The Revolutionary Government of Zanzibar

The Ministry of Health Zanzibar

The Zanzibar Family Planning Costed Implementation Plan

2018 – 2022

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ACRONYMS

ANC	Antenatal Care
AWLN	Africa Women Leaders Network
CBD	Community Based Distributors
CMS	Central Medical Store
cPAC	Comprehensive Post Abortion Care
CPR	Contraceptive Prevalence Rate
DANIDA	Danish International Development Agency
DHMT	District Health Management Team
DMM	District Material Manager
DMT	District Management Team
DP	District Pharmacist
DPHNO	District Public Health Nursing Officer
eLMIS	Electronic Logistic Management Information System
FP	Family Planning
FANC	Focused Antenatal Care
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICPD	International Conference on Population and Development
IEC	Information Education Communication
IPC	Infection Prevention and Control
IRCH	Integrated Reproductive and Child Health
IUCD	Intra Uterine Contraceptive Device
LARC	Long acting reversible contraceptives
MCH	Maternal and Child Health
mCPR	Modern Contraceptive Prevalence Rate
MKUZA	Mkakati wa Kukuza Uchumi na Kupunguza. Umasikini Zanzibar
MOHSW	Ministry of Health and Social Welfare
MRL	Muslim Religious Leaders
MTEF	Medium Term Expenditure Framework
NACTE	National Accreditation Council of Technical Education
P4P	Pay for Performance
PBP	Performance-Based Performance
PIRO	Pemba Island Relief Organization
PMTCT	Prevention of Mother to Child Transmission
QIRI	Quality Improvement Recognition Initiative
RCHP	Reproductive and Child Health Program
RGZ	Revolutionary Government of Zanzibar
R&R	Report and Request
SBCC	Social Behaviour Change Communication
SBMR	Standard Based Management and Recognition
SRH	Sexual and Reproductive Health
TDHS	Tanzania Demographic Health Survey
UMATI	Uzazi na Malezi Bora Tanzania
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
URT	United Republic of Tanzania
USAID	The United States Agency for International Development
WHO	World Health Organization
ZANA	Zanzibar Nurses Association
ZANGOC	Zanzibar NGOs Cluster
ZAYEDESA	Zanzibar Youth Education Environment Development Support Association
ZILS	Zanzibar Integrated Logistic System
ZFPCIP	Zanzibar Family Planning Costed Implementation Plan
ZFDCB	Zanzibar Food, Drug and Cosmetics Board
ZFPP	Zanzibar Family Planning Project
ZPHA	Zanzibar Pharmaceutical Association

FOREWORD

The Revolutionary Government of Zanzibar (RGOZ) aspires to have achieved transformation of Zanzibar into a middle-income country and eradicate abject poverty by 2020 . Enabling people to attain their desired number of children and determine the spacing of pregnancies is a priority for the RGOZ, both as means to reduce maternal mortality and stabilize population growth, which has been identified as a potential constraint affecting social and economic performance

In 2008, the RGOZ launched the Road Map to Accelerate the Reduction of Maternal, Newborn and Child Mortality in Zanzibar (2008 – 2015). Family Planning is one of the fundamental interventions of the plan, and an operational target to increase modern contraceptive prevalence rate (mCPR) from 9 percent to 20 percent by 2015, was included. However, contraceptive uptake has not been growing at the desired growth rate. A dramatic decrease in mCPR was subsequently observed in 2004/5, when the mCPR reached 9 percent from 15 percent in 1999. Thereafter, the mCPR begun to rise again, and after a period of 10 years since the loss was registered, Zanzibar is finally close to regaining its 1999 mCPR rates. In 2016, the modern contraceptive prevalence among currently married women reached 14 percent.

A situation analysis conducted in 2016 identified strategic issues and challenges facing the current FP program to inform the development of a five-year plan to meet the country goal of increasing modern contraceptive prevalence to 20 percent by 2022.

The RGOZ is committed to accelerate progress to achieve its goal by 2022. This document, the Zanzibar Family Planning Costed Implementation Plan (ZFPCIP) is a results-based and actionable costed plan to guide intervention programming, resource mobilization and allocation, and performance measurement. It is intended to guide all stakeholders towards collective action to address challenges experienced with the program relative to service delivery, contraceptive security, demand generation, and enabling environment. The ZFPCIP intends to enhance engagement and commitment of stakeholders to support FP services to realize the set contraceptive prevalence rate (CPR) goal. In addition, the government will continue to create an enabling environment for effective stakeholders participation and collaboration to build a robust programming of FP services.

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ACKNOWLEDGMENTS

The Ministry of Health would like to express its appreciation to all partners, groups, and individuals who supported the development of the Zanzibar Family Planning Costed Implementation plan (ZFPCIP) 2018-2022. This document is the result of extensive consultations with stakeholders working at all levels, including key sector ministries, development partners, implementing partners, professional associations, academia, and Non-governmental organisations working in aligned areas.

We would like to thank United Nations Population Fund (UNFPA) for the financial and technical support that greatly contributed to the development of this document. Particularly, we would like to mention Dr. Azzah Nofly, Dr. Jarrie Kabba - Kebbay and Batula Abdi for their commitment and close follow up in making sure that the milestone of having a costed plan for Family planning in Zanzibar is realized. We are also grateful to representatives from WHO-Zanzibar, Jhpiego, UMATI and EngenderHealth for their effective participation and contribution that have enriched the quality of this document.

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It is our strong belief and conviction that the interventions and activities contained in the ZFPCIP will be implemented effectively to address the FP issues in n Zanzibar and realise the CPR target of 20 percent by 2022.

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INTRODUCTION

The Revolutionary Government of Zanzibar (RGOZ) aspires to have achieved transformation of Zanzibar into a middle-income country by 2020 and enable it to eradicate absolute poverty in the society through building a strong and competitive economy; achieving high quality livelihoods for its citizens and improving good governance and the rule of law without compromising its rich culture[1]. The rapidly increasing population is recognized as a potential constraint affecting economic performance, due to among other factors, the age dependency burden, labour force supply, rural and urban distribution and high population densities. The Vision 2020 translated into 5-year Zanzibar Strategies for Growth and Reduction of Poverty (MKUZA I, II, III) calls for the harmonization of population and economic growth through stabilizing population growth rate at 2.8 percent per annum by the year 2015[2]. Further, it aims to reduce maternal mortality ratio from 473/100,000 in 2007 to 170/100,000 by 2015, through several core cluster strategies, including improving the availability of Family Planning information and services for men and women[2]. The Roadmap to accelerate the reduction of maternal, newborn and child mortality in Zanzibar (2008 – 2015) specifies an operational goal to increase modern contraceptive prevalence rate (mCPR) from 9 percent to 20 percent[3].

The Zanzibar Family Planning Costed Implementation Plan (ZFPCIP) 2018–2022 describes the annual action plans to achieve specific outputs and outcomes to attain the mCPR goal of 20% by 2022. The implementation of the ZFPCIP will contribute to RGOZ's dedication to achieve various goals and commitments, including FP2020 commitments; Every Woman, Every Child, Every Adolescent Commitments; and Sustainable Development Goals. The ZFPCIP describes scheduled activities under four strategy areas of implementation: service delivery, commodity security, enabling environment, and demand creation; details activity cost estimates representing financial resources needed during implementation period; and defines measurable results that need to be achieved and metrics to facilitate performance measurement. Further, the ZFPCIP delineates key institutional arrangements to support execution of the plan throughout the five-year period.

The ZFPCIP serves as an operational guide for all stakeholders involved in the family planning program, across all government sectors, development partners, and implementing partners. Specifically, the ZFPCIP:

- Reflects priority intervention areas for family planning programming: The ZFPCIP articulates identified priorities for family planning based on a consultative process among key stakeholders of family planning.
- Identifies financial resource requirements: The ZFPCIP includes cost estimates to enable The government and partners to understand the family planning programme's budgetary needs for the next five years. As such, the ZFPCIP functions as a resource-mobilisation tool to secure donor and government commitments for the family planning programme, identify funding gaps, and inform advocacy efforts.
- Stipulates desired performance at various levels: The ZFPCIP provides benchmarks and indicators that the government can use to monitor annual performance and progress towards its goals. It defines performance targets at various levels of the results framework, including goals, outcomes, and outputs.

The cost of the total plan is TZS 38,243,198,303, which will increase the number of women in currently using modern contraception from approximately 54,488 to 89,812 by 2022. Overall, service delivery reflects the largest share of costs (53%), at TZS 20,400,712,890.

COUNTRY CONTEXT: POPULATION AND FAMILY PLANNING SITUATION

Zanzibar consists of two major islands, Unguja and Pemba, and is part of the United Republic of Tanzania. Together, the two islands have a total of five regions and eleven districts covering a total area of 2,654 square kilometres. Zanzibar has a young, rapidly growing and increasingly urbanized population. According to the 2012 Population and Housing Census, the population of Zanzibar is estimated to be 1,303,569, of which, approximately 46.3 percent resides in the urban areas — an increase of 17 percent since 2002[4]. Furthermore, an estimated 33.1 percent of the population is young between the ages of 10 to 24 years old — majority of whom are adolescents below the age of 19 years[4]. As shown in Table 1, half of the female population are in their reproductive years, 15-49 years old, and more than 1 in 5 of these women is an adolescent (22 percent)[4]. An almost even split between rural and urban residence exists among women of reproductive age, and close to 1 in 2 of the WRA (42%) are between the age of 15-24 years old[4].

Table 1: Distribution of the female population by age group and residence

Age Group	Total	Rural	Urban
Total female population, 0-80+	672,892	356,245	316,647
10 – 14 years	83,269	44,678	38,591
15 – 19 years	74,541	38,158	36,383
20 – 24 years	67,737	32,510	35,227
25 – 29 years	54,707	26,325	28,382
30 – 34 years	44,238	21,218	23,020
35 – 39 years	38,619	19,462	19,157
40 – 44 years	30,765	16,198	14,567
45 – 49 years	28,400	15,136	13,264
Total, 15-49 years	339,007	169,007	170,000
Percent of total females, WRA	50%	47%	54%
Percent of WRA, Adolescent 15-19 years	22%	23%	21%
Percent of WRA, Youth 15-24 years	42%	42%	42%
Percent of WRA, Young 10-24 years	47%	49%	44%

Zanzibar's population has grown by 32.8 percent over a period of 10 years since 2002[5]. The population is currently estimated to be growing at a rate of 2.8 percent per year, and is expected to double by 2036[5]. Urban West is the fastest growing region of Zanzibar at 4.2 percent per year, followed by Zanzibar North at 3.2 percent per year[4]. The rapid population growth, coupled with the small size of the islands, makes the population density to be high at 530 people per square kilometers[5]. In fact, except for Dar-es-salaam which has the highest concentration of people per square kilometre in Tanzania, 4 of the 5 Zanzibar regions have the highest population densities in the entire country[5].

A summary of socioeconomic indicators is provided in Table 2. The rapid population growth is unmatched with the pace of economic growth, presenting challenges in achieving Zanzibar's Vision 2020 of

achieving a middle-income status. Moreover, achievement of the desired socio-economic goals (such as attaining a high and sustainable economic growth averaging 9-10 percent per annum, a high level of employment in the modern sector, high education standards, universal education, and improved quality of life), will continue to be highly constrained by the demands of high population pressures on resources. Considering these challenges and counter effects to socioeconomic growth, Tanzania aspires to slow its population growth rate. To do so, the Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP II) called for the following: implementation of the Zanzibar Population Policy (2008), encouragement the formation of sustainable family sizes, promotion of public awareness on the importance of quality population, integration of population issues into sector plans and programs, and improvements in collection, processing and dissemination of population data[2].

High fertility rates that drive rapid population growth also contribute to a persistently high maternal mortality ratio in Zanzibar, estimated at 350 per 100,000 live births in 2012[5]. As such, the Roadmap to accelerate the reduction of maternal, newborn, and child mortality in Zanzibar, 2008-2015, acknowledged and included family planning as one of the key interventions to reduce maternal morbidity and mortality[6].

Table 2: Zanzibar Socioeconomic Indicators

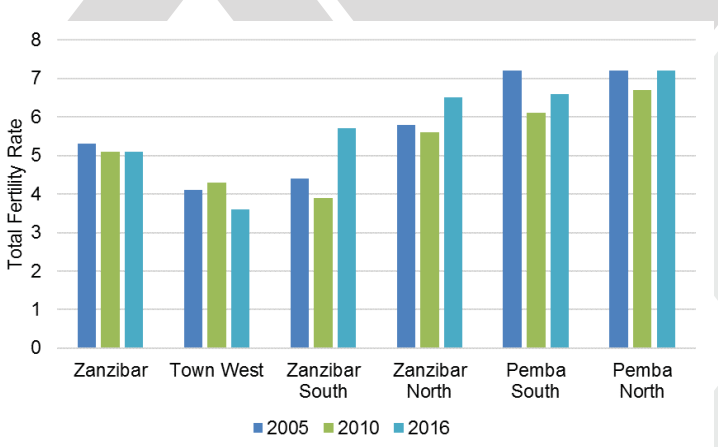
INDICATOR	
Human development index (rank)	0.488 Tanzania[7]
Population (millions)	1,303,569[5]
Annual population growth rate	2.8[5]
Youth population, 15–24 years	285,747*
Adult literacy	Female (77%) | Male (83%)[8]
Infant mortality rate (per 1,000)	43/1000[8]
Under five mortality rate (per 1,000)	67/1000[8]
Maternal mortality ratio (per 100,000 births)	350 per 100,000 live births (2012)[5]
HIV prevalence, adult (ages 15–49), total	0.6*
Life expectancy (years)	63.7*

* Represents national projections for Tanzania

FERTILITY TRENDS

The major contributing factor to the rapid population is the high level of fertility — the total fertility rate (TFR) currently stands at 5.1 children per woman[8]. Variations in TFR exists across the five regions — Pemba North (7.2) has twice the TFR as that in Urban West (3.6), Error! Reference source not found. Further, a marked increase in TFR is observed in Zanzibar

Figure 1: Fertility Trends By Region, 2005-2016

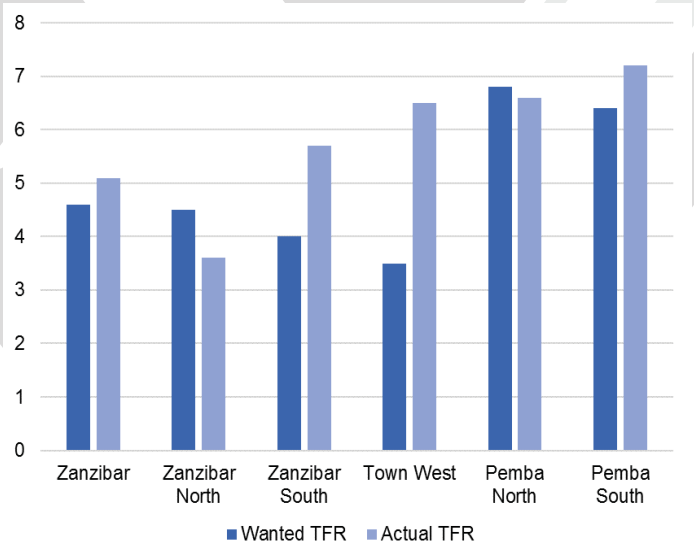


South and North, although slightly lower, over the past 10 years.

Wanted fertility rates reflect the level of fertility that would result if all unwanted births were prevented; its comparison with actual fertility rates, show a service discrepancy in terms of meeting the desires of the population. On average, 4 percent of Tanzanian women who had children in the past five years, report that their pregnancy was unwanted, and 27 percent report their pregnancy was mistimed[8]. A 2013 study estimated Zanzibar as having the lowest unintended pregnancy rate (61 pregnancies per 1000 women) in Tanzania, and a low abortion incidence rate, at 11 abortions per 1,000 women[9]. The current wanted fertility rate for Zanzibar has remained relatively unchanged over the past 10 years at 4.6 children per woman, lower than the actual TFR of 5.1[8]. However, across the different regions, the gap between wanted and actual fertility rate varies considerably, Figure 2. Despite having the lowest TFR, Urban West, has the largest gap of 3 points, followed by Zanzibar South at 1.7 points. The wanted and actual fertility rates in Pemba North are relatively at par, and in fact, residents in Zanzibar North have fewer children per woman than they desire[8].

Research consistently shows a strong correlation between women's higher educational attainment and reduced childbearing[10]. The variation in wanted fertility rates corresponds with secondary school educational attainment; in fact, a negative correlation exists between wanted fertility rates and secondary education attainment.

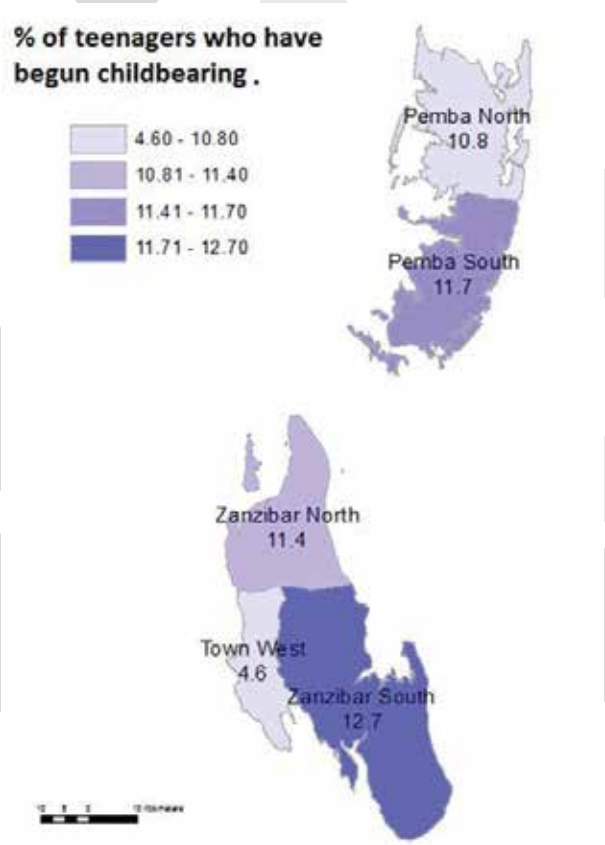
Figure 2: Wanted vs. Actual Fertility Rates by Region, 2016



ADOLESCENT FERTILITY AND TEENAGE PREGNANCY

Teenage pregnancy*in Zanzibar is three times lower compared to mainland Tanzania. The proportion of all women aged 15–19 years who have had a live birth or who are currently pregnant is 8.2 percent[8]. Similarly, the age-specific fertility rate for 15-19-year-olds is three times lower than the mainland at 45 pregnancies per 1000 women. There is, however, considerable disparities of teenage pregnancies across the five regions, ranging from 4.6 percent in Urban West to 12.7 percent in Zanzibar South, a factor of almost 3 times, Figure 3.

Figure 3: Teenage pregnancy rates by region

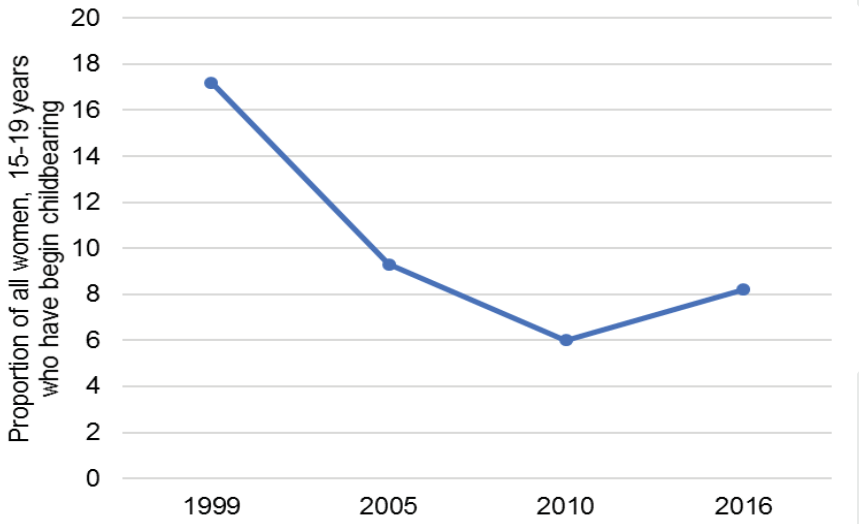


Teenage pregnancies have been on a general decline for the past 20 years, with the most dramatic decrease observed between 1999 and 2004/5, Figure 4. However, between 2010 and 2016, teenage pregnancies are observed to have increased by 36 percent, from 6 percent to 8.2 percent. This increase is observed in all regions, except for Zanzibar South, where a decline from 17.9 percent to 12.7 percent. A high rate of secondary school attainment among females (15.1 percent), compared to the mainland (6.9 percent) and Muslim beliefs and tradition— rather than contraceptive use — may be imparting a protective effect in curbing teenage pregnancies[8].Indeed, the median age of first birth is slightly above the Government guidelines of 20 years, at 21.7 years, and the median age at first sexual

*Teenage pregnancy is a pregnancy that occurs among women younger than 20 years of age. For the purposes of measuring pregnancy rates among adolescent women, data are collected and reported in the demographic and health survey (DHS) on pregnancy among adolescent women ages 15–19 years. Teenage (adolescent) childbearing is measured as the proportion of all women ages 15–19 who have had a live birth or who are currently pregnant. It is important to note that this measure does not capture the number of adolescent women who have been pregnant but whose pregnancies ended in miscarriage or abortion. The full extent of adolescent pregnancy may, however, be underestimated given recent estimates of 11 abortions out of every 100 live births among Zanzibar women ages 15–49 years (Keogh SC. et al).

intercourse among women of 25-49 years of age is 19.6 years[8]. The median age of marriage among 25-49 year-old females is 20.3 years[8].

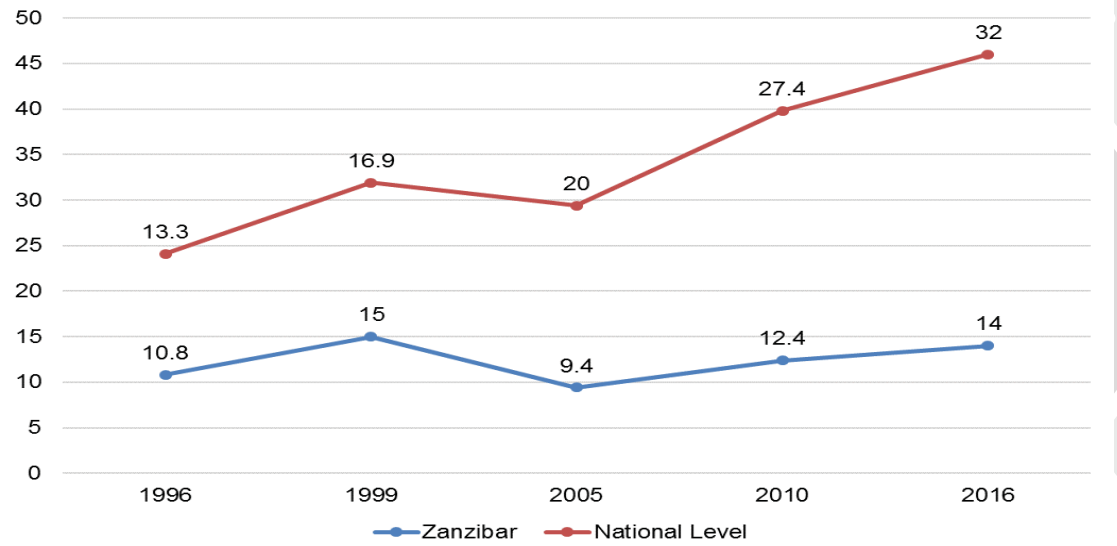
Figure 4: Teenage pregnancy trends, 1999 - 2016



CONTRACEPTIVE USE

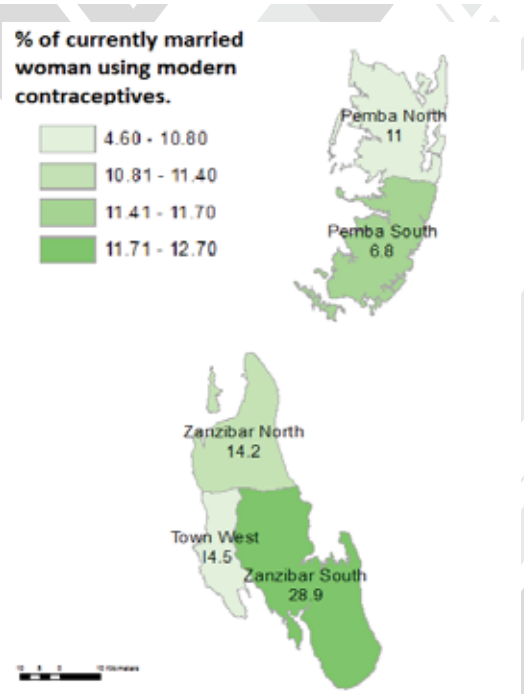
Ever since the inception of family planning services in 1959, modern contraceptive use rate (mCPR) among currently married women progressively rose to a peak of 15 percent in 1999[11]. However, a dramatic decrease in mCPR was subsequently observed in 2004/5, when the mCPR reached 9 percent[12]. Thereafter, the mCPR begun to rise again, and after a period of 10 years since the loss was registered, Zanzibar is finally close to regaining its 1999 mCPR rates. As of 2016, the modern contraceptive prevalence among currently married women reached 14 percent, Figure 5, with an annual percentage point of 0.3. Despite these gains, modern contraceptive use remains to be more than twice lower than the national level rate of 32 percent.

Figure 5: Modern contraceptive use trends, Zanzibar vs Nationwide levels, 1996-2016



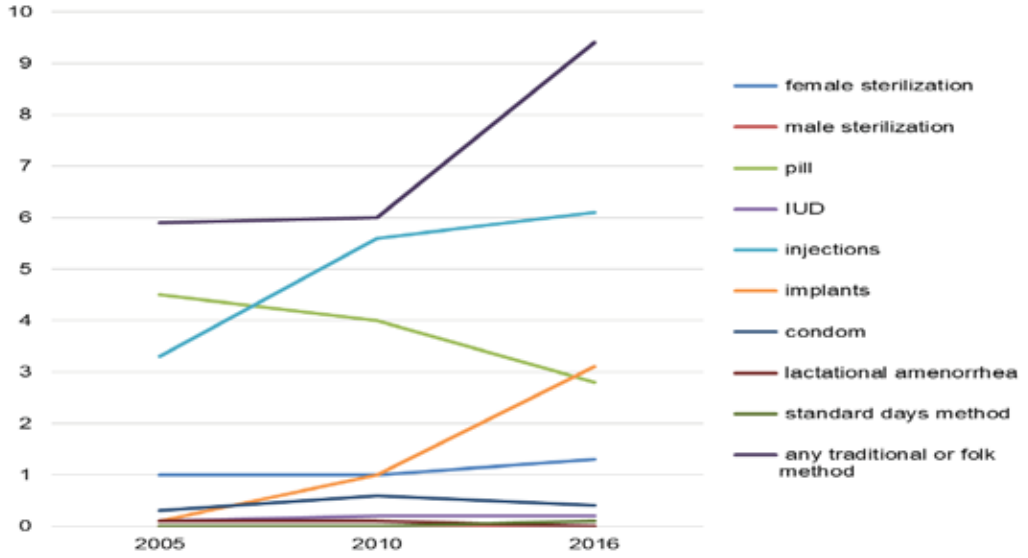
Review of mCPR trends across regions show that since 2004/5, mCPR has generally been growing in all regions except for Pemba South. Both, Pemba North and Zanzibar North, observed considerable increases in mCPR in the past five years. However, growth in contraceptive uptake has stalled in Zanzibar South and UrbanUrban West[8]. Variations in mCPR across regions are shown in Figure 6.

Figure 6: Modern contraceptive use by region



The most pre-dominantly used modern contraceptive method among currently married women are injectables (6.1 percent), followed by implants (3.1 percent) and pills (2.8 percent)[8]. A trend analysis between 2005 and 2016, Figure 7 showed that implants are the fastest growing modern method, followed by injectables, and condoms. Pills have seen a progressive decline in the past 10 years, as more women shifted to methods such as injectables and implants. Furthermore, traditional methods are on the rise, reported at 9.4 percent - mostly related to use of the withdrawal method.

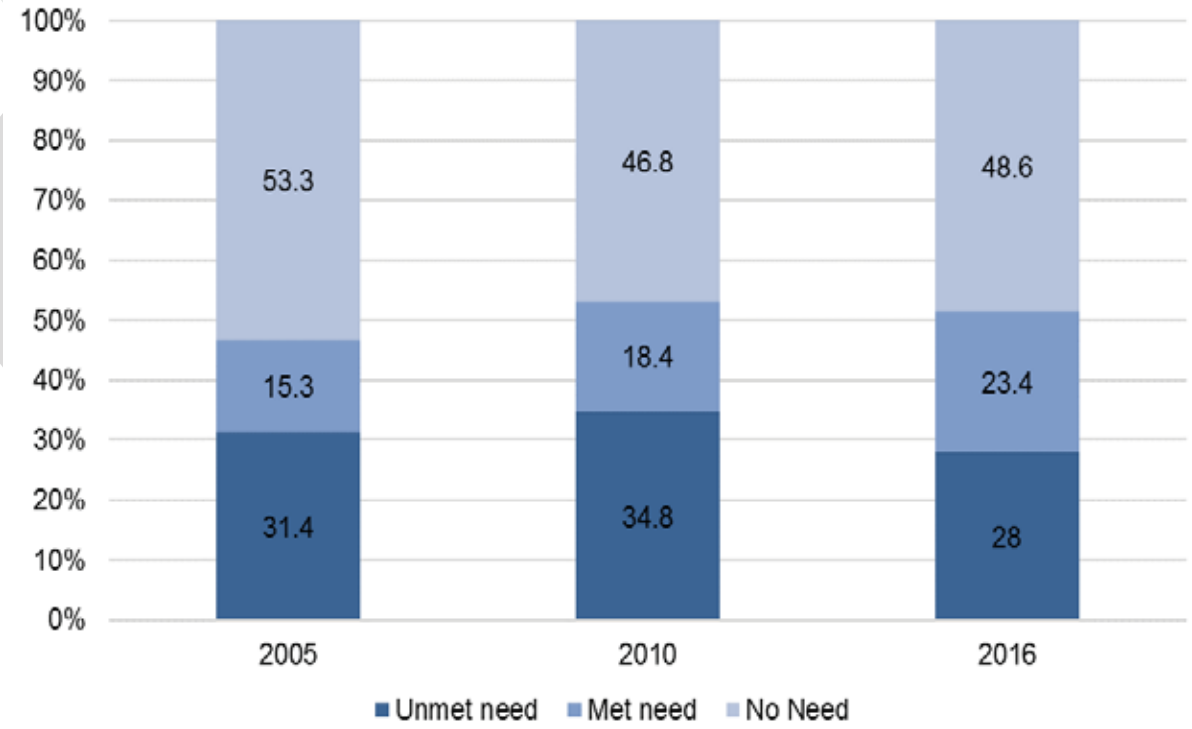
Figure 7: Percentage distribution of method use by currently married women, 2005-2016



DEMAND FOR FAMILY PLANNING

Overall demand for family planning (the sum of unmet and met need) has only slightly increased in the past 10 years, from 46.7 percent in 2005 to 51.4 percent in 2016, Figure 8. Furthermore, unmet need has moderately declined from 34.8 percent in 2010 to 28 percent in 2016[8]. The largest share of unmet need in 2016 was for spacing, at 20.4 percent compared with 7.6 percent for limiting. Of the total demand, 27.3 percent is satisfied by modern methods. This varies across different regions, ranging from 15.5 percent in Pemba South to 47.2 percent in Zanzibar South.

Figure 8: Contraceptive demand among currently married women, 2005 -2016



PROBLEM SUMMARY:

1. Young, rapidly growing and increasingly urbanized population
2. Stagnant high fertility rate, with considerable regional variation.
3. Consistently low demand for contraceptives over time.
4. Relatively low teenage pregnancy rates, but steadily rising
5. A notable shift in method mix, a decline in pill use and a rise in implants.

PROGRAM CONTEXT: STRATEGIC ISSUES AND CHALLENGES

Family Planning services in Zanzibar date back to 1959, when the Family Planning Association of Tanzania (UMATI) introduced services in limited geographical areas, primarily in urban locations. In 1974, the Government of Tanzania begun to scale services nationwide, as part of maternal and child health services; and in 1985, the Zanzibar Family Planning Project (ZFPP) was launched as part of efforts to reduce maternal morbidity and mortality[13]. Over time, the Family Planning program in Zanzibar has been governed by a series of policies and strategic plans, under the umbrella of the Reproductive and Child Health programme, and the Directorate of Preventive Services of the Ministry of Health as the coordinating body. In 2008, the RGOZ launched the Road Map to Accelerate the Reduction of Maternal, Newborn and Child Mortality in Zanzibar (2008 – 2015). The goal was to accelerate the reduction of maternal, neonatal and child morbidity and mortality and contribute to the attainment of Millennium Development Goals number 4 and 5 by 2015[3].Family Planning was acknowledged as one of the fundamental interventions to reduce maternal mortality, and an operational target to increase modern contraceptive prevalence from 9 percent to 20 percent by 2015, was included.

In 2016, a situation analysis was conducted to identify strategic issues and challenges facing the current FP program to inform the development of a five-year plan to meet the country goal of increasing modern contraceptive prevalence to 20 percent by 2022[14]. Key findings from the analysis are described below under four technical areas, identified as essential components of an effectively functioning family planning program.

SERVICE DELIVERY

The FP program is committed to ease access to services by ensuring the establishment of a wide array of service delivery points, including public and private sector facility-based services, community-based services, outreach services, retail outlets and pharmacies. By offering FP services as part of maternal and child health (MCH) services, the program leverages the vast public health facility infrastructure existing across the two islands; as such, 95 percent of the Zanzibar population are within five kilometres to the nearest public health facility, which also provides FP services[14]. Family Planning services are provided in 168 health facilities of which, 59 percent (99) are in Unguja, and the rest, 69, in Pemba. Almost all are public sector facilities (92 percent), and the remainder are parastatal, private- or faith-based owned[14]. Community-based distribution (CBD) services also provide further reach at household levels, albeit limited to a few methods, i.e. pills and condoms. CBD services are supplemented by outreach services, which tend to also provide long acting reversible contraception (LARC).

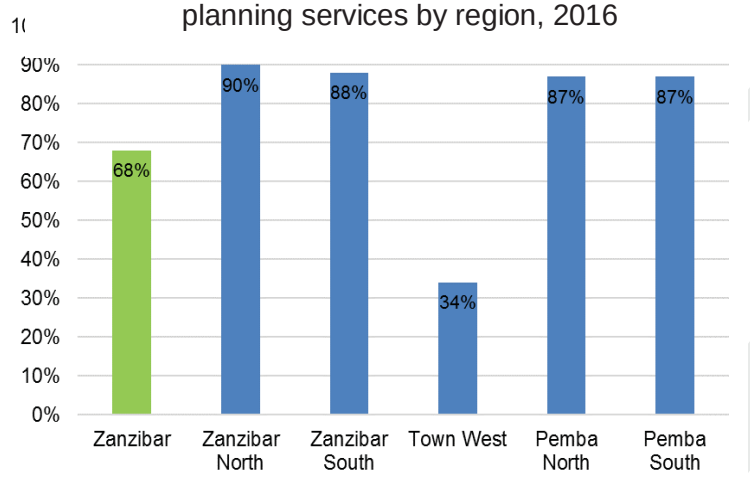
The FP program faces several service delivery problems and challenges undermining further progress in ensuring voluntary, informed choice and access to a broad range of contraceptive methods.

Facility-based service delivery: On average, 68 percent of health facilities in Zanzibar provide modern contraceptive services, considerably lower than the national average of 80 percent, and this has not changed in the past 10 years.[8,15] The low average figure is attributed by the notably low proportion of facilities offering this service in Urban West (34 percent), relative to other regions in Zanzibar and the entire nation of Zanzibar, Figure 9.

The Zanzibar Health Sector Strategic Plan (ZHSSP III 2013/14-2018/19) has emphasized the importance of improving efficiency and effectiveness of service delivery through integration of related health programs[16]. FP service delivery is offered in an integrated manner to reduce missed opportunities, such that when women come in for other services (such as child care, post-abortion care, postpartum services, etc.), providers initiate a discussion on family planning. However, among women of reproductive age who are not using contraceptives, and who visited a health facility in the past 12 months, only 11.1 percent reported to have discussed family planning with a provider[8]. Parallel to

the data on low coverage of FP services in Urban West, women residing in this region (8.3 percent) were least likely to have discussed FP with a provider compared to other regions[8].

Figure 9: Percentage of facilities providing family planning services by region, 2016



Government has worked closely with partners over the years to improve quality provision of family planning services, including training and support to providers and supervisors. Several guidelines and protocols for staff responsible for service provision have been developed. Some of these guidelines include: Adolescent Friendly Service Standards (November 2006), the National Family Planning Procedure Manual, the FP Job Aid, November 2016), Male Involvement in FP November 2016), and the National Package of Essential Reproductive and Child Health Interventions. Most facilities that provide FP services (77 percent) were found to have at least one national guideline for FP services[17].

During the period between 2010 and 2015, a total number of 1,213 health providers covering all 11 districts received FP training. However, the 2015 Service Provision Assessment reported that only few facilities (34 percent) have at least one staff who was trained on FP in the past 24 months[17]. The situation is poorer in Urban West and Zanzibar South regions, where only 11 percent and 12 percent of facilities, respectively, had a trained staff in the past 24 months[17]. Further review of training on specific topics, show that about 51 percent of providers have been trained on clinical skills related to FP service provision; 44 percent on IUCD insertion and removal, 43 percent on implant insertion and removal, 36 percent on family planning for clients living with HIV, and 35 percent on postpartum family planning[17]. It is interesting to note that despite that almost equal proportions of providers have been trained on IUCD and implants, IUCD remains underutilized despite its attractive benefits over implants. The uptake of IUCD is 16 times less that of implants — stakeholders reported possession of expired IUCDs due to lack of demand for the method[14]. As further described in subsequent sections, more facilities are likely to have implants (98 percent) available than IUCDs (64 percent) — this is perhaps due to the ordering procedures which are based on consumption[17]. To incentivize health staff, the MOH, with support from DANIDA, has successfully implemented a pilot performance-based financing initiative, which also focuses on family planning services. Currently, the ministry introduced Star Rating assessing performance.

In addition to the problem of inadequate health workers trained on FP, the general health workforce in Zanzibar faces several constraints including inequitable distribution of staff between rural and urban areas, lack of incentives either for special responsibilities or rural residence, inadequate training to perform managerial and administrative functions, and lack of a performance appraisal scheme. Further, whereas the Ministry of Education is responsible for pre-service training, there is lack of harmonization between the priority needs of the Health sector human resources with what is offered in pre-service

institutions[14]. As such, graduating clinical staff have limited skills in FP service delivery, and often need in-service training before they start providing FP services.

Other issues related to quality provision include inadequacy of the physical infrastructure of facilities jeopardizing privacy and confidentiality, including inadequate equipment and supplies, low adherence to infection prevention and control procedures, and low education provided to clients. More than half of facilities surveyed during the 2014/15 Service Provision Assessment were not able to meet counselling conditions for privacy and confidentiality[17]. A Quality Improvement Recognition Initiative (QIRI) has been scaled to all districts, and in 2010 a Standard Based Management and Recognition (SMBR) approach was also introduced. However, both initiatives suffer from lack of sustained funding.

Community-Based Distribution: As a source of modern contraceptives, community-based distribution has seen a gradual decline across Tanzania over the past 17 years — from 2.5 percent of women citing CBD agents as their source of supply in 1999 to 0.2 percent citing the same in 2016[8]. 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. According to the 2016 DHS, only 1.9 percent of women who were not using contraception reported to have been visited by a community health worker (CHW) in the past 12 months[8]. As in the mainland, CBD agents in Zanzibar are volunteers who mainly advocate and distribute short-acting methods, i.e. pills and condoms. Besides inadequate funding to scale and sustain CBD services, in areas where CBDs are engaged, they appear to be poorly motivated and underutilized in day-to-day duties[14].

Youth Services: As an island of young people, Zanzibar puts a high precedence on ensuring adolescents have the right to access information, life skills, and services regarding Sexual and Reproductive Health (SRH), including family planning. The ZHSRSP II recognizes the need to promote adolescent SRH through improving knowledge and access to youth-friendly facilities and services[16].

Teenage childbearing rates, albeit high, have been consistently lower than those at the national level, as well as the mainland — this is perhaps because of the protective benefits of keeping girls longer in school and religious and cultural customs. For adolescents and young people who are sexually active and need to be protected from an unwanted pregnancy, access to contraceptive information and services remains a problem. The key problems cited by youth include stigma around using FP as an unmarried person, myths around contraceptive use, user fees (in the private sector), provider attitudes, and inadequate credible information sources (girls received information on FP from their friends and other family members, particularly mothers and sisters, rather than from service providers)[18]. Improving access to information often requires a multi-sectoral effort, however there are challenges harmonizing policies between, for example the Ministry of Education and Ministry of Health on the scope of SRH information and services to be provided to primary and secondary school students.

Outreach: Outreach efforts conducted as part of implementing partner activities on a quarterly basis in the selected districts with low coverage of FP services, have shown to accelerate uptake of modern contraceptives. However, the scale of outreach efforts is small, and currently no district has reached a coverage of 20%. Further, since occurrence of outreach efforts is project-based, there are issues of sustainability around the intervention.

Private Sector: Health Sector Reforms acknowledge the role and value of the private sector, and partnerships with the public sector. Institutional efforts to forge partnership between the two sectors have been realized to a limited extent. For example, since 1994, the Ministry allowed the provision of health care services, including family planning, by private facilities and pharmacies. Private hospitals and pharmacies are regulated by the Ministry through its semi-autonomous Zanzibar Pharmaceutical Association (ZPHA) and Zanzibar Food and Drug Board (ZFDB), respectively, to ensure quality and compliance of policies, guidelines and standard operating procedures.

Several challenges exist about family planning provision through the private sector. Whereas all facilities, including the private sector, are mandated to report on services rendered through the Health Management Information System (HMIS), reporting by private health facilities is the weakest. This could also be due to lack of training opportunities and supervision support, which the private sector receives less of than the public sector. Private sector providers have difficulties accessing continuing professional development opportunities like in-service trainings. Even when they can do so, the opportunity costs (monetary and time) of attending such lengthy trainings prevent many private providers from participating. Private provider skills are therefore not always up-to-date, limiting their ability to effectively participate in quality service delivery.

Other policy factors act as a disincentive to the provision of FP services by the private sector, for instance, some facilities that have special arrangements with the MOHSW for commodity supply, are required to offer commodities for free, and only charge a small fee for the service[19]. In such an arrangement, private facilities have found it difficult to recover associated costs, like staff and facility overhead costs. Another disincentive has been the lack of coverage of FP services in insurance schemes; however, things are changing. In 2016, AAR Health Care Tanzania because the first insurance scheme approving coverage for family planning services worth up to 300,000 Tanzanian shillings (approximately US $138) annually for clients renewing their plan after May 2016[20]. It is expected that other private health insurance schemes will follow suit, further incentivizing private health facilities to provide this service.

COMMODITY SECURITY

Provision of quality, accessible and affordable FP services depends on the consistent availability of commodities at various levels, from the national level to the health facility. Commodity security requires among other things, sufficient and sustainable financing, strong supply chains system, supportive policies and regulations, and active coordination among partners.

Despite several initiatives by the RGOZ to address commodity security at various levels of the health system, there are still many problems that challenge progress of the program. Frequent stock-out of some contraceptive commodities, especially long acting methods, at the facility level is a key problem[21]. The Service Provision Assessment survey conducted in 2014/2015, showed that only 45 percent of facilities visited in Zanzibar were observed to have every modern method provided by that facility available on the day of survey[17]. The issue of stock-outs was also reported by health providers in a 2016 exploratory study, more frequently affecting Pemba than Unguja[22].

Contraceptive financing and procurement process: FP commodities are included in the government list of essential medicines. However, due to insufficient funds from the government, procurement of FP commodities is currently entirely dependent on development partners' support. Commodities are normally procured by partners by the request of the MOHSW. Currently, all financing for contraceptives come from two major external sources, mainly UNFPA and USAID. The government is committed to use its own funds to procure commodities, as demonstrated by recent development of policy documents and guidelines for resource mobilization.

Logistics and supplies of FP commodities: The Central Medical Stores (CMS) is responsible for distribution of all FP commodities to the facility level based on submitted requisition orders. However, facilities have continued to experience stock-out of some contraceptive methods due to challenges encountered in the requisition and commodity delivery process. The MOHSW has implemented an electronic Logistic Management System (elms) since 2015 to track stock status and commodity logistic data from the facility to the central level. The system is designed to be transparent and can be accessible by all FP service providers. Despite these efforts, scale-up of the elms is still limited to managers at district and zonal levels, Cheechako health facilities and cottage hospitals.

Quality of data remains a challenge especially at primary health facility level where tools (store ledger and daily dispensing register) for recording logistic data are paper-based. Data submitted are of mediocre quality leading to frequent rejections from the Logistic Management Unit (LMU), causing the reports to be sent back to district level electronically for correction. The iterative corrective process causes delays in the entire process of distribution of FP commodities to facility levels. The inaccurate commodity requisition data from the facility level also contributed to the inadequate/shortage of commodities distributed to the facility from CMS. In addition, since 2012, the MOHSW shifted its policy on the modality of procurement and distribution of health commodities from a push to a pull system, The Zanzibar Integrated Logistic System (ZILS). With this system, some improvements have been noticed, particularly when there is adequate stock at CMS, however stock-out problems continue to be experienced when there are commodity shortages at the CMS.

Supportive supervision at various levels is critical to addressing stock-outs and redistribution issues. Routine monitoring is conducted monthly by District Pharmacist (DP) who is responsible for making supervision and redistribution in the district. However, inadequate resources for effective supervision interfere with the normal process, and hence supervisory visits are not conducted as per schedule.

Contraceptive quantification: John Snow Inc (JSI) has provided technical support to the LMU, a unit under the Chief Pharmacist Office (CPO) responsible for quantification of Life Saving Commodities, including Family Planning. Experience has shown that, data from health facilities are inaccurate hence impede proper quantification process. This has contributed to acute shortages of commodities at facility level. Per the landscape assessment of contraceptive commodity stock status conducted by Africa Women Leaders Network (AWLN) Zanzibar in 2014, frequent stock-outs of contraceptives have been cited as greatly limiting women's access to needed family planning commodities [23]. The survey confirmed a shortage of supplies at facilities while there was two years' worth of supplies in the CMS warehouse. The survey revealed that challenges originated at facility level when forecasting and ordering the supplies starts. This was caused by inadequate skills of health facility staff to accurately fill out the report and requisition (R&R) forms.

All health facilities that provide FP services are required to have LARC and short acting contraceptives, provided they have skilled providers and meet FP service delivery standards. Short-acting methods are available in almost all health facilities (96 percent) compared to other methods[24]. Variation has been observed in the availability of long acting methods particularly IUCD in some health facilities as result of lack of skills to majority of health service providers in providing this method to clients. This has affected the ability of health facilities to provide a wide choice of FP commodities to clients.

Quality assurance for contraceptive commodities: The Zanzibar Food and Drug Board (ZFDB) is responsible body for inspecting all health commodities before entering to the CMS, however FP commodities are not regularly inspected as per regulation, unless initiated by CMS. The ZFDB lacks adequate capacity to conduct regular inspections for FP commodities.

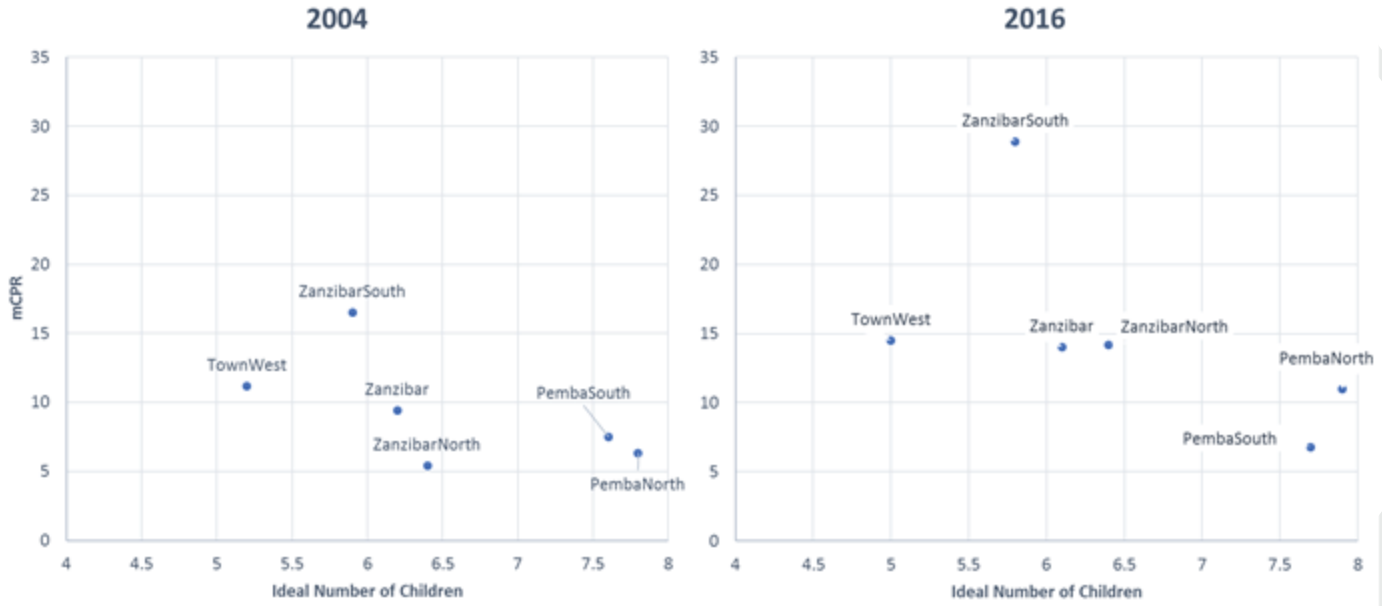
DEMAND CREATION

Generating demand for modern contraceptives is a fundamental function of an effective FP program, and necessary to impart knowledge to facilitate decision-making, and promote acceptance to initiate and sustain use. Despite various efforts by the government and stakeholders to implement demand generation efforts, demand for FP has only slightly increased over the years. The situation in Zanzibar is such that people report wanting less children than they currently have (i.e. wanted fertility rates are less than actual fertility rates), but are not demanding to use modern contraceptives to help protect them from an unintended pregnancy.

Although childbearing preferences vary considerably between regions, they have not changed much over time. When comparing the relationship between the mean ideal number of children and modern contraceptive use in the past 10 years, i.e. 2004 and 2015/6 across regions, most regions have

experienced increased contraceptive use but not an equivalent decrease the ideal number of children, Figure 10. Within a 10-year period, Urban West is the only region that appears to have made a slight left diagonal shift towards a desire of less children with increased contraceptive use; Pemba North appears to have made a right diagonal shift towards a desire for more children despite an almost doubling of modern contraceptive use[8,12], Figure 10. This indicates that the demand for having less children in most regions, which would in turn contribute towards the country's goals of a lower population growth rate, has not experienced a sizable increase despite increase in modern contraceptive use.

Figure 10: mCPR and ideal number of children, 2004 and 2016



Awareness of contraceptive methods is almost universal among currently married women for all methods, except for male sterilization (46.9 percent), lactational amenorrhea method (37.8 percent), emergency contraceptives (20.7 percent), and Standard Days Method (11.5 percent)[8]. The low awareness of emergency contraceptives could be related to the fact that the method was only registered and approved for public use in the past four years. Engenderhealth in collaboration with the Integrated Reproductive and Child Health Programme (IRCHP) initiated an awareness programme at community level in 2009 to increase coverage of clients with permanent methods. Such efforts have not produced acceptable results in uptake.

Women tend to be less exposed to family planning messages through the media than men — 53.3 percent of women, compared with 39.1 percent of men, have not heard/saw a FP message on radio, television, newspaper or mobile phone. Accordingly, there is notable variation in FP message exposure across regions, ranging from 42 percent in Urban West to 75.4 percent in Pemba North/73.3 percent in Pemba South[8].

Some cultural norms and religious beliefs exert a negative force in demand generation efforts. Male dominate decision-making, including on contraceptive use; given their low involvement in reproductive health matters, it makes it difficult for the program to reach them with information[14]. The MOH, therefore, recruited and trained male CBDs to educate communities and increase male involvement in FP and RH matters. Another challenge is that contraceptives are viewed as unacceptable by practicing Muslims who comprise 95 percent of the population. Efforts made to work with religious leaders to find

clarity on the Qur'an passages found that FP use is acceptable in certain conditions, such as marriage. In 2011, a book, namely Uislamu na Uzazi wa Mpangilio, which means "Islam and Family Pla nning" was developed as a guide tailored towards equipping Muslim Religious Leaders (MRLs) with necessary information and skills to better understand, accept, and support the provision of family planning information and services. The book helped to clarify prevailing misconceptions on what Islam teaches about family planning. Like mainland Tanzania, myths and misconceptions around modern methods of FP also prevail. A 2017 study that explored factors affecting utilization of FP services in Zanzibar showed that myths and misconceptions surround lack of FP use[22].

ENABLING ENVIRONMENT

An enabling environment — a range of interlinked policy, governance, sociocultural, and economic factors — forms the basis of a highly functioning and sustainable family planning programme. Gains from investments in supply and demand elements of a program can be faltered by lack of a conducive environment at all levels, including from the health system to the community level. Repositioning family planning efforts to bring the program back on track in the past 10 years (that is, after progress had stalled in the 1990s) are indicative of an increasingly conducive environment of the Zanzibar Family Planning program; however, these efforts need to be sustained and enhanced to propel the program further forward to achieve its goal.

Political Will & Commitment: The government's political will in support of family planning manifests itself in the reflection of FP in national development agendas. FP is featured in MKUZA II & III, Vision 2020, health policy and in other strategic documents. For example, the MKUZA III called adequate access to and promotion of family planning services as being essential for a long-term demographic transition towards more balanced and sustainable population growth[2]. Specifically, the MKUZA III intends to: (i) encourage good practices and healthy lifestyles through community health volunteers in health, nutrition, WASH, sexual and reproductive health (SRH), family planning and positive parenting; and (ii) support access to and distribution of Reproductive Health and Family Planning facilities. Furthermore, there are an annual national and International events/commemorations that call for government to align and ratify international instruments related to RH/FP, putting FP central agenda at all levels.

Financing and Resource Mobilization: The government has a budget line item for essential medicines, of which FP commodities are included. However, due to competing priorities, funds have not been specifically allocated to FP commodities. As such, development partners support procurement of FP commodities. In circumstances where there is a large gap realized, the governments releases funds to procure FP commodities. The government also funds operating costs of the FP service delivery platform, particularly facility based services and depends on development partners to support FP program interventions, such as provider training and demand generation.

Through the Health Sector Strategic Plan, the government has developed policy documents and guidelines for resource mobilization with the partners[25]. Partners are also encouraged to use a newly developed internet-based resource tracking tool (which is) to plan and report on activities in a coordinated fashion, facilitating the efficient compilation of the annual MTEF[25]. Development partners are, however, not well coordinated and integrated into the MOH planning system, partly due to the lack of a sector budget support mechanism, as well as the existence of mismatched financial years across the MOHSW and partners which has introduced inefficiencies[25]. Lack of consistency and sustainable funding for supporting Family Planning program continues to be a critical challenge in achieving the set FP targets for increasing the contraceptive prevalence rate.[14]

Legal and Policy Environment: The presence or absence of certain national laws and policies, together with their implementation, affect a supportive environment. The GOT, and the RGOZ, continue to refine the country's regulatory environment to support a conducive policy environment for family planning.

For example, in July 2016, the high court ruled the 1971 Marriage Act that allows girls to marry at 15 with parental consent and 14 with the permission of a court, as unconstitutional. The age of marriage was elevated to 18 years. This change is intended to reduce adolescent pregnancy, delay sexual debut, and improve maternal and child health (MCH) outcomes for young women. Further, the government has embraced the concept of task sharing; however, even in the presence of global evidence to support safe provision of certain clinical contraceptive methods by lower-level providers, (for example injectables by community health workers and sterilization by clinical officers) the government remains concerned about the safety of clients, due to weak existing supervision system, facilities and equipment. Hence, enacting such task sharing policies, with potential to considerably increase access to contraceptives, will remain dormant until safety considerations are effectively addressed.

Other challenges relate to implementation of existing policies, which depend on in-country capacity and structures; but are also influenced by the availability of resources, leadership, skilled staff, and relationships that link them to programmatic action. For example, the National Family Planning Guidelines and Standards, 2013, recognizes that all males and females, including young people (10 – 24 years of age) irrespective of their parity and marital status are eligible to access accurate and complete family planning information, education and services. However, there are challenges in implementing this policy in practice. One of which relates to the lack of harmonization of policies between, for example the Ministry of Education and Ministry of Health on the scope of SRH information and services to be provided to primary and secondary school students.

The program is having a suitable number of partners whom they share the same interests towards Maternal Reproductive and child health. The coordination of these partnerships is carried out through integration meetings conducted semi-annually by the technical working group and through annual program review meetings[14]. These platforms are avenues of assessing levels of resources required and means for mobilizing funds.

Institutional capacity to manage FP program: The FP unit within the MOH is tasked to coordinate the national FP program, however it faces several capacity challenges including inadequate staff, and insufficient skills related to logistic management, and monitoring and evaluation. The government lacks sufficient funds to provide mentorship and support to managerial level staff at regional, district, and central levels on FP matters.

Coordination and harmonization: At the central level, the MOH has introduced an annual joint review whereby all MOH stakeholders meet and discuss various issues implemented for the previous year as well as plans for the coming year.

There is also a Reproductive, Maternal, Neonatal, Child & Adolescent Health (RMNCAH) Technical Working Group which acts as a coordination platform to discuss all issues pertaining to reproductive and child health functions. The group is placed at the national level, and engages all interested partners, senior leaders and members from the programs present RCH issues, especially those that need higher level decisions. Since the group covers many areas, there is a recommendation to establish a coordinating body dedicated to FP matters under the auspices of the RMNCAH TWG.

Mandated by the MOH, the District Health Management Teams (DHMTs) under the supervision of Zonal Health Management teams (ZHMTs) have authority to play a leadership role to coordinate FP services at the district level. The DHMTs work in collaboration with different programs and partners in the district. The management team develops joint Annual Comprehensive District Health Plans in close collaboration with all stakeholders working in health. The Basket Fund, established in 2008, at district level is meant to help to harmonize interventions at community and district level and minimize duplication of efforts[25]. Low budgeting for FP interventions because of low prioritization of FP services within Comprehensive Districts Health Plans continues to be a big challenge to elevate Family Planning

interventions at the district levels[14]. For example, due to limited financial resources, supportive supervisions are not carried out as planned schedule to various service delivery points in the district[14].

Routine Monitoring of FP Program: Since 2004, the MOH has moved from vertical-specific disease or program HMIS to an integrated Health Management Information System (HMIS). It has also introduced DHIS-2 — a web based tool for routine health data collection from all public and private health facilities. Despite advancements in the tools, the existing inadequate capacity for data reporting and analysis, and lack of motivation, continue to hamper effective data utilization for decision-making at various levels.[26,27]

SUMMARY OF KEY STRATEGIC ISSUES

SERVICE DELIVERY
1. Low coverage of facilities providing family planning services in the Urban West region 2. Missed opportunities to provide FP services to women visiting facilities, due to inadequate integration of FP services into other health services within a facility. 3. Inadequate number of staff trained in FP services, especially in Urban West and Zanzibar South, and on long-acting and permanent contraceptive methods. 4. Underutilization of IUCD. 5. Sub-optimal instructional content on FP in pre-service curriculums and lesson plans. 6. Few health facilities meet infrastructure, essential equipment and infection prevention control standards for FP service delivery. 7. Weak CBD system, plagued with problems of scale and sustainability. 8. Inadequate youth-friendly providers limiting access to services for youth and adolescents. 9. Limited participation of private sector facilities in FP service provision, due to operational and policy issues.
CONTRACEPTIVE SECURITY
1. Limited government-own financing for contraceptive commodities, essential equipment, and reliance on external donors for commodity financing. 2. General inefficiencies in the supply chain system. 3. Poor quantification process due to inaccurate requisition/consumption data from facilities. 4. Inadequate facilities/equipment to support eLMIS. 5. Limited skills to use the eLMIS across all levels of the health system. 6. Limited routine supervision to ensure commodity security at various levels. 7. Weak approach or mechanism for quality assurance checks.
DEMAND GENERATION
1. Low, and stagnant, demand for contraceptive methods, despite desire to have fewer children than they currently have. 2. Desire to have fewer children has not increased over time. 3. Limited access to information through mass media channels, especially for women. 4. Religious and cultural norms serve as a protective effect to preventing teenage pregnancies, but also exert a negative effect on adoption of modern contraceptives. 5. Prevailing myths and misconceptions on modern FP in the community. 6. Limited scale and consistency of social and behaviour change interventions at various levels. 7. Lack of information, education, communication (IEC) materials in health facilities and community. 8. Provider bias, leading to barriers to information and poor client-provider interactions, especially among adolescents and young unmarried women.
ENABLING ENVIRONMENT
1. Low level of Coordination among stakeholders 2. Low prioritization of FP services within Comprehensive Districts Health Plans 3. Limited supportive supervision for FP services at the district levels 4. Lack of consistency and sustainable funding for supporting Family Planning program 5. Lack of well-defined strategy or mechanism agreed for both parties to manage public -private partnership in FP service provision 6. Inadequate collaboration and integration of Family Planning activities and interventions 7. Low prioritization of family planning in the national health agenda

8. inadequate capacity for data reporting and analysis
9. Poor feedback mechanism, lack of motivation/incentive to report
10. Limited information use from HMIS.
11. Inadequate functioning Monitoring and Evaluation system to support Family Planning

RESULTS FRAMEWORK

The RGOZ aims to reach an mCPR of 20 percent among married women by 2022. The ZFPCIP provides a common roadmap to all stakeholders for the implementation of interventions to advance family planning uptake among all women and men who need or desire to plan childbearing.

Achieving the FP goal contributes to the government's socio -economic development goal to eradicate abject poverty and attain sustainable human development by year 2020[2]. It also contributes to Improved Access to Quality Health and Sanitation Services, Safe and Clean Water, and a Mitigated Disease Burden under Key Results Area C: Providing Quality Services for All of the MKUZA III[2]. Further, the ZFPCIP reflects actions to facilitate implementation of international commitments related to family planning, including commitments made for FP2020; Every Woman, Every Child, Every Adolescent; and SDGs.

Vision

Zanzibar women and men are able to attain their desired number and spacing of their children.

Mission

To support women and men of Zanzibar to choose, obtain, and use quality contraceptives whenever they need them in an equitable and sustainable manner.

Goal

To increase the mCPR among married women from 14 percent in 2016 to 20 percent by 2022.

STRATEGY AREAS

Achievement of the goal will be carried out through effective and efficient implementation of interventions under four strategy areas, outlined in the ZFPCIP Results Framework (Figure 11), with key outcomes, as follows:

Strategy Area I: Service Delivery

Outcome 1: Improved availability of and access to quality family planning services across all types of service delivery points (including facility-and community-based).

Strategy Area II: Contraceptive Security

Outcome 2. Adequate amounts of a broad range of contraceptives methods are consistently available at service delivery points.

Strategy III: Demand Creation

Outcome 3: Total demand for family planning increases to promote new and continued use of modern contraceptives.

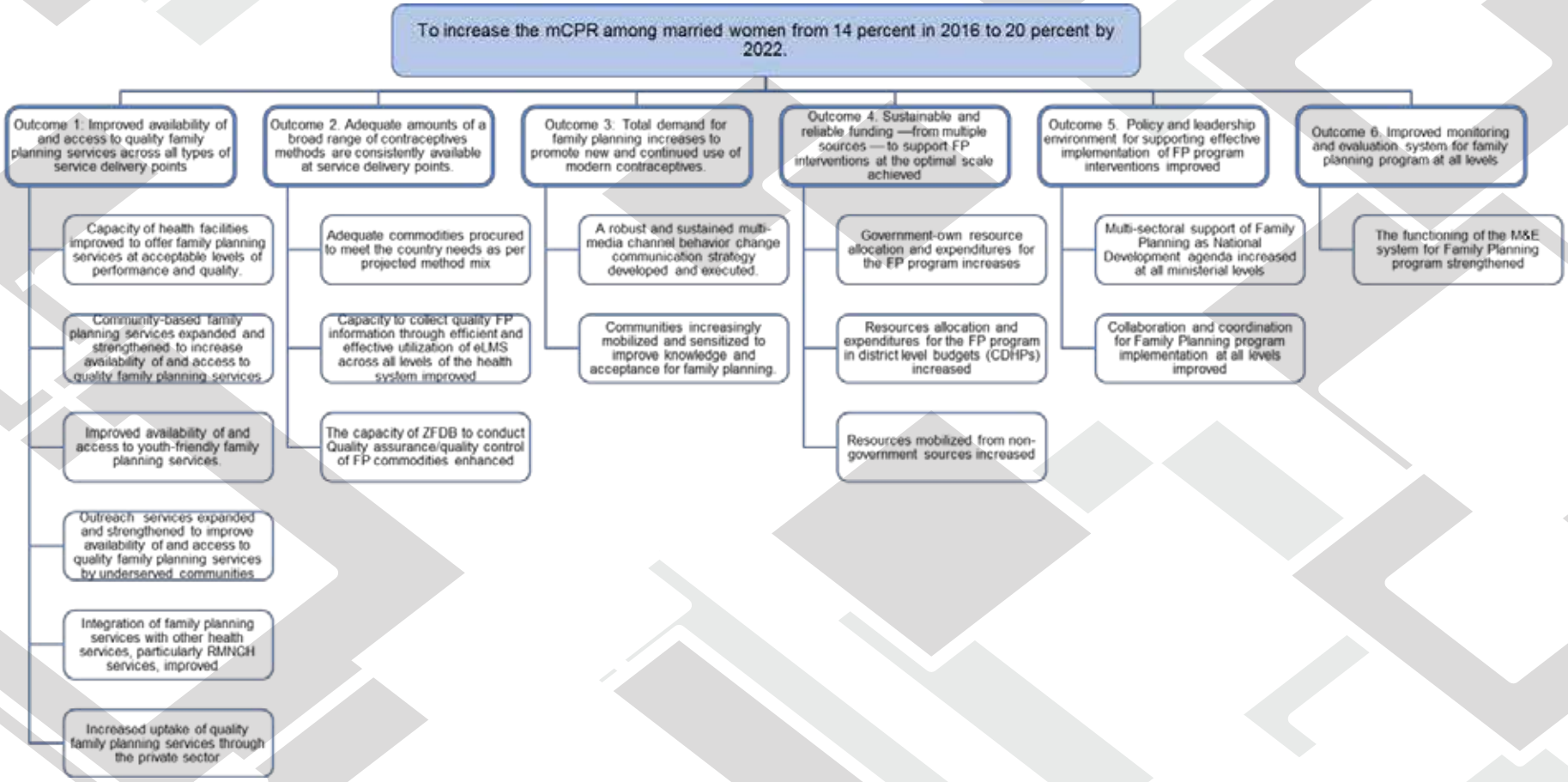
Strategy IV: Enabling Environment

Outcome 4: Sustainable and reliable funding from multiple sources to support FP interventions at the optimal scale achieved

Outcome 5: Policy and leadership environment for supporting effective implementation of FP program interventions improved

Outcome 6: Improved monitoring and evaluation system for family planning program at all levels

Figure 11: Results Framework

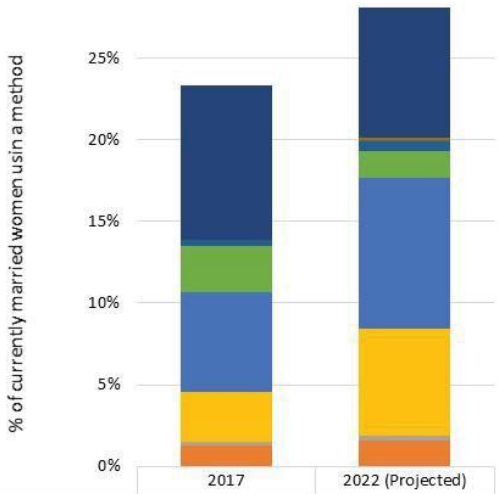


DEMOGRAPHIC AND COMMODITY PROJECTIONS

This plan, and associated performance targets and cost estimates, takes into consideration a forecast of the number of users to be served by the program, associated contraceptive commodity requirements, and method mix shifts over a five-year period.

The desired increase in mCPR among married women of reproductive age (MWRA) from 14 percent to 20 percent by 2022, will require an average growth rate in mCPR of 1.2 percentage points per annum. In 2022, the most popular modern method will continue to be injectables, followed by implants. Method mix projections for currently married women are estimated to enable projection estimations of commodity requirement needs. Figure 12 provides the projected current and projected method mix in 2022. The projected method mix is estimated based on: (1) historical trends over the past ten years, from 2004/5 to 2015/6, and (2) current requirements for a growth multiplier of the mCPR among currently married women. Implants and injectables are projected to considerably increase to 6.5 percent and 9.3 percent, respectively. Oral contraceptives will decline in use to 1.6%, as users shift to long-acting methods. IUD historically low trends of uptake are projected to continue, and hence uptake will only slightly increase to 0.3%. As users increasingly adopt modern methods, traditional methods are projected to also slightly decline to 8.4%

Figure 12: Current and projected method mix



	2017	2022 (Projected)
Traditional Methods	9.4%	8.0%
Lactational amenorrhea	0.0%	0.1%
Standard Days Method	0.0%	0.1%
Female condoms	0.0%	0.0%
Male condoms	0.4%	0.6%
Pills	2.8%	1.6%
Injectables	6.1%	9.3%
Implants	3.1%	6.5%
IUDs	0.2%	0.3%
Female sterilisations	1.3%	1.6%
Male sterilisations	0.0%	0.0%

Note: Estimates for method mix at baseline for all women have been generated using DHS 2015 data and Census WRA population estimates. The current method mix profile (2017) is assumed to be the same as 2015/2016 as provided by the Tanzania Demographic Health Survey.

Based on the above projected method mix, an average of 41,000 and 30,600 married and unmarried women of reproductive age, respectively, will need to be served with modern family planning services on annual basis in the next five years to meet the mCPR goal. The projected number of contraceptive commodities to be procured per method per year is showed in Table 3.The projected number of women per year is showed in Table 4 and Table 5.

Table 3: Projected Annual Commodity Requirements

Commodity	FY2018	FY 2019	FY 2020	FY 2021	FY 2022
Pills	166,441	155,061	142,912	129,962	116,175
Male condoms	215,653	241,845	269,335	298,174	328,418
Injectables	134,833	151,770	169,550	188,206	207,775
Implants	9,731	11,191	12,725	14,337	16,029
IUDs	366	402	439	478	519

Table 4: Projected number of currently married women users by method, 2018 to 2022

Method	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Male sterilisations	0	0	0	0	0
Female sterilisations	3,118	3,347	3,586	3,835	4,097
IUDs	504	566	630	697	768
Implants	8,666	10,511	12,453	14,495	16,642
Injectables	15,452	17,393	19,430	21,568	23,811
Pills	5,869	5,468	5,039	4,583	4,097
Male condoms	1,009	1,131	1,260	1,395	1,536
Standard Days Method	229	236	242	249	256
Lactational amenorrhea	46	94	145	199	256
Total Number of Users (Currently Married Women)	34,893	38,745	42,786	47,022	51,462

Table 5: Projected number of women of reproductive age (married and unmarried), 2018 to 2022

Method	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Male sterilizations	0	0	0	0	0
Female sterilizations	5,441	5,840	6,258	6,694	7,149
IUDs	880	987	1,099	1,217	1,340
Implants	15,124	18,344	21,733	25,297	29,044
Injectables	26,967	30,354	33,910	37,641	41,555
Pills	10,243	9,542	8,795	7,998	7,149
Male condoms	1,760	1,974	2,199	2,434	2,681
Standard Days Method	400	411	423	435	447
Lactational amenorrhea	80	165	254	348	447
Total Number of Users (married and unmarried Women)	60,895	67,618	74,670	82,063	89,812

STRATEGY AREA I: SERVICE DELIVERY

The Zanzibar FP Program is currently serving an estimated 51,560 women of reproductive age with modern contraceptive methods†. To achieve the goal of this plan, the service delivery platform must be capable to reach and serve an increasing number of users over the five-year period, representing a median estimate of 71,144 (married and unmarried) users per year.

Given the strategic issues identified, interventions will focus on increasing coverage of quality FP services across all service delivery channels, including at facility and community-based. Coverage will also be increased: (i) within existing facilities through service integration to not miss opportunities of engaging potential users who visit facilities for other services; (ii) to underserved areas through mobile outreach activities; and (iii) across private sector providers. Given that a considerable proportion of the WRA population are 15-24 year-old youth (42%), it will be imperative to boost services geared to reaching and serving this growing segment of the population.

Concerted efforts under this strategy area will contribute to improved availability of and access to quality family planning services across all types of service delivery points (including facility-and community-based). A summary of key outputs contributing to this outcome are summarized in Table 6. The total estimated cost for service delivery during the five-year period is TZS 28,634,133,907.

Table 6: Service Delivery Results and Performance Targets

Outcome 1: Improved availability of and access to quality family planning services across all types of service delivery points (including facility-and community-based).		
Outcome Performance Targets by 2022: • An estimated 71,144 WRA are provided with family planning services on an annual basis. • Of all women of reproductive age using modern contraceptives: ○ 6.5% are using implants ○ 0.3% are using IUCDs ○ 1.6% are using female sterilisation ○ 9.3% are using injectables ○ 1.6% are using oral contraceptives • Unmet need among currently married women is reduced from 28% to 22% • Teenage pregnancy rates, measured as the proportion of all women aged 15–19 years who have had a live birth or who are currently pregnant, are reduced from 8.2% to 6% • % of demand for satisfied by modern methods among all women is increased from 28.8% (2015) to 29.5%. • Regional disparities in demand satisfied increasingly decline.		
Outputs	Performance Targets	Cost (TZS)
1.1. Capacity of health facilities improved to offer family planning services at acceptable levels of performance and quality, as	• At least 2 providers per facility (~172 facilities) trained in clinical provision of family planning every 3 years. • 20 trainers recruited and trained to become family planning trainers • Component of FP clinical skills in pre-service curriculum of the College of Health Sciences reviewed and updated	8,393,658,273

† *Based on extrapolation of 2012 population projections, WRA in 2016 = 368,288. Assuming a mCPR of 14%, the number of users = 51,560.*

stipulated in the National Family Planning Guidelines and Standards, and the National FP Procedures Manual.	• 172 health facilities are refurbished to enable provision of quality FP services, as stipulated in the National FP Procedure Manual and the National Family Planning Guidelines and Standards. • 153 health facilities are equipped with essential equipment and supplies to enable provision of quality FP services, as stipulated by the National Family Planning Guidelines and Standards. • 80% of the Reproductive and Child health service staff required for the provision of FP services recruited and trained. Staff redistributed across facilities to meet guidelines stipulated in the Essential Health Care Package (2007), and reduce disparities in staff availability • The proportion of health facilities providing modern contraceptive methods in Urban West increases from 34% to over 50% 44 supportive supervisory visits conducted each year across both public and private facilities. One supervisory visit per district conducted (11 districts = 44 visits)	
1.2. Community-based family planning services expanded and strengthened to increase availability of and access to quality family planning services	• Percentage of women who are visited by a fieldworker who discusses family planning increases from 1.9% (2016) to 2.2% (2022) • Community Health Volunteers in all 11 districts (2,043) receive training updates on comprehensive Reproductive MNCAH including FP	10,681,283,200
1.3. Improved availability of and access to youth-friendly family planning services.	• Youth-friendly health services mainstreamed to all health facilities offering FP as defined by ASRH standards; (facilities ensure enforcement of quality standards of care for adolescents for all health care workers by employing a whole of clinic approach, and provider training to reduce bias) • Coverage of health providers trained on youth-friendly health services increases from 26%[22] (2017) to 42%.	626,775,800
1.4. Outreach services expanded and strengthened to improve availability of and	• Outreach services are conducted in all districts— at least once outreach session per quarter.	7,802,794,800

access to quality family planning services by underserved communities		
1.5. Integration of family planning services with other health services, particularly RMNCAH services, improved	• At least 20% of women of reproductive age not using contraceptives, and visited a health facility 12 month prior to the survey report to have discussed family planning with a provider. • RMNCAH service delivery guidelines, training curriculum, and job aids, reviewed and updated to include postpartum FP. • 80% of RMNCAH service providers orientated on guidelines for integrating FP into services delivery by 2019 • At least 2 providers per 50 facilities offered PPIUCD training. • At least 2 providers per 50 facilities offered comprehensive post-abortion care (PAC) training.	465,550,008
1.6. Increased uptake of quality family planning services through the private sector	• Providers in at least 10 private facilities provide family planning services	234,388,560

1.1. Capacity of health facilities improved to offer family planning services at acceptable levels of performance and quality.

The primary aim is to increase the number, and equitable distribution, of health facilities that offer quality family planning services across both the public and private sectors, in accordance with the National Family Planning Guidelines and Standards, and the National FP Procedures Manual. Existing health facilities will be refurbished and equipped with essential equipment and supplies; and efforts will be made to facilitate equitable distribution of health staff to reduce disparities in staff availability. Given the low coverage of FP providing facilities in the most populous and fasted growing region (i.e. Urban West), the plan calls for a concerted effort to map priority sub-regional areas and facilities, and undertake necessary upgrades to enable quality FP service delivery.

Advancing the number and skills of health staff will be an essential component of capacity development, and as such in-service providers, who have never received FP training, will receive comprehensive family planning training; and existing FP providers will receive refresher trainings as per required national standards (i.e. at least once every two years). The pool of trainers from both public and private sectors will also be expanded to meet the heightened need for provider trainings, and existing trainers will receive refresher trainings. Based on current trends, it is anticipated that there will be an increasing demand for clinical contraceptive methods, including injectables and LARCs; as such a requisite number of trainings will focus on upgrading skills of existing in-service providers to offer these methods. Further, the pre-service curriculum of the College of Health Sciences, as well as those

from other private training institutions, will be strengthened to ensure that the new health workforce is competent to offer quality family planning services upon graduation, and a healthy pipeline of staff is established over time. Pre-service tutors will be kept up to date with developments in family planning service provision by offering continuing education seminars.

Regular and consistent on-site mentoring and supervision of trained providers will also be conducted to support quality provision, as part of continued quality improvement efforts. Other facility-based interventions are described under items 1.3, 1.5, and 1.6 below.

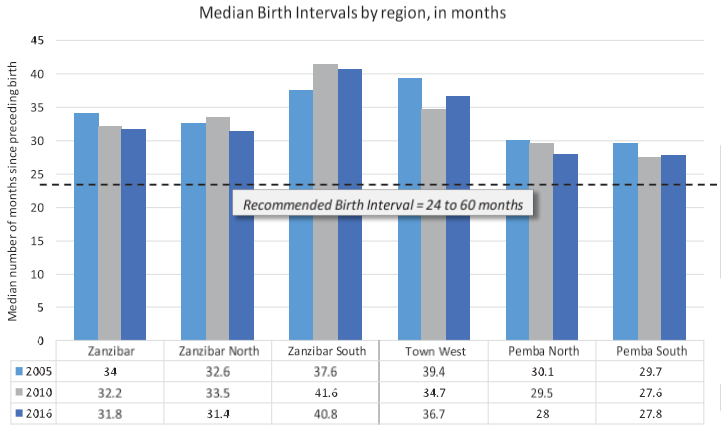
1.2. Community-based family planning services expanded and strengthened to increase availability of and access to quality family planning services

Community-based family planning services will extend the reach of facility-based services by (i) educating, mobilizing, and referring potential users to the facility; and (ii) provide non-clinical methods, including oral contraceptives, condoms, and the standard days method (using beads). Under this plan, community-based family planning services, provided by community health volunteers, will be extended to all 11 districts. The focus will be to equip them with knowledge, skills, and support to offer FP information and services as part of integrated community-level reproductive, maternal, newborn, and child health (RMNACH) activities.

1.3. Improved availability of and access to youth-friendly family planning services

As youth represent a considerable proportion of the WRA population segment, efforts to remove barriers to access to contraceptive services and improve birth spacing will be key. Since the youth population is heterogenous, with diverse needs requiring varied programming approaches, the program will focus on the following sub-segments: (i) first-time mothers, who can be reached through a strengthened post-partum FP approach; and (ii) rural-based sexually active, unmarried youth (including adolescents aged 15–19 and youth aged 20-24). Prioritization of these segments is informed by the observed regional disparities in teenage pregnancy — all regions, except Urban West, which is mostly urbanized, have teenage pregnancy rates higher than the national average (Figure 3). Furthermore, although the median birth-interval in Zanzibar is within the recommended range of 24 to 60 months, DHS data over the past 10 years show a declining trend in all regions, except for Zanzibar South (Figure 13)[8,11,12]. Since youth also tend to have the lowest median birth interval, reaching young first-time mothers will help to improve birth spacing.

Figure 13: Median Birth Intervals by Region, in Months



Interventions to bolster youth-friendliness of service delivery points will focus on:

Reducing provider biases and concerns in the provision of contraception to both married and unmarried adolescents by supporting implementation of quality standards of adolescent friendly services. Efforts will ensure that pre- and in-service FP training incorporate quality standards of care for adolescents for all health care workers.

Encourage early uptake of contraceptives, especially among young first-time mothers, by strengthening provision of youth-friendly postpartum family planning, ANC and MCH services, as well as post abortion care. This will involve mainstreaming youth-friendly approaches in job aids, standard operating procedures, and training modules.

1.4. Outreach services expanded and strengthened to improve availability of and access to quality family planning services, particularly LARCs, by underserved communities

Regular outreach activities will be carried out to reach people who are in areas with limited access to LARCs, primarily due to lack of qualified providers and equipped facilities, particularly in the seven districts with a high proportion of rural populations. Team(s) of trained providers from district hospitals will travel to lower level facilities (health centres and dispensaries) at ward level once every quarter to provide LARCs, and permanent methods, where appropriate.

1.5. Integration of family planning services with other health services, particularly RMNCAH services, improved

The RMNCAH platform (which includes ANC, PNC, PAC, newborn, child, and adolescent) provides ample opportunities to provide family planning throughout the continuum of care. To not miss opportunities to engage potential users who visit facilities for other services, providers of ANC, PNC, PAC, newborn and child health services will be trained to provide information and education on FP, with referral, at a minimum; and where appropriate provide FP methods. The existing RMNCAH service delivery guidelines, training curriculum and job aids will be reviewed and updated to include FP components. A technical working group, involving experts from both RMNCAH and FP, will also be formed to steer forward the revision process.

1.6. Increased uptake of quality family planning services through the private sector

The role of the private sector as a FP service provider is crucial to complement public sector delivery, and thus will be enhanced, taking into consideration segments of the population most likely to use and directly benefit from these services. This is hoped to also allow meagre resources to target hard-to-reach and/or under-served populations. With the recent inclusion of FP in health insurance, by a few but increasingly growing private insurance providers, the private sector is increasingly an important provider. As much as possible, organized FP trainings and supervisions will include health providers and facilities, respectively, from both the public and private sectors.

STRATEGY AREA II: COMMODITY SECURITY

A robust program requires continuous and uninterrupted supply of a wide range of contraceptive commodities offered through public and private facilities, and through social marketing efforts to meets client's needs.

Given the strategic issues identified, interventions will contribute to improved availability of and access to quality family planning services across all types of service delivery points (including facility-and community-based). A summary of key outputs and activities contributing to this outcome are summarized in Table 7. The total estimated cost for service delivery during the five-year period is TZS 11,956,209,787.

Table 7: Commodity Security Results and Performance Targets

Outcome 2. Adequate amounts of a broad range of contraceptives methods are consistently available at service delivery points.		
Outcome Performance Targets by 2022: Reduced stock out rates of FP commodities at facility level, from 45% in 2014/2015 to 20% by 2022		
Outputs	Performance Targets	Cost (TZS)
3.1. Adequate commodities procured to meet the country needs as per projected method mix	• 970,840 Injectable vials procured by the year 2022 • 2,442 IUD kits procured by the year 2022 • 69,136 Implant kits procured by the year 2022 • 887,637 Pills procured by the year 2022 • 1,544,133 Male condoms • Bi-annual contraceptive commodity quantifications conducted, reviewed, and approved by key stakeholders. • Annual quantification forecast reviewed conducted. • Quantification accuracy for FP commodities increased to 95% by the year 2022	10,252,741,578
3.2. Capacity to collect quality FP information through efficient and effective utilization of eLMS across all levels of the health system improved	• Increased the accuracy and timely health facilities' reporting rates on F P commodities though eLMIS • Health facilities have fully functioning eLMIS in place from 20% to 50%. • Existence of information system reports at all levels of the health system that show: a) inventory balance for contraceptives commodities, b) quantity of contraceptives commodities dispensed or issued	1,238,415,090
3.3. The capacity of Zanzibar Food and Drug Board (ZFDB) to conduct Quality assurance/quality	• Quality assurance/control for FP commodities in Zanzibar improved by the year 2022 (Regular supervision visits are conducted to monitor quality on a quarterly basis)	465,053,120

control of FP commodities enhanced		

4.1. Adequate commodities procured to meet the country needs as per projected method mix The projected annual volume of contraceptive commodities to meet the needs of a population of WRA (married and unmarried), as well as the desired mCPR goal is shown in Table 3. These estimates will be updated annually during quantification exercises and shared with government and development partners to inform the actual procurement. High-level advocacy will be conducted to Members of House of Representatives and the Ministerial Cabinet to increase government allocation in the procurements of contraceptives as per projected methods mix and other FP related supplies.

A Commodity Security sub-committee comprising of key stakeholders will be established, and meetings dedicated to discussing contraceptive related issues will be convened on quarterly basis. The sub-committee will play an advisory role to the FP steering committee on matters related to contraceptive security, and will focus on finding solutions for various constraints related to procurement schedules, supplies and distribution of commodities to service delivery points. Members of the sub-committee will include representatives from the MOH, relevant non-governmental organizations (NGOs), stakeholders from the private and/or commercial sector, and international/national donor(s).

FP commodities quantification meetings will also be conducted after every two years and findings presented for discussion and endorsement by the Commodity subcommittee. On an annual basis, a review meeting for FP commodity quantification will also be held.

4.2. Capacity to collect quality FP information through efficient and effective utilization of eLMIS across all levels of the health system improved.

Access to quality and real-time data on contraceptive commodities availability and consumption at various service delivery points and storage facilities will be critical to inform decisions on logistic arrangements, and thus ensuring a consistent supply of needed commodities at the right place and the right time. High level advocacy meetings with policy makers and other stakeholders will be held to expand and improve eLMIS for effective management of commodities from the primary service delivery points up to national level. Functioning of eLMIS will be improved and scaled to ensure effective management of commodities logistic issues at various levels. Standard operating procedures (SOPs) for eLMIS will be updated and disseminated. Equipment, such as computers, to facilitate the use of the eLMIS at service delivery points will be procured and installed. Health providers will be trained to use the eLMIS, and quarterly supervision visits will also be conducted to monitor implementation and offer technical support.

4.3. Capacity of the ZFDCB to conduct quality assurance/quality control of FP commodities enhanced by the year 2017

Proper quality assurance and quality control mechanisms for medical commodities and supplies is essential to guarantee the safety of the clients. The capacity of the ZFDCB, an organ responsible for inspecting all health commodities before entering to the CMS, will be strengthened to ensure FP commodities that meet set quality standards are entering CMS. The ZFDCB laboratory will be equipped with essential equipment to be able to perform the quality control and assurance check of FP commodities. Key technical staff will also be trained to perform QC/QA check for FP commodities.

STRATEGY AREA III: DEMAND CREATION

A stagnant low demand for modern contraceptives is the challenge that the FP program must overcome. The fact that wanted fertility rates are lower than the actual fertility rate show a preference for people to have less children. A high unmet need, higher than the national average, shows that women desire to plan their families but are many are not doing so using modern contraceptives. The percentage of demand satisfied by modern methods is 45.6 percent, considerably lower than the nationwide average of 63.6 percent.

Raising the mCPR will require increasing the number of new acceptors and continuing users through an intensified, multi-faceted, tailored, and consistent social and behavioural change communication (SBCC) efforts. A summary of key outputs and performance targets contributing to this outcome are described below and summarized in Table 8. The total estimated cost for demand creation delivery during the five-year period is TZS 1,796,625,033.

Table 8: Demand Results and Performance targets

Outcome 3: Total demand for family planning increases to promote new and continued use of modern contraceptives.		
Outcome Performance Targets by 2022: • Demand for family planning among currently married women increases from 51.4 percent (2016) to 55 percent (2022). • Unmet need among married women is reduced from 28 percent (2016) to 25 percent (2022). • Demand for family planning among currently married women in South Pemba from 43.9% (2016) to 50% (2022)		
Outputs	Performance Targets	Cost (TZS)
3.1.A robust and sustained multi-media channel behaviour change communication strategy developed and executed.	• Proportion of all users who are new acceptors increase by an average of at least 10% each year. • The mean number of ideal children decreases with increase in modern contraceptive method use, across all regions. • Increased awareness of modern contraceptive methods, in addition to those less known, such as emergency contraceptives, standard days method, and male sterilization. • Percentage of recent/current users reporting they were informed about side effects or problems of method used increases from 53.2% (2010) to ≥ 65% (2020) • Percentage of women ages 15–49 reporting they received family planning information from a	1,259,268,089
3.2.Communities increasingly mobilized and sensitized to improve knowledge and acceptance for family planning.		537,356,944

	provider who visited them in the past 12 months increases from 4.1% ◆ Percentage of women ages 15–49 reporting non-exposure to family planning messages on radio, on television, or in print in past 12 months decreases from 53.3% (2016) to 30% (2022) ◆Proportion of women who want to use FP who avoid use because of barriers of a psychosocial nature; for example, fear or social, religious or cultural restrictions is reduced.	

3.1 A robust and sustained multi-media channel behaviour change communication strategy developed and executed.

A SBCC strategy will be devised, informed by a comprehensive formative research to understand the drivers of use and non-use of modern contraceptives among various population segments and geographical areas. The aim will be to develop and deliver a strategic and rights-based communication effort tailored to the diverse needs of the population, and delivered consistently over time throughout Zanzibar. High intensity efforts will target the underserved and priority population groups, in accordance to criteria informed by the formative research. For example, a priority group may be postpartum women, especially young mothers, with the aim to improve healthy spacing of pregnancies. With teenage pregnancies on the rise, and associated regional disparities, the planned formative research will also assess the drivers of these trends to inform a tailored SBCC effort among adolescents and young people.

The focus of the SBCC effort will be to reduce barriers to acceptance of modern methods, including increasing knowledge beyond awareness, understanding rights, addressing myths and misconceptions, allaying fears, and providing supportive information in line with religious and cultural beliefs. FP posters and pamphlets materials will be updated and placed across all health facilities, and other popular/appropriate areas. Newspapers and magazines will also be used in a creative manner to increase awareness. Targeted TV and radio efforts, particularly use of regional media, will be used to raise awareness in a culturally acceptable manner through soap operas, radio/TV spots, and discussion forums. Use of digital media, such as mobile health platforms, will be used to reach people, especially in consideration of privacy benefits offered. As key gatekeepers of information, journalists' capacity to provide accurate FP information will be enhanced, and they will also be supported to increase coverage of FP issues and news. Provider bias will be addressed as part of health staff training and supportive supervision sessions; effort will emphasize a right-based approach to FP service delivery, and use of early adopters to encourage their peers to change attitudes. The protective factors of education and social-cultural values — higher age of first marriage, first sexual intercourse, and secondary school attainment than national averages — will be leveraged in attempts to slow/reverse current teenage childbearing trends.

3.2. Communities increasingly mobilized and sensitized to improve knowledge and acceptance for family planning.

Community mobilization efforts are an important engine to driving up demand for family planning, and encouraging people to adopt and sustain new behaviours. These efforts also empower community members and groups to act to facilitate change, which may manifest well beyond an intervention period. The word, community, is used here to describe a group of people living in the same place or having a characteristic in common. As such, these include communities convened because of geographical attributes, but also include beneficiary communities of men, religious and cultural leaders, parents of teenagers, and youth.

The existing national community mobilization guide/package will be reviewed and adapted to the Zanzibar context to guide efforts. At least 350 community mobilizers will be trained and supported to deliver messages through community-owned and driven approaches. Further, the national FP champions' advocacy package will also be adapted to Zanzibar's context. Family planning champions will be identified, and then mobilised and supported, to bring family planning to the attention of communities. Efforts will be made to engage men, religious and cultural leaders, parents of teenagers, and youth in their own communities, to remove barriers to use and improve acceptance. Zanzibar has made great strides in shifting deep-rooted negative views towards contraception among devout Islamic society. Efforts will be made to scale up the guide **Uislamu na Uzazi wa Mpangilio** to more Muslim Religious Leaders (MRLs), thus equipping them with the necessary information and skills to better understand, accept, and support the provision of family planning services. With changed attitudes, these key community figures can bring about changes in social norms about family planning and thus creating an enabling environment for increased demand and uptake of family planning services.

STRATEGY AREA IV: ENABLING ENVIRONMENT

The entire Family Planning program, and particularly the supply and demand facets of the program, must have a sound foundation supported by effective leadership and management, supportive laws, policies, and guidelines to facilitate effective operationalization of FP services at all levels.

Given the strategic issues identified, interventions will contribute to ensuring the existence of an enabling environment (consisting of supportive policies and guidelines) that facilitates adequate financial resource allocation; good stewardship and accountability measures at all levels. A summary of key outputs and activities contributing to this outcome are summarized in Table 9. The total estimated cost for enabling environment during the five-year period is TZS 4,713,478,556.

Table 9: Enabling Environment Results and Performance Targets

Outcome 4. Sustainable and reliable funding from multiple sources to support FP interventions at the optimal scale achieved		
Outcome Performance Target by 2022: Increasing amounts of resources mobilized from multiple sources (government, development partners, implementing partners, civil society and the private sector) to fulfil financial needs of the program.		
Outputs	**Performance Targets**	**Cost (TZS)**
4.1. Government-own resource allocation and expenditures for the FP program is realized	• A budget line item for the FP program under the government Medium Term Expenditure Framework (MTEF) is established	69,957,647

4.2. Resources allocation and expenditures for the FP program in comprehensive district health plans (CDHPs) increased	• All districts allocate funds to support FP activities in their annual CDHPs	195,461,888
4.3. Resources mobilized from non-government sources increased	• Increased amount of FP resources mobilized from existing and new development partners, implementing partners, civil society and the private sector by 2022	101,141,775
Outcome 5. Policy and leadership environment for supporting effective implementation of FP Program interventions improved **Outcome Performance Targets by 2022:** Increased favorable environment for non-health sectors in support of FP as a development tool in the national development agenda Improved coordination of implementing partners, resulting in technical and financial efficiency gains.		
5.1. Multi-sectoral support of Family Planning as National Development agenda increased at all ministerial levels	• ministerial action plans to support FP implementation as national developmental agenda developed and implemented	100,149,628
5.2. Collaboration and coordination for Family Planning program implementation at all levels improved	The RMNCH technical working group incorporate Family Planning agenda by 2017 The Family Planning Steering Committee is established and functional by the end of 2017 • A comprehensive joint annual plan for FP showing contributions of different stakeholders to the CIP developed and operationalized every year • Periodic technical meetings with different stakeholders to discuss issues pertaining to FP conducted in each quarter from the financial year 2017/2018 to 2021/2022 5 National (annual stakeholders review meeting) to share FP experiences and best practices conducted by the year 2022.	935,329,543
Outcome 6. Improved monitoring and evaluation system for Family planning program at all		

levels		
Outcome Performance Targets by 2022: • Quality Family planning data are accessible and available to guide decision making on for FP program improvement at all levels by the year 2022 • More than 90 % of health facilities are producing quality FP data by the year 2022		
Outputs	Performance Targets	Cost (TZS)
6.1 The functioning of the M&E system for Family Planning program strengthened	• RMNCAH data collection tools (registers, summary form, FP Cards and manuals and FP job aid updated and printed by the end of 2017 • 90 % of health facilities visited for Annual data quality assessment in Unguja and Pemba 90% health facilities visited for FP quarterly data cleaning • Meetings for sharing of best practices and experiences on family planning program conducted by the year 2017 • Success stories on Family Planning performance improvement are documented and shared in each year starting from the year 2017 on wards • National and international exchange visits to learn best practices conducted	3,362,417,822

4.1. Government own resources allocation and expenditures for the FP program is realized

Under the ZFPCIP, there will be an enhanced focus towards ensuring that a consistent and sustained level of financial resources are deployed by the central government to support the family planning program, including procurement of contraceptive commodities, supplies and essential equipment. Currently, the program is heavily dependent on financial support from development partners, mainly UNFPA and USAID. Through increased targeted advocacy efforts to key decision-makers at the central government, including officials from Ministry of Finance and Planning, the aim will be to establish a budget line item for FP commodities, essential equipment, supplies and programmatic interventions.

4.2. Resources allocation and expenditures for the FP program in district level budgets (CDHPs) increased

As a decentralized health system, districts are a potential source of financial resources. However, currently, very few districts allocate financial resources for family planning interventions through CDHPs due to multiple funding priorities, and low awareness of the need to include a budget for family planning. As such, intensified and targeted advocacy efforts to district key decision makers will be implemented to advocate to increase FP funding allocation through CDHPs. District Health Management Teams (DHMTs) will be sensitized on the importance to mobilize local own resources at the district to ensure that access to the FP financing will be both sufficient and stable, even if central and donor funds suffer delays. Furthermore, the newly established Basket Fund at district level will form the basis toward harmonization of interventions at community and district levels, specifically by minimizing duplication of actions and ineffective use of meagre resources (MOH Strategy Plan III).

4.3. Resources mobilized from non-government sources increased

The Integrated Reproductive Child Health Programme (IRCHP) will continue to raise funds through other opportunities. Efforts will be directed towards engaging other development partners to support family planning issues. Although family planning substantially contributes to development, only a few donors support the family planning programme. The levels and types of donors could be increasingly leveraged once a clear case in support of family planning as a development tool is made. Other sources of financing to be explored include health insurance schemes.

5.1 Ministerial policies and guidelines to support FP services provision among Young people and adolescent synchronized

The RGOZ has recognized that it is critical to expand access to youth-friendly sexual reproductive health services and promote health seeking behaviour that are culturally appropriate manner for young people. Efforts will be directed towards advocating for harmonization of ministerial youth related policies to support a conducive environment and eliminate operational barriers that hamper accessibility and availability of SRH services, including FP services, by young and adolescents and increasing uptake of family planning services among young people

5.2. Collaboration and coordination for Family Planning program implementation all levels improved

Implementation of a vibrant and well-coordinated family planning program requires considerable collaboration and coordination of partner's efforts. Guided by the MOH policy, which requires all health programmes including IRCHP to work with due compliance to accountability, transparency and coordinated manner at various levels; the RMNCAH technical working group will be expanded to incorporate a broader FP agenda. A FP steering committee will also be established to unify all FP stakeholders towards a common vision and goal as stipulated in the ZFPCIP. The Steering committee will also play a technical and advisory role to the MOH on matters related to achieving its overall goal for the program. Joint comprehensive annual plans for family planning interventions will be developed to facilitate smooth implementation in a more coordinated manner. These plans will reflect funded activities that align with the ZFPCIP on an annual basis. Technical meetings will be organized and conducted on semi-annual and annual basis to for sharing and discuss progress, success and challenges pertaining to implementation of ZFPCIP. DHMTs will coordinate efforts of different FP partners working in the district. The management team in collaboration with other stakeholders will operationalize the ZFPCIP at the district level by advocating and supporting DHMT to include FP in annual comprehensive district plans. This will expand opportunity for the RCH to accommodate several family planning activities that include advocacy, supportive supervision and monitoring at the district
level.

6.1 The functioning of the M&E system for Family Planning program strengthened

The Ministry HMIS has set a strong web-based DHIS-2 tool for routine data collection from all public facilities, which provides the basis for monitoring and evaluation family planning interventions. The use of DHIS-2 has enabled the Ministry to generate data that guide data-driven planning and implementation of FP services. To improve the functioning of the HMIS, RMNCAH data collection tools data dictionary, FP Card, guidelines and register will be reviewed and updated to accommodate national FP program data and information requirements as per ZFPCIP indicators. The updated tools will be made available to all health service delivery points providing family planning services. Responsible facility level staff and DHMT members will be oriented on the updated tools. Annual FP data quality assessment and quarterly data auditing and cleaning will be conducted in health facilities in Unguja and Pemba. Considerable efforts will also be directed at building the capacity and mechanism to share and utilize information generated for improving FP program performance. Priority will be geared towards improving routine FP data analysis, reporting, sharing, or discussion with stakeholders to inform performance improvements of the FP program.

Regular quarterly meetings dedicated to sharing of information in regards to CIP progress implementation, sharing of collected best practices and experiences on FP program implementation will be conducted. At community level, on quarterly basis community health volunteers will meet and discuss FP related issues with their health providers within their catchment areas. MOH senior management members and IRCHP staff responsible for managing FP program will be supported to attend both national and international events to share and learn best practices on FP program for scaling at large.

INSTITUTIONAL IMPLEMENTATION ARRANGEMENTS

Implementation of the ZFPCIP will span a period of five years, from July 2018 to June 2023, in alignment with the RGOZ fiscal year calendar. It will involve a broad range of stakeholders under the stewardship of the RGOZ. This section seeks to describe institutional arrangements for operationalizing the ZFPCIP to bring about sustained action and results, by delineating who and how several functions of execution will be carried out, including leadership and governance, stakeholder coordination, resource mobilization, and performance monitoring.

The ZFPCIP will be an integral part of the Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH) ONE Strategic Plan II 2018/19-2022/23, currently in development; and its implementation will contribute to achieving targeted strategies and interventions of the RMNCAH strategic plan, particularly operational targets for FP. Effective implementation of this plan will also be governed by political commitment, accountability at higher level of administration as seen in the national strategic plan (MKUZA III) and Health Sector Strategic Plan III 2013/14-2018/19. This section seeks to describe institutional arrangements for executing the ZFPCIP to achieve desired results; particularly how key elements to facilitate execution — including, leadership and governance, stakeholder coordination, resource mobilisation, and performance monitoring will be organized.

Leadership and Governance

The MOH will steward the execution of the ZFPCIP through engagement of a broad range of stakeholders, including key government ministries/ agencies, development partners, civil society organizations, private sector, community based organizations and communities.

The Integrated Reproductive and Child Health Programme (IRCHP) operating under the Directorate of Preventive Services and Health Promotion will be responsible for the overall technical leadership, guidance and stakeholder coordination and monitoring of the plan. The IRCHP will perform the following roles:

- Work in concert with the Planning Department and Principal Secretary office to mobilize financial and human resources necessary for execution of the plan.
- Ensure availability of adequate levels of contraceptive commodities and a competent health workforce in public health facilities necessary for the delivery of quality FP services.
- Develop standard guidelines and protocols for ensuring quality provision of FP services
  Coordinate advocacy/demand generation to increase service uptake
- Work in collaboration with National Council of Technical Education to ensure the curriculum for health care providers trainees cater for FP current issues. The Council is responsible for
- Accreditation of Diploma Training Program for health providers.

The Central Medical Stores (CMS) will liaise with Logistic Management Unit (LMU) to ensure a constant availability of contraceptive commodities by running a robust supply chain management system with a goal of preventing stock outs at the last mile, and availability of a broad range of methods.

The Zanzibar Food, Drugs and Cosmetic Board (ZFDB), under its mandate as a regulator body, will have the role to control the quality, safety and effectiveness of contraceptive commodities for purposes of protecting public's health.

The District Health Management Teams (DHMTs) have the critical role in planning, implementing and monitoring of the FP services in the respective areas. The DHMT will ensure that FP activities and services are budgeted in comprehensive district health plans. Other responsibilities of the DHMTs

include logistic management of contraceptives and maintaining a functional health management information system (HMIS).

Non-health sectoral ministries, including the Ministry of Youth, Employment, Women and Children Development – Zanzibar and the Ministry of Education will have a role to play in promoting FP to potential users, or those in need, participating in their respective programs.

Development partners and United Nations agencies are instrumental in the successful implementation of the ZFPCIP by providing the necessary financial resources and technical expertise. They will work in close collaboration with the government to facilitate planning, implementation, and monitoring of the family planning programme.

Civil society and Non-government organizations includes a diverse group of organisations, including faith-based organizations, community-based organizations, media, the private sector, and academia. Collectively, civil society plays critical roles in accelerating access and utilisation of quality family planning services and thus is a key implementer of the ZFPCIP. Civil society entities will also complement the public sector in delivering services at facility and community levels, and mobilizing people to adopt positive health behaviours and use services. These stakeholders also have the comparative advantage in influencing policy changes and community mobilization for enhanced service uptake.

The effective execution of this plan will be governed by political commitment, accountability at higher level of administration as seen in the national strategic plan (MKUZA III) and Health Sector Strategic Plan III 2013/14-2018/19. Enhanced political will has huge potentials in increasing the required resources and helps to make FP services acceptable in all levels. Resources for implementation of the ZFPCIP will be mobilized through government budgetary processes, external budget support from development partners and program partners (NGOs and private sector).

Coordination

Zanzibar has a diverse group of stakeholders who will be contributing to the implementation of the ZFPCIP; as such, there will be an immense need to coordinate activities to ensure efficient delivery of program interventions with limited resources. An active and consistent coordination mechanisms at all levels (central and district levels) is necessary to prevent duplication of efforts, enhance efficient use of resources, track progress and results, and facilitate knowledge sharing. At the central level, the RMNCAH-TWG and the FP Advocacy Committee will represent an essential platform to coordinate all stakeholders working on FP matters.

Resource Mobilization

Resources for implementation of the ZFPCIP will be mobilized through multiple sources, including government budgetary processes, external budget support from development partners and program partners (NGOs and private sector).

High level advocacy will be conducted to Members of House of Representatives and the Ministerial Cabinet to request for an increase in government allocations for the procurements of contraceptives commodities and other FP related supplies. Currently, the supply of contraceptive commodities relies on supports from different partners, mainly UNFPA and USAID. Furthermore, dialogues will be conducted with the Ministry of Finance Senior officials to appeal for budget/ceiling increases.

The government will collaborate with development partners, NGOs and FP private providers to mobilize resources by solicit support from diverse sources through existing fora. An analysis of resource gaps will be conducted on annual basis to inform advocacy and coordination efforts.

The IRCHP will continue with efforts of fundraising through looking funding opportunities. The Programme staff will be capacitated in areas of proposal development and fund-raising techniques for them to be able to search for prospective donors and any other key supporters.

Monitoring and Evaluation

The performance monitoring of the ZFPCIP will be an integral part of existing performance monitoring mechanisms. These include: routine data collection system (HMIS) and quarterly activity implementation report (Bango Kitita). The report is then widely shared with stakeholders in different fora i.e. Annual Joint Health Sector Review meeting, Annual RCH meeting, Annual Performance Report, Annual Health Bulletin and Annual Public Expenditure Review. The District Heath Information Software (DHIS-2) used by HMIS to provides routine service indicators, whereas Plan of Action reporting template has been designed to capture activity implemented and expenditure per quarter.

In addition, the electronic Logistic Management Information System (eLMIS) that operates under the Office of Chief Pharmacists' has been established to monitor the status of commodities. Commodity data from health facilities are filled manually in R&R forms by service providers who then send the report to the District Pharmaceutical Managers on quarterly basis. The compiled report is submitted to CMS through electronic system (eLMIS). Monitoring of commodity security will be done through technical working group (TWG) and Commodity Security Meetings for assessing stock status and management of commodities in general.

A mid-term review of the ZFPCIP will be conducted to gauge the progress with execution at the mid-point of the CIP lifespan; this will occur on or around 2020. At this time, stakeholders will also have an opportunity to review the plan, and make course corrections to maximize results or accelerate attainment of results by 2022.

BUDGETARY REQUIREMENTS

The cost of the total plan is TZS 47,100,447,284, which will increase the number of women in currently using modern contraception from approximately 54,488 to 89,812 by 2022.

Table 10 summarizes the plan costs by year. Overall, service delivery reflects the largest share of costs (61%), at TZS 28,634,133,907.

Table 10: ZFPCIP Annual Cost Estimates, FY2018-FY2022

Strategy Area	2017/18	2018/19	2019/20	2020/21	2021/22	Total Costs by Strategy Area (TZS)	% of Total Costs by Strategy Area
Service Delivery	5,300,997,671	6,234,031,709	6,491,056,529	5,640,623,815	5,052,951,300	28,634,133,907	61%
Commodity Security	1,784,966,945	3,526,642,311	2,423,692,092	2,443,482,722	2,281,030,917	11,956,209,787	25%
Demand Creation	86,995,000	599,406,681	475,503,728	301,797,216	332,922,408	1,796,625,033	4%
Enabling Environment	986,409,000	1,049,067,911	1,011,150,056	812,605,954	854,245,636	4,713,478,556	10%
Total Costs Per Year	8,159,368,616	11,409,148,611	10,401,402,405	9,198,509,707	8,521,150,262	47,100,447,284	
% of Costs Per Year	17%	24%	22%	20%	18%		

APPENDIX: IMPLEMENTATION PLAN

Activities	Sub-activities	Timeline (Fiscal Year)					Costs (TZS)
		2018	2019	2020	2021	2022	
STRATEGY AREA I: SERVICE DELIVERY							
Outcome 1: Improved availability of and access to quality family planning services across all types of service delivery points (including facility-and community-based).							
Output 1.1. Capacity of health facilities improved to offer family planning services at acceptable levels of performance and quality, as stipulated in the National Family Planning Guidelines and Standards, and the National FP Procedures Manual.							
1.1a) Renovate and equip 80% of selected health facilities with equipment and supplies to comply with MOH standards for Family planning service provision	Conduct health facility assessment visits to identify gaps in quality service delivery	X	X				1,456,055,748
	Engage contractors to renovate facilities according to identified gaps			X	X	X	
	Procure and distribute equipment and supplies to 153 health facilities			X	X	X	
	Develop and implement preventive maintenance plan for MOHSW buildings		X				

Activities	Sub-activities	Timeline (Fiscal Year)					Costs (TZS)
		2018	2019	2020	2021	2022	
1.1b) Facilitate recruitment and equitable distribution of trained health providers to facilitate delivery of quality family planning services	Set up/organize advertisement of jobs With the aim to achieve coverage of at least 80% of required health workers at facility level	X	X	X	X	X	17,277,232
	Conduct interviews and selection process for applicants	X	X	X	X	X	
	Conduct a 2-day semi-annual meeting to discuss and agree on the distribution of health workers, according to minimum staff requirements, to ensure equity based on the Essential Health Care Package guideline, 2007	X	X	X	X	X	
1.1c) Implement a comprehensive family planning training effort to improve the skills of in-service providers.	Review and update training package for trainers		X				6,678,588,190
	Train at least 2 providers per facility to provide clinical family planning		X	X	X		

Activities	Sub-activities	Timeline (Fiscal Year)					Costs (TZS)
		2018	2019	2020	2021	2022	
	services (Module I)						
	Conduct training of trainers on FP		X	X	X	X	
	Train at least 2 providers per facility on LARC (IUCD and implant) services provision (Module II)		X	X	X	X	
	Train 15 providers on sterilization services provision (Module III)	X	X	X	X	X	
	Support and mentor newly trained service providers	X	X	X	X	X	
	Conduct refresher trainings for service providers	X	X	X	X	X	
1.1d) Conduct supportive supervision visits to all public and private health facilities providing FP services using integrated supportive supervision checklist at least once a quarter	Conduct a 5-day workshop to review integrated supervision and monitoring checklist to capture FP.		X				10,850,246
	Conduct orientation training to programme, Regional Secretariat and DHMTs on reviewed		X				

Activities	Sub-activities	Timeline (Fiscal Year)					Costs (TZS)
		2018	2019	2020	2021	2022	
	supervision checklist						
	Conduct quarterly visits to select health facilities per district to assess quality of service provision	X	X	X	X	X	
1.1e) Operationalize Performance-Based Financing to family planning health care providers via the Quality Improvement unit of the MOH	Provide financial rewards to qualifying providers	X	X	X	X	X	N/A
1.1f) Support providers and facilities to adhere to family planning guidelines and standards to provide quality services	Conduct quarterly visits to 172 health facilities from central level to perform verification to family planning providers to ensure adherence to existing performance based guidelines	X	X	X	X	X	90,376,920
	Reward high performance facilities through recognition, incentives and opportunity for advancement	X	X	X	X	X	
	Conduct quarterly feedback sharing meeting in discussing challenges, success stories and plan	X	X	X	X	X	

Activities	Sub-activities	Timeline (Fiscal Year)					Costs (TZS)
		2018	2019	2020	2021	2022	
	for way forward						
1.1g) Enhance pre-service education to ensure new graduates are skilled to provide quality FP services	Update family planning contents in the pre-service training curricula at the School of Health and Medical Sciences		X			X	140,509,936
	Orient pre-service tutors on FP service provision		X			X	
	Conduct annual collaborative meeting with Civil Servant Committee to facilitate immediate recruitment of new grandaunts	X	X	X	X	X	
Output 1.2: Community-based family planning services expanded and strengthened to increase availability of and access to quality family planning services							
1.2a) Update Community health volunteers on comprehensive Reproductive MNCAH including FP		X	X	X	X	X	10,681,283,200
Output 1.3: Improved availability of and access to youth-friendly family planning services across FP and RMNCAH services in health facilities							

Activities	Sub-activities	Timeline (Fiscal Year)					Costs (TZS)
		2018	2019	2020	2021	2022	
1.3a) Enhance capacity of in-service providers to provide youth-friendly services	Update in-service FP training manuals to incorporate quality standards of care for adolescents for all health care workers.		X				626,775,800
	Train trainers on youth-friendly services		X				
	Training of health workers on youth-friendly services			X	X		
Output 1.4: Outreach services expanded and strengthened to improve availability of and access to quality family planning services by underserved communities							
1.4a) Provide FP services through outreach services in 11 districts with low FP prevalence	Mobilize communities for planned outreach services	X	X	X	X	X	7,802,794,800
	Deliver outreach services	X	X	X	X	X	
Output 1.5: Integration of family planning services with other health services, particularly RMNCAH services, improved							
1.5a) Develop and roll-out guidance and service protocols for provision of integrated FP services in RMNCAH service delivery points	Revise the RMNACH technical working group terms of reference/scope to in -cooperate family planning		X				465,550,008

Activities	Sub-activities	Timeline (Fiscal Year)					Costs (TZS)
		2018	2019	2020	2021	2022	
	Revise RMNCAH services delivery guidelines and job aids to incorporate FP services		X				
	Revise RMNCAH training curriculum to incorporate FP services		X				
	Orient RMNCAH service providers on the integrated services delivery guidelines			X			
Output 1.6: Increased uptake of quality family planning services through the private sector							
Sensitise private organisations on the importance of promoting and using FP services and support capacity building	Train private providers on comprehensive FP service delivery	X		X	X		234,388,560

Activities	Sub activities	Timeline (Fiscal Year)					Costs (TZS)
		2018	2019	2020	2021	2022	
STRATEGY AREA II: COMMODITY SECURITY							
Outcome 2: Adequate amounts of a broad range of contraceptives methods are consistently available at service delivery points.							
Output 2.1. Adequate commodities procured to meet the country needs as per projected method mix							
2.1a) Procure, store and distribute FP commodities and supplies	Procure, store and distribute FP commodities as per projected method mix on annual basis	X	X	X	X	X	10,221,297,298
	Procure, store and distribute other supplies needed for FP provision	X	X	X	X	X	
2.1b) Convene quarterly Commodity Security meeting with key players to facilitate effective stock management at all levels	Conduct quarterly contraceptive commodity security meetings with key players	X	X	X	X	X	4,204,800
2.1c) Conduct joint stakeholder quantification exercises of FP	Collect data to inform quantification exercise	X		X		X	21,720,680

commodities after every two years at national level	Conduct meetings on generate and agree on assumptions for quantifications	X		X		X	
	Develop and disseminate quantification plan	X		X		X	
	Print quantification plan	X		X		X	
	Conduct stakeholders meeting to disseminate the quantification plan	X		X		X	
2.1d) Convene annual meeting to review and update the quantification plan of FP commodities at national level	Conduct annual meeting to review and update the quantification plan	X	X	X	X	X	5,518,800
	Print the reviewed quantification plan	X	X	X	X	X	
Output 2.2. Capacity to collect quality FP information through efficient and effective utilization of eLMS across all levels of the health system improved							
2.2a) Convene high level advocacy meetings with policy makers and other stakeholders to expand and improve eLMIS for effective management of commodities.	Conduct advocacy meetings with policy makers and other stakeholders to advocate for expansion and improvement of eLMIS	X	X				4,868,800

2.2b) Update and improve functioning of the eLMIS	Conduct workshop to update SoP for LMIS to ensure Reproductive Health Commodities Security (RHCS)		X				1,199,172,050
	Printing and distribute the SoP		X				
	Equip remaining HF with computers and modem to implement eLMIS		X				
	Train national TOT on updated eLMIS and SoPs		X				
	Train two (2) health providers in each health facility on the use of updated eLMIS (facility edition)			X	X		
2.2c) Conduct semi-annual supportive supervision and monitoring visits	Conduct semi-annual supportive supervision and monitoring visits to Unguja and Pemba	X	X	X	X	X	34,374,240
Output 2.3. The capacity of Zanzibar Food and Drug Board (ZFDCB) to conduct Quality assurance/quality control of FP commodities enhanced by the year 2019							
2.3a) Strengthen capacity of ZFDCB to analyse FP commodities for Quality Assurance/Quality Control (QA/QC)	Upgrade ZFDCB laboratories with proper equipment and supplies.		X				283,832,640

Laboratory.	Train ZFDCB staff on analysis of FP commodities		X				
2.3b) Support Zanzibar Food, Drug, and Cosmetics Board (ZFDCB) to conduct Quality assurance/quality control of FP commodities in Unguja and Pemba	Conduct Post Marketing Surveillance (Medicines outlet Inspection)-Unguja		X	X			139,256,320
	Conduct Post Marketing Surveillance (Medicines outlet Inspection)-Pemba		X	X			

Activities	Sub activities	Timeline (Fiscal Year)					Costs (TZS)
		2018	2019	2020	2021	2022	
STRATEGY AREA III: DEMAND GENERATION							
Outcome 3: Total demand for family planning increases to promote new and continued use of modern contraceptives.							
Output 3.1. A robust and sustained multi-media channel behaviour change communication strategy developed and executed.							
3.1a) Develop a comprehensive SBCC strategy to guide communication efforts	Conduct a comprehensive formative research study to inform the development of a SBCC strategy		X				112,258,384
	Design a SBCC strategy, with a clear M&E framework		X				
	Update and develop new key messages (including pre-testing) for various media channels.		X				
3.1b) Implement a comprehensive and targeted multi-media campaign to increase demand and use of FP services	Develop, print, and distribute IEC materials (T-shirts, leaflets, Posters, billboard and fact sheets)			X			1,147,009,705
	Develop and air TV and radio messages		X	X	X	X	
	Develop and air radio soap		X	X	X	X	

Activities	Sub activities	Timeline (Fiscal Year)					Costs (TZS)
		2018	2019	2020	2021	2022	
	opera, theatre groups, panorama						
	Produce theatre production of FP messages			X			
	Orient and support journalists to cover FP issues and news		X			X	
Output 3.2. Communities increasingly mobilized and sensitized to improve knowledge and acceptance for family planning.							
3.2a) Develop and implement a community mobilization effort delivered according to key audiences	Develop community mobilization package (for training and implementation)		X				120,578,688
	Train regional and districts personnel on community mobilization		X				
	Conduct male sensitization meetings in FP		X	X	X	X	
	Conduct youth mobilization meeting on FP services		X	X	X	X	
	Conduct community awareness meeting at district level		X	X	X	X	
	Conduct zonal-wide community mobilization campaign		X	X	X	X	

Activities	Sub activities	Timeline (Fiscal Year)					Costs (TZS)
		2018	2019	2020	2021	2022	
3.2c) Develop and implement an advocacy campaign to support changes in social and cultural norms	Develop training package for FP advocacy		X				
	Train regional and districts personnel on advocacy package and process		X				
	Conduct Advocacy Meetings with Community and religious leaders.			X	X	X	

Activities	Sub activities	Timeline (Fiscal Year)					Costs (TZS)
		2018	2019	2020	2021	2022	
STRATEGY AREA IV: ENABLING ENVIRONMENT							
Outcome 4. Sustainable and reliable funding — from multiple sources — to support FP interventions at the optimal scale achieved							
Output 4.1. Government own resources allocation and expenditures for the FP program increases by the year 2022							
4.1a) Organize dialogue meetings with Ministry of Finance top officials and central government to increase budget allocation for family planning activities	Conduct targeted advocacy meeting with Ministry of finance top officials to advocate for increased budget allocation for FP activities	X	X	X	X	X	69,957,647
	Conduct advocacy meetings to the Central government to increase on Budget allocation for procurement storage and distribution of FP Commodities	X	X	X	X	X	
Output 4.2. Resources allocation and expenditures for the FP program in district level budgets (CDHPs) increased							
4.2a) Conduct mobilization with regional and district authorities to allocate resources for FP activities	Conduct advocacy meetings with district leaders to mobilize increasing resource allocation for FP in the CDHPs	X		X		X	195,461,888
Output 4.3 Resources mobilized from non-government sources increased							

Activities	Sub activities	Timeline (Fiscal Year)					Costs (TZS)
		2018	2019	2020	2021	2022	
4.3a). Solicit support for FP interventions and activities from Private sectors, Civil Societies and related DPs	Conduct meetings with Development partners to advocate for increasing resources to support Family Planning activities	X	X	X	X	X	101,141,775
	Engage a consultant to conduct an economic analysis of benefit of adding FP into health insurance		X				
	Organize advocacy forums with private sectors and health insurance companies to explore the opportunities for expanding coverage of FP services			X		X	
Outcome 5. Policy and leadership environment for supporting effective implementation of FP program interventions improved							
Output 5.1 Multi-sectoral support of Family Planning as National Development agenda increased at all ministerial levels							
5.1a) Conduct advocacy to ensure multi-sector support for FP program implementation across ministries	Conduct advocacy meetings with relevant ministries to solicit multisectoral collaboration and commitments in support of FP implementation	X		X			50,979,748

Activities	Sub activities	Timeline (Fiscal Year)					Costs (TZS)
		2018	2019	2020	2021	2022	
5.1b) Participate in different national fora (health day, WPD, African child day, women day etc) to promote FP to be the national agenda	Organize events to Promote Family Planning in different National fora	X	X	X	X	X	49,169,880
Output 5.2. Collaboration and coordination for Family Planning program implementation all levels improved							
5.2a) Establish and manage Family Planning Steering Committee that will involve key stakeholders	Conduct a meeting to formulate FP steering committee	X					341,126,359
	Conduct quarterly FP steering meetings with different stakeholders to discuss issues pertaining to FP	X	X	X	X	X	
	Conduct National (annual stakeholders review meeting) to share FP experiences and best practices	X	X	X	X	X	
5.2b) Coordinate and communicate the CIP to facilitate execution	Conduct central level meeting to share/disseminate CIP with stakeholders	X					594,203,184
	Identify 5 NGOs to collaborate with in the delivery of FP services (three in Unguja and	X					

Activities	Sub activities	Timeline (Fiscal Year)					Costs (TZS)
		2018	2019	2020	2021	2022	
	two in Pemba						
	Conduct orientation meeting with identified NGOs on the new costed FP strategies	X					
	Develop comprehensive annual plan for FP services in collaboration with NGOs and other stake holders	X	X	X	X	X	
Outcome 6. Improved monitoring and evaluation system for Family planning program at all levels							
Output 6.1. The functioning of the M&E system for Family Planning program strengthened							
6.1a) Revise RMNCAH data collection tools, FP Cards registers and manuals	Conduct a workshop to review and update RMNCAH data collection tools, FP Cards registers and manuals	X	X	X	X	X	2,423,456,549
	Print and distribute reviewed RMNCAH data collection tools (registers, summary form and Manuals) to health facilities	X	X	X	X	X	
	Conduct orientation meetings with DHMTs and HSPs on updated RMNCAH data collection tools in Unguja and Pemba	X			X		

Activities	Sub activities	Timeline (Fiscal Year)					Costs (TZS)
		2018	2019	2020	2021	2022	
6.1b) Conduct periodic data quality assessments to health facilities of Unguja and Pemba	Conduct annual data quality assessments to health facilities of Unguja and Pemba	X	X	X	X	X	938,961,274
	Conduct quarterly data cleaning to the health facilities in Unguja and Pemba	X	X	X	X	X	

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