

Costed Implementation Plans

Guidance and Lessons Learned



At the 2012 London Summit on Family Planning, global leaders made new commitments of \$2.6 billion to help deliver contraceptives to an additional 120 million women by 2020. Strategic use of family planning funds with greater country ownership and accountability is a high priority in the context of the Family Planning (FP) 2020 movement, a coordinated effort to sustain the momentum from the London Summit.



“Costed implementation plans are crucial for determining the financing gap and mobilizing resources. They are important for the governments to determine the internal resources that have to be mobilized to fill the gap.”

ISHRAT HUSAIN, Senior Health Adviser, Africa Bureau, USAID

Despite progress in expanding use of family planning services, many women continue to have unmet need. To meet this need and expand access, leaders must be strategic in how they invest limited resources among competing priorities. These leaders and their partners also need ways to assess their resource requirements and to justify resource mobilization efforts. Costed implementation plans (or CIPs) can help determine requirements for human, financial, and technical resources, as well as for commodities and equipment.

This report offers lessons on why developing a costed implementation plan is important in the context of FP2020 and describes a five-step process for how to develop such a plan. The report is based on FHI 360/PROGRESS experience working with the Ministries of Health and partners in developing such plans in four countries.

A CIP contains cost estimates of multi-year action plans for achieving goals of a family planning program through specific activities. This planning and management tool can be used by governments and partners to:

- determine priority goals and objectives to be achieved
- define targets for programmatic inputs required to be achieved to meet priority goals
- specify key interventions and activities needed to meet the priority goals
- determine costs associated with the interventions and activities
- advocate for resources needed for the plan
- monitor activities specified in the plan

In the last three years, the PROGRESS project has provided technical leadership in the development of CIPs in Kenya, Nigeria (Gombe State), Senegal, and Tanzania, working with Ministries of Health and multiple partners.





Why a Family Planning Costed Implementation Plan Is Important

Costed Plans Provide Guidance for FP2020 at the Country Level

In Kenya, the National Council for Population and Development, in conjunction with the Division of Reproductive Health and other partners, identified the Kenya CIP as a guide for the FP2020 process. The Tanzania and Senegal national plans also provide such guidance for FP2020.

Ownership of the CIP by the Ministry Leads to Action, Accountability, and Advocacy

The Tanzania CIP resulted in a new line item in the national budget for contraceptive commodities, and sharp increases in funding for family planning occurred. It also provided a basis for advocating for funds to meet specific goals.

Costed Planning Triggers Greater Stakeholder Involvement

In 2012, an invitation for Senegal to present at the London Summit on Family Planning prompted stakeholders to develop a costed implementation plan that is now being implemented.

Monitoring of CIP Helps Ensures Strategic Implementation

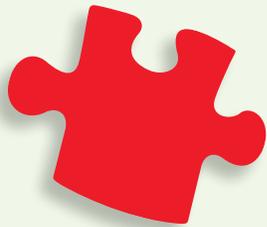
A monitoring process in Tanzania has tracked expenditures and program performance for the CIP activities and led to a re-focus of investments with better planning and coordination in lower performing regions.

Policy Change Leads to Costed Plan for Expanded Service Approaches

A policy change in Nigeria led the Gombe State Ministry of Health and stakeholders to develop a CIP that identified expanded service delivery options and resources needed to reach identified goals.



Steps in the Development of a Costed Implementation Plan



1

Identify the Approach and Purpose of the Plan

Stakeholders build on the national context, identify the process they will follow, and agree on the purpose of the plan.



2

Determine Focus Areas

Conducting a situation analysis and developing projections for the contraceptive prevalence rate goals lead to the key focus areas for the CIP.



3

Develop Priority Activities and Set Targets

Developing priorities and setting targets to accomplish the goals in each focus area form the basis for the commodities and the human and health system resources needed in the CIP.



4

Generate Cost Estimates for the Plan

The costing estimates require detailed descriptions of activities so that the type and magnitude of resources required to support each activity can be determined.



5

Implement the Plan and Monitor Progress

While implementation utilizes existing structures, monitoring involves developing indicators and a data collection and analysis process to assess progress in resource mobilization, activities, and results.



Identify the Approach and Purpose of the Plan

1

In the context of Millennium Development Goals and other national plans and commitments, many countries have developed national goals for contraceptive prevalence, maternity and child mortality reduction, and related issues.

Goals in these country-specific plans can provide the foundation for developing a CIP. In addition, some countries are now beginning to assess how funding through the FP2020 process might support family planning priorities. Key issues in the existing national plans and new discussions related to the FP2020 process include contraceptive prevalence mix and trends, health systems strengthening, commodity forecasting and funding, human resources including task shifting, and the impact of the youth “bulge” on family planning services.

The starting point for developing a CIP is having a clearly defined purpose for its use. Each of the four countries developing the CIPs had a different purpose for developing a CIP and approach to the process.

In Senegal, for example, the government developed the CIP in preparation for making commitments to specific activities and to ask for resources at the 2012 London Summit. An accelerated planning process emerged several months before the Summit involving FHI 360 and McKinsey and Company, a consultant group working for the Gates Foundation. The two groups worked closely with the Ministry of Health (MOH) and other in-country partners such as the World Health Organization (WHO) and the United Nations Population Fund (UNFPA). The stakeholders identified and costed major priorities for family planning activities with well-defined goals.

In Tanzania, extensive stakeholder engagement took place in developing the CIP. The stakeholders sought primarily to determine what funds were needed and could be mobilized to meet goals in existing national plans. Another purpose for the CIP was to serve as an advocacy tool to inform policy dialogue, planning, and budgeting to strengthen family planning as a priority area within the health system and in the national development agenda. The stakeholders agreed that the CIP goal would



align with the country's National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008–2015, which had already set a goal to increase the contraceptive prevalence rate (CPR) from 20% to 60% by 2015. The Tanzania CIP linked with other existing strategic plans in the country as well. The year-long intensive process involved national and district government leaders, family planning implementing partners, and a wide spectrum of donors, resulting in a detailed five-year program called the National Family Planning Costed Implementation Program (NFPCIP). In 2010, the Minister of Health and Social Welfare launched the NFPCIP in a public ceremony. After the release of the CIP, the Government of Tanzania boosted funding through a new line-item for family planning in the national budget.

After the launch, another purpose emerged – to monitor the implementation of the CIP. The Ministry again chose FHI 360 as the secretariat for monitoring the implementation process, with multiple stakeholders involved in monitoring particular sections. In 2012, the stakeholders working with the Ministry amended the CIP, with new targets to monitor program outputs resulting from the financial investments made.

In Kenya, the CIP grew out of a process that began in 2009 with a regional meeting of African countries in Rwanda called by USAID. Inspired by the meeting to set a goal of 56% CPR by 2015, the Kenya Division of Reproductive Health (DRH) and its team realized it needed a plan of action to attain this goal. The Kenya DRH then learned about the CIP in Tanzania from FHI 360 and realized that such a tool would be useful. The DRH decided to develop its own CIP so that an implementation plan might help the country reach a CPR 56% by 2015, up from the current 46%. In 2010, the DRH hosted a meeting of stakeholders and formed a CIP task force, requesting FHI 360/PROGRESS to coordinate the group. The task force identified five purposes for the Kenya CIP:

“National FP/RH policy...with costed and resourced implementation plan.”

SAMPLE INDICATOR, FP2020 Working Group on Performance Monitoring and Accountability

Nigeria:

Identifying the Purpose of a CIP in the National Context

- inform policy dialogue, planning, and budgeting at national, regional, and district levels
- identify budgetary needs that can achieve targets and make accurate projections
- provide reliable financial information on which to build an annual plan
- mobilize and sustain quality resources for cost-effective, scaled up services
- develop benchmarks that can guide the government and development partners to monitor and support the family planning program

The purpose of the CIP developed in the Gombe State of Nigeria focused on translating a policy at the national level into an implementation plan for integrating community-based approaches into a full array of family planning services (see box). This approach evolved in Gombe State after a successful project there showed that community health extension workers could provide injectables at the community level. A national policy change encouraged states to scale up this task-sharing practice. The costed plan that emerged went beyond this specific service to a broader implementation plan covering all family planning services in the state.

After a successful pilot project and advocacy efforts to expand community-based access to injectable contraceptives in Gombe State, the Federal Ministry of Health (FMOH) changed the national policy to allow this service. With more service delivery options, stakeholders used a tool called the Invest FP Calculator to project the resources required to reach contraceptive prevalence goals and found that both facility and community-based family planning services were needed. Stakeholders then determined they needed a thorough implementation plan to understand the number of health workers and other activities needed, as well as the costs involved to expand both service delivery strategies. In addition, Gombe State officials were encouraged to expand family planning service delivery by the commitment made by the FMOH officials at the 2012 London Summit to “train our frontline health workers to deliver a range of contraceptives, and especially to improve the utilization of long-acting methods like intra-uterine devices, injectable contraceptives, and implants.”



Determine Focus Areas

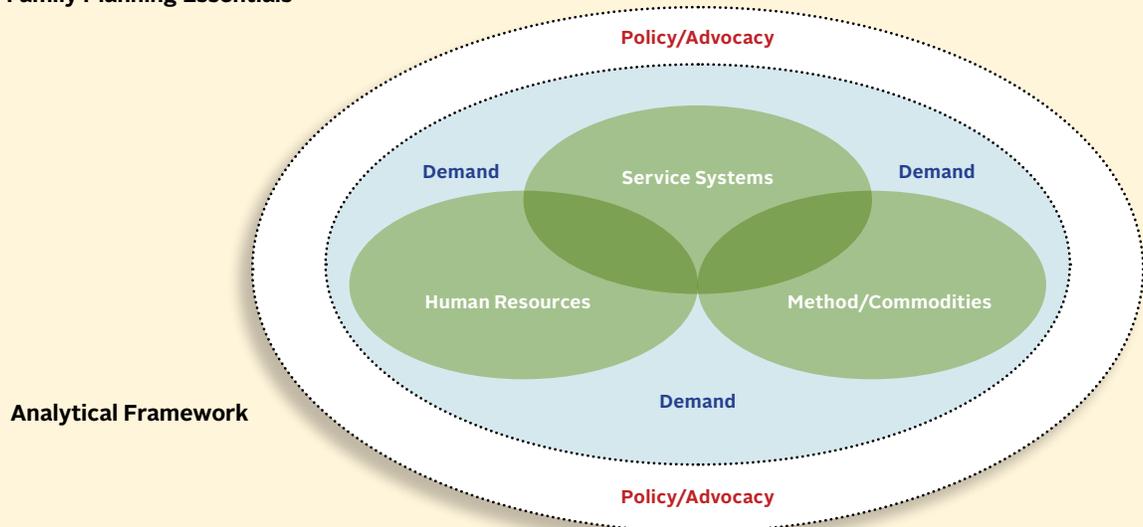
2

In this step, stakeholders conduct a situational analysis, develop projections for the CPR goal, and utilize the situational analysis findings to determine the focus areas for the CIP.

This exercise looks at what has worked to expand family planning services (strengths), why some areas or populations lack services (weaknesses), how services can be expanded in the country (opportunities), and what constraints need to be recognized and addressed (threats). This exercise is what some might think of as a SWOT analysis. The situational analysis involves this holistic view of the family planning program, looking at each essential element. It involves primarily a desk review and consultations with stakeholders and can utilize various models or frameworks.

Conduct situational analysis. A situational analysis involves the collection, review, and analysis of information and data from various sources to inform past and current status of the family planning program.

Figure 1. Family Planning Essentials



One guidance approach developed by EngenderHealth emphasizes supply, enabling environment, and demand, which it calls the “SEED Programming Model.” Another approach is the analytical framework depicted in Figure 1, where policy/advocacy and demand encircle and influence the three key parts of a family planning system: service systems, providers, and commodities.

Some of the illustrative questions to answer in a situational analysis include:

- What are the key issues concerning the implementation of the family planning program?
- What operational barriers prevent attainment of set goals?
- What is working well and why?

Develop projections for the CPR goal.

The situational analysis provides the data base for the CIP, including the desired CPR goal, if unknown, and the required CPR annual growth to achieve the national (or state) goal. This information is then used to project the number of women and men of reproductive age to be reached each year. Considerations include population growth and trends, age structure of the population, current CPR, current and desired method

Tanzania:

Tools Useful for Projections of CPR and Resource Needs

The Tanzania CIP process drew on a software modeling tool called FamPlan, developed by the Futures Group. The tool generated scenarios to ascertain when the national CPR goal of 60% would be achieved if current CPR trends continued and what annual rate of change in CPR was needed to achieve the target by 2015. Projection results showed that if past trends in CPR continued, by 2015 the country would only reach a 40% CPR, but that if CPR increased by 5 percentage points each year, between 2010 and 2015, the country could reach the goal. Despite the very high annual rate of change, the Tanzania Ministry of Health decided to retain this goal for developing strategic interventions and estimate resource requirements. Other projections were also made using FamPlan, including the annual number of family planning users, method mix by region needed to reach target by 2015, and the total volume of contraceptive commodities needed each year from 2010 to 2015, by method. These projections were then used to develop and prioritize the strategic actions and for costing purposes.



Table 1. **Data Needed to Inform Projections for CPR Goal**

Category	Information/Data Needs	Illustrative Questions to Answer
Demographic Data <i>(Source: Demographic and Health Survey, Census data)</i>	Population growth and trends Population age, gender, occupation, rural/urban Contraceptive use trends by age, geography Trends in method mix by age and geography Source of contraceptive methods and information	Annual rate of population growth? Largest segment of the population, and of the reproductive population? Annual change in CPR? By age? By geographical area? Trend of method mix? Average annual change in method use by each method?

mix, and other related data. Table 1 provides a summary of the types of information needed and the questions to address.

Where a country has not already established a CPR goal and the period of achievement, the first step in planning is to project the CPR. In situations where a CPR goal is known, then the task is to understand the demographic determinants to achieve the CPR goal within the specified timeline so as to inform the process of estimating resource requirements. In Tanzania, for example, a goal of 60% CPR already had been established. Existing tools can provide information on demographic determinants that drive the estimates for resource requirements. This information includes required annual rate of change in CPR, number of new acceptors required to reach CPR targets, profile of the method

mix each year with targets, and amount of contraceptive commodities needed each year by method. For more on the tools used in Tanzania, see box on page 9.

Determine focus areas. After conducting the situational analysis and generating consensus on the projection of demographic determinants to reach CPR goals, the next step is to identify the priority focus areas for the CIP. The teams working on the CIP in the four countries identified priority focus areas, which provided the organizing structure for the next steps: developing and prioritizing individual activities and results. For more on how the situational analysis worked in Kenya, which led to youth being identified as a priority focus area for the CIP, see box on page 11.

Kenya:

Situational Analysis Leads to Priority Focus Areas

Between the 2003 and 2008/09 Kenya Demographic Health Surveys, the CPR increased about 6% nationwide, from 40% to 46%. The national plans call for a 2% increase per year, which requires first maintaining the higher level of 46% with a larger number of people in their reproductive years. FHI 360/PROGRESS analyzed the DHS reports and other documents to understand which population segments (age groups, provinces, etc.) contributed most to the increases and why, including possible causal factors such as policies, strategies, and types of activities. The analysis attempted to isolate factors that might be replicated or scaled up and to identify ways to tailor activities to population segments that had negative or stagnant changes in CPR. The analysis found that while older groups are the largest contributors to CPR, the younger age groups have shown faster increases, suggesting they are the large contributors to CPR in the future. This finding, along with consultations with stakeholders, including members of the CIP Task Force, influenced the priority setting process for thematic areas and activities in the CIP.

“The CIP is a tool that will empower us in Kenya to confidently advocate for investments in FP for the Kenya Vision 2030 with accurate figures of cost and priorities. In fact, the CIP can be referred to as the “Bible” of family planning program implementation in Kenya. The Ministry of Public Health and Sanitation appreciates the critical role FHI 360 has played in helping us in developing the CIP.”

**DR. BASHIR M. ISAAC, Director,
Division of Reproductive Health, Kenya**





Develop Priority Activities and Set Targets

3

Identifying the national context and purposes of the CIP, along with defining the analytical framework using demographic determinants and a situational analysis, should bring stakeholders to an identification of overall thematic priorities. The four CIPs arrived at similar focus areas for the most part, even though the wording is slightly different. As Table 2 shows (page 13), all four focused on several themes, grouped by rows in the table: some aspect of commodities and supply chains; issues related to advocacy, clients, and demand creation; providers, human resources, and capacity building; and aspects of service delivery systems, including the youth sector. Two of the four included an explicit focus on monitoring and evaluation.

From these priorities, the detailed work begins: developing and prioritizing the activities and results that are needed to accomplish the goals within each priority area. The activities for a specific number of results are identified, which are needed to achieve certain goals. The teams working

on the various thematic areas need to prioritize the activities with implementation plans and targets for each year. Indicators to monitor and assess program performance can also be developed at this stage.

A key component of the activity generation process is setting targets for resource requirements, including commodities, human resources, and health system resources needed to achieve the set CPR goal. Table 3 (page 14) identifies some of the data helpful in this process, which requires understanding of baseline information and standards for family planning service delivery. For example, in determining the number of providers that need to be trained, one has to understand the number of currently active trained providers and standards for number of the providers per client in order to determine the gap that exists.

The process of identifying and prioritizing specific activities can take various forms, including a series of technical expert consultations, working groups on specified areas, or individual expert(s). In Tanzania, for example, separate working groups that involved a wide range of partners fleshed

Table 2. **Focus Areas in National Costed Implementation Plans, Grouped Approximately into Parallel Areas**

Kenya (5 areas)	Nigeria/Gombe State (4 areas)	Senegal (7 areas)	Tanzania (5 areas)
Commodity security	Commodity security and expanding method mix	Supply chain model	Contraceptive security and logistics
Demand creation	Increased use of family planning by women, men & youth	Advocacy Communications	Advocacy
Human resources	Building the capacity of providers	Strengthen private sector	Capacity building
Youth Integration/ cross-cutting issues	Support for family planning at state and community levels	Community-based distribution Strengthen access in public sector, focus on long-acting methods and youth	Service delivery systems
		M&E structure of CIP	Management systems/ M&E

out the details for each of the five focus areas. Technical consultations were held on each topic to refine and agree on proposed activities. This process took time, but it allowed for a wide range of expertise to be incorporated into the plan and to build “ownership” of the plan by multiple stakeholders. In Senegal, the Ministry of Health worked with FHI 360 and McKinsey and Company to develop activities that could then be presented to the stakeholders involved in the process. In Kenya, The Division of Reproductive Health task team worked with FHI 360 to develop the priority activity areas. In Nigeria, FHI 360

worked with the Gombe State MOH and RH Technical Working Group to develop the activities.

The prioritization process of the proposed activities needs to be based on clearly agreed upon criteria. These guidelines could include likelihood of achieving results in the specified period of time, ability to achieve a significant level of outcome in the specified period of time, and stakeholder endorsement. Each of the countries took slightly different approaches, due to the processes and context for the plan.



Table 3. **Data Needed to Inform Targets for Resource Requirements**

Category	Information/Data Needs	Illustrative Questions to Answer
Service Data <i>(Source: Country HMIS, Service Provision Assessments)</i>	<p>Number and geographical distribution of trained providers (facility-based and community level) and facilities equipped to offer the method</p> <p>Relevant policies and training guidelines for clinical and community services</p> <p>Role of private sector provision, including social marketing</p>	<p>Distribution of family planning providers and facilities?</p> <p>Infrastructure variations across the country?</p> <p>Geographical distribution of family planning projects?</p> <p>Standards for family planning service delivery?</p>

In Tanzania, from the extensive planning process, prioritization criteria emerged that were then applied to all five of the focus areas in the CIP. These criteria were:

- Potential to increase CPR
- Actions needed as essential foundations on which to build other program activities
- Actions that maximize return on investment of resources
- Actions that are evidence-based
- Potential to increase visibility of family planning and reposition in national agenda

Kenya took a different approach, working with key informant interviews, stakeholder meetings, and analysis of documents and secondary data obtained largely from projects that have implemented FP programs. The Kenya CIP identified separate key

points for each of the five focus areas. And, within each of the five, it divided priority activities by what is most needed to maintain the 46% CPR (2010) and what are new and innovative activities to accelerate CPR to the goal of 56% established in the CIP. For example, for the human resources priority area, the CIP identified capacity building and supervision of providers as possible causes of the CPR increase in the previous five years and prioritized activities to maintain those patterns.

In Nigeria, the Gombe State MOH identified four focus areas based on findings from a baseline assessment. The activities identified in each area are designed to improve access to and uptake of FP methods in Gombe State such that the CPR can increase to 22% in 2018 (up from 3% in 2008). The Gombe State MOH turned to

the Federal Ministry of Health (FMOH) for guidance on intervention activities. The FMOH had developed a guidance document for its new policy allowing community health extension workers (CHEWs) to provide injectables, with eight strategic intervention areas that cover expansion of family planning services generically, going beyond CHEWs and injectables. The priority areas included: advocacy and social mobilization, training and capacity building, commodities and logistics management, and others.

With these criteria established in a CIP, specific activities are then identified and written into the plan, sometimes in a detailed appendix. These activities are usually grouped under strategic priorities within each focus area, depending on how the document is presented. The activities need to be specific so as to allow for a realistic and concrete costing process. The specificity can appear in the actual activities listed or through monitoring indicators, as done in Tanzania.

In Kenya, activities are listed in the CIP report with similar degree of detail. For example, under the youth thematic area, the portion that required new/innovative activities to accelerate CPR to 56%, there

are six priority areas, with most of them having subparts. The subparts have such details as: “Revise, print, and distribute adolescent RH communication guidelines to all wards (target 20 copies for each of about 25 wards in each of the 47 counties, total = 23,500).”

“We register our special appreciation to FHI 360, who has been on the front line of all community-based access to family planning activities in Gombe State, for their unflinching support since the era of the pilot project through the post-pilot phase and now in developing our capacity to scale up the project... Their commitment to the process encouraged us to develop this Framework [Gombe State Framework for the Implementation of Expanded Access to Family Planning Services 2013–2018] for expanding access to family planning.”

**ALHAJI UMARU GURAMA, Permanent Secretary,
Ministry of Health, Gombe State, Nigeria**



Generate Cost Estimates for the Plan

4

A methodology based on the cost of specific activities can be used to develop cost estimates for the implementation plan. Therefore, the costing requires detailed descriptions of activities so that the type and magnitude of resources required to support each activity can be identified. The goal is not to project possible costs or conduct a modeling exercise. The exercise should be concrete and specific, resulting in real costs that are expected to meet the various goals. Thus, ideally, the work team would first define the sub-activities that are needed to implement the activity, along with the specific inputs and resources for each of the sub-activities (materials, equipment, per diem, diesel, rent, etc.). Then, the team identifies unit costs, followed by assigning unit costs to the resource requirements.

In the Tanzania CIP, the Service Delivery focus area has eight strategic actions. Specific activities are listed under each Strategic Action in the main report, and

the appendix includes detailed descriptions of inputs, number of units required, and the costs. For example, Strategic Action 2 under the Service Delivery area is to foster cost-effective integration and referral of family planning with HIV, antenatal care, postpartum, and post-abortion care services for men, women, and youth. Under this area are four subareas, the first being: “develop, implement operational tools for cost-effective integration and referral of family planning” with HIV, antenatal, post-abortion care, and other services for men, women, and youth.

Table 4 (page 17) shows how the CIP accomplishes this specific activity, using the data included in the detailed appendix to the Tanzania CIP. The first activity line shows that the planning group estimated 30 person-days for a facilitator with a per-unit cost, in this case a per diem for a facilitator of 80,000 Tanzania shillings (about US\$50) for a total cost of 2.4 million Tanzania shillings (US\$1,500). Per diem for participants would be the same 80,000 shillings, with 510 units needed for this task, or 40.8 million shillings (\$25,500).

Table 4. Example of Costing Detail by Activities, Excerpt from Tanzania CIP

Strategic Action Area III: Service Delivery					FY2010-11	
Index	Activities to Achieve Strategic Action (i)	Description of Input	Measurement Unit (iv)	Unit Cost of Input (v)*	Number of Units (vi)	Estimates (v) x (vi) = (vii)*
Strategic Action 2. Foster cost-effective integration and referral of FP with HIV, ANC, postpartum, and PAC services for men, women, and youth						
2a)	Develop and implement operational tools for cost-effective integration and referral of FP with HIV, ANC, postpartum, and PAC services for men, women, and youth	Facilitator Per Diem	Person-days	80,000	30	2,400,000
		Per Diems Domestic	Person-days	80,000	510	40,800,000
		Conference Facilities	Per Person day	47,250	480	22,680,000
		Stationery Supplies	Per person	30,000	32	960,000
		Diesel	Litre	1,800	600	1,080,000
		Service & Repair	Trip	250,000	2	500,000
		Driver per Diem	Person-Days	45,000	30	1,350,000
		Travel Ticket - Domestic	Trip	500,000	2	1,000,000
		Travel Ticket - Domestic	Trip	50,000	20	1,000,000
		Printing	Per Copy	5,000	5,000	25,000,000
					Subtotal	96,770,000

* Tanzania shillings

As Senegal developed an overall costed plan to help provide guidance in the London Summit presentation, FHI 360/PROGRESS developed guidance for the costing process, emphasizing the importance of being specific, having accurate unit costs, and avoiding economic projections or modeling. These costs were aggregated into overall numbers to inform the draft plan for the London Summit and then launched in November 2012 in Senegal. The details of the costing effort, with unit costs in multiple programmatic areas by region, can now be

used as stakeholders in regions of the country are being engaged to participate in implementing the plan. The costing aspect of the plan takes time and attention to detail, but it does not require complex calculations. The process of engaging stakeholders to participate and buy into the costing system and programmatic implementation plan does take time.





Implement the Plan and Monitor Progress

5

For a completed CIP to be a living document with impact on activities, a process to implement the plan and monitor progress needs to follow.

Implementation of the plan follows the institutional arrangements as defined in the CIP. In all four countries, implementation is organized around the existing governance structures, with the department within the Ministry of Health responsible for family planning providing leadership and oversight. Implementation also involves collaboration with relevant stakeholders, including related ministries and agencies, development partners, the civil society, professional associations, faith-based organizations, and the private sector, utilizing a technical working group where possible. A fundamental part of the implementation phase is mobilizing resources for the plan. In the Kenya and Tanzania CIPs, a resource mobilization

framework is included describing the key sources of funding and the mechanisms to mobilize funds.

Monitoring refers to assessing progress in mobilizing financial resources for implementation of the plan, tracking the degree of implementation of activities in the CIP, and measuring results against the program targets. A plan for continuous monitoring with defined indicators and a mechanism for data collection and analysis guides this effort. CIPs for Nigeria, Senegal, and Tanzania have included indicators for monitoring the plan. In Tanzania, a web-based tool for collecting data and generating reports has been put in place. Since the launch of the Tanzania CIP, quarterly data have been collected on expenditures, source of funds, program outputs, and geographic coverage for each activity implemented, in addition to information on commodity availability (see box on page 19).

Tanzania:

Monitoring Implementation of the NFPCIP

Subsequent to the launch of the NFPCIP in Tanzania, a monitoring plan and process was established to track family planning investments from multiple donors and expenditures from various implementing partners in order to assess progress in financing the CIP and identify challenges and financing gaps on a semi-annual basis. FHI 360 through PROGRESS worked with the MOHSW to develop indicators and data collection tools, and provided data collection and analytical support for this monitoring process using a web-based management information system and other tools. For the first two years of the NFPCIP, financial expenditures were over twice the target (year 1, 198% of target; year 2, 202%). Also, expenditures for contraceptive commodities exceeded the targets by 177% and 187%, respectively. However, the proportion of contraceptive funding by the government decreased from 37% (FY 2011) to 28% (FY 2012).



“The CIP has helped us to determine budgetary needs to reposition our family planning efforts. Monitoring the CIP is helping us to be more strategic in how resources are invested in the country to get results. Also, straightaway from the CIP launch in Tanzania, high level officials started to look at FP as part of the development agenda.”

MAURICE HIZA, National Family Planning Coordinator, Government of Tanzania

Useful Tools for Developing a Costed Implementation Plan

Elements of Family Planning Success

This toolkit includes materials organized by the 10 essential elements of family planning success and the process used to identify these 10 elements. These materials can help teams in determining the interventions to include as priority activities. For more, go to: <http://www.k4health.org/toolkits/fpsuccess>

FamPlan and Reality Check

Computer software tools such as FamPlan, developed by Futures Group, and Reality Check, developed by EngenderHealth, can be used to project contraceptive and method-specific prevalence rates. A key feature of both tools is that they enable users to quickly test future scenarios for a program, including whether current goals are achievable or feasible.

For more information on these tools, go to:

FamPlan:

www.healthpolicyinitiative.com/Publications/Documents/1256_1_FampmanE.pdf

Reality ✓:

www.engenderhealth.org/pubs/family-planning/reality-check.php

High Impact Practices

USAID and partners collaboratively have identified “High Impact Practices” (HIPs) for Family Planning that can be used to help determine which interventions to develop for the priority activities in a CIP. The HIP project includes a systematic process to review evidence periodically, and identify and prioritize practices for use at the country level. The current list includes eight practices for “Creating an Enabling Environment,” which are correlated with improved health behaviors and/or outcomes, and six practices in “Service Delivery,” divided into “proven” and “promising” groups. These practices improve use of family planning services, including contraceptive use and continuation, provided that there is careful monitoring of coverage, quality, and cost, and that operations research helps understand how to improve implementation. For more information, go to: <http://www.k4health.org/topics/high-impact-practices-family-planning>

Supply–Enabling Environment–Demand (SEED) Programming Model

This programming framework developed by EngenderHealth is based on the principle that sexual and reproductive health (SRH) programs will be more successful and sustainable if they comprehensively address the multifaceted determinants of health, and if they include synergistic interventions that: attend to the availability and quality of services and other supply-related issues, strengthen health systems and foster an enabling environment for SRH-seeking behavior, and improve knowledge of SRH and cultivate demand for services.

SEED:

<http://www.engenderhealth.org/our-work/seed/>

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