unit in a nearby facility. However, the situational analysis found no standard number of times per day, week, month, or year that CHWs are supervised. Some CHWs said they are supervised monthly, others after five months, and still others after six months. However, according to staff at the facility level, CHWs are supposed to submit their reports on a quarterly basis as part of their supervision. In view of both CHWs and health facility staff, submission of reports is the basis for CBDs to receive CBFP commodities and medicines. Likewise, supervisors at the facility have a checklist to assess the performance of CHWs; however, supportive supervision of CHWs by facility-based staff is inadequate and irregular.

3) Health Information Systems

The management information system for CBFP services is composed of six forms that CHWs fill out at the community level and the MTUHA book no. 10 that the supervisor fills out at the facility level. The six forms the CHWs fill out are the client card, referral form (CBD Form #7), referral feedback form (CBD Form #8), monthly order/receipt form (CBD Form #9), client daily register form (CBD Form #10), and monthly report form (CBD Form #13). Data are collected

from CHWs on a monthly basis and handed over to the immediate supervisor at the health facility, who compiles and summarizes the data. The data are then forwarded to the district level, where the council health management team (CHMT) includes them in Tanzania's health management information system (HMIS), known as MTUHA. The CHMT then compiles all the CBFP data and forwards it to the central/national level for consolidation and dissemination.
The community-based information system in place has limitations and presents challenges in data collection, analysis, and utilization. The data collection tools are vast and not user-friendly. Often, the reports are inaccurately filled, poorly interpreted, and rarely used for implementation of CBFP initiatives. Moreover, the information gathered is seldom disseminated and shared among stakeholders, let alone used for decision-making at all levels of the health system. When data are aggregated at the facility level, the contribution of CHWs in FP provision is not made visible, and thus the value of CBFP services and matters related to service delivery do not receive adequate attention by decision-makers at the district level.

4) Commodities and Supplies

Commodity stock-outs at the facility level greatly affect the availability of commodities for CHWs. The design of the logistics and supply chain is such that CHWs request and receive commodities and supplies from the nearby health facility where their supervisor sits. Hence, when commodities do not reach the facilities, CHWs are also affected. The NFPCIP addresses these broader issues.

Key community-level issues that the situational analysis identified were that 1) CHWs and health facility providers have inadequate knowledge about ordering CBFP commodities and drugs (i.e., how to use recording and reporting forms and the integrated logistics system); 2) the contribution of CHWs to service delivery is not clearly visible, so commodities are not always ordered for them; 3) there is a shortage of reporting tools for CHWs; 4) CHWs have weak skills for managing inventory; and 5) the community is not involved enough in securing commodities.

5) Financing

The CBFP program was originally conceived and continues to be largely implemented where CHWs are recruited and trained, primarily as part-time volunteers, and where donor funding covers the operational costs of the program, including training, supervision, and equipment. Considerable political commitment to improving access to health services through strengthening community-based health care has not translated into the allocation of financial resources at the national and district levels, largely because of competing priorities for the health care budget.

The situational analysis revealed the following issues that contribute to a lack of financial sustainability within the program: 1) the absence of a budget line to support CBFP services in the national medium-term expenditures framework; 2) limited or lack of inclusion of CBFP

activities in the comprehensive council health plans and budgets; 3) the exclusion of CHWs as part of the government scheme of service (by design of the program); and 4) the general lack of a sustainability strategy/plan in the design of CHWs programs.

The current financing mechanism, which is largely dependent on volunteer CHWs and intermittent donor funding, has imposed several challenges to the program. These are 1) inequitable and variable remuneration schemes for CHWs, including monthly transport allowances, in-kind contributions, income-generating activities, and, for a few workers, salaries; 2) geographically small-scale, unsustainable projects; and 3) attrition of CHWs due to reliance on monetary compensation, which can be irregular or end altogether when project funding runs out.

6) Leadership and Governance

Naturally, the design of the CBFP program — with governance structures outside the formal health system, in between the formal health system and communities — makes its governance more challenging and complex. Key issues resulting from the situational analysis were 1) inadequate involvement of community leaders in the governance of the program; 2) poor coordination and collaboration among various programs and across vertical programs; and 3) lack of clear laws and regulations relevant to the governing and scale-up of CHW programs.

2.3.2 Category II: Demand

Prevailing social-cultural norms, gender dynamics, religious doctrine, and myths and misconceptions hinder the use of FP services by those who need them. CHWs play a pivotal role in addressing these barriers and hence fostering social and behavior change communication (SBCC) at the community level. CHWs are familiar with and respected by communities, serving as an essential conduit of health promotion messages to improve individual knowledge and attitudes, dispel myths and misconceptions, and influence positive social norms. According to the 2010 Tanzania DHS, CHWs are an important source of FP information; 43 percent and 31 percent of women and men, respectively, cited CHWs as their source of FP messages. Interestingly, women and men living in urban areas were more likely than those living in rural areas to discuss FP with CHWs. A similar pattern was observed with wealth quintiles, with women in higher wealth quintiles more likely to discuss FP with a CHW than women in lower quintiles. CHWs lack the skills, support, and adequate and consistent supply of information, education and communication materials necessary to effectively carry out SBCC interventions, including interpersonal communication, advocacy, and social mobilization.

2.3.3 Category III: Enabling Environment

Although the nation's policy environment has been and continues to be favourable to engaging CHWs in the provision of FP services, considerable challenges in policy implementation have limited the ability of the country to benefit from this approach.

The general lack of adequate resources for FP services has affected the scale and sustainability of CBFP services. The reliance on volunteers (i.e., the lack of a formalized community health cadre) has meant dependence on donor funding, which tends to be short-lived and geographically limited. Leadership and governance of CBFP services at all levels have also faced challenges due to competing priorities. The lack of guidance and directives for planning and budgeting for CBFP in comprehensive council health plans (CCHPs) contributes to LGAs paying less attention to allocating resources for CBFP services.

In 2014, the MOHSW issued the national CBHP policy guidelines, promising to institute a long-term solution to these issues. In these new policy guidelines, CHWs are part the health cadre in the formal health system that provides primary health care services, including FP, as part of a standardized package. The guidelines, when fully implemented, will empower communities and build capacity to respond to local health needs through a sustainable and integrated CBHP.

In May 2014, the MOHSW and the Prime Minister's Office, Regional Administration and Local Government, endorsed the development of a new directive, to be issued in July 2014 that makes it compulsory for LGAs to make financial allocations for FP. This move is expected to further strengthen the implementation of the CBHP in the country.

In another move, the Reproductive, Maternal, Newborn and Child Health Sharpened Plan (2014-2015) was launched. This plan includes FP as one of the core interventions for improving MNCH. It is also expected to further strengthen leadership and community action toward implementing CBFP.

3

CBFP OPERATIONAL PLAN

3.1 Results Framework

This operational plan is designed to address challenges and needs for expanding access to quality FP services at the community level. It represents a fundamental approach for increasing the CPR to 60 percent by 2015, as well as for meeting FP2020 commitments by 2020. A revised CPR goal for 2020 will be determined once data on CPR are obtained from the 2015 DHS.

This operational plan is guided by the goal of the NFPCIP. It has three strategic results to be achieved over a period of six years. As depicted in the results framework in Figure 2, these strategic results correspond to three intervention areas: supply, demand, and enabling environment. The intervention areas in this operational plan are organized around concepts outlined in EngenderHealth's SEED™ Assessment Guide for Family Planning Programming (2011) and WHO's Health System Building Blocks (WHO, 2007). A further description of these concepts is included as Appendix 1.

3.1.1 Goal

The goal of the operational plan is to increase access to quality CBFP services to contribute to reaching a national CPR of 60 percent by 2015 and fulfilling FP2020 commitments by 2020.

3.1.2 Strategic Results

Quality community-based FP services are available and accessible in all regions by 2020.

The adoption of positive contraceptive behavior by the population served by CHWs is increased by 2020.

A supportive enabling environment is in place to ensure effective and efficient provision of CBFP services by 2020.

3.1.3 Resource Needs and Prioritization

Efficiency strategies have been adopted to maximize the use of limited resources to implement interventions and achieve desired results in a short time. First, in developing the technical strategy for this operational plan, attention was placed on including interventions that are feasible and expected to be successful. Second, although this COP-CBFP covers all regions of the country, resource investments will be prioritized to the 15 regions expected to contribute the most to the national CPR goal based on their population size, current CPR, and intensity of investments (Appendix 2). These 15 regions are Mwanza, Geita, Simiyu, Mara,

Kigoma, Shinyanga, Tabora, Dar es Salaam, Singida, Kagera, Mbeya, Iringa, Lindi, Mtwara, and Morogoro. This focus does not, however, imply that the operational plan will not or should not be implemented in the rest of the regions in Tanzania. This approach for prioritizing investments is in line with the benefit and efficiency principles adopted in the NFPCIP and the Sharpened Plan, 2014-2015.

Tables showing Summary of Cost Estimates by Strategic Result for the period of 2014 to 2020.

Strategic Result 1: Quality community-based family planning services are available and accessible in 15 selected regions all districts (all wards) by 2020.

Key Intervention Area	Year1	Year2	Year3	Year4	Year5	Year6	Total Cost
National guidelines and standards for CBFP services revised/updated and implemented	2,357,349,562	183,810,097	-	-	1,498,246,109	-	**4,039,405,768**
Service protocols/guidelines, Job Aid and Training curriculum (incl. for refresher training) for CBFP revised/updated, disseminated and used	-	11,841,546,664	1,219,745,231	-	-	-	**13,061,291,895**
Support systems for ensuring efficient and effective provision of quality CBFP services improved	-	568,911,565	1,621,188,855	227,758,003	239,997,900	232,246,517	**2,890,102,840**
Motivational scheme for CHWs improved, implemented and evaluated	20,275,200	-	-	23,875,743	-	-	**44,150,943**
Community health workers recruited, trained and supported in 15 selected regions to provide CBFP services by 2020.	-	70,394,503,452	76,334,609,084	80,191,411,243	70,138,028,255	67,809,972,349	**364,868,524,383**
The platform for CBFP service delivery expanded, beyond household-to-household approach	-	-	137,467,814	78,849,269	74,905,083	-	**291,222,166**

Key Intervention Area	Year1	Year2	Year3	Year4	Year5	Year6	Total Cost
Local evidence generated to inform policy and programmatic decisions to expand the range of methods provided by CHWs	-	-	94,563,262	115,543,427	74,905,083	-	**285,011,771**
Policy and operational guidelines developed and disseminated	-	73,077,315	-	-	-	-	**73,077,315**
Timely collection, submission and reporting of comprehensive & accurate data from CBFP services at ward level in each of the 15 regions (2,057 wards) improved	-	-	7,778,537,996	-	-	-	**7,778,537,996**
Data from CBFP services used at all levels to improve services and support decision-making.	20,275,200	1,471,879,905	462,982,543	488,909,565	516,288,501	545,200,657	**3,505,536,370**
Guidelines and standards, training manual and job aids for FP provision from ADDOs	1,289,332,282	3,802,582,536	3,628,488,396	-	-	-	**8,720,403,214**
An expanded range of contraceptive methods available and accessible in ADDOs	-	-	74,541,161	9,699,521	-	-	**84,240,681**

Strategic Result 2: Increased adoption of positive contraceptive behaviour among the population served by CHWs with a focus on 15 priority regions, by 2020.

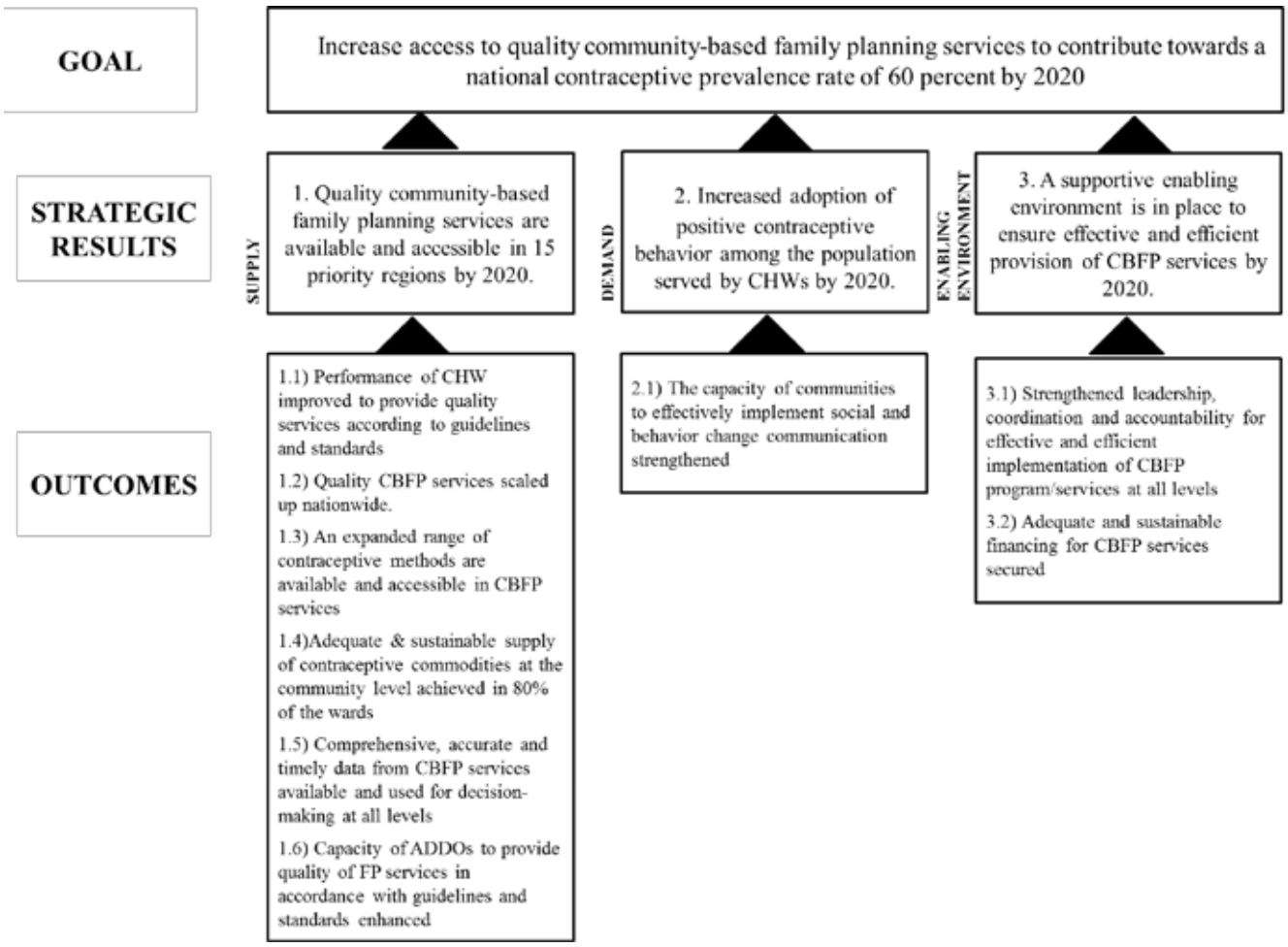
Key Intervention Area	Year1	Year2	Year3	Year4	Year5	Year6	Total
Improved skills of CHWs to apply SBCC effectively to their work and deliver higher quality care to clients	-	-	-	-	-	-	-
Increased engagement of key community groups (champions, peer educators, traditional leaders, CHWs) to implement SBCC interventions in their communities	-	-	162,506,539	53,795,034	52,016,590	-	**268,318,163**

Strategic Result 3: A supportive enabling environment is in place to ensure effective and efficient provision of CBFP services by 2020.

Key Intervention Area	Year1	Year2	Year3	Year4	Year5	Year6	Total
Improved coordination of CBFP efforts at central level	-	669,082	706,550	746,117	787,900	832,022	**3,741,670**
District councils has and implements a partnership framework to support effective coordination of CBFP services/activities in respective district	25,185,600	132,979,968	163,036,452	148,290,750	181,807,817	165,364,353	**816,664,939**
Continuous advocacy efforts conducted by champions to ensure accountability at LGA level towards a supportive enabling environment for quality provision of CBFP services.	75,662,611	71,905,753	-	-	-	-	**147,568,365**

Key Intervention Area	Year1	Year2	Year3	Year4	Year5	Year6	Total
Community engagement and ownership enhanced to ensure accountability, acceptability and support for good quality CBFP service provision.	-	-	447,550,074	315,075,252	-	-	**762,625,326**
Financial resource allocation to CBFP services at all levels (CCHP, national, and district) increases	530,745,600	560,467,354	720,996,765	-	25,212,785	-	**1,837,422,504**
Approaches for sustainable financing generated, operationalized and institutionalized	45,631,133	9,690,420	62,062,446	10,806,137	69,208,068	-	**197,398,204**

Figure 2: Results Framework for Strengthening CBFP Services at Scale



3.1.4 Guiding Principles

In line with the new CBHP policy guidelines, the following principles have been adopted to guide the implementation of this COP-CBFP.

1) Community Ownership: Mechanisms for community involvement and participation are implemented in such a way that they foster ownership, accountability, and sustainability of the initiative by the community.

2) Scale: To make an impact at the national level, interventions should be designed with the intention for large-scale implementation. Furthermore, the former term CBD is broadened to CBFP to embrace all FP provision outside health facilities (i.e., provision through various community agents, platforms, and approaches beyond the traditional household-to-household approach).

3) Integration: Efforts will be made to ensure that the delivery of FP services is combined with the delivery of other reproductive health and primary health care activities (e.g., HIV/AIDS, hygiene, or nutrition services) that are currently delivered and managed separately, with the goal of maximizing coverage and optimizing use of scarce resources.

4) Innovation and Learning: Innovations will ensure that the most promising, best practices are used to improve efficiency, effectiveness, and impact.

5) Sustainability: Efforts to sustain interventions beyond a project's life cycle should be integral to CBFP initiatives or programs from the beginning. These efforts should reflect the multiple domains of sustainability: financial (i.e., ability to mobilize and manage funding from multiple sources to achieve set objectives), institutional (i.e., ability to effectively plan, manage, coordinate, and oversee service delivery over time), and technical (i.e., ability to provide and sustain an essential package of quality, integrated services aligned with national standards).

6) Accountability: Good governance structures and mechanisms are present at all levels and enable regular monitoring and evaluation to inform decision-making and promote accountability for results.

7) Partnerships: Partnership, coordination, and joint programming are promoted among stakeholders (e.g., the regional secretariat, district councils, private sector, faith-based sector, academia, professional organizations, CSOs, and communities) to improve collaboration and maximize the use of limited resources by avoiding duplication of effort.

3.2 Plan of Action

3.2.1 Key Intervention Area I: Supply

Activities in this intervention area intend to increase availability and accessibility of quality CBFP services nationwide by 2020. To achieve this, the following six outcomes are expected.

1.1) Performance of CHWs improved to provide quality services according to guidelines and standards

Summary of Activities

The situational analysis of Tanzania's CBFP program demonstrated the need to update/revise and support broad implementation of the current guidelines for initiating and managing CBFP services. Priority areas that need revision include the selection criteria for CHWs, roles and responsibilities, motivational schemes, supervision, and the development of standards to serve as quality benchmarks for service delivery and for the program as a whole. Similarly, protocols, job aids, and recording tools for service delivery were deemed outdated (last updated in 2005) and in need of revision to align with revised guidelines and standards, global evidence, and global recommendations.

To ensure continuous provision of quality CBFP services, mechanisms for ongoing quality assurance/quality improvement (QA/QI) will be strengthened and institutionalized. At the same time, comprehensive and continuous motivational schemes will be implemented to foster retention of CHWs.

Outcome Target

At least 80 percent of CHWs in each ward nationwide demonstrate quality provision of CBFP services according to guidelines and standards by 2020.

Indicator

Proportion of CHWs in each ward providing quality CBFP services according to guidelines and standards.

Means of Verification

Data from supervision checklists.

Outputs/Activities	Implementation Targets						Indicators
	YR 1	YR 2	YR 3	YR4	YR5	YR6	
1.1a National guidelines and standards for CBFP services revised/updated and implemented							
1.1a i) Revise/update, disseminate, and support use of the national guidelines for initiating and managing CBFP services at all levels of the health system	61,483 copies	8 meetings			30,000 copies		# of revised guidelines and standards for CBFP services printed
							Dissemination coverage: numbers/types of staff (RHC officers, supervisors, managers) by region/district reached by central and zonal dissemination meetings
1.1b Service protocols/guidelines, job aid, and training curriculum (including for refresher training) for CBFP revised/updated, disseminated, and used							
1.1b i) Revise, disseminate, and support use of the CBFP service protocols/guidelines and job aid		61,483 provider manual copies 61,483 job-aid copies					# of revised service protocols/guidelines and job aids printed
							# of trainers and supervisors by district oriented to the revised materials
							# of CHWs by district oriented to the revised service protocols/guidelines and job aid
1.1b ii) Revise/update and disseminate training curriculum for CBFP		10,000 copies					# of revised CBFP training curricula printed
		2500 trainers and supervisors	2050 trainers and supervisors				# of trainers and supervisors by district/region/zone oriented to the revised training curriculum

1.1c Support systems for ensuring efficient and effective provision of quality CBFP services improved							
1.1ci) Adapt and implement a QA/QI tool (e.g., standard-based management and recognition tool) for community use			30,000 copies				A QA/QI tool for CBFP adopted/adapted and implemented
			8 meetings				# of supervisors/managers by district oriented to the QA/QI tool
1.1cii) Develop, disseminate, and support use of CBFP supervision guidelines and tools according to updated guidelines and standards		15,000 copies					# of CBFP supervisory guidelines and tools/checklist printed
			8 meetings				# of supervisors/managers by district/region/zone oriented to the CBFP supervision guidelines and tools
1.1ciii) Conduct supervision visits of CBFP services using supervisory checklist		8 meetings					# of supervisors by district/region/central oriented to the supervisory guidelines/checklist
							# of wards receiving supervision visits using the revised tool at least once per quarter
1.1d) Motivational scheme for CHWs improved, implemented, and evaluated							
1.1d i)Develop a comprehensive and continuous motivational scheme for CHWs. *(Activity is part of updating the national CBFP guidelines and standards.)*							The revised national guidelines and standards reflect a clear and comprehensive motivational scheme for CHWs
1.1d ii) Monitor and evaluate implementation of the motivational scheme to improve outcomes. Incorporate changes in second revisions of the national CBFP guidelines and standards							Evidence collected to inform decision-making on a standard motivational scheme to be used for CHWs # of wards where new motivational scheme has been introduced/implemented

1.2) Quality CBFP services scaled up nationwide

Summary of Activities

This outcome focuses on geographical expansion of CBFP services to contribute to the national CPR target. The operational plan calls for CBFP services to be available and accessible in at least 15 priority regions by 2020. The revised national CBFP guidelines and standards will inform inclusive engagement of key stakeholder at the national, regional, district, and community levels to gain support for expanding and sustaining CBFP services in respective wards.

Scale-up will involve recruiting, training, and supporting 87,340 CHWs to provide CBFP services by 2020. The breakdown of CHWs by district/region is included in Appendix 3. The projections for these figures are derived from 2012 national census data on the number of households per region, and from the current guidelines for initiating and managing CBFP; recommendations are for CHWs to serve 100 to 150 households in urban settings and 25 to 100 households in rural settings.

For recruitment purposes, active CHWs who already provide health services, including HIV/AIDS and MNCH services, in the catchment areas will be leveraged and empowered to provide FP services. This is in line with government policy guidelines that are being developed to formalize and sustain a national program of "generalist" CHWs. The traditional approach for CBFP service provision, which focuses on household-to-household visits, will be expanded to include other existing community structures such as women's groups, savings groups, and extension workers. As such, mapping existing community structures will be key to optimizing the use of local resources.

Given the novelty of using such community structures to provide CBFP services in Tanzania, a study to assess the feasibility and effectiveness of this approach will be conducted in select pilot sites prior to nationwide expansion. Recommendations from the study will inform future revisions to the national CBFP guidelines and standards, planned for year five. Currently active CHWs who may not necessarily meet the revised selection criteria will also be recruited as part of the new CHW cadre based on their performance. They will receive refresher training to supplement their current knowledge and skills with new information that will be added to the revised guidelines and standards.

Outcome Target

At least 80 percent of the wards nationwide have an actively functioning CBFP program by 2020.

Indicator

Number of wards with actively functioning CBFP services nationwide, as defined by guidelines and standards.

Means of Verification

- Survey/mapping exercise of CBFP services.
- Data from supervision visits.

Outputs/Activities	Implementation Targets						Indicators
	YR 1	YR 2	YR 3	YR4	YR5	YR6	
1.2. a) Community health workers recruited, trained, and supported nationwide to provide CBFP services by 2020							
1.2a i) Conduct sensitization meetings at all levels to gain support for expanding/introducing CBFP services in respective wards		258 meetings	200 meetings	60 meetings			# of sensitization meetings conducted
							# of districts that develop and endorse a scale-up plan for CBFP services
1.2a ii) Work within existing community structures to recruit CHWs to foster ownership and sustainability		85 meetings	80 meetings				# of community meetings at the village level conducted by districts/wards to recruit CHWs
1.2a iii) Train 87,340 recruited CHWs according to updated training curriculum		37,500 CHWs	25,000 CHWs	15,000 CHWs	9,850 CHWs		# of CHWs recruited, trained, and certified to provide FP services by district
1.2a iv) Support 87,340 trained and certified CHWs with working tools and incentives		37,500 CHWs	25,000 CHWs	15,000 CHWs	9,850 CHWs		# of CHWs who have received working tools as per guidelines and standards
1.2a v) Conduct refresher training for currently active CHWs (as of launch of new training curriculum and service protocols for CHWs, expected in year 2) to upgrade skills according to revised guidelines and standards		2500 CHWs	1250 CHWs				# of currently active CHWs receiving refresher training

1.2b The platform for CBFP service delivery expanded beyond household-to-household approach to include worksites, institutions, and community groups.							
1.2b i) Conduct mapping of community-level structures to identify types and assess their potential for integrating FP information/service provision			5 meetings				# and description of potential types of community-level structures that could be leveraged as CBFP service delivery platforms
1.2b ii) Conduct studies to assess the feasibility and effectiveness of using specific community structures for CBFP service provision			2 studies				Evidence generated to inform decision-making on the type/model of community-level structure to be leveraged as CBFP service delivery platform

1.3) An expanded range of contraceptive methods available and accessible through CBFP services

Summary of Activities

According to the recently revised National Family Planning Guidelines and Standards (2013), CHWs can provide oral contraceptives (POPs, COCs and emergency), barrier methods (female & male condoms), emergency contraceptives, and natural family planning methods (LAM & SDM). The latter two, natural methods and emergency contraceptives are new methods that CHWs are now expected to provide. Under this operational plan, efforts will be directed to support CHWs to effectively provide these newly added methods, i.e. natural methods and emergency contraceptives.

Furthermore, analysis of method use over time shows a trend toward increased use of injectables and implants. If this trend continues, it is projected that injectables is expected to constitute 44 percent of the total method mix and that oral contraceptives and implants will constitute 17.4 percent and 10.4 percent, respectively (NFPCIP, 2013). To foster contraceptive choice, activities will be implemented to support the introduction of CBD of injectables; this will involve strengthening the current CBFP platform in select sites to meet quality standards and conducting an introductory study to assess the feasibility of introducing this approach in Tanzania. Experiences and lessons learned from this exercise will then inform future decisions to scale up the approach nationwide, including changing current policies and guidelines.

Outcome Target

The method mix offered by CHWs expanded to include at least four new modern contraceptive methods.

Indicator

Number of new modern contraceptive methods included in the CBFP method mix.

Means of Verification

Review of guidelines and standards for CBFP services.

Outputs/Activities	Implementation Targets						Indicators
	YR 1	YR 2	YR 3	YR4	YR5	YR6	
1.3a Local evidence generated to inform policy and programmatic decisions to expand the range of methods provided by CHWs							
1.3a i) Conduct two feasibility studies on community-based provision of natural methods (LAM and SDM) and/or emergency contraceptives in the Tanzanian context. Disseminate findings and generate recommendations for program decisions							Evidence and recommendations generated on the feasibility of community-based provision of natural methods (LAM or SDM) and/or emergency contraceptives in the Tanzanian context
				1 meeting	8 meetings		# of dissemination meetings conducted
							# and types of stakeholders participating in the meetings
1.3a ii) Conduct feasibility study for CBD of injectables in select sites, disseminate findings, and generate recommendations for policy and program decisions							Evidence and recommendations generated on the feasibility of CBD injectables in the Tanzanian context
				1 meeting			# of dissemination meetings conducted
							# and types of stakeholders participating in the meetings

Outputs/Activities	Implementation Targets						Indicators
	YR 1	YR 2	YR 3	YR4	YR5	YR6	
1.3a iii) Develop and implement an advocacy effort for policy change to allow community-based provision of injectables		4 meetings					# and types of advocacy efforts implemented to facilitate policy change
							Decision made on whether to allow community-based provision of injectables
1.3a iv) Develop and disseminate operational guidelines on community-based provision of injectables (Activity included as part of second revision to the national guidelines and standards scheduled for 2019-2020)							Second revisions to the national guidelines and standards incorporate operational guidelines on community-based provision of injectables

1.4) Comprehensive, accurate, and timely data from CBFP services available and used for decision-making at all levels

Summary of Activities

This outcome intends to specifically address the limitations and challenges in data collection, analysis, and utilization identified in the situational analysis of the CBFP program (Section 2.3). As part of revisions to the current guidelines, the entire process, functioning, and tools of the community-based management information system will be appraised and revised for effectiveness and efficiency. As part of this effort, approaches will also be introduced to help close the gap between data generation and use to improve health outcomes at the community, facility, and district levels. For example, components of the curriculum on data for decision-making, intended for district level staff, will be adapted and incorporated into the revised guidelines for managing CBFP services.

With the increasing advent of technology in health service delivery, the feasibility of adopting innovative mhealth tools as a standard of practice, to improve data collection and use at the community level, will also be assessed. Local evidence has already been generated on the use of a mobile-based job aid as a tool to facilitate automated data collection and reporting at the community and facility levels. These research findings will be appraised and decisions will be made as to whether the tool can be implemented at scale.

Outcome Target

At least 80 percent of districts pass data quality audits and demonstrate use of data in decision-making.

Indicator

Proportion of districts with successful audits on availability and use of comprehensive and accurate data.

Means of Verification

Data from supervision checklists.

Outputs/Activities	Implementation Targets						Indicators
	YR 1	YR 2	YR 3	YR4	YR5	YR6	
1.4a Timely collection, submission, and reporting of comprehensive and accurate data from CBFP services at the ward level in each region improved							
1.4a i) Revise/update, print, and distribute tools for data collection, reporting, storage, and use *(Activity included as part of first and second revisions to the national guidelines and standards)*							The revised national guidelines and standards incorporates updated CBFP data collection tools
1.4a ii) Scale-up use of innovative tools for improving timeliness, accuracy, and comprehensiveness of data collection and reporting							Recommendations for adopting and/or scaling up use of mhealth technology by CHWs
			828 wards				# of wards using innovative tools for data collection and reporting
1.4b Data from CBFP services used at all levels to improve services and support decision-making							
1.4b i) Revise the reporting, supervision, and monitoring sections of guidelines, training curriculum, and supervision protocols to incorporate approaches to foster data for decision-making							The national guidelines and standards, training curriculum, and supervision guide incorporate updated content on reporting, supervision, and monitoring
1.4b ii) Sensitize CHW supervisors (including the facility in-charges responsible for compiling the MTUHA report) at the ward level to the importance of incorporating data generated from CBFP services in MTUHA forms							# of data for decision-making workshops conducted for ward-level CHW supervisors

Outputs/Activities	Implementation Targets						Indicators
	YR 1	YR 2	YR 3	YR4	YR5	YR6	
1.4b iii) Build the capacity of districts and regional program managers on data for decision-making		79 meetings					# of data for decision-making workshops conducted for district/regional CHW supervisors
							# of CHW district/regional supervisors by district attending D-4D workshops
1.4b iv) Develop learning/best practice sites and establish a mechanism for dissemination within and across districts			2 meetings	2 meetings	2 meetings	2 meetings	# of region-to-region exchanges conducted to facilitate knowledge sharing on good/best practices

1.5) Capacity of ADDOs to provide quality FP services in accordance with guidelines and standards enhanced

Summary of Activities

ADDOs represent an important service delivery outlet for increasing access to contraceptives beyond the clinic walls. After national scale-up, 5,757 ADDOs are already accredited (Pharmacy Council, Feb 2014) and 18,892 ADDO dispensers trained and licensed (Pharmacy Council, March 2014). ADDOs are currently licensed to sell condoms and oral contraceptives; however, strengthening their capacity will be instrumental for increasing the reach of an expanded range of contraceptives methods, including the dedicated emergency contraceptive Postinor 2, Cyclebeads for SDM, and the injectable vials. A study conducted with ADDOs in Ruvuma and Morogoro regions in 2009, and the subsequent CBFP situational analysis in 2013, demonstrated that most dispensers are either nurse assistants or medical attendants, who have a better knowledge base for training and providing FP commodities. The studies also showed that the ADDO training module contains content on counselling, screening, and provision of condoms, oral contraceptives, LAM, and Cyclebeads for SDM. However, the knowledge and skills of ADDO dispensers need to be further augmented, physical infrastructure issues need to be addressed, and supervision needs to be enhanced to ensure the provision of FP services, including referrals for LAPMs that are conducted according to quality standards. When made, such changes will be reflected in the ADDO facility and personnel standards. Furthermore, the safety and feasibility of expanding the FP options available at drug shops need to be determined to inform policy review.

Outcome Target

Proportion of women citing ADDOs as their source of FP information and supply increased from 11.1 percent (i.e., the current level according to the 2010 DHS) to 25 percent by 2020.

Indicators

- Proportion of women citing ADDOs as their source of FP information and supply.
- Proportion of ADDOs providing quality FP services according to national standards.
- Percent of stock-out days for FP products in ADDOs.

Means of Verification

- 2015 DHS and 2020 DHS.
- Data from supervision checklists and drug register books at ADDOs.
- Pharmacy Council database.

Outputs/Activities	Implementation Targets						Indicators
	YR 1	YR 2	YR 3	YR4	YR5	YR6	
1.5a) Guidelines and standards, training manual, and job aids for FP provision from ADDOs revised/updated and implemented (areas of focus: conducive physical space, counseling, supervision, referral services)							
1.5ai) Revise/update, disseminate, and support use of the ADDO manual, training materials, and job aids		20,000 training manual 10,000 job aids					# of revised ADDO manuals, training materials, and job aids printed
		8 meetings					Dissemination coverage: numbers/types of staff (RHC officers, supervisors, managers) by regions/ districts reached at central and zonal dissemination meetings
1.5 aii Conduct refresher training on FP to the currently existing dispensers in all priority regions (1-2 days)-			332 meetings	300 meetings			# of Training conducted by region/district # of ADDos dispensers attended FP refresher training by distict

Outputs/Activities	Implementation Targets						Indicators
	YR 1	YR 2	YR 3	YR4	YR5	YR6	
1.5bi) Conduct feasibility and safety study on provision of the expanded method mix (Cyclebeads and injectable vials) from ADDOs							# of methods dispensed by ADDOs increased to include Cyclebeads and injectable vials
1.5bii) Advocate and work with with Tanzania Food and Drugs Authority and the Pharmacy Council to include injectable vials and Postinor 2 on the approved list of prescription medicines that ADDOs can dispense				2 meetings			Decision from the Tanzania Food and Drugs Authority/ Pharmacy Council to incorporate injectable vials in the approved list of prescription medicines that ADDOs can dispense

3.2.2 Key Intervention Area II: Demand

Activities in this intervention area intend to achieve the following outcome: increased adoption of positive contraceptive behaviour among the population served by CHWs by 2020.

Summary of Activities

Considerable efforts to increase demand for FP are already reflected in the NFPCIP and are being implemented. Thus, activities described here will focus only on strengthening the capacity of communities to effectively implement SBCC. CHWs' skills for interpersonal communication, advocacy, and social mobilization will be enhanced. Community champions will be engaged as change agents to foster transformation of social norms toward positive attitudes, behaviours, and practices related to FP. These activities will complement existing national efforts to address the knowledge-use gap described in the NFPCIP (e.g., the ongoing Green Star campaign).

Outcome Target

Proportion of women citing CHWs as their source of FP information and supply increased from 43 percent (i.e., current level according to the 2010 DHS) to 50 percent by 2020.

Indicator

Proportion of women citing CHWs as their source of FP information and supply.

Means of Verification

2015 DHS, 2020 DHS, and other behaviour change communication surveys.

Outputs/Activities	Implementation Targets						Indicators
	YR 1	YR 2	YR 3	YR4	YR5	YR6	
2.1a) Improved skills of CHWs to apply SBCC effectively to their work and deliver higher-quality care to clients							
2.1ai) Include or improve an SBCC section in any revision of the training curriculum and service guidelines that focus on CHWs *(Linked to activity 1.1bii)*							Proportion of revised training curriculum and service guidelines include SBCC component
IIA1.2 Conduct training of CHWs on SBCC and advocacy as per the CHW training curriculum *(Linked to activity 1.2biii)*							# of CHWs recruited, trained, and certified to provide FP services by district
2.2b) Increased engagement of key community groups (champions, peer educators, traditional leaders, CHWs) to implement SBCC interventions in their communities							
2.1bi) Recruit champions in select communities and conduct orientation workshops using the updated, nationally approved government orientation guide, advocacy package, and SBCC message guide *(Linked to NFPCIP Strategic Action Area IV: Advocacy and Strategic Communication, Strategic Result 4: A coordinated network of FP champions established and supported}*							# of community-level champions recruited # of community-level champions oriented
2.1bii) Support organization of community mobilization and SBCC interventions to enhance FP knowledge and address myths and misconceptions through edutainment							# and type of community-level SBCC interventions conducted

3.2.3 Key Intervention Area III: Enabling Environment

Under this key intervention area, efforts to further an enabling environment for CBFP services will complement activities planned under the CBHP strategic plan, guided by the CBHP policy guidelines. These efforts include strengthening leadership, coordination, and accountability for effective and efficient implementation of CBFP services at all levels and securing adequate and sustainable financing for CBFP services.

3.1) Strengthened leadership, coordination, and accountability for effective and efficient implementation of CBFP services at all levels

Summary of Activities

Strong leadership and accountability are key to universal access to FP services at the community level and to ensuring equity and quality services. Effective coordination at the community level will involve integrating CBFP into existing coordinating structures to not only enhance information sharing and learning but also ensure sustained efforts to implement CBFP. To ensure that CBFP data help meet community and national FP targets, monitoring activities will be linked to quarterly tracking of the NFPCIP. Strengthening the capacity of champions and advocates to involve NGOs and CSOs will be critical for holding local leadership accountable for delivering CBFP services. Groups of advocates will focus on key issues that require leadership to meet community demand for FP while ensuring community ownership of CBFP initiatives. Several advocacy interventions will be implemented to promote FP, including policy dialogues with community leaders, the development of policy briefs with data and key messages, and the engagement of community media (ie., radio and TV) and social media, especially mobile phone technology targeting youth.

Outcome Target

At least 80 percent of the districts have established coordination mechanisms to enhance accountability and sustainability of CBFP services to increase access to FP services in their respective communities by 2020.

Indicators

Proportion of districts with functional CBFP coordination mechanisms.

Proportion of wards accessing CBFP services.

Means of Verification

Data from CCHPs.

Data from coordination meetings.

Outputs/Activities	Implementation Targets						Indicators
	YR 1	YR 2	YR 3	YR4	YR5	YR6	
3.1a) Improved coordination of CBFP efforts at central level							
3.1ai) Establish a CBFP technical working group to facilitate coordination of activities and discuss progress, challenges, and solutions (including troubleshooting issues arising from field implementation)		4 meetings	4 meetings	4 meetings	4 meetings	4 meetings	Frequency of and representation at CBFP technical working group meetings
3.1aii) A mechanism for monitoring implementation of CBFP services is included as part of the NFPCIP performance monitoring mechanism (tracking tools and semi-annual review meetings)		2 meetings	2 meetings	2 meetings	2 meetings	2 meetings	COP-CBFP targets and indicators included in the NFPCIP monitoring database
3.1b) District councils have and implement a partnership framework to support effective coordination of CBFP services/activities in respective districts							
3.1bi)District councils implement a partnership framework to strengthen engagement and coordination of CBFP services at the district level	159 districts	159 districts	159 districts	159 districts	159 districts	159 districts	# of districts with an established partnership framework for CBFP services
3.1c) Continuous advocacy efforts conducted by champions to ensure accountability at the LGA level toward a supportive enabling environment for quality provision of CBFP services							
3.1ci) Support champions at the district level to use FP advocacy messages and tools. Advocacy to enhance accountability at the LGA level							# of community champions oriented to advocacy messages # of champions using advocacy messages to increase accountability at the LGA level for CBFP services
3.1d) Community engagement and ownership enhanced to ensure accountability, acceptability, and support for high-quality CBFP service provision							
3.1di) Orient existing champions (i.e., leaders) in respective areas to enable them to advocate for community-level accountability, acceptability, and support for high-quality CBFP service provision			420	280			# of community champions oriented to advocacy messages

Adequate and sustainable financing for CBFP services secured

Summary of Activities

Identifying feasible approaches to sustainable financing to reap the long-term benefits of CBFP interventions. Under this result, efforts will be directed towards mobilizing resources from all sources (i.e. public and private) and determining innovative models that could scale andn sustain CBFP efforts over time.

Outcome Target

Eighty percent of the resource investments needed to scale up and sustain CBFP achieved by 2020.

Indicators

Trend in the amount of financial resource investments allocated and expended for CBFP efforts.

At least one innovative financing model for CBFP services developed and tested by 2020.

Means of Verification

Resource and expenditure monitoring database.

Outputs/Activities	Implementation Targets						Indicators
	YR 1	YR 2	YR 3	YR4	YR5	YR6	
3.2a) Financial resource allocation to CBFP services at all levels (i.e., CCHP, national, and district levels) increased							
3.2ai) Advocate for re-source allocation for CBFP services in CCHP budgets			100 districts	59 districts			Proportion of CCHP budgets including finan-cial resource allocation for CBFP efforts in respective districts
3.2aii) Conduct budget analysis at the CCHP level to track resource allocation and expenditures for CBFP activities							Proportion of CCHP budgets reflecting allocations for CBFP services
3.1aii) Advocate through symposiums and meetings to the donor community and NGOs/FBOs to finance CBFP interventions							Proportion of the donor community financing CBFP services Proportion of NGOs/ FBOs financing CBFP services

Outputs/Activities	Implementation Targets						Indicators
	YR 1	YR 2	YR 3	YR4	YR5	YR6	
3.2bi) Identify different approaches for sustaining financing of CBFP services, including community-based prepayment schemes (e.g., Community Health Fund or CHW engagement in selling social marketing products) or the formation of public-private partnerships for in-kind support							# and types of innovative financing models identified
3.2bii) Evaluate the feasibility and effectiveness of different approaches for generating sustainable financing for CBFP services							Evidence generated on the feasibility and effectiveness of innovative financing models

INSTITUTIONAL IMPLEMENTATION ARRANGEMENTS

The institutional arrangements for implementation of this operational plan will involve all stakeholders from national to village levels. Stakeholders at each level will have roles and responsibilities, including modalities of implementation, provision of feedback, supervision, and monitoring and evaluation. The roles and responsibility of key stakeholders at various levels are described below.

4.1. National Level

4.1.1 Ministry of Health and Social Welfare

The MOHSW is responsible for overall coordination and oversight of the operational plan and for ensuring quality and adherence to guidelines and regulations. The National Technical Working Group for the Community Health Care Program, under the directorate of preventive services appointed by the MOHSW will provide direction and guidance to ensure that the implementation of the COP-CBFP is in line with the national CBHP policy guidelines and national CBHP strategic plan. The MOHSW will:

- Approve policies and guidelines that affect implementation, resource mobilization, and monitoring and evaluation.
- Set standards and develop/update national CBFP guidelines, standards, and management protocols to ensure the quality and uniformity of training.
- Ensure that data and information generated from the COP-CBFP are captured in the national HMIS.
- Ensure that the key intervention areas and activities of the operational plan are integrated, harmonized with, and supported by programs in the health sector and other sectors.
- Help mobilize resources to support implementation of the COP-CBFP.
- Empower LGAs to administer the CBFP program, by providing standardized CBFP guidelines to the CHMT and other stakeholders.

4.1.2 Reproductive and Child Health Section (Family Planning Unit)

As part of the MOHSW, the FP unit of the RCHS will also be responsible for developing or updating policies and guidelines that affect implementation, resource mobilization, and monitoring and evaluation. The RCHS will also set standards and develop/update national CBFP guidelines, standards, and management protocols to ensure the quality and uniformity of training. For instance, this may include developing training curricula/guides for CHWs, trainers, and supervisors. Through the National Family Planning Technical Working Group, the RCHS will provide oversight to the implementation of this operational plan. The RCHS will:

- Facilitate joint planning with development partners and CBFP stakeholders for effective co-ordination and implementation of the operational plan.
- Facilitate capacity development and technical support for CBFP implementers at all levels.
- Provide frequent feedback on the progress of the program to appropriate stakeholders (e.g., the National Technical Working Group for the Community Health Care Program) through meetings and workshops.

- Monitor and evaluate the implementation of the operational plan through the National Family Planning Technical Working Group.
- Ensure that the implementation of CBFP services is based on innovative, evidence-based approaches.

4.1.3 Pharmacy Council

Established by the parliamentary Act No. 7 of 2002, the Pharmacy Council provides management and control for the pharmacy profession and related matters, including regulating and overseeing the operations of the ADDOs program. In the context of CBFP, the Pharmacy Council will:

- Review and revise/update ADDOs guidelines and standards, including the training curriculum, to incorporate FP.
- Revisit the ADDOs medicines list and incorporate additional, approved FP commodities.
- Conduct regular supervision and inspection of ADDOs to ensure that they provide quality services and adhere to national guidelines and regulations.
- Regulate the working environments of ADDOs so they are structurally conducive to FP counseling.
- Ensure that ADDO dispensers have sufficient and correct tools for keeping records.

4.1.4 Development Partners

Both bilateral and multilateral donor agencies will be called upon to increase their support and to augment the financial and technical resources that will be required to implement this operational plan. The MOHSW will continue to call on cooperating agencies to identify and coordinate the wide variety of expertise and experience needed to implement the plan using state-of-the-art information and interventions.

4.1.5 Implementing Partners

Although most FP services are provided through public-sector facilities, NGOs and FBOs also play important roles in service delivery, especially for CBFP. As such, they will be critical partners in implementing this operational plan. The organizations are important sources of broader health care, especially in rural areas of Tanzania, and some have experience providing integrated services that include FP. The MOHSW will continue to look to these partners as CBFP services are improved and expanded. These organizations will be expected to ensure coordination and training and ensure adherence to set service standards and guidelines. They will also contribute their service data for monitoring and evaluation (to assist the MOHSW in maintaining comprehensive implementation) and will identify needs and opportunities for expanding and integrating services. Civil society and NGOs are responsible for soliciting resource for, initiating, supporting, and implementing sustainable CBFP projects following the national CBHP policy guidelines, the national CBHP strategic plan, and the national guidelines and standards for CBFP services. They cooperate with the MOHSW and LGAs (e.g., by sharing resources and, when applicable, offering quality CBFP services and logistics). They also share experiences/reports with the MOHSW, LGAs, and other stakeholders. They will:

- Support CBFP initiatives in their areas (e.g., by sharing resources when applicable)
- Provide technical assistance in their specialized fields of CBFP interventions.
- Work closely with the community at all stages of implementation.
- Work closely with CHMTs and the community at all stages of project implementation.

4.2 Zonal Level

Technical support, including training and continuing education, will be provided at the zonal level. The zonal RCH coordinators will collaborate with central, regional and district level MOHSW, NGOs, the private-sector, and zonal training teams to:

- Maintain standards of CBFP services through continuing education and long-term training.
- Build the capacity of regional and district resource teams for CBFP training.
- Provide management support and evaluation of service performance.
- Strengthen and maintain effective partnerships and networking with key stakeholders such as the MOHSW, regional health management teams (RHMTs), CHMTs, NGOs, CBOs, and FBOs.
- Collect, analyze, and utilize data for planning purposes and to send to upper levels.
- Receive, analyze, and compile reports for the district and national levels.
- Provide feedback to the regional secretariat.

4.3 Regional Level

Through the RHMT, the regional secretariat will provide technical and advisory support to the LGAs to ensure proper implementation of the COP-CBFP. Moreover, the regional secretariat will ensure that the operational plan is incorporated into the CCHP and budget, and will supervise its implementation. The regional secretariat should create a conducive environment for the implementation of the plan. The RHMT will:

- Support the CHMT in coordinating the implementation of the COP-CBFP
- Provide linkage between the Nationalregional secretariat and councils and between the national and district/council levels.
- Interpret policies and guidelines from the central level to the district level for effective implementation of the COP-CBFP.
- Mobilize resources to support COP-CBFP activities in the region.
- Facilitate capacity building at the district level to implement the COP-CBFP.
- Coordinate, monitor, and supervise COP-CBFP activities in the region.

4.4 District Level

4.4.1 Local Government Authorities

Health services, including CBFP, are the shared responsibility of the MOHSW and LGAs.

With planning and budgeting for health services delivery decentralized to the district level, it is imperative that FP (especially CBFP) is prioritized in CCHPs. As LGAs assume greater responsibility for planning, budgeting, and monitoring delivery of services in the communities in their districts, they will play critical roles in achieving the objectives of this operational plan. The LGAs will:

- Assess the overall council health plans and implementation reports (i.e., technical and financial reports) on matters related to the CBFP program.
- Monitor and provide supportive supervision to the CHMT.

4.4.2 Council Health Management Team

CHMTs will be responsible for coordinating and implementing the COP-CBFP activities at the district/council level and facilitating partnerships/collaborations with stakeholders. More specifically, the CHMTs will:

- Ensure that COP-CBFP activities are incorporated into the district/council plans and implemented by different stakeholders.
- Facilitate capacity building for CHWs for effective implementation of the COP-CBFP.
- Ensure that systems are in place at the community level to promote CBFP.
- Compile, interpret, and utilize data and submit district/council reports to the regional level.
- Monitor and evaluate implementation of the COP-CBFP at the district level.
- Facilitate recruitment of CHWs and training according to identified needs/gaps.
- Coordinate all CBFP activities in the district.
- Ensure smooth running of CBFP activities by providing technical assistance and medical supplies.
- Compile, reports, and record information from NGOs and government projects on CBFP activities and submit them to higher levels of the MOHSW and relevant NGOs partners (through the district RCH coordinator)
- Devise mechanisms to ensure effective supportive supervision to CBFP activities on a quarterly basis.
- Exchange information and experience with other interested parties.

4.4.3 Ward Development Committee

Through the Ward Development Committee, the ward will be responsible for supervising the implementation of the COP-CBFP in their respective areas of jurisdiction. This will include coordinating the program activities at the village level. The ward will also work with village governments to mobilize communities to contribute resources for the program.

4.5 Health Facility Level

Health facilities such as hospitals, health centers, and dispensaries will be key for implementing the COP-CBFP in terms of service provision. Health facilities will:

- Receive referrals from CHWs and provide necessary services.

- Assess CBFP service provision for quality improvement.
- Plan, implement, and monitor and evaluate CBFP activities at the facilities.
- Compile data from CHWs, send the data to the district level, and utilize the data for planning purposes (e.g. to request commodities and supplies for CBFP activities).
- Provide technical support to CBFP service providers.

4.6 Village Level

It is the responsibility of each individual or household to take care of his or her own health. The communities have an obligation to their own health and should participate in CBFP issues. Therefore, household members will need to have the capacity to fulfill their duties to achieve better health. The community is the backbone of CBFP and is responsible for project ownership and sustainability. This should be made clear to and be accepted by the community before the program interventions starts. Stakeholders at the village level will:

- Participate in decision-making, planning, implementation, and monitoring and evaluation of the project through facilitation by CHMTs and other stakeholders.
- Mobilize community resources for the implementation of the COP-CBFP.
- Participate in the implementation of the COP-CBFP at the community level.
- Mobilize the community to participate in CBFP interventions.
- Set and promote community norms, behaviors, and decision-making systems.
- Arrange village health events and activities to respond to the community's CBFP needs.

MONITORING AND EVALUATION

Monitoring and evaluation is essential to any intervention, as it helps track the progress of implementation, identify gaps, and inform decision-making. Monitoring and evaluation of the COP-CBFP will be incorporated into the MOHSW's national monitoring and evaluation system. To ensure smooth monitoring of the COP-CBFP, the key strategic interventions and program output indicators will be incorporated into the existing NFPCIP monitoring database. However, not only program outputs but also financial aspects of the COP-CBFP will be monitored. The management information system unit of the RCHS will lead the monitoring and evaluation for the COP-CBFP. Appropriate indicators will be identified and incorporated into the HMIS, and a format will be agreed upon for periodic reporting (e.g., the data analysis plan). At a minimum, reports will be collected and submitted on a quarterly basis, in line with the government's financial cycle. Quarterly progress reports will be discussed with the National Family Planning Technical Working Group and during semi-annual meetings with FP implementers.

Periodic supportive supervision at the district level and quarterly supportive supervision at the central and regional levels will also be part of the monitoring efforts.

Districts and regions will compile their reports and submit them online through the NFPCIP web-based monitoring database. The reports will be analyzed together with reports from CBFP implementing partners.

Evaluation of the COP-CBFP will be part of national surveys such as the DHS and the Services Availability Survey. All stakeholders will use the results of national evaluation to correct deficiencies, build on program successes, and plan for consolidation and continuity.

The COP-CBFP may be revised, if necessary, following a medium-to-long period of implementation (i.e., 2-3 years), as informed by reviews of progress implementation.

APPENDICES

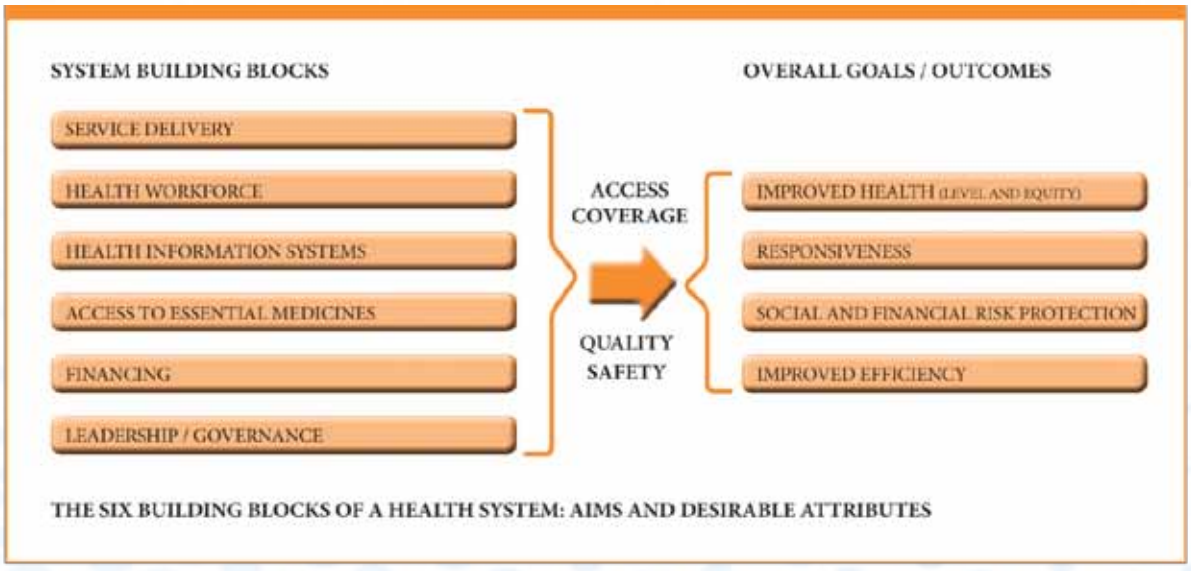
Appendix 1: Conceptual Foundation of the COP-CBFP

The intervention areas in this operational plan are organized around concepts outlined in EngenderHealth's SEED™ Assessment Guide for Family Planning Programming (2011) and WHO's Health System Building Blocks (WHO, 2007). The SEED model embraces the principle that FP and sexual and reproductive health (SRH) programs can be successful and sustainable if they address the multifaceted determinants of health using comprehensive and synergistic interventions.

Specifically, programs must:

- Attend to the availability and quality of services and other supply-related issues.
- Strengthen health systems and foster an enabling environment for FP/SRH-seeking behavior.
- Improve knowledge of FP/SRH and cultivate demand for FP/SRH services.

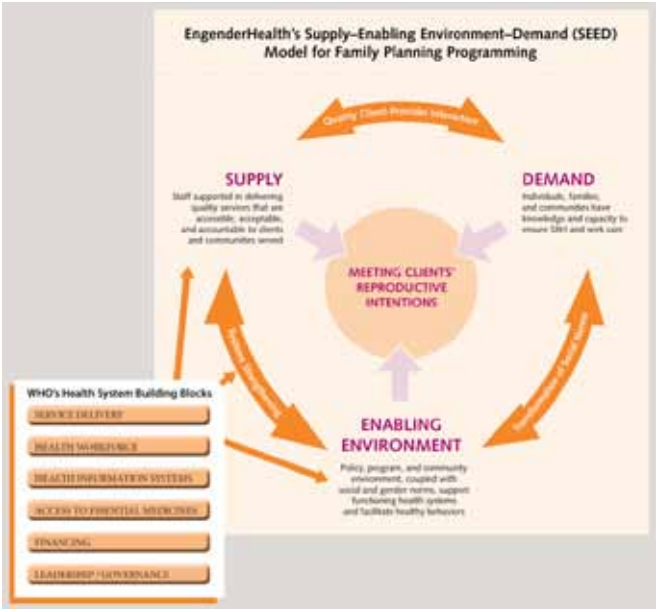
Whereas the SEED model conceptualizes synergistic processes required for successful FP/RH programs, the WHO framework focuses on the structure of health systems by describing six core components or building blocks: 1) service delivery, 2) the health workforce, 3) health information systems, 4) access to essential medicines, 5) financing, and 6) leadership/governance (Figure 3). The building blocks strengthen health systems in different ways. Cross-cutting components, such as leadership/governance and health information systems, regulate the other blocks in the system. Financing and the health workforce provide key inputs required to make the system function; whereas, medical products, medical technologies, and service delivery are the immediate outputs of the health system.



Source: Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and their Measurement Strategies, WHO 2010 (framework originally published in 2007).

The combination of the WHO framework and the SEED model allows this operational plan to utilize the boundaries and foundation defined by WHO's building blocks while considering the synergies, dynamic links, and interactions outlined in the SEED model (Figure 4).

Figure 4: Incorporating WHO building blocks into the SEED model



Adapted from: The SEED Assessment Guide for Family Planning Programming, EngenderHealth 2011.

Appendix 2: Priority Regions for Scale-up of CBFP services

The FP2020 initiative provided another opportunity to focus efforts in regions of the country most likely to benefit from specific interventions already under way as part of the NFPCIP. Table 11 highlights 15 regions that are expected to contribute 36 percent of the 60 percent CPR target. Note that Geita and Simiyu, formerly part of Mwanza and Shinyanga regions, respectively, were added as two additional regions, given the 2012 creation of new regions by the government.

Table 2 : Fifteen regions contributing to the CPR target

Region	District	# Wards	# Household	# CHWs Needed
Kigoma	Kibondo	13	374,488	3,745
	Kasulu	19		
	kigoma rural	11		
	Kigoma MC	19		
	Uvinza	14		
	Buhingwe	15		
	kakonko	11		
	Kasulu TC	9		
Shinyanga	Shinyanga Municipal	17	261,732	2,617
	Kishapu	20		
	Shinyanga district	26		
	Kahama	35		
	Kahama TC	20		
Kagera	Karagwe	22	524,793	5,248
	Bukoba DC	29		
	Muleba	43		
	Biharamulo	15		
	Ngara	20		
	Bukoba MC	14		
	Missenyi	20		
	Kyerwa	18		
Mwanza	Ukerewe	24	486,184	4,862
	Magu	18		
	Nyamagana	12		
	Kwimba	30		
	Sengerema	34		
	Ilemela	9		
	Misungwi	27		

Region	District	# Wards	# Household	# CHWs Needed
Mara	Tarime	30	312,444	3,124
	Serengeti	28		
	Musoma	14		
	Bunda	28		
	Musoma MC	13		
	Rorya	21		
	Butiama	20		
Simiyu	Bariadi	25	229,946	2,299
	Itilima	22		
	Meatu	25		
	Maswa	26		
	Busega	13		
Geita	Geita DC	35	286,757	2,868
	Nyanga'hwale DC	12		
	Mbogwe	16		
	Bukombe	13		
	Chato	22		
Tabora	Nzega	37	383,432	3,834
	Igunga	26		
	Uyui	24		
	Urambo	16		
	Sikonge	17		
	Tabora MC	25		
	Kaliua	21		
Singida	Iramba	17	258,280	2,583
	Singida DC	21		
	Manyoni	30		
	Singida MC	16		
	Ikungi	26		
	Mkalama	14		
Dar es Salaam	Kinondoni MC	34	1,095,095	10,951
	Ilala MC	26		
	Temeke MC	30		
Mbeya	Chunya	30	635,047	6,350
	Mbeya	25		
	Kyela	20		
	Rungwe	37		
	Ileje	18		
	Mbozi	18		
	Mbarali	20		
	Mbeya city council	36		
	Momba	13		
	Tunduma TC	1		

Region	District	# Wards	# Household	# CHWs Needed
Morogoro	Kilosa	35	506,289	5,063
	Morogoro	29		
	Kilombero	19		
	Ulanga	24		
	Morogoro MC	19		
	Mvomero	17		
	Gairo	11		
Mtwara	Mtwara DC	28	344,834	3,448
	Newala Dc	28		
	Masasi	22		
	Tandahimba	30		
	Mtwara MC	15		
	Nanyumbu	14		
	Masasi TC	12		
Iringa	Iringa DC	25	223,028	2,230
	Mufundi	27		
	Iringa MC	16		
	Kilolo	22		
	Mafinga	3		
Lindi	Kilwa	21	225,972	2,260
	Lindi DC	30		
	Nachingwea	26		
	Liwale	20		
	Ruangwa	21		
	Lindi MC	18		
Dodoma	Kondoa	28	453,844	4,538
	Mpwapwa	30		
	Kongwa	22		
	Chamwino	32		
	Dodoma MC	37		
	Bahi	20		
	Chemba	20		
Arusha	Monduli	15	378,825	3,788
	Meru	17		
	Arusha MC	19		
	Karatu	14		
	Ngorongoro	21		
	Arusha DC	21		
	Longido	16		
Kilimanjaro	Rombo	24	384,867	3,849
	Mwanga	20		
	Same	31		
	Moshi	31		
	Hai	14		
	Moshi MC	21		
	Siha	12		

Region	District	# Wards	# Household	# CHWs Needed
Tanga	Lushoto	44	438,277	4,383
	Korogwe	20		
	Muheza	33		
	Tanga CC	24		
	Pangani	13		
	Handeni	20		
	Kilindi	20		
	Mkinga	21		
	Korogwe TC	8		
	Handeni TC	12		
Pwani	Bagamoyo	22	257,511	2,575
	Kibaha	11		
	Kisarawe	15		
	Mkuranga	18		
	Rufiji	26		
	Mafia	8		
	Kibaha TC	11		
Ruvuma	Tunduru	35	303,071	3,031
	Songea	17		
	Mbinga	34		
	Songea MC	21		
	Namtumbo	18		
	Nyasa	15		
Rukwa	kalambo	17	199,766	1,998
	Sumbawanga	15		
	Nkasi	17		
	Sumbawanga MC	15		
Manyara	Babati	21	273,284	2,733
	Hanang	25		
	Mbulu	32		
	Simanjiro	17		
	Kiteto	19		
	Babati TC	8		
Njombe	Njombe TC	13	170,160	1,702
	Wanging'ombe	17		
	Makete	22		
	Njombe	11		
	Ludewa	25		
	Makambako TC	8		
Katavi	Mpanda TC	9	101,224	1,012
	Mpanda	9		
	Mlele	24		
Total #CHWs needed	**159**	**3312**		**91092**

Appendix 3: Issues -Recommendations Matrix

Financing and Sustainability of CBFP			
	Policy Level	**Program Level**	**Service Delivery Level**
Strengths	• Political commitment for family planning is increasing, as demonstrated by a national costed implementation plan, FP2020 commitments, and Sharpened Plan. • CBFP features well in the NFPCIP as Strategic Result #3 dedicated to strengthening and expanding availability of CBFP services • Nationally, efforts to strengthen community health workers as part of primary health care have been revitalized with the recent release of Policy Guidelines, followed by the current development of a strategic plan.	• Some level of funding for CBFP is available, albeit short-termed and mostly through implementing partner (NGO) projects.	
Issue	• There is no budget line to support CBFP services in MTEF. • CBFP providers are not part of the government salaried health staff cadre system – i.e. they are regarded as volunteers and given incentives. • In addition to competing priorities for financing health care, lack of specific guidance and directives for planning and budgeting for CBFP in council health plans contributes lack of dedicated financing for CBFP at this level. • Although Family Planning activities are included in the Comprehensive Council Health Plan, but in most cases the allocated amounts are lower compared to the needs.	• Financing for CBFP activities is highly donor dependent, making this approach to service delivery short-termed and unsustainable. • Inadequate government financing for the entire family planning program means that the little funding available is allocated to commodity procurement and less to improve service delivery. • At district level, some funding is allocated to CBFP but this is neither universal nor consistent across all districts.	

Financing and Sustainability of CBFP			
	Policy Level	**Program Level**	**Service Delivery Level**
Proposed Recommendations	• Sensitization of district officers on the importance and contribution of CHWs in FP. • Increased involvement of DRCHCOs in CCHP planning to influence CBFP inclusion in the plans. • Collaboration between MOHSW, MOF, and Ministry of Local Government to ensure sufficient budget allocation. • Issuance of a circular/directive to instruct all DED/DMOs to give priority on CBFP activities. • Advocacy in having CHWs to be part of the government formal health care. • Advocacy to ensure new CHW Policy Guidelines include FP in the service package and considerable attention given to FP issues in the strategic plan. • Advocacy on efforts directed towards having a budget line item for CBFP • Advocate for health insurance to cover FP and CHF to cover CHFP. • Institute a by-law whereby the Village government allocates some % of its revenue for community activities, particularly incentives for CHWs • Village government structure should provide for an advisory body to support CHW work • Ensure FP 2020 commitments include CBFP	• Enhance advocacy and lobbying especially for government support to funding CBFP • Increase community involvement in planning and budgeting for CBFP • Develop cost recovery schemes for CBFP. Subsidize marketing of televisions and radios as a cost-effective means of promoting family planning. • Advocate for allocation of (10–20%) of the total family-planning budget for CBFP • Use effectiveness and cost implications when decisions are made on which FP methods to be used. • Integrate microfinance/economic strengthening initiatives to support CHWs. • Disseminate NFPCIP at district levels	

Human Resources			
	Policy Level	Program Level	Service Delivery Level
Strengths	• Efforts to strengthen the CHW platform, as part of primary health care are currently on-going. CHWs are part of the formal health system.	• Guidelines and tools for the CBFP are available. • CHWs are supervised by staff from the Reproductive and Child Health unit from the nearby facility.	• Community structures that can facilitate recruitment of CHWs are available. • Despite the difficult working environment some CHWs seemed to have served for long duration
Issue	• CBFP providers are not part of the government salaried health staff cadre system, and hence are regarded as volunteers and not compensated. This creates irregularity in their compensation, affecting their motivation and retention. • The definition of a community health worker is unclear, but also for a CBFP provider it is limiting. For example, for CBFP, CHWs are referred to as CHWs performing household visits. However, other CHWs, such peer educators, are providing CBFP information and hence part of the CBFP system. • Current policy stipulates the types of methods that can be distributed by CHWs as limited to oral contraceptives and condoms. Some non-prescription methods or those which are WHO-recommended at this level are missing, including natural methods and depo-provera. • Lack of policy-level directives for provision of monetary or non-monetary incentives. • Providing incentives – both monetary and non-monetary is not reflected as neither a policy nor standard but a guideline hence not consistently enforced	• CHWs often perform multiple tasks across different health areas, resulting in some cases having excessive workload. • Roles of CHWs are outdated and do not match current established needs of the FP Program • Lack of a career development path for CHWs. • Guidelines, training curriculum for managing CBFP program are available but outdated. • Inadequate/irregular supportive supervision/training follow-ups provided for CBFPs • Inadequate competent facility-based staff to conduct supportive supervision for CHWs. • Limited understanding of the value/role of CHWs in family planning by facility level staff. • Limited refresher training – few and far between • High attrition rate of CHWs • Low motivation of CHWs. • Inadequate incentives provided to CHWs. • The criteria and guidelines for selecting and recruiting CHWs are not consistently used/their use is not enforced. For example, some CHWs are not recognized by their communities. • Some CHWs have not received any FP training. • There was no defined mechanism observed at the local level to retain CHWs.	• CHWs lack or have inadequate working tools, and protocols, and job aids to support provision of FP services • No specific relations existed between CHWs and the Community leaders • CHWs were inadequate in numbers and quality. While most villages had only one CHW who could not serve adequately some big villages, other villages do not have any.

Proposed Recommendations	• Advocate for recognition of CHWs as part of the formal cadre of health workers by MOHSW • CBFP should be clearly outlined in the new CHW policy, guidelines and standards as important platform for FP service delivery • Revise the definition of CHW to make sure it is clear and matches current needs of the FP program • Advocacy to make incentives – monetary/ non-monetary mandatory • Update the National Guidelines for CHWs to reflect revised roles, scope of CBFP services, selection criteria and recruitment approach. • Expand the types of methods a CHW can provide at community level • Advocate for more staff in health facilities to strengthen CHW supervision	• Reflect incentives (monetary&/or non-monetary) as a standard of practice for CBFP Programs • The National guidelines should consist of standards of practice, and reflect - frequency of refresher trainings/how long after initial training; training follow-ups; incentives; selection criteria and recruitment standards (must involve community etc.); equipping CHWs with working tools • Update training curriculum to reflect changes in guidelines. Ensure curriculum is competency-based. • Update skills of facility staff to be able to supervise CHW. • Improve competencies of supervisors on providing supportive supervision to CHWs. • Develop/pilot/institute a performance based reward system for CHW/CHWs. • Develop comprehensive guidelines, tools and standards for supervision • Develop and determine standards for CHW:client ratio similar to for example doctor: patient ratios etc. • Devise standards for level of workload consistent with the CHW ladder development. • Propose to sensitize health providers at facility level & others on the importance and value of CBFP in FP services. • Develop and institute alternative mechanisms/approaches to support CHWs e.g. technology &/or promote a ladder of CHWs so that active CHWs can be supervisors for others • Have in place a scheme for career development for CHWs regardless of CHWs being in the formal health system. • Attention to the provision of an enabling work environment for CHWs is essential for achieving high levels of productivity • The ideal location of training should be where CHWs will have sufficient opportunity to practice • Undertake periodic training and refresher training for CHWs. • Provide CHWs with working gear (supplies and equipment) and incentives • Recruit an adequate number of CHWs at each village • Provide CHWAs a reasonable monthly stipend	

Service Delivery Systems[1]			
	Policy Level	**Program Level**	**Service Delivery Level**
Strengths	• The draft national operational guidelines for integrating MNCH and HIV services (NOGI) clearly stipulates the community level as a platform for providing integrated service delivery, and defines the expanded role of CHWs providing HIV services at community level	• Different players working on CBFPs have relative strengths. For example UMATI for being capable to train CHWs and CHW supervisors; PSI for being good at marketing programmes and facilitating the process of changing communities; Pathfinder international credited with initiating and running integrated RH programmes.	• Some FP services are integrated with other services. For example some CHWs educate mothers on the use condoms during antennal clinics visits
Issue	• Lack of policy directives regarding types and scope of integration at community level • Lack of policy directives to encourage collaboration at all levels (intra-sectoral and multi-sectoral) in order to advance CBFP • Challenges with financing for integration exists despite having evidence on feasible interventions that need to be scaled up. • There is no clear and formal partnerships between and among the stakeholders. CHW exists as projects that are mostly answerable to the donors who do the planning and administration with varied participation level by the village government • There are no explicit guidelines on mainstreaming CHW initiatives undertaken by various agencies.	• Poor geographical coverage of CBFP providers – not all areas needing CBFP have active CHWs. • Where present, there are few CHWs per number of people to serve. • Lack of standards for CBFP program – at service delivery & program levels • Lack of quality assurance systems for CBFP • CBFP service delivery platform confined to the traditional model of household visits. • Inadequate of recognition of community level structures, such as VICOBA, women groups, agricultural extension workers etc. that can be tapped for CBFP • Lack of guidelines on what, where and how to foster integration • Weak coordination mechanisms for CBFP services at ward and district levels • Inadequate community involvement in CBFP services - community leaders bypassed by CBFP programs. Similarly, districts are bypassed by CBFP programs. • Inadequate support by LGA & MOHSW on mandate for partner projects & implementation in selected areas • Unreliable supply of equipment, commodities, transport and other material support for their work.	• Community members mentioned services provided by CHWs are available but are inadequate.

Service Delivery Systems[1]			
	Policy Level	**Program Level**	**Service Delivery Level**
Proposed Recommendations	• Scale up of CBFP country wide with emphasis needed for regions with low infrastructure/low CPR	• Develop and disseminate standards of practice for CHWs – program & service delivery levels • The National Guideline for CBFP should include a revised broadened definition of a community platform for CBFP service delivery beyond traditional sense to include informal community groups e.g. women groups • Sensitize the community governing structure on FP • Encourage efforts (HBC training & job aids integrated with FP) to operationalize the NOGI at community level • Private sector CHWs to expand coverage and sustainability • Strengthen integrative supportive supervision and management • Enhance recruitment and training of young people as health workers • Harmonize donor support for integration of CBFP services • Supply CHWs with adequate IEC materials • Equip CHWs mobile phones and airtime as a tool for their work.	

1 Service Delivery System refers to availability of CBFP services; organization of CBFP service delivery including community structures, integration of services & referral; Quality Assurance; community participation in CBFP.

Contraceptive Security for CBFP Services			
	Policy	**Programmatic**	**Service Delivery**
Strengths		• Current guidelines allow for the existing ordering system from health facilities includes community level commodity needs	• CHWs get supplies from nearby reporting health facilities
Issue	• Commodities for CHWs are considered part of health facility orders, however in some case their allocation is not separately taken into consideration. When understock of commodities occur, the health facility is prioritized over community level.	• The supply chain system faces several challenges (described in NFPCIP). • Shortage of reporting tools for CHWs • Inconsistent availability/stock levels of Family planning commodities especially pills, injectables and female condoms offered by CHWs. • Inadequate knowledge on ordering CBFP commodities and drugs (use of R&R forms and ILS system) at health facility and community level • Frequent stock outs of FP commodities at facility level	• Weak inventory management by CHWs, including security/storage quality problems • Record management and reporting is poor. • In some places-overstocking leading to expirations • There is no clear role for community leaders in ensuring commodity security etc.
Proposed Recommendations	• Address supply bottlenecks at facility levels • Community-based distribution of injectables is an innovation that deserves consideration by decision makers who are seeking measures to strengthen family planning services	• Strengthen the supply chain between facility and community level • Sensitize health facility staff on importance of including community level orders for FP commodities.	• Strengthen training of CHWs on inventory management/logistics management • Provide reporting tools

Behavioral Change Communication			
	Policy	**Programmatic**	**Service Delivery**
Strengths		• A national SBCC campaign exists that includes both mass media and community level interventions	• Women are more aware of CBFP services and are willing to use them
Issue	• Inadequate resource mobilization for BCC activities	• Inadequate SBCC Interventions (household visits, meeting, cultural, theater, etc. • SBCC interventions not prioritized by program planners. • Inadequate knowledge on effective implementation of SBCC.	• CHWs lack adequate Information, Education and Communication (IEC) materials to promote the utilization of FP services in the community. • Provider bias on issues related to eligibility to use method (particularly for youth and PLWH/A) and method choice
Proposed Recommendations	• Central authorities should mobilize funds from various sources to strengthen BCC	• Increase availability, access to and use of quality reproductive health information and services • Advocacy is so much imperative to the political and religious leaders to accept and take up the role of ensuring full availability, accessibility and utilization of CBFP. • Scale up a mobile-phone based software project to support community health workers in providing high quality family planning counseling to their clients. • Design and distribute IEC materials to promote FP services in the community • Use health days for deliberation and education on FP issues • CHWs need to be trained on youth friendly services so that they change their negative attitude about family planning for the young people • Update supervisors on BCC issues and include in the supervision tools	

Health Management Information System for CBFP Services			
	Policy	**Programmatic**	**Service Delivery**
Strengths		• A functioning M&E unit exists at the central level • DHIS exists for gathering information on health activities, including at community level	
Issue		• Few HRH in facilities unable to supervise CHWs • Some CHWs do not report to facilities • Shortage of CHW reporting tools • The supervisors neither record CHW contributions nor refer feedback provided to CHWs	• FP registers at facility level do not explicitly include/record CHW contribution, data is aggregated as part of health facility records • Referral feedback from CHW is not emphasized • New health workers in health facilities are not trained to provide supervision to CHWs • Inconsistency of CHW reporting to the health facilities (some no reports received, others says monthly, others says quarterly)
Proposed Recommendations	• Promote inclusion of CHW report in MTUHA	• Provide reporting tools • Revisit the supervision system and feedbacks • Ensure CHW contribution is recorded	

ADDOs			
	Policy	**Programmatic**	**Service Delivery**
Strengths	• Strong national policy exists for ADDO, explicitly including FP commodities as a service dispensers provide.	• Most dispensers are either nurse assistants or medical attendants which provides a better knowledge base for training and providing FP commodities • Some ADDO facilities are within reach of clients • There are various sources from which FP supplies can be sought by ADDO owners.	• ADDO dispensers commonly recommend and provide FP methods to their costumers • The practice of referring clients for long acting contraception is commonly done by ADDOs dispensers • Some ADDO facilities have layout that ensure interaction between the client and the dispenser. • Condoms and pills are commonly available in most ADDO facilities. • FP drug register books are available in most ADDO facilities.
Issue	• Few ADDOs provide injectables which is contrary to regulations provided that prohibit them from doing so.	• There are various obstacles in the practice including inadequate instructions to guide dispensers, long distances and poor transport for clients and poor relationship between ADDOs and health facilities where referral are directed • ADDO facilities are not within reach of clients especially those in rural areas as ADDOs are mainly available in peri-urban areas • There are few FP service protocols in most ADDO facilities • Generally it is noted that prices of FP commodities vary by facility and geographical locations • Supervision by RHCOs. which is important to oversee and support ADDOs in providing quality FP services is rarely conducted.	• There is limited knowledge and skills among dispensers on various FP commodities and procedures. • Not all dispensers provide adequate instructions on the use of FP methods. • Some ADDO facilities have limited physical settings for working. Not all of the ADDOs had a room for examination and treatment. Also, few provide privacy and washing facilities and and space for processing used instruments and materials. • Counseling on the lactational amenorrhea method (LAM) is not provided. • The use of drug register books is questionable

ADDOs			
	Policy	**Programmatic**	**Service Delivery**
Proposed Recommendations	• The Ministry of Health and Social welfare and relevant stakeholders should revisit the policy / regulation on the mandate of ADDOS to handle injectables and emergency contraceptives. • Subsidizing the costs of popular family planning commodities should be considered especially in hard to reach areas.	• Curriculum for training ADDO dispensers should be revisited to ensure necessary topics are covered including counselling and contraindications of family planning methods • More efforts should be directed by the government and stakeholders to offer trainings for ADDO dispensers to increase their knowledge and skills in FP methods and other related aspects of family planning such as counseling • The practice of referring clients for long acting FP methods should be encouraged. This should be done through training dispensers on rational for referring clients, providing guiding instructions, strengthening the link between ADDOs and Health facilities and improving accessibility to health facilities. • There is need to improve the physical setting of ADDO shops in order to affect the quality of care given, as well as to clients' satisfaction with the facility. • More establishment of ADDOs should encouraged and their location should also consider better coverage to make better physical accessibility by clients. • More service protocol should be provided in ADDOs to improve FP services • There should be efforts to encourage ADDO dispensers in keeping records of FP usage. • There is need to have a more accurate study of ADDO sales performance for each FP product in order to determine the supplies needed by them. • There is need to promote the use of female condoms. • There is need to study and determine costs of popular FP commodities in order to come up with a reasonable price that can be afforded by customers especially in rural areas. • There is need to support supervisory activities in order to monitors what is happening in ADDO shops and to also support when there are problems	

Appendix 4: Annual resource requirements by Key Intervention Area

Key intervention 1: Supply

	(i)Sub-Activity	Required Input				FY2015-16		
Activity		Item Code (ii)	Description of Input (iii)	Measurement Unit (iv)	Unit Cost of Input (v)	Number of Units (x)	Estimates (v) x (x) = (xi)	
Strategic Result 1: Quality community-based family planning services are available and accessible in 15 selected regions all districts (all wards) by 2020.								
Outcome 1.1: Performance of CHW improved to provide quality services according to Guidelines and standards								
Indicator: # of wards with CBFP services provided according to guidelines and standards.								
1.1a) National guidelines and standards for CBFP services revised/updated and implemented								
1.1ai) Revise/update, disseminate, & support use the National Guidelines for initiating and managing CBFP services at all levels of the health system	Engage a consultant To revise/update guidelines for CBFP		Consultancy	Person-days	640,000	60	40,550,400	
	Subtotal						**40,550,400**	
	Conduct 4 stakeholders technical workshops to review revised/updated guidelines and standards.	3560153	per diem- domestic	Person-days	80,000	120	10,137,600	
		3560118	conference package	Person-days	65,000	300	20,592,000	
		3560133	Facilitator	Person-days	80,000	32	2,703,360	
		3560179	Travel allowance	Trip	40,000	128	5,406,720	
		3560139	Fuel	Kms	440	1440	669,082	
		3560185	perdiem-Driver	Person-days	45,000	36	1,710,720	
		3560104	Air ticket-return	Person-days	250,000	4	1,056,000	
		3560142	handouts	Copies	20,000	100	2,112,000	
	Subtotal						**44,387,482**	
	Print revised/updated guidelines and standards		Print	Copies	35,000	61,483	2,272,411,680	
	Subtotal						**2,272,411,680**	
	Conduct 8 orientation workshops for 240 implementers nationwide (One orientation per zone = 15 selected regions (invite zonal representatives); Total = 8 workshops; each 30 people).	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Person-days	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	Total activity						**2,357,349,562**	
	Total strategic activity						***2,357,349,562***	
1.1b) Service protocols/guidelines, Job Aid and Training curriculum (incl. for refresher training) for CBFP revised/updated, disseminated and used								
1.1bi) Revise, disseminate, and support use of the CBFP service protocols/guidelines and job aid	Engage a consultant to revise service providers' manual and Job Aid for managing CBFP services	3560120	consultancy	Person-days	640,000			
	Subtotal							
	Conduct stakeholders techical workshops to revise service providers' manual, and Job Aid- 4 meetings	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Trip	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	Pretest the revised provider's manual and Job Aid as part of on going program.	3560211	Participant's- half perdiem	Person-days	15,000			
	Subtotal							
	Print the revised service providers manual ,Job Aid (distrisbution and dessimination will be part of the TOT)		Print provider's manual	Copies	35,000			
			Print Job aid	Copies	35,000			
	Subtotal							
	Conduct stakeholders techical workshop to finalize provoder's manual, and Job Aid based on pre-testing results. *5 day workshop*	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Trip	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	Print the revised/updated Provider's manual and Job Aid	3560163	Print Provider's manual	copies	35,000			
		3560163	Print Job Aid	copies	35,000			
	Subtotal							
	Conduct orientation meeting Zonal meetings for revised/updated CBFP service protocols/guidelines and job aid at zonal level	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Trip	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	Total activity							

	FY2016-17		FY2017-18		FY2018-19		FY2019-20		FY2020-21	
	Number of Units (xii)	Estimates (v) x (xii) = (xiii)	Number of Units (xiv)	Estimates (v) x (xiv) = (xv)	Number of Units (xvi)	Estimates (v) x (xvi) = (xvii)	Number of Units (xvi)	Estimates (v) x (xvi) = (xvii)	Number of Units (xvi)	Estimates (v) x (xvi) = (xvii)
							60	50,425,570		
								50,425,570		
							150	15,757,991		
							375	32,008,418		
							40	4,202,131		
							160	8,404,262		
							1800	1,040,027		
							45	2,659,161		
							5	1,641,457		
							125	3,282,915		
								68,996,362		
							30,000	1,378,824,177		
		-						**1,378,824,177**		
	600	43,490,304		-						
	888	63,375,409		-						
	96	8,564,244		-						
	384	17,128,489		-						
	72,000	35,327,508		-						
	144	7,226,081		-						
	12	3,345,408		-						
	240	5,352,653		-						
		183,810,097		**-**						
		183,810,097		**-**		**-**		**1,498,246,109**		**-**
		183,810,097		**-**		**-**		***1,498,246,109***		**-**
	60	42,821,222								
		42,821,222								
	120	8,698,060.80								
	300	21,410,611								
	32	2,854,748								
	128	5,709,496								
	1,440	706,550								
	36	1,806,520								
	4	1,115,136								
	100	2,230,272								
		44,531,395								
	50	836,352								
		836,352								
	61,483	2,399,674,930								
	61,483	2,399,674,930								
		4,799,349,861								
	60	4,349,030								-
	125	8,921,088								-
	12	1,070,531								-
	32	1,427,374								-
	360	176,638								-
	15	752,717								-
	1	278,784								-
	25	557,568								-
		17,533,729								-
	61,483	2,399,666,734								
	61,483	2,399,666,734								-
		4,799,333,468								-
	480	34,792,243								
	480	34,256,978								
	48	4,282,122								
	192	8,564,244								
	8,640	4,239,301								
	144	7,226,081								
	16	4,460,544								
	240	5,352,653								
		103,174,167								
		9,807,580,195								-

Activity	(i)Sub-Activity	Required Input				FY2015-16		
		Item Code (ii)	Description of Input (iii)	Measurement Unit (iv)	Unit Cost of Input (v)	Number of Units (x)	Estimates (v) x (x) = (xi)	
	Engage a consultant to revise service providers' manual, Job Aid and training cirriculum for managing CBFP services	3560120	consultancy	Person-days	640,000			
	Subtotal							
	Conduct stakeholders techical workshops to revise service providers' manual, and Job Aid- 3 meetings	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Trip	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	Pretest the revised training cirriculum. 3 weeks - workshop	3560117	connference package	day	80,000			
		3560180	Travel allowance	trip	20,000			
		3560155	Per diem- domestic	person-days	80,000			
		3560142	Handouts	copies	20,000			
		3560185	Driver perdiem	person-days	45,000			
		3560139	Fuel	kms	440			
		3560104	Airticket	trip	250,000			
	Subtotal							
	Conduct stakeholders techical workshop to finalize training cirriculum based on pre-testing results. 5 *day workshop*	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Trip	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	Print the revised/updated Training cirriculum		Print Training cirriculum	copies	35,000			
	Subtotal							
	Conduct dissemination workshops for revised/updated supportive supervision tools for CBFP services at zonal meetings (8 zones)	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Trip	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	Conduct orientation workshops for CBFP supervisors and trainers on the updated training cirriculum. **(3 day meeting, 25 participants)- 4555**	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Trip	250,000			
1.1bii) Revise/update & disseminate training curriculum for CBFP		3560173	handouts	Copies	20,000			
	Subtotal							
	Total activity							
	Total strategic activity							
1.1c) Support systems for ensuring efficient and effective provision of quality CBFP services improved								
	Conduct workshops to review and adapt the tool to include community-based FP. **(3meetings @ 3 day)**	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Person-days	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	Print revised tool	3560163	Print management and recorgnition tool	Copies	35,000			
	Subtotal							
	Conduct dissemination meeting at zonal level to orient supervisors on the reiwed standard-based management and recognition tool	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
1.1ci) Adapt & implement a QA/QI tool (e.g. standard-based management and recognition tool) for community use		3560104	Air ticket-return	Person-days	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	Total activity							
	Conduct stakeholders technical workhop to revise/updated supervisory checklist. (3meetings @ 3 days)	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			

	FY2016-17		FY2017-18		FY2018-19		FY2019-20		FY2020-21	
	Number of Units (xii)	Estimates (v) x (xii) = (xiii)	Number of Units (xiv)	Estimates (v) x (xiv) = (xv)	Number of Units (xvi)	Estimates (v) x (xvi) = (xvii)	Number of Units (xvi)	Estimates (v) x (xvi) = (xvii)	Number of Units (xvi)	Estimates (v) x (xvi) = (xvii)
										-
	30	21,410,611								
		21,410,611								
	90	6,523,546								
	225	16,057,958								
	24	2,141,061								
	96	4,282,122								
	1,080	529,913								
	27	1,354,890								
	3	836,352								
	75	1,672,704								
		33,398,546								
	630	56,202,854								-
	20	446,054								-
	400	35,684,352								-
	125	2,787,840								-
	60	3,010,867								-
	1,500	735,990								-
	1	348,480								-
		99,216,438								-
	60	4,349,030								-
	125	8,921,088								-
	12	1,070,531								-
	32	1,427,374								-
	360	176,638								-
	15	752,717								-
	1	278,784								-
	20	446,054								-
		17,422,216								-
	10,000	390,297,600								-
		390,297,600								-
	240	17,396,122								
	240	17,128,489								
	32	2,854,748								
	192	8,564,244								
	8,640	4,239,301								
	72	3,613,041								
	16	4,460,544								
	240	5,352,653								
		63,609,142								
	7,500	543,628,800	6,150	470,739,050		-				
	7,500	535,265,280	6,150	463,496,911		-				
	800	71,368,704	656	61,799,588		-				
	2,000	89,210,880	1,640	77,249,485		-				
	45,000	22,079,693	36,900	19,119,248		-				
	1,125	56,453,760	923	48,884,440		-				
	125	34,848,000	103	30,175,580		-				
	2,500	55,756,800	2,050	48,280,928		-				
		1,408,611,917		**1,219,745,231**		**-**				
		2,033,966,469		**1,219,745,231**		**-**	**-**	**-**	**-**	**-**
		11,841,546,664		***1,219,745,231***		**-**	**-**	**-**	**-**	**-**
			90	6,888,864						
			225	16,957,204						
			18	1,695,720						
			96	4,521,921						
			1,080	559,588						
			27	1,430,764						
			3	883,188						
			75	1,766,375						
				34,703,625						
			30,000	1,236,462,797						
				1,236,462,797						
			240	18,370,304						
			240	18,087,684						
			32	3,014,614						
			192	9,043,842						
			8,640	4,476,702						
			72	3,815,371						
			16	4,710,334						
			240	5,652,401						
				67,171,254						
				1,338,337,675						
	90	6,523,546								
	225	16,057,958								
	18	1,605,796								
	96	4,282,122								
	1,080	529,913								
	27	1,354,890								

Activity	(i)Sub-Activity	Required Input				FY2015-16		
		Item Code (ii)	Description of Input (iii)	Measurement Unit (iv)	Unit Cost of Input (v)	Number of Units (x)	Estimates (v) x (x) = (xi)	
		3560104	Air ticket-return	Person-days	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	Pretest revised/updated supervisory checklist	3560117	connference package	day	65,000			
		3560180	Travel allowance	trip	40,000			
		3560153	Per diem- domestic	Person-days	40,000			
		3560173	Handouts	copies	20,000			
		3560186	Driver perdiem	person-days	22,000			
		3560139	Fuel	kms	440			
	Subtotal							
	Printing of revised/updated supervisory checklist	3560162	Print supervisory checklist	Copies	1,500			
	Subtotal							
	Conduct dissemination meeting within the Zones on revised/updated supportive supervision tools for CBFP services	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Trip	250,000			
1.1cii) Develop, disseminate, and support use of CBFP supervision guidelines & tools according to updated guidelines & standards		3560173	handouts	Copies	20,000			
	Subtotal							
	Total activity							
	Conduct 8 workshops at zonal level to orient RHCOs at district and regional level on supervision checklist. (One workshop = 30 people, 8 workshop. Start from YR 2)	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Person-days	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	District supervisors conduct semi-annual supervisory visits in their communities to assess the quality of services provided at community level (40% of districts each year, from yr 2, one day meeting) - total number	3560153	per diem- domestic	Person-days	65,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
	Subtotal							
	Central level supervisors conduct a supervisory visits once per year to assess the quality of services provided at community level (25% of districts each year, from yr 2)	3560153	per diem- domestic	Person-days	65,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Person-days	250,000			
	Subtotal							
	Monthly supportive supervision by ward-level supervisors (involves monthly meetings – with CHWs, cost: transport allowance for CHWs??? – not sure)	3560153	per diem- domestic	Person-days	65,000			
1.1ciii) Conduct supervision visits of CBFP services using supervisory checklist		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
	Subtotal							
	Total activity							
	Total strategic activity							
1.1d) Motivational scheme for CHWs improved, implemented and evaluated								
1.1dii) Develop a comprehensive and continuous motivational scheme for CHWs. (Activity is part of updating the National Guidelines & Standards)	Engange a consultant to develop a comprehensive and continuous motivational scheme for CHWs and present recommendations at the National guideline review meeting.	3560120	consultancy	Person-days	640,000	30	20,275,200	
	Total activity						**20,275,200**	
1.1diii) Monitor and evaluate implementation performance of the motivational scheme to improve outcomes . Incorporate changes in second revisions of the National Guidelines	Hire a consulant to monitor and evaluate implementation performance of the motivational scheme to improve outcomes.	3560120	consultancy	Person-days	640,000			
	Total activity						-	
	Total strategic activity						***20,275,200***	
Outcome 1.2) Quality CBFP services scaled up to 15 priority regions.								
Indicator: # of wards with available and accessible CBFP services								
1.2a) Community health workers recruited, trained and supported in 15 selected regions to provide CBFP services by 2020.								
	Conduct a two-days sensitization meeting with regional and district management team and relevant non-governmental stakeholders in each region . Output from meeting: District scale-up plan for CBFP services	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Person-days	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	Conduct one-day sensitization meeting with various community stakeholders and leaders in each division (1 district = 10 divisions; each session = 50 people; each session = 1 division; 10 sessions per region. Government, village leaders, WEO, VEO, religious leaders, TBA, VHWs, facility in-charges, FP provider) - 25*10	3560143	per diem- domestic	Person-days	40,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Person-days	250,000			
		3560173	handouts	Copies	2,000			
	Subtotal							

	FY2016-17		FY2017-18		FY2018-19		FY2019-20		FY2020-21	
	Number of Units (xii)	Estimates (v) x (xii) = (xiii)	Number of Units (xiv)	Estimates (v) x (xiv) = (xv)	Number of Units (xvi)	Estimates (v) x (xvi) = (xvii)	Numbe r of Units (xvi)	Estimates (v) x (xvi) = (xvii)	Number of Units (xvi)	Estimates (v) x (xvi) = (xvii)
	3	836,352								
	75	1,672,704								
		32,863,281								
	200	14,496,768								
	56	2,497,905								
	840	37,468,570								
	40	892,109								
	32	772,789								
	788	386,395								
		56,514,535								
	15,000	25,090,560								
		25,090,560								
		-	240	18,370,304						
		-	240	18,087,684						
		-	32	3,014,614						
		-	192	9,043,842						
		-	8,640	4,476,702						
		-	72	3,815,371						
		-	16	4,710,334						
		-	240	5,652,401.36						
		-		**67,171,254**						
		114,468,376		**67,171,254**						
	1,440	104,376,730		-		-				
	1,480	105,625,682		-		-				
	96	8,564,244		-		-				
	192	8,564,244		-		-				
	7,200	3,532,751		-		-				
	216	10,839,122		-		-				
	12	3,345,408		-		-				
	240	5,352,653		-		-				
		250,200,834		**-**		**-**				
	1,590	115,249,306	1,590	121,703,267	1,590	128,518,650	1,590	135,715,694	1,590	143,315,773
	1,272	56,738,120	1,272	59,915,454	1,272	63,270,720	1,272	66,813,880	1,272	70,555,457
	5,724	2,808,537	5,724	2,965,815	5,724	3,131,901	5,724	3,307,287	5,724	3,492,495
	239	11,968,197	239	12,638,416	239	13,346,167	239	14,093,553	239	14,882,792
		186,764,159		**197,222,952**		**208,267,438**		**219,930,414**		**232,246,517**
	160	11,597,414	160	12,246,870	160	12,932,694	156	13,315,502		-
	64	2,854,748	64	3,014,614	64	3,183,432	62	3,277,662		-
	1,440	706,550	1,440	746,117	1,440	787,900	1,404	811,221		-
	24	1,204,347	24	1,271,790	24	1,343,011	23	1,382,764		-
	4	1,115,136	4	1,177,584	4	1,243,528	4	1,280,337		-
		17,478,196		**18,456,975**		**19,490,565**		**20,067,486**		**-**
		454,443,189		**215,679,927**		**227,758,003**		**239,997,900**		**232,246,517**
		568,911,565	**-**	***1,621,188,855***	**-**	***227,758,003***	**-**	***239,997,900***	**-**	***232,246,517***
					30	23,875,743				
		-		**-**		**23,875,743**		**-**		**-**
		-		***-***		***23,875,743***		***-***		***-***
	480	34,792,243		-						
	752	53,669,265		-						
	48	4,282,122		-						
	256	11,418,993		-						
	190	93,206		-						
	144	7,226,081		-						
	48	13,381,632		-						
	240	5,352,653		-						
		130,216,195		**-**						
	7500	334,540,800	5000	235,516,723		-				
	8250	588,791,808	5500	414,509,433		-				
	900	80,289,792	600	56,524,014		-				
	6000	267,632,640	4000	188,413,379		-				
	2849	1,398,086	1899.6	984,253		-				
	3375	169,361,280	4500	238,460,682		-				
	1125	313,632,000	750	220,796,928		-				
	7500	16,727,040	5000	11,775,836		-				
		1,772,373,446		**1,366,981,247**		**-**				

1.2ai) Conduct sensitization meetings at all levels to gain support for expanding CBFP services in respective wards.	Conduct a one-day sensitization meeting of the community at village level in each ward. (half per diem for government staff at ward level – 4 villages per ward; two government staff as facilitators) : 3312 wards*4villages- 265 meetings	3560143	per diem- domestic	Person-days	40,000		
		3560117	conference package	Person-days	64,000		
		3560133	Facilitator	Person-days	80,000		
		3560180	Travel allowance	Trip	40,000		
		3560139	Fuel	Kms	440		
		3560186	perdiem-Driver	Person-days	45,000		
		3560104	Air ticket-return	Person-days	250,000		
		3560173	handouts	Copies	2,000		
	Subtotal						
	Total activity						
1.2aii) Work within existing community structures to recruit CHWs	Convene community meetings at village level to support recruitment of an adequate number of CHW per catchment area, accordance to guidance stipulated in guidelines and standards (2 government staff; half per diem)- 3312 wards*4villages- 165 meetings	3560143	per diem- domestic	Person-days	40,000		
		3560117	conference package	Person-days	64,000		
		3560133	Facilitator	Person-days	80,000		
		3560180	Travel allowance	Trip	40,000		
		3560139	Fuel	Kms	440		
		3560186	perdiem-Driver	Person-days	45,000		
		3560104	Air ticket-return	Person-days	250,000		
		3560173	handouts	Copies	2,000		
	Total activity						
1.2aiii) Train 87,340 recruited CHWs according to updated training curriculum	Conduct training workshop for newly recruited 87340 CHWs	3560153	per diem- domestic	Person-days	65,000		
		3560117	conference package	Person-days	64,000		
		3560133	Facilitator	Person-days	80,000		
		3560180	Travel allowance	Trip	40,000		
		3560139	Fuel	Kms	440		
		3560186	perdiem-Driver	Person-days	45,000		
		3560104	Air ticket-return	Person-days	250,000		
		3560173	handouts	Copies	20,000		
	Total activity						
1.2aiv) Support 87,340 trained and certified CHWs with working tools and incentives	Provide monthly monetary incentives (25,000/=) for each recruited CHWs, according to guidelines and standards		Perdiem- participants	Person-days	25,000		
	Subtotal						
	Convene monthly meetings to review reports, progress, and challenges (transport allowance for participants)	3560211	half per diem- domestic	Person-days	15,000		
		3560210	Travel allowance	Trip	10,000		
	Subtotal						
	Conduct refresher training to CBFP workers [Linked to xx](25% of total number of chws every after 2 years)	3560153	per diem- domestic	Person-days	65,000		
		3560117	conference package	Person-days	64,000		
		3560133	Facilitator	Person-days	80,000		
		3560180	Travel allowance	Trip	40,000		
		3560139	Fuel	Kms	440		
		3560186	perdiem-Driver	Person-days	45,000		
		3560104	Air ticket-return	Person-days	250,000		
		3560173	handouts	Copies	20,000		
	Subtotal						
	Total activity						
1.2v) Conduct refresher training for currently active CHWs (as of launch of new training curriculum and service protocols for CHWs, expected in YR 2) to upgrade skills according to revised guidelines and standards	Conduct refresher training to already exising FP workers (3752)	3560153	per diem- domestic	Person-days	65,000		
		3560117	conference package	Person-days	64,000		
		3560133	Facilitator	Person-days	80,000		
		3560180	Travel allowance	Trip	40,000		
		3560139	Fuel	Kms	440		
		3560186	perdiem-Driver	Person-days	45,000		
		3560104	Air ticket-return	Person-days	250,000		
		3560173	handouts	Copies	20,000		
	Total activity						
	Total strategic activity						
1.2b) The platform for CBFP service delivery expanded, beyond household-to-household approach.							
1.2bi) Conduct mapping of community level structures to identify types and assess potential for integrating FP information/service provision	Hire a consultancy firm to conduct a mapping exercise to identify and assess potential platforms for integrating CBFP services	3560120	Consultancy	Person-days	640,000		
	Subtotal						
	Conduct stakeholders technical workshops to review mapping exercise to identify and assess potential platforms for integrating CBFP services	3560153	per diem- domestic	Person-days	65,000		
		3560117	conference package	Person-days	64,000		
		3560133	Facilitator	Person-days	80,000		
		3560180	Travel allowance	Trip	40,000		
		3560139	Fuel	Kms	440		
		3560186	perdiem-Driver	Person-days	45,000		
		3560104	Air ticket-return	Person-days	250,000		
		3560173	handouts	Copies	20,000		
	Subtotal						
	Disseminate findings and generate recommendations for models for study based on evidence-based practices from other countries	3560153	per diem- domestic	Person-days	65,000		
		3560117	conference package	Person-days	64,000		
		3560133	Facilitator	Person-days	80,000		
		3560180	Travel allowance	Trip	40,000		
		3560139	Fuel	Kms	440		
		3560186	perdiem-Driver	Person-days	45,000		
		3560104	Air ticket-return	Person-days	250,000		
		3560173	handouts	Copies	20,000		
	Subtotal						
	Total activity						
	Conduct a pilot study to assess feasibility and effectiveness of integrating FP into community structures (2 studies,, two-year length, one per yr)		Consultancy	Person-days	640,000		
	Subtotal						
	Conduct stakeholders technical meetings to review feasibilty of integrating Fp into community structures	3560153	per diem- domestic	Person-days	65,000		
		3560117	conference package	Person-days	64,000		
		3560133	Facilitator	Person-days	80,000		
		3560180	Travel allowance	Trip	40,000		

	5000	223,027,200	5000	235,516,723	3000	149,223,396		-		
	5500	392,527,872	5500	414,509,433	3300	262,633,177		-		
	600	53,526,528	600	56,524,014	360	35,813,615		-		
	4000	178,421,760	4000	188,413,379	2400	119,378,717		-		
	1900	932,057	1900	984,253	1140	623,622		-		
	2250	112,907,520	2250	119,230,341	1350	75,544,344		-		
	750	209,088,000	750	220,796,928	450	139,896,934		-		
	5000	11,151,360	5000	11,775,836	3000	7,461,170		-		
		1,181,582,297		**1,247,750,906**		**790,574,974**		**-**		
		3,084,171,939		**2,614,732,153**		**790,574,974**		**-**		
	4250	189,573,120	4000	188,413,379		-		-		-
	4675	333,648,691	4400	331,607,546		-		-		-
	510	45,497,549	480	45,219,211		-		-		-
	3400	151,658,496	3200	150,730,703		-		-		-
	1615	792,249	1520	787,402		-		-		-
	1913	95,971,392	1800	95,384,273		-		-		-
	638	177,724,800	600	176,637,542		-		-		-
	4250	9,478,656	4000	9,420,669		-		-		-
		1,004,344,953		**998,200,725**		**-**		**-**		**-**
	225,000	16,308,864,000	150,000	11,481,440,256	90,000	7,274,640,546	59,100	5,044,526,740		-
	225,000	16,057,958,400	150,000	11,304,802,714	90,000	7,162,722,999	59,100	4,966,918,637		-
	18,000	1,605,795,840	12,000	1,130,480,271	7,200	716,272,300	4,728	496,691,864		-
	30,000	1,338,163,200	20,000	942,066,893	12,000	596,893,583	7,880	413,909,886		-
	562,500	275,996,160	375,000	194,301,297	225,000	123,109,302	147,750	85,368,914		-
	33,750	1,693,612,800	22,500	1,192,303,411	13,500	755,443,441	8,865	523,854,700		-
	1,875	522,720,000	1,250	367,994,880	750	233,161,556	493	161,683,549		-
	37,500	836,352,000	25,000	588,791,808	15,000	373,058,490	9,850	258,693,679		-
		38,639,462,400		**27,202,181,530**		**17,235,302,217**		**11,951,647,969**		**-**
	450,000	12,545,280,000	750,000	22,079,692,800	768,000	23,875,743,331	886,200	29,093,190,143	886,200	30,722,408,791
		12,545,280,000		**22,079,692,800**		**23,875,743,331**		**29,093,190,143**		**30,722,408,791**
	450,000	7,527,168,000	750,000	13,247,815,680	768,000	14,325,445,999	886,200	17,455,914,086	886,200	18,433,445,274
	450,000	5,018,112,000	750,000	8,831,877,120	768,000	9,550,297,332	886,200	11,637,276,057	886,200	12,288,963,516
		12,545,280,000		**22,079,692,800**		**23,875,743,331**		**29,093,190,143**		**30,722,408,791**
					75,000	6,062,200,455		-	29,700	2,677,030,475
					75,000	5,968,935,833		-	29,700	2,635,845,391
					6,000	596,893,583		-	2,376	263,584,539
					10,000	497,411,319		-	3,960	219,653,783
					281,250	153,886,627		-	111,375	67,955,389
					11,250	629,536,201		-	4,455	277,999,319
					625	194,301,297		-	248	85,802,259
					12,500	310,882,075		-	4,950	137,283,614
						14,414,047,390		**-**		**6,365,154,767**
		25,090,560,000		**44,159,385,600**		**62,165,534,052**		**58,186,380,285**		**67,809,972,349**
	15,000	1,087,257,600	7,500	574,072,013		-		-		-
	15,000	1,070,530,560	7,500	565,240,136		-		-		-
	1,200	107,053,056	600	56,524,014		-		-		-
	2,000	89,210,880	1,000	47,103,345		-		-		-
	37,500	18,399,744	18,750	9,715,065		-		-		-
	2,250	112,907,520	1,125	59,615,171		-		-		-
	125	34,848,000	63	18,399,744		-		-		-
	2,500	55,756,800	1,250	29,439,590		-		-		-
		2,575,964,160		**1,360,109,076**						
-		***70,394,503,452***		***76,334,609,084***		***80,191,411,243***		***70,138,028,255***		***67,809,972,349***
			30	22,609,605						
				22,609,605						
			150	11,481,440						
			375	28,262,007						
			30	2,826,201						
			160	7,536,535						
			1800	932,646						
			45	2,384,607						
			4	1,177,584						
			125	2,943,959						
				57,544,979						
				-	10	808,293				
					75	5,968,936				
					6	596,894				
					32	1,591,716				
					150	82,073				
					9	503,629				
					1	310,882				
					25	621,764				
				-		**10,484,187**				
				80,154,584	**-**	**10,484,187**				
			30	22,609,605	30	23,875,743				
				22,609,605		**23,875,743**				
			90	6,888,864	90	7,274,641				
			225	16,957,204	225	17,906,807				
			18	1,695,720	18	1,790,681				
			96	4,521,921	96	4,775,149				

		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Person-days	250,000			
		3560173	handouts	Copies	20,000			
	Disseminate findings and generate recommendations for models for study (study dissemination on 2nd yr)-central level	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Person-days	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	Disseminate findings and generate recommendations for models for study (study dissemination on 2nd yr)-zonal level	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
1.2bii) Conduct studies to assess the feasibility and effectiveness of using specific community structures for CBFP service provision		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Person-days	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	Total activity							
	Total strategic activity							
1.3) An expanded range of contraceptive methods are available and accessible in CBFP services								
The method mix offered by CHWs expanded to include at least three new modern contraceptive methods.								
1.3a) Local evidence generated to inform policy and programmatic decisions to expand the range of methods provided by CHWs								
	Conduct a pilot study to assess feasibility and effectiveness of integrating FP into community structures (2 studies,, two-year length, one per yr)		Consultancy	Person-days	80,000			
	Subtotal							
	Conduct stakeholders technical meetings to review feasibilty of integrating Fp into community structures	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Person-days	250,000			
		3560173	handouts	Copies	20,000			
	Disseminate findings and generate recommendations for models for study (study dissemination on 2nd yr)-central level	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Person-days	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	Disseminate findings and generate recommendations for models for study (study dissemination on 2nd yr)-zonal level	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
1.3ai)Conduct feasibility studies (2) on community-based provision of natural methods (LAM, & SDM) and/or ECs in the Tanzanian context assessed, disseminate findings, and generate recommendations for program decisions.		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Person-days	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	Total activity							
	Conduct a pilot study to assess feasibility and effectiveness of integrating FP into community structures (2 studies,, two-year length, one per yr)	3560120	Consultancy	Person-days	640,000			
	Subtotal							
	Conduct stakeholders technical meetings to review feasibilty of integrating Fp into community structures	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Person-days	250,000			
		3560173	handouts	Copies	20,000			
	Disseminate findings and generate recommendations for models for study (study dissemination on 1nd yr)-central level	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
1.3aii) Conduct feasibility study for CBD of Injectables in select sites, disseminate findings, and generate recommendations for policy and program decisions.		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Person-days	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	Total activity							
	Total strategic activity							

		1080	559,588	1080	590,925				
		27	1,430,764	27	1,510,887				
		3	883,188	3	932,646				
		75	1,766,375	75	1,865,292				
			34,703,625		**36,647,028**				
				10	808,293				
				35	2,785,503				
				4	397,929				
				48	2,387,574				
				225	123,109				
				4.5	251,814				
				1.5	466,323				
				25	621,764				
					7,842,311				
						240	20,485,388		
						240	20,170,228		
						32	3,361,705		
						192	10,085,114		
						8,640	4,992,131		
						72	4,254,657		
						16	5,252,664		
						240	6,303,196		
					-		**74,905,083**		
			57,313,230		**68,365,082**		**74,905,083**		
			137,467,814		**78,849,269**		**74,905,083**		

		30	2,826,201	30	2,984,468				
			2,826,201		**2,984,468**				
		90	6,888,864	90	7,274,641				
		225	16,957,204	225	17,906,807				
		18	1,695,720	18	1,790,681				
		96	4,521,921	96	4,775,149				
		540	279,794	540	295,462				
		27	1,430,764	27	1,510,887				
		3	883,188	3	932,646				
		75	1,766,375	75	1,865,292				
			34,423,831		**36,351,565**				
				10	808,293				
				35	2,785,503				
				4	397,929				
				48	2,387,574				
				225	123,109				
				4.5	251,814				
				1.5	466,323				
				25	621,764				
					7,842,311				
						240	20,485,387.8		
						240	20,170,228.0		
						32	3,361,704.7		
						192	10,085,114.0		
						8,640	4,992,131.4		
						72	4,254,657.5		
						16	5,252,663.5		
						240	6,303,196.2		
					-		**74,905,083**		
			37,250,031		**47,178,344**		**74,905,083**		
		30	22,609,605	30	23,875,743				
			22,609,605		**23,875,743**				
		90	6,888,864	90	7,274,641				
		225	16,957,204	225	17,906,807				
		18	1,695,720	18	1,790,681				
		96	4,521,921	96	4,775,149				
		1080	559,588	1080	590,925				
		27	1,430,764	27	1,510,887				
		3	883,188	3	932,646				
		75	1,766,375	75	1,865,292				
			34,703,625		**36,647,028**				
				10	808,293				
				35	2,785,503				
				4	397,929				
				48	2,387,574				
				225	123,109				
				4.5	251,814				
				1.5	466,323				
				25	621,764				
					7,842,311				
			57,313,230	**-**	**68,365,082**	**-**	**-**		
			94,563,262		**115,543,427**		**74,905,083**		**-**

1.3b) Policy and operational guidelines developed and disseminated							
	Recruite consultant to develop an advocacy plan and develop and print messages and tools.	3560120	Consultancy	Person-days	640,000		
	Subtotal						
	conducting a stakeholder mapping exercise to inform advocacy efforts to change policy and guidelines; and developing the plan- 3 meetings	3560153	per diem- domestic	Person-days	65,000		
		3560117	conference package	Person-days	64,000		
		3560133	Facilitator	Person-days	80,000		
		3560180	Travel allowance	Trip	40,000		
		3560139	Fuel	Kms	440		
		3560186	perdiem-Driver	Person-days	45,000		
		3560104	Air ticket-return	Trip	250,000		
		3560173	handouts	Copies	20,000		
	Subtotal						
	Conduct a dissemination meeting for advocacy plan developed	3560153	per diem- domestic	Person-days	65,000		
		3560117	conference package	Person-days	64,000		
		3560133	Facilitator	Person-days	80,000		
		3560180	Travel allowance	Trip	40,000		
		3560139	Fuel	Kms	440		
		3560186	perdiem-Driver	Person-days	45,000		
		3560104	Air ticket-return	Trip	250,000		
		3560173	handouts	Copies	20,000		
1.3bi) Develop & implement an advocacy effort for policy change to allow community-based provision of injectables	**Subtotal**						
	Print advocay messages	3560162	Print messages	copies	1,500		
	Subtotal						
	Total activity						
1.3bii) Develop and disseminate operational guidelines on community-based provision of injectables (* activity included as part of second revisions to the National Guidelines & Standards scheduled for FY2019-20)	Engage a consultant to develop operational guidelines on community-based provision of injectables (*** activity included as part of second revisions to the National Guidelines & Standards)**	3560120	Consultancy	Person-days	640,000		
	Total activity						
	Total strategic activity						
1.4) Comprehensive, accurate and timely data from CBFP services available and used for decision-making at all levels							
Indicator:							
1.4a) Timely collection, submission and reporting of comprehensive & accurate data from CBFP services at ward level improved							
1.4ai) Revise/update, print & distribute tools for data collection, reporting, storage and use.	Conduct a 3 day workshop to revise/update data collection tools (Form 9, 10, & 13) **(* activity included as part of revisions to the National Guidelines & Standards)**	3560153	per diem- domestic	Person-days	65,000		
		3560117	conference package	Person-days	64,000		
		3560133	Facilitator	Person-days	80,000		
		3560180	Travel allowance	Trip	40,000		
		3560139	Fuel	Kms	440		
		3560186	perdiem-Driver	Person-days	45,000		
		3560104	Air ticket-return	Trip	250,000		
		3560173	handouts	Copies	20,000		
	Total activity						
1.4aii) Scale-up use of innovative tools for improving timeliness, accuracy, and comprehensiveness of data collection and reporting	Conduct orientation workshops for CBFP supervisors and CHWs on the innovative tools for improving timeliness, accuracy, and comprehensiveness of data collection and reporting . (5 day meeting, 25 participants)- 25% fo wards	3560153	per diem- domestic	Person-days	65,000		
		3560117	conference package	Person-days	64,000		
		3560133	Facilitator	Person-days	80,000		
		3560180	Travel allowance	Trip	40,000		
		3560139	Fuel	Kms	440		
		3560186	perdiem-Driver	Person-days	45,000		
		3560104	Air ticket-return	Trip	250,000		
		3560173	handouts	Copies	20,000		
	Total activity						
	Total strategic activity						
1.4b) Data from CBFP services used at all levels to improve services and support decision-making							
1.4bi) Revise the reporting, supervision and monitoring sections of guidelines, training curriculum, and supervision protocols to incorporate approaches to foster data for decision-making **(* activity included as part of revisions to the National Guidelines & Standards)**	conduct stakeholders meeting to review data collection tools.	3560153	per diem- domestic	Person-days	65,000		
		3560117	conference package	Person-days	64,000		
		3560133	Facilitator	Person-days	80,000		
		3560180	Travel allowance	Trip	40,000		
		3560139	Fuel	Kms	440		
		3560186	perdiem-Driver	Person-days	45,000		
		3560104	Air ticket-return	Person-days	250,000		
		3560173	handouts	Copies	20,000		
	Subtotal						
	Training of CHWs on the revised/updated tools	3560153	per diem- domestic	Person-days	65,000		
		3560117	conference package	Person-days	64,000		
		3560133	Facilitator	Person-days	80,000		
		3560180	Travel allowance	Trip	40,000		
		3560139	Fuel	Kms	440		
		3560186	perdiem-Driver	Person-days	45,000		
		3560104	Air ticket-return	Person-days	250,000		
		3560173	handouts	Copies	20,000		
	Subtotal						
	Printing of revised data collection forms			Copies			
				Copies			
	Subtotal						
1.4bii)Sensitize CHW supervisors (including the facility in-charges responsible for compiling the	Conduct data for decision-making workshop for CHW supervisors (3 days) **(* activity included as part of revisions to the National Guidelines & Standards)**	3560153	per diem- domestic	Person-days	65,000		
		3560117	conference package	Person-days	64,000		
		3560133	Facilitator	Person-days	80,000		
		3560180	Travel allowance	Trip	40,000		
		3560139	Fuel	Kms	440		

	30	21,410,611								
		21,410,611								
	90	6,523,546								
	225	16,057,958								
	18	1,605,796								
	96	4,282,122								
	1080	529,913								
	27	1,354,890								
	3	836,352								
	75	1,672,704								
		32,863,281								
	40	2,899,354								
	105	7,493,714								
	8	713,687								
	48	2,141,061								
	675	331,195								
	18	903,260								
	1.5	418,176								
	25	557,568								
		15,458,015								
	2,000	3,345,408								
		3,345,408								
		73,077,315								
		73,077,315		**-**		**-**		**-**		**-**

			41400	3,168,877,511		-				
			41400	3,120,125,549		-				
			3312	312,012,555		-				
			11040	520,020,925		-				
			124200	64,352,589		-				
			6210	329,075,741		-				
			345	101,566,587		-				
			6900	162,506,539		-				
				7,778,537,996		**-**				
-		**-**		***7,778,537,996***		**-**		**-**		**-**

MTUHA report) at the ward level to the importance of incorporating data generated from CBFP services in MTUHA forms		3560186	perdiem-Driver	Person-days	45,000				
		3560104	Air ticket-return	Person-days	250,000				
		3560173	handouts	Copies	20,000				
	Total activity								
	Engage consultant to develop a Data for Decision making cirriculum	3560120	Consultancy	Person-days	640,000	30	20,275,200		
	Subtotal						**20,275,200**		
	Conduct data for decision-making workshop for CHW supervisors at district and regional levels (3days)	3560153	per diem- domestic	Person-days	65,000			7,110	
		3560117	conference package	Person-days	64,000			8,769	
		3560133	Facilitator	Person-days	80,000			632	
		3560180	Travel allowance	Trip	40,000			1,896	
		3560139	Fuel	Kms	440			42,423	
		3560186	perdiem-Driver	Person-days	45,000			1,273	
1.4biii) Build the capacity of districts and regional program managers on data for decision making		3560104	Air ticket-return	Person-days	250,000			187	
		3560173	handouts	Copies	20,000			2,370	
	Total activity								
	Conduct quarterly one day workshops to share best practices within regions	3560153	per diem- domestic	Person-days	65,000				
		3560117	conference package	Person-days	64,000				
		3560133	Facilitator	Person-days	80,000				
		3560180	Travel allowance	Trip	40,000				
		3560139	Fuel	Kms	440				
		3560186	perdiem-Driver	Person-days	45,000				
		3560104	Air ticket-return	Person-days	250,000				
		3560173	handouts	Copies	20,000				
	Subtotal								
	Conduct semi-annual meetings within region to region to share best practices and lessons learned.	3560153	per diem- domestic	Person-days	65,000				
		3560117	conference package	Person-days	64,000				
		3560133	Facilitator	Person-days	80,000				
		3560180	Travel allowance	Trip	40,000				
1.4biv) Develop learning/best practice sites and establish a mechanism for the dissemination with in and across districts.		3560139	Fuel	Kms	440				
		3560186	perdiem-Driver	Person-days	45,000				
		3560104	Air ticket-return	Person-days	250,000				
	Subtotal								
	Total activity								
	Total strategic activity						***20,275,200***		
1.5) Capacity of ADDOs to provide quality of FP services in accordance with guidelines and standards enhanced									
1.5a) Guidelines and standards, training manual and job aids for FP provision from ADDOs									
	Engage consultant to revise/update training manual and job aids for FP provision from ADDOs (**100 days**)	3560120	Consultancy	Person-days	640,000	100	67,584,000		
	Subtotal						**67,584,000**		
	Conduct 4 stakeholder technical workshops for 25 people	3560153	per diem- domestic	Person-days	65,000	150	10,296,000		
		3560117	conference package	Person-days	64,000	375	25,344,000		
		3560133	Facilitator	Person-days	80,000	40	3,379,200		
		3560180	Travel allowance	Trip	40,000	160	6,758,400		
		3560139	Fuel	Kms	440	1800	836,352		
		3560186	perdiem-Driver	Person-days	45,000	45	2,138,400		
		3560104	Air ticket-return	Trip	250,000	5	1,320,000		
		3560173	handouts	Copies	20,000	125	2,640,000		
	Subtotal						**52,712,352**		
	Engage consultant for translation of training; job aids	3560178	Translation	per-page	20,000	400	8,448,000		
	Subtotal						**8,448,000**		
	Print 20,000 copies of training manual; 50,000 job aids	3560163	Print training manual		35,000	20,000	739,200,000		
		3560163	Print job aids		35,000	10,000	369,600,000		
	Subtotal						**1,108,800,000**		
	Conduct dissemination workshops at Zonal level for the revised/updated guidelines and standards	3560153	per diem- domestic	Person-days	65,000	240	16,473,600		
		3560117	conference package	Person-days	64,000	240	16,220,160		
		3560133	Facilitator	Person-days	80,000	32	2,703,360		
		3560180	Travel allowance	Trip	40,000	192	8,110,080		
		3560139	Fuel	Kms	440	8,640	4,014,490		
		3560186	perdiem-Driver	Person-days	45,000	72	3,421,440		
1.5ai) Revise/update, disseminate, & support use the ADDO training manual and job aids in accordance to revised guidelines and standards		3560104	Air ticket-return	Trip	250,000	16	4,224,000		
		3560173	handouts	Copies	20,000	240	5,068,800		
	Subtotal						**60,235,930**		
	Total activity						**1,289,332,282**		
	Conduct a 2 day refresher workshop forADDOS on revised/updated guidelines and standards.	3560153	per diem- domestic	Person-days	65,000			16,600	
		3560117	conference package	Person-days	64,000			19,920	
		3560133	Facilitator	Person-days	80,000			1,992	
		3560180	Travel allowance	Trip	40,000			6,640	
		3560139	Fuel	Kms	440			298,800	
		3560186	perdiem-Driver	Person-days	45,000			2,988	
1.5ai) Refresher training on FP for already existing ADDO trained dispensers		3560104	Air ticket-return	Trip	250,000			664	
		3560173	handouts	Copies	20,000			9,960	
	Total activity								
	Total strategic activity						***1,289,332,282***		
1.5b) An expanded range of contraceptive methods available and accessible in ADDOs									
	Engage a consultant to carryout feasibility study on the provision of the expanded method mix from ADDOs. (cycle beads and inectables)		Consultancy		640,000				
	Subtotal								
	Conduct 4 stakeholder technical workshops for 25 people	3560153	per diem- domestic	Person-days	65,000				
		3560117	conference package	Person-days	64,000				
		3560133	Facilitator	Person-days	80,000				
		3560180	Travel allowance	Trip	40,000				
		3560139	Fuel	Kms	440				
		3560186	perdiem-Driver	Person-days	45,000				
		3560104	Air ticket-return	Trip	250,000				

515,360,102.40						-		
625,832,165						-		
56,381,276						-		
84,571,914						-		
20,815,262						-		
63,865,010						-		
52,196,728						-		
52,857,446						-		
1,471,879,905		**-**		**-**		**-**		
	1,200	91,851,522	1,200	96,995,207	1,200	102,426,938.89	1,200	108,162,847
	760	57,277,667	760	60,485,216	760	63,872,388.56	760	67,449,242
	120	11,304,803	120	11,937,872	120	12,606,392.48	120	13,312,350
	480	22,609,605	480	23,875,743	480	25,212,784.96	480	26,624,701
	10,800	5,595,877	10,800	5,909,246	10,800	6,240,164.28	10,800	6,589,613
	180	9,538,427	180	10,072,579	180	10,636,643.65	180	11,232,296
	30	8,831,877	30	9,326,462	30	9,848,744.12	30	10,400,274
	600	14,131,003	600	14,922,340	600	15,757,990.60	600	16,640,438
		221,140,782		**233,524,666**		**246,602,048**		**260,411,762**
	120	9,185,152	120	9,699,521	120	10,242,694	120	10,816,285
	76	5,727,767	76	6,048,522	76	6,387,239	76	6,744,924
	12	1,130,480	12	1,193,787	12	1,260,639	12	1,331,235
	48	2,260,961	48	2,387,574	48	2,521,278	48	2,662,470
	1,080	559,588	1,080	590,925	1,080	624,016	1,080	658,961
	18	953,843	18	1,007,258	18	1,063,664	18	1,123,230
	3	883,188	3	932,646	3	984,874	3	1,040,027
		20,700,978		**21,860,233**		**23,084,406**		**24,377,132**
		241,841,760		**255,384,899**		**269,686,453**		**284,788,895**
1,471,879,905		***462,982,543***		***488,909,565***		***516,288,501***		***545,200,657***

1,203,231,744	15,000	1,148,144,026						
1,421,664,584	18,000	1,356,576,326						
177,708,073	1,800	169,572,041						
296,180,122	6,000	282,620,068						
146,609,160	270,000	139,896,934						
149,941,187	2,700	143,076,409						
185,112,576	600	176,637,542						
222,135,091	9,000	211,965,051						
3,802,582,536		**3,628,488,396**						
3,802,582,536		***3,628,488,396***						

	30	22,609,605						
		22,609,605						
	120	9,185,152						
	300	22,609,605						
	24	2,260,961						
	128	6,029,228						
	1440	746,117						
	36	1,907,685						
	4	1,177,584						

		3560173	handouts	Copies	20,000			
	Subtotal							
1.6bi) Conduct feasibility study on the provision of the expanded method mix from ADDOs. (cycle beads and injectables)	Conduct dissemination meeting feasibility study on the provision of the expanded method mix from ADDOs. (cycle beads and injectables)	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Trip	250,000			
		3560173	handouts	Copies	20,000			
	Subtotal							
	Total activity							
1.5bii) Advocate and work with TFDA and Pharmacy Council to include injectables in ADDO approved list of prescription medicines	Conduct stakeholder workshops with TFDA and the Pharmacy council to include injectables in ADDO approved list of prescription medicines	3560153	per diem- domestic	Person-days	65,000			
		3560117	conference package	Person-days	64,000			
		3560133	Facilitator	Person-days	80,000			
		3560180	Travel allowance	Trip	40,000			
		3560139	Fuel	Kms	440			
		3560186	perdiem-Driver	Person-days	45,000			
		3560104	Air ticket-return	Trip	250,000			
		3560173	handouts	Copies	20,000			
	Total activity							
	Total strategic activity							
	Grand Total						**3,687,232,243**	

		25	588,792						
			44,505,124						
		10	765,429		-				
		35	2,637,787		-				
		4	376,827		-				
		48	2,260,961		-				
		225	116,581		-				
		4.5	238,461		-				
		1.5	441,594		-				
		25	588,792		-				
			7,426,431		-				
			74,541,161		-				
				120	9,699,521				
				120	9,550,297				
				8	795,858				
				48	2,387,574				
				2,160	1,181,849				
				18	1,007,258				
				4	1,243,528				
				60	1,492,234				
					27,358,120				
	-		***74,541,161***		***9,699,521***				**-**
	88,336,311,534		**91,426,665,503**		**81,145,746,292**		**72,542,370,931**		**68,587,419,523**

Key intervention 2: Demand

Index	Activity	(i)Sub-Activity	Required Input				FY2015-16	
			Item Code (ii)	Description of Input (iii)	Measurement Unit (iv)	Unit Cost of Input (v)	Number of Units (x)	Estimates (v) x (x) = (xi)
SR2) Increased adoption of positive contraceptive behaviour among the population served by CHWs with a focus on 15 priority regions, by 2020.								
2.1) Enhancing CHWs' skills for interpersonal communication, advocacy and social mobilization								
2.1a) Improved skills of CHWs to apply SBCC effectively to their work and deliver higher quality care to clients								
	2.1ai) Include and or improve SBCC section in any revision of training curriculum and service guidelines that focus on CHW **(link to revision/udate of guidelines and stantards)**							
	2.1aii) Conduct training of CHWs on SBCC and advocacy as per CHW training curriculum **(link to revision/udate of guidelines and stantards)**							
		Total Activity						
		Total strategic activity						-
2.2) Engaging community champions as change agents to foster transformation of social norms towards positive attitudes positive attitudes, behaviours, and practices related to family planning.								
2.2b) Increased engagement of key community groups (champions, peer educators, traditional leaders, CHWs) to implement SBCC interventions in their communities								
	2.1bi) Recruit champions in select communities and conduct orientation workshops using the updated nationally approved government orientation guide, advocacy package and SBCC message guide **{Linked to NFPCIP Strategic Action Area IV: Advocacy and Strategic Communication, Strategic Result 4: A coordinated network of FP champions established and supported}**	Conduct orientation workshops for recruited champions using the updated nationally approved government orientation guide, advocacy package and SBCC message guide.	3560153	per diem- domestic	Person-days	65,000		
			3560117	conference package	Person-days	64,000		
			3560133	Facilitator	Person-days	80,000		
			3560180	Travel allowance	Trip	40,000		
			3560139	Fuel	Kms	440		
			3560186	perdiem-Driver	Person-days	45,000		
			3560104	Air ticket-return	Trip	250,000		
			3560173	handouts	Copies	20,000		
		Total Activity						
		Implement dialogues on community radios						
		Subtotal						
		Conduct community dialogues on FP, including the critical role of men in FP (40% of 3312 wards= 10 pax per ward)	3560210	Perdiem-participants	Person-days	10,000		
			3560158	Perdiem-facilitators	Person-days	40,000		
		Subtotal						
		Support CHWs/peer educators to conduct interpersonal communication						
		Subtotal						
		Post materials on community bulletin boards, including those that target men and youth						
		Subtotal						
	2.1bii) Support organization of community mobilization and SBCC interventions to enhance FP knowledge and address myths and misconceptions through edutainment	Support communities to conduct local drama on SBCC (also focus on male involvement) in (40% of 3312 wards= 1 pax per ward)	3560126	Perdiem-participants	Per-event	150,000		
		Subtotal						
		Promote use of mobile technology (m4RH)						
		Total Activity						
		Total strategic activity						-
		Grand Total						-

	FY2016-17		FY2017-18		FY2018-19		FY2019-20		FY2020-21	
	Number of Units (xii)	Estimates (v) x (xii) = (xiii)	Number of Units (xiv)	Estimates (v) x (xiv) = (xv)	Number of Units (xvi)	Estimates (v) x (xvi) = (xvii)	Number of Units (xvi)	Estimates (v) x (xvi) = (xvii)	Number of Units (xvi)	Estimates (v) x (xvi) = (xvii)
	-	-	-	-	-	-	-	-	-	-
				-		-				
			1000	11,775,836	320	3,979,291	1230	16,151,940		
			200	9,420,669	64	3,183,432	246	12,921,552		
				21,196,505		**7,162,723**		**29,073,493**		
			800	141,310,034	250	46,632,311	123	22,943,097		
				141,310,034		**46,632,311**		**22,943,097**		
				162,506,539		**53,795,034**		**52,016,590**		-
		-	-	***162,506,539***	-	***53,795,034***	-	***52,016,590***	-	-
		-		**162,506,539**		**53,795,034**		**52,016,590**		-

Key intervention 3: Enabling Environment

Index	Activity	(i)Sub-Activity	Required Input				FY2015-16		
			Item Code (ii)	Description of Input (iii)	Measurement Unit (iv)	Unit Cost of Input (v)	Number of Units (x)	Estimates (v) x (x) = (xi)	
SR3) A supportive enabling environment is in place to ensure effective and efficient provision of CBFP services									
3.1) Strengthened leadership, coordination and accountability for effective and efficient implementation of CBFP program/services at all levels									
3.1a) Improved coordination of CBFP efforts at central level									
	3.1ai) Establish a CBFP technical working group to facilitate coordination of activities, discuss progress, challenges, and solutions (including troubleshooting issues arising from field implementation)	Host quarterly working group meetings to facilitate coordination of activities, discuss progress, challenges, and solutions (including troubleshooting issues arising from field implementation)	3560138	Food & Refreshments	per person	10,000			
		Total Activity							
	3.1aii) A mechanism for monitoring implementation of CBFP services is included as part of the NFPCIP performance monitoring mechanism (tracking tools and semi-annual review meetings)	Host semi-annual meetings to share information on implimentation of CBFP services and contribution to the overall national program	3560141	Perdiem- Participants	Person-day	40,000			
			3560162	Food & Refreshments	Per person	10,000			
		Total Activity							
		Total strategic activity						**-**	
3.1b) District councils has and implements a partnership framework to support effective coordination of CBFP services/activities in respective district									
		CBFP working group at district level established, TOR developed	3560166	Food & Refreshments	Person-day	10,000	2385	25,185,600	
		Subtotal						**25,185,600**	
	3.1bi) District councils implements a partnership framework to strengthen engagement and coordination of CBFP services at district level	Host Quarterly working group meetings to facilitate coordination and information exchange- per district	3560168	Food & Refreshments	Person-day	10,000			
		Subtotal							
		Total Activity						**25,185,600**	
		Total strategic activity						***25,185,600***	
3.1c) Continuous advocacy efforts conducted by champions to ensure accountability at LGA level towards a supportive enabling environment for quality provision of CBFP services.									
		Engage a consultant to develop advocacy messages on the role of CBFP	3560120	Consultancy	Person-days	640,000	30	20,275,200	
		Subtotal						**20,275,200**	
		Conduct a stakeholders techinical workshop to Develop advocacy messages for Champions on the role of CBFP to increase district level CPR and importance of resource allocation CCHP. (3 meetings)	3560153	Per diem- domestics	Person-days	65,000	90	6,177,600	
			3560117	Conference	Person-days	64,000	225	15,206,400	
			3560133	Facilitator	Person-days	80,000	24	2,027,520	
			3560180	Travel allowance	Trip	40,000	96	4,055,040	
			3560139	Fuel	Kms	440	1080	501,811	
			3560186	perdiem-Driver	Person-days	45,000	27	1,283,040	
			3560104	Air ticket-return	Person-days	250,000	3	792,000	
			3560173	handouts	Copies	20,000	75	1,584,000	
		Subtotal						**31,627,411**	
		Printing of advocacy messages on the role of CBFP		Printing		1,500	15000	23,760,000	
		Subtotal						**23,760,000**	
		Conduct dessimation meetings (national and regional level) for the advocacy messages developed,	3560153	Per diem- domestics	Person-days	80,000			
			3560117	Conference	Person-days	80,000			
			3560133	Facilitator	Person-days	80,000			
			3560180	Travel allowance	Trip	40,000			
			3560139	Fuel	Kms	440			
			3560186	perdiem-Driver	Person-days	45,000			
			3560104	Air ticket-return	Person-days	250,000			
	3.1ci) Support champions at district level to use FP advocacy messages and tools Advocacy to enhance accountability at LGA		3560173	handouts	Copies	20,000			
		Subtotal							
		Total activity						**75,662,611**	
		Total strategic activity						***75,662,611***	
3.1d) Community engagement and ownership enhanced to ensure accountability, acceptability and support for good quality CBFP service provision.									
		Conduct 5 day orientation workshop for existing champions (i.e. leaders) in respective areas to enable them to advocate for community level accountability, acceptability and support for good quality CBFP service provision.	3560153	Per diem- domestics	Person-days	65,000			
			3560117	Conference	Person-days	64,000			
			3560133	Facilitator	Person-days	80,000			
			3560180	Travel allowance	Trip	40,000			
			3560139	Fuel	Kms	440			
	3.1di) Conduct orientation for existing champions (i.e, leaders) in respective areas to enable them to advocate for community level accountability, acceptability and support for good quality CBFP service provision,		3560186	perdiem-Driver	Person-days	45,000			
			3560104	Air ticket-return	Person-days	250,000			
			3560173	Handouts	Copies	20,000			
		Total Activity							
		Total strategic activity							
3.2) Adequate and sustainable financing for CBFP services secured									
3.2a) Financial resource allocation to CBFP services at all levels (CCHP, national, and district) increases									
		Conduct advocacy meetings targeting key personel at the district level	3560153	Per diem- domestics	Person-days	65,000			
			3560117	Conference	Person-days	64,000			
			3560133	Facilitator	Person-days	80,000			
			3560180	Travel allowance	Trip	40,000			
			3560139	Fuel	Kms	440			
			3560186	perdiem-Driver	Person-days	45,000			
			3560104	Air ticket-return	Person-days	250,000			
	3.2ai) Advocate for resource allocation for CBFP services in CCHP budgets		3560173	handouts	Copies	20,000			
		Total Activity							
	3.2aii) Conduct budget analysis at CCHP level to track resource allocation and expenditure for CBFP activities	Hire a consultatnt to do budget analysis at CCHP level to track resource allocation and spending for CBFP activities	3560120	Consultancy	Person-day	640,000			
		Total Activity							
		Conduct advocacy meetings targeting key personel at the district level	3560153	Per diem- domestics	Person-days	65,000	1,500	102,960,000	
			3560117	Conference	Person-days	64,000	2,500	168,960,000	
			3560133	Facilitator	Person-days	80,000	400	33,792,000	
			3560180	Travel allowance	Trip	40,000	3,200	135,168,000	
			3560139	Fuel	Kms	440	15,000	6,969,600	
			3560186	perdiem-Driver	Person-days	45,000	300	14,256,000	
	3.2aiii) Advocate through symposium and meetings to donor community, NGOs /FBOs financing CBFP interventions		3560104	Air ticket-return	Person-days	250,000	100	26,400,000	
			3560173	handouts	Copies	20,000	2,000	42,240,000	
		Total Activity						**530,745,600**	
		Total strategic activity						***530,745,600***	
3.2b) Approaches for sustainable financing generated, operationalized and institutionalized									
		Hire a consultant to conduct an assessment of opportunities and develop scheme for CBFP financing	3560120	Consultancy	Person-days	640,000	30	20,275,200	
		Subtotal						**20,275,200**	
		Conduct 2 stakeholders meeting to asses opportunities and develop scheme for CBFP financing	3560153	per diem- domestic	Person-days	65,000	60	4,118,400	
			3560117	conference package	Person-days	64,000	120	8,110,080	
			3560133	Facilitator	Person-days	80,000	16	1,351,680	
			3560180	Travel allowance	Trip	40,000	58	2,433,024	
			3560139	Fuel	Kms	440	720	334,541	
			3560186	perdiem-Driver	Person-days	45,000	16	769,824	
			3560104	Air ticket-return	Person-days	250,000	2	475,200	
			3560173	handouts	Copies	20,000	36	760,320	
		Subtotal						**18,353,069**	
		Conduct a stakeholders meeting to desseminate findngs.	3560153	per diem- domestic	Person-days	65,000	15	1,029,600	
			3560117	conference package	Person-days	64,000	35	2,365,440	
			3560133	Facilitator	Person-days	80,000	4	337,920	
			3560180	Travel allowance	Trip	40,000	48	2,027,520	
			3560139	Fuel	Kms	440	225	104,544	
	3.2bi) Identify the different approaches for sustaining financing of CBFP services, including community-based prepayment schemes, such as CHF, or CHW engagement in selling social marketing products, or forming public-private partnerships for in-kind support etc.		3560186	perdiem-Driver	Person-days	45,000	5	213,840	
			3560104	Air ticket-return	Person-days	250,000	2	396,000	
			3560173	handouts	Copies	20,000	25	528,000	
		Subtotal						**7,002,864**	
		Total Activity						**45,631,133**	
		Engage two consultants to conduct research on 2 different approaches in generating sustainable financing for CBFP services (2 yrs each) - 2 approaches	3560120	Consultancy	Person-days	640,000			
		Subtotal							
		Conduct 4 stakeholders meeting to assess 2 different approaches in generating sustainable financing for CBFP services	3560153	per diem- domestic	Person-days	65,000			
			3560117	conference package	Person-days	64,000			
			3560133	Facilitator	Person-days	80,000			
			3560180	Travel allowance	Trip	40,000			
			3560139	Fuel	Kms	440			
			3560186	perdiem-Driver	Person-days	45,000			
			3560104	Air ticket-return	Person-days	250,000			
			3560173	handouts	Copies	20,000			
		Subtotal							
		Conduct stakeholder's workshop to desseminate research findings,	3560153	per diem- domestic	Person-days	65,000			
			3560117	conference package	Person-days	64,000			
			3560133	Facilitator	Person-days	80,000			
			3560180	Travel allowance	Trip	40,000			
			3560139	Fuel	Kms	440			
			3560186	perdiem-Driver	Person-days	45,000			
			3560104	Air ticket-return	Person-days	250,000			
	3.2bii) Evaluate feasibility and effectiveness of different approaches in generating sustainable financing for CBFP services		3560173	handouts	Copies	20,000			
		Subtotal							
		Total Activity							
		Total strategic activity						***45,631,132.80***	
		Grand Total						**677,224,944**	

FY2016-17		FY2017-18		FY2018-19		FY2019-20		FY2020-21	
Number of Units (xii)	Estimates (v) x (xii) = (xiii)	Number of Units (xiv)	Estimates (v) x (xiv) = (xv)	Number of Units (xvi)	Estimates (v) x (xvi) = (xvii)	Number of Units (xvi)	Estimates (v) x (xvi) = (xvii)	Number of Units (xvi)	Estimates (v) x (xvi) = (xvii)
60	669,082	60	706,550	60	746,117	60	787,900	60	832,022
	669,082		**706,550**		**746,117**		**787,900**		**832,022**
	-		-		-		-		-
	669,082	-	***706,550***	-	***746,117***	-	***787,900***	-	***832,022***
2385	26,595,994	2385	28,085,369	2385	29,658,150	2385	31,319,006	2385	33,072,871
	26,595,994		**28,085,369**		**29,658,150**		**31,319,006**		**33,072,871**
9540	106,383,974	9540	112,341,477	9540	118,632,600	9540	125,276,025	9540	132,291,483
	106,383,974		**112,341,477**		**118,632,600**		**125,276,025**		**132,291,483**
	132,979,968		**140,426,846**		**148,290,750**		**156,595,032**		**165,364,353**
	132,979,968		***163,036,452***		***148,290,750***		***181,807,817***		***165,364,353***
240	21,410,611								
240	21,410,611								
32	2,854,748								
192	8,564,244								
8,640	4,239,301								
72	3,613,041								
16	4,460,544								
240	5,352,653								
	71,905,753								
	71,905,753								
	71,905,753								
		2,520	192,888,196.30	1,680	135,793,290				
		2,400	180,876,843.42	1,600	127,337,298				
		180	16,957,204.07	120	11,937,872				
		336	15,826,723.80	224	11,142,014				
		9,450	4,896,392.68	6,300	3,447,060				
		378	20,030,697.31	252	14,101,611				
		21	6,182,313.98	14	4,352,349				
		420	9,891,702.37	280	6,963,758				
			447,550,074		**315,075,252**		-		
			447,550,074		***315,075,252***		-		
1,500	108,725,760	885	67,740,497.51						
2,500	178,421,760	1,475	111,163,893.35						
400	35,684,352	236	22,232,778.67						
3,200	142,737,408	1,888	88,931,114.68						
15,000	7,359,898	8,850	4,585,510.60						
300	15,054,336	177	9,379,453.50						
100	27,878,400	59	17,369,358.34						
2,000	44,605,440	1,180	27,790,973.34						
	560,467,354		**349,193,579.99**						
		30	22,609,605			30	25,212,785		
			22,609,605				**25,212,785**		
		885	67,740,498						
		1,475	111,163,893						
		236	22,232,779						
		1,888	88,931,115						
		8,850	4,585,511						
		177	9,379,454						
		59	17,369,358						
		1,180	27,790,973						
			349,193,580						
	560,467,354		***720,996,765***				***25,212,785***		
30	21,410,611	30	22,609,605	30	23,875,743	30	25,212,785		
			44,020,217				**49,088,528**		
30	2,174,515	30	2,296,288	30	2,424,880	30	2,560,673		
60	4,282,122	60	4,521,921	60	4,775,149	60	5,042,557		
8	713,687	8	753,654	8	795,858	8	840,426		
28.8	1,284,637	28.8	1,356,576	28.8	1,432,545	28.8	1,512,767		
360	176,638	360	186,529	360	196,975	360	208,005		
8.1	406,467	8.1	429,229	8.1	453,266	8.1	478,649		
0.9	250,906	0.9	264,956	0.9	279,794	0.9	295,462		
18	401,449	18	423,930	18	447,670	18	472,740		
	9,690,420		**10,233,084**		**10,806,137**		**11,411,280**		
		15	1,148,144			15	1,280,337		
		35	2,637,787			35	2,941,492		
		4	376,827			4	420,213		
		48	2,260,961			48	2,521,278		
		225	116,581			225	130,003		
		5	238,461			5	265,916		
		2	441,594			2	492,437		
		25	588,792			25	656,583		
			7,809,146				**8,708,260**		
	9,690,420		**62,062,446**		**10,806,137**		**69,208,068**		-
	9,690,420		***62,062,446***		***10,806,137***		***69,208,068***		-
	775,712,577		1,394,352,287		474,918,255		277,016,569		166,196,375

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