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VOLUME II

FAMILY PLANNING SERVICES

SUPPORT (621-0173)

TECHNICAL ANALYSES

LOGISTICS AND MANAGEMENT INFORMATION SYSTEMS

TRAINING AND SERVICE DELIVERY

INFORMATION, EDUCATION AND COMMUNICATION

VOLUNTARY SURGICAL CONTRACEPTION

PARASTATAL/PRIVATE SECTOR

INSTITUTIONAL

SOCIAL SOUNDNESS

PROJECT PAPER REPORT

LOGISTICS AND MANAGEMENT INFORMATION SYSTEMS

(LMIS)

MAY 1990

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GLOSSARY

CLISWG	Contraceptive Logistics Information Systems Working Group
CPR	Contraceptive Prevalence Rate
CPT	Contraceptive Procurement Table
DHS	Demographic Health Survey
DSM	Dar es Salaam
EDP	Essential Drug Programme
EPI	Extended Programme on Immunization
FP	Family Planning
FPSS	Family Planning Support Services project (USAID)
HC	Health Centres
IPHCTC	Integrated Primary Health Care Transport & Commodities Committee
IPPF	International Planned Parenthood Federation
LMIS	Logistics and Management Information Systems
MCH-3	MOH PCH reporting format
MMU	Mobile Maintenance Unit
MOH	Ministry of Health
NGO	Non-governmental Organization
PHC	Primary Health Care
PID	Project Implementation Document
PNO	Principle Nursing Officer
PP	Project Paper
SDP	Service Delivery Point
TCDC	Technical Coordination between Developing Countries
UMATI	Kiswahili acronym for Family Planning Assoc of Tanzania
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

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UMATI staff, and particularly the Executive Director, willingly shared a wealth of experience in managing family planning initiatives.

The UNFPA Representative and Senior Advisor on Population and the UNICEF Representative not only shared information but provided consistent encouragement throughout the task.

Unique appreciation is due the authors of the MOH Plan of Operations. This carefully prepared and thorough document provided the policy guidance from which much of this report is derived.

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EXECUTIVE SUMMARY

The Logistics and Management Information Systems (LMIS) Team reviewed the current status of Family Planning (FP) LMIS activities, Ministry of Health plans for FP expansion and the resources available to undertake these activities.

During the Project Implementation Document preparation impediments were discussed and recommendations were made regarding LMIS activities that might be included in the anticipated USAID Family Planning Support Services (FPSS) project.

These activities include:

- o CONTRACEPTIVE PROCUREMENT. A projected US\$ 6.6 million of contraceptives must be purchased to supplement anticipated procurement by existing donors.
- o WAREHOUSING. The volume of contraceptives arriving in the country already exceed the available warehouse space. Expansion of the FP programme will require additional space at the central and selected zonal sites. Funds for this purpose are included in the budget.
- o TRANSPORT. Distribution to peripheral service delivery points will occur via an integrated PHC transport system. Vehicle purchase and maintenance is included.
- o FP MANAGEMENT INFORMATION SYSTEMS. Four phases of FP MIS implementation include, (i) the use of an existing SENTINEL SYSTEM to provide baseline information on the adequacy of contraceptive supplies, (ii) review and redesign of CLINIC DATA COLLECTION and the FP data aggregation process to assure the appropriate use of indicators used to measure FP programmatic achievements, (iii) FP MIS INNOVATIONS including the use of data to project social impact and the possible implementation of Women's Health Cards, and (iv) EVALUATION of accumulated service delivery and administrative data in advising the MOH on programmatic issues.

A joint MOH & UMATI Contraceptive Logistics Working Group (CLISWG) is proposed as the implementing agency for much of the FP MIS activities.

1.0 BACKGROUND. The following report is the Logistics and Management Information Systems (LMIS) Team contribution to the development of a Project Paper (PP) for the anticipated USAID Family Planning Support Services (FPSS) Project.

Similar team work in January 1990 served the preparation of the Project Implementation Document (PID).

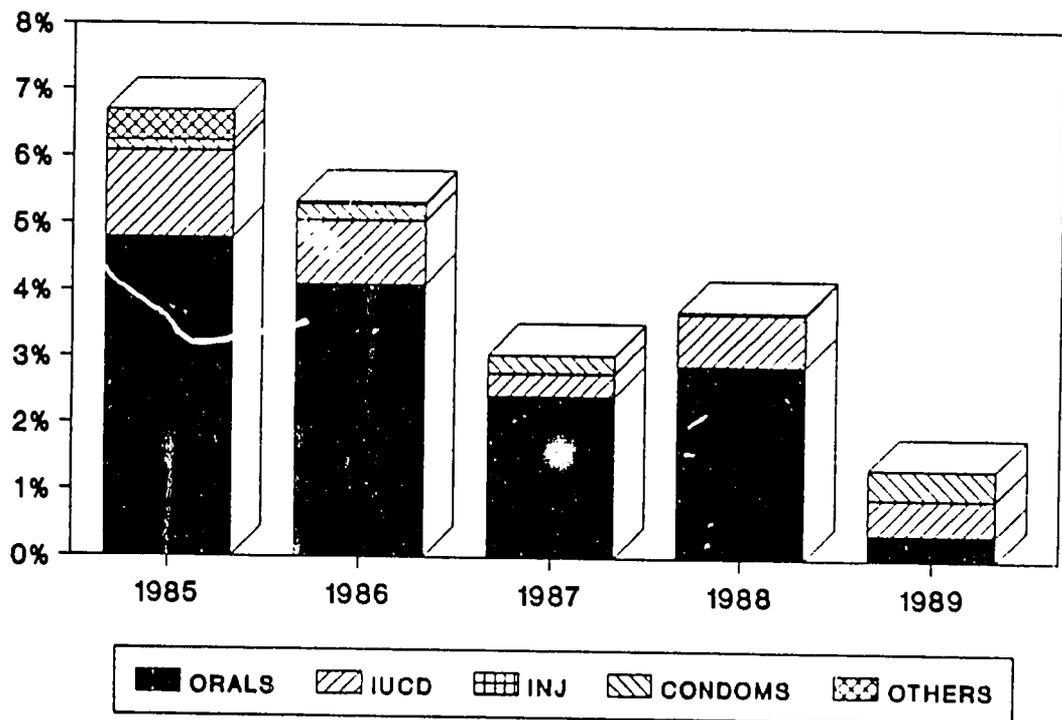
A Project Advisory Committee consisting of representatives of the Ministry of Health (MOH) and other agencies involved in Family Planning reviewed the LMIS Findings and Recommendations. The same Advisory Committee reviewed an LMIS task definition presentation, on assumptions and product, at the beginning of the PP phase. This presentation is included in the Appendix.

Development of the USAID FPSS project occurs in the context of increasing GOT commitment to family planning (FP) services. The MOH has recently completed a FP Plan of Operations which describes expanded FP programming. UNFPA has recently initiated a four year assistance package.

This report reviews the existing situation in logistics and MIS, reviews anticipated programmes and resources, and attempts to identify those impediments that might be ameliorated through FPSS assistance.

2.0 CONTRACEPTIVE COMMODITIES. UMATI (an affiliate of the International Planned Parenthood Association (IPPF)) has responsibility contraceptive projections and ordering. It also has responsibility for moving contraceptives from port to the MOH distribution systems discussed below. IPPF and, increasingly, UNFPA have been the primary donors of contraceptive commodities.

ESTIMATED CONTRACEPTIVE PREVALENCE RATE, UMATI Contraceptives Rec'd & Distr.



UMATI ANN RPTs per Mbunda 4/89

1. UMATI CPRs, 1985-89

CONTRACEPTIVE PREVALENCE RATES. The contraceptive prevalence rates (CPRs) referred to throughout this document are commodity-based calculations. The CPRs in the above graph are calculated dividing the quantities of each method distributed from the UMATI warehouse, and dividing by internationally accepted use factors.

For example, the use factor for oral pills, thirteen, is generated from research which concludes that, on the average,

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thirteen cycles of oral pills are required to provide coverage to one couple.

This number is calculated for each method, and aggregated to produce the total Couple Years of Protection (CYP). The aggregate CYP is then divided by the number of Women In Fertility Age (WIFA). This number is calculated as 23% of the total population based on the most recent national census.

2.1 ADEQUATE SUPPLY. Problems with contraceptive procurement during the last few years have led to a decreasing contraceptive prevalence rates (CPR). Extensive stockoutages of the major method, oral pills, have occurred during the last year. The immediate problem has been resolved through the receipt and distribution of a USAID shipment of Lo-Femenal and the recent arrival of UNFPA procured Microgynon.

ASSUMPTIONS. A meeting of representatives of the three contraceptive donors at UMATI in February 1990 selected target CPRs for the immediate three-year future in an attempt to determine contraceptive requirements.¹ This meeting assumed 1989 rates might have reached the earlier recorded CPR of 5.3%, had sufficient commodities existed, and predicted CPRs of 8.3% for 1991, and 10.3% for 1992.

The approved USAID FPSS PID lists as the project purpose, an increase in CPR of 12 to 14% over the seven year life of project. The implied 1% CPR annual increase $((14-5)/7)$ is based on experience with other countries at a similar level of FP development in the same geographical region.

This report assumes the projections prescribed at the UMATI February meeting followed by the slightly less than 1% annual increase required to meet the 14% CPR FPSS project purpose.

The provision of USAID bilateral contraceptives through FPSS will require the annual preparation of Contraceptive Procurement Tables (CPTs). This projection methodology involves an analysis

¹. Atkinson, Brice, Tanzania Contraceptive Needs Assessment, National Family Planning and AIDS Control Programs, JSI/FPLM, March 1990.

of multi-donor contributions compared to use rates, and projects requirements for the following three years.

Adoption of this annual procedure, and conformance with its results, should eliminate stockoutages at the national level.

Lastly, the projection respects the assumed brand preference of current acceptors for MICROGYNON by phasing in the supply of Lo-Femenal for new acceptors. For vaginal foaming tablets it also assumes an acceptor brand preference for the UNFPA provided Neo-Sampoo over the USAID provided Conceptorol. Information regarding these brand preferences, although anecdotal in Tanzania, are consistent with information available from other countries.

2.2 COMMODITY PROJECTIONS. Application of these assumptions results in a phased increase in the provision of USAID contraceptives under the FPSS project. Specific projections by commodity by year, with specific budgeted amounts, are included in tables included in the appendix.

In summary, the USAID budget for commodity procurement commences at USD 352,000 during the first year of the project, representing 34% of the total multi-donor contraceptive procurement. The life-of-project contraceptive procurement costs to the FPSS project, including freight, will total US\$ 6.6 million.

During the design of a UNFPA follow-on project, at about midway through the FPSS project, the MOH would be well-advised to call a meeting with representatives from contraceptive donor groups. Such a group should review CPR and method mix at that point in time, identify method mix targets, design interventions to achieve these targets, and plan contraceptive procurement by donor for the following years. This meeting should also review the status of training of FP service providers and predict the appropriate time to commence the procurement of progesterone-only pills. This process may require technical assistance.

USAID FPSS contraceptive commodity procurement projections assume continuation of UNFPA and IPPF contraceptive procurement budgets, beyond the current four year UNFPA project, at not less than current levels.

It is also important to note that these projections also assume the last USAID provided contraceptive will be consumed on the last day of the FPSS project. The maintenance of safety stocks at the central, zonal, district, and service delivery points

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(SDPs) will require a follow-on project including a provision for contraceptive purchase be signed prior to the completion of this project. Alternatively, the next UNFPA project take this into account when budgeting contraceptive procurement.

The team believes the average 1% per annum increase in CPR, beginning from an assumed current CPR of 5%, is not inflated and provides little or no margin of safety in the FPSS contraceptive procurement budget.

2.3 CONTRACEPTIVE SECURITY. This issue has been discussed sufficiently by the LMIS team during the preparation of the PID.

The above projections, plus the following discussions on transport and warehousing, assume sufficient political will on the part of USAID, other donors, the MOH, and UMATI to implement those procedures discussed in the MIS section. Those procedures are intended, in part, to diminish "leakage" and assure adequate and reliable supplies to the designated SDPs.

3.0 WAREHOUSING AND STORAGE. The existing contraceptive storage system at the time the PID was written included storage at the central level in an UMATI warehouse, storage at 20 Regional MOH warehouses, and storage at SDPs.

During the PID development process, the LMIS team recommended a distribution system under which UMATI would collect contraceptives at the Port, maintain a safety stock at the national level, and distribute to Zonal MOH warehouses.

3.1 CENTRAL LEVEL STORAGE. A March meeting of the MOH and NGO's involved in FP resulted in approval of this distribution system. Such a system might imply UMATI responsibility for central storage of contraceptives. Since the UMATI warehouse measures only 72 square meters and USAID CPRs predict a requirement of not less than 155 square meters as the beginning of the project, growing to 409 square meters by the end of the project, it is clear that the UMATI warehouse is clearly inadequate.

During the preparation of the PP, the MOH and UNFPA representatives have been involved with separate discussions regarding an integrated PHC distribution system that would include contraceptives. Preliminary discussion concerning this system includes mention of integrated PHC warehousing options. These options would also require the construction or renovation of storage space.

Given the continuing discussion at the time the PP is being written, the most prudent course for the PP would be to budget for contraceptive storage based on current warehouse rental rates. these funds could be used to support construction upon the submission of definite and considered plans

PROJECTED CONTRACEPTIVE STORAGE COSTS, NATIONAL LEVEL		
YEAR	SQUARE METRES	RENTAL CHARGE
1991	121	\$4,107
1992	150	\$5,097
1993	161	\$5,463
1994	172	\$5,829
1995	183	\$6,196
1996	194	\$6,562
1997	204	\$6,926
total		\$42,805

2. PROJECTED STORAGE COST

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for warehouse construction.

In the interim, funds would be available to assure adequate rental space. In anticipation of UMATI warehouse construction, the budget also includes support for an UMATI warehouse manager, and a watchman.

3.2 ZONAL WAREHOUSE STORAGE. Contraceptives will be stored at six Zonal warehouses and distributed from these warehouses jointly with EDP kits. The capacity required at these zonal warehouses will vary according to differing geographical use rates. The excess capacity currently available at these zonal warehouses is not available during PP preparation; neither are we able to anticipate available space in these warehouses seven years from now.

By the start-up date of the FPSS project, the Integrated Primary Health Care (PHC) Transport and Commodities Committee (IPHCTC) should be able to advise PHC donors of current and predicted zonal warehouse capacity.

Should the committee fail to have this information available, the Contraceptive Logistics Information System Working Group (CLISWG) should undertake such a survey.

In the meantime, although some Zonal warehouses have excess capacity, others already exceed capacity. By budgeting an amount equal to the national level storage costs, the FPSS project will assure funds required to expand Zonal capacity when required.

3.3 SDP STORAGE CAPACITY. Most health centres and dispensaries that provide family planning services reportedly lack cupboard space to store contraceptives properly and securely. A provision for the purchase of locked cupboards is included in the attached budget.

CLISWG should be asked to assist in assuring these funds are expended where appropriate space does not yet exist, and in a manner that assures accountability.

4.0 TRANSPORT. The existing contraceptive transport system during the PID development phase involved UMATI collecting contraceptives at the port, as consignee, and distributing these contraceptives to Regional MOH warehouses. Distribution from regions to districts, and from districts to health centres (HCs) had not been formally specified.

Often the districts drive to the regions to collect contraceptives. Some districts close to Dar es Salaam reportedly drive to UMATI to collect contraceptives.² Sometimes the contraceptives accompany Essential Drug Programme (EDP) kits during distribution to HCs and Dispensaries in Expanded Programme on Immunization (EPI) vehicles.

UMATI's ability to distribute from Port to Region has been constrained by the availability of a single three ton truck. UMATI has relied extensively upon contracted private transport. This has proved not only expensive, but difficult to monitor.

During the PID process, the LMIS team recommended that UMATI retain responsibility for collecting contraceptives at the port and for transporting these contraceptives to the Zonal Warehouses. From the Zones, contraceptives would move together with EDP kits to Districts, then again together with EDP kits to Health Centres and Dispensaries.

These recommendations were accepted at the Morogoro March workshop and have been adopted as policy by the Ministry of Health (MOH).

4.1 FROM PORT TO ZONAL WAREHOUSE. At the end of the FPSS project, 204 square meters of contraceptives will need to be distributed annually. Assuming one distribution to each zone each quarter, this would predict an average vehicle space requirement of 11 square metres per trip (204/18).

In addition to the existing UMATI three ton truck, UNFPA is providing a ten ton truck for use at the central level. Given the age of the three ton truck and the short life span of vehicles in Tanzania, the team recommends a second ten ton truck to be purchased later in the project.

². Friedman & Springsteen, FPLM trip report, March 1989.

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4.2 FROM ZONAL WAREHOUSES TO DISTRICTS. EDP has six seven-ton trucks and three ten-ton trucks. Informants suggest that existing transport from the Zones to Districts can easily accommodate the minimal additional load required for contraceptives (a six percent increase in space). In any case, the calculations described below include Zonal to District in the calculation of the FP share of integrated costs.

4.3 FROM DISTRICTS TO HCs & DISPENSARIES. The EDP kit distribution system depends on what logisticians refer to as a "pull" effect. Clinicians at HCs and Dispensaries are not able to prescribe essential drugs unless the EDP kits arrive on time. By associating the delivery of contraceptives with the EDP kits, contraceptives are more likely to reach HCs and dispensaries.

During the PID process the LMIS project team assessed the cost of the integrated distribution system, including vehicle purchase, vehicle maintenance, and petrol. These are included in the appendix. The team also assessed the aggregate space required by an integrated distribution system. This is also in the appendix.

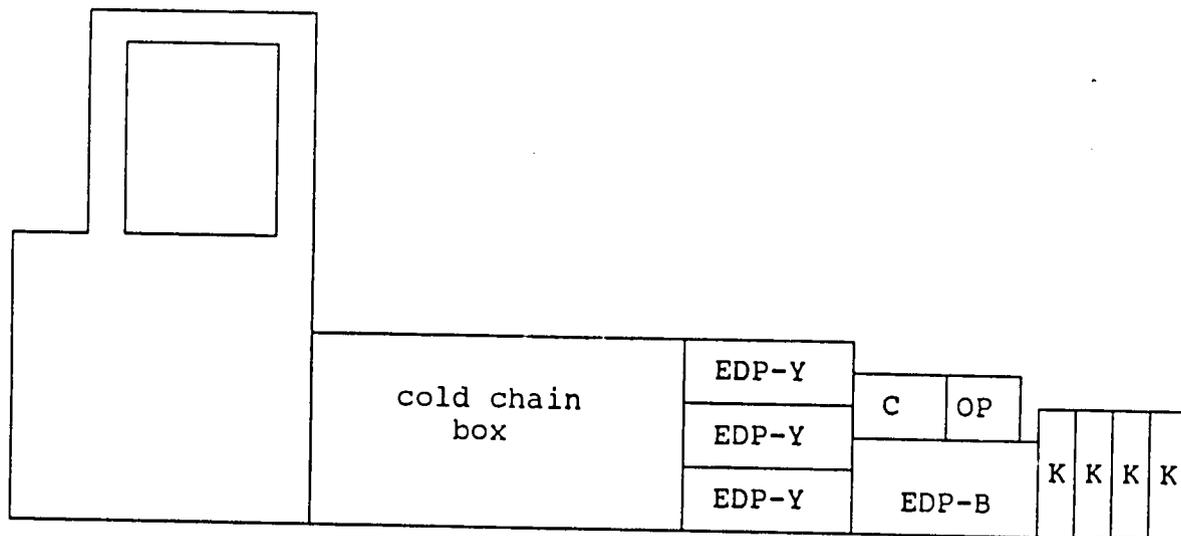


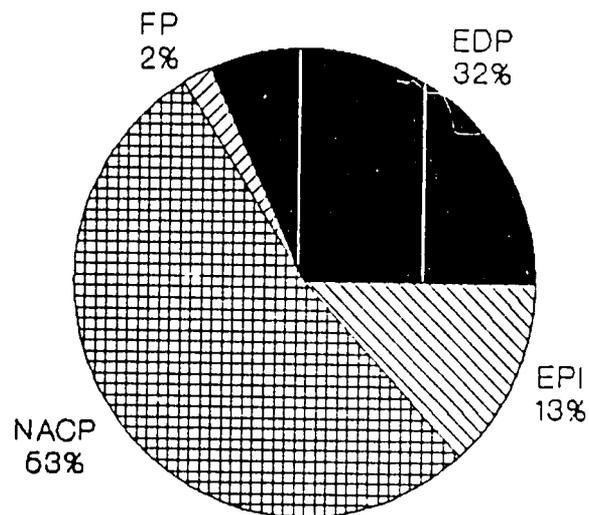
Figure 4. AN INTEGRATED SUZUKI

EDP-Y = Yellow (dispensary) EDP kit
 EDP-B = Blue (HC) EDP kit
 C = Condoms

OP = Oral Pills
 K = Kerosene

By applying the portion of aggregate space required for contraceptives to the total costs, it was possible to estimate the portion of aggregate costs that might be included in the FPSS budget. During preparation of the PID, indications were that this total FPSS sum could be converted into vehicle contributions and other donors would be able to rebudget vehicle purchase costs to assure the availability of maintenance and petrol.

PORTIONS OF INTEGRATED SPACE REQUIRED PHC INTEGRATED DISTRIBUTION

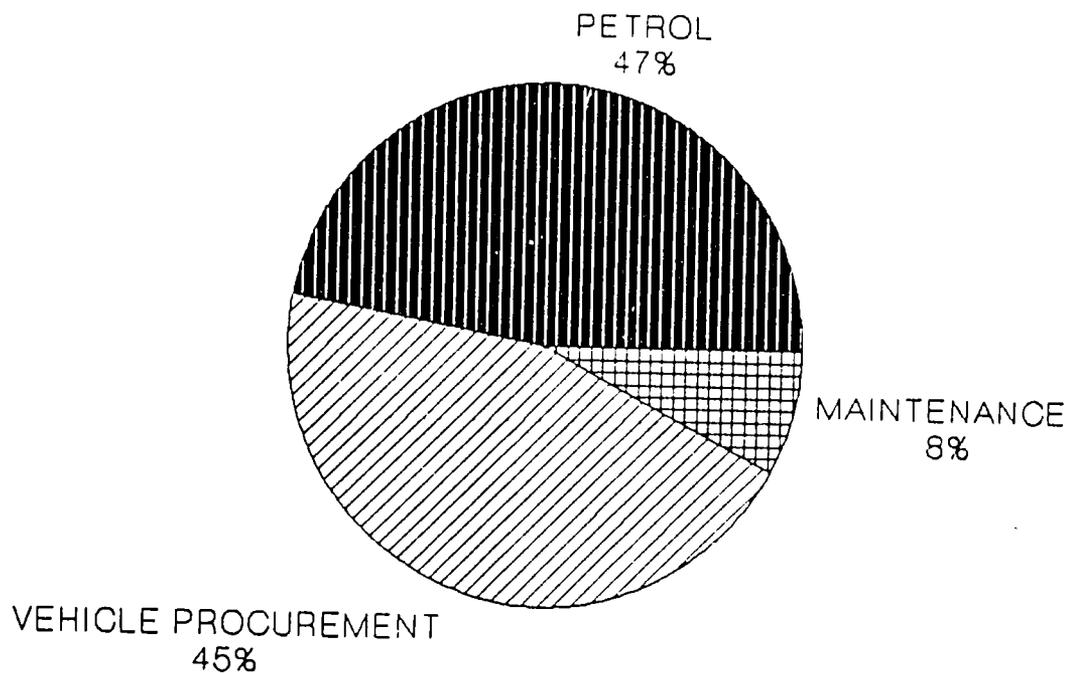


5. 1990 RELATIVE SPACE ALLOCATION

It has not been possible to reconfirm this assumption during preparation for the PP, so these costs are listed as separate line items in the budget.

A proposal currently before the MOH would create an Integrated PHC Transport and Commodities Committee. This committee will include multiple programmes, and with the assistance of technical assistance, will advise the MOH, and donors, on the most effective application of transport and warehousing resources.

ESTIMATED ANNUAL TRANSPORT COSTS PHC INTEGRATED DISTRIBUTION



6. EST. ANNUAL TRANSPORT COSTS

The proposal specifies that other donors with extensive experience in maintaining existing transport systems would assume responsibility for an expanded integrated vehicle maintenance system. The LMIS budget in the appendix includes provisions for two mobile maintenance units that would be accessible for the zonally phased implementation of this expanded and decentralized system.

The Integrated Transport Committee envisages a Mobile Maintenance Unit (MMU) as a Land Rover converted to accommodate the parts and supplies required by for on-site maintenance. Such MMUs will be stationed at the zonal warehouses and move from district to district, thereby eliminating the current need to bring vehicles into Dar es Salam for servicing.

4.4 INCLUSION OF CONTRACEPTIVES IN EDP KITS. The benefits of the EDP "pull" effect can best serve the distribution of contraceptive if contraceptives are included inside EDP kits. In response to an inquiry for the UNICEF office in DSM, UNIPAC in Copenhagen indicated a willingness to include contraceptives inside the EDP kit.

This requires considerable planning. Quantities of contraceptives to be included in yellow (dispensaries) and blue (HC) kits must be determined. Shipments of contraceptives must be routed to UNIPAC in Copenhagen in sufficient quantities to assure adequate supply.

The impact on the size of the packaging and shipping must be calculated. This information should be available within a year of project start-up. Inclusion of contraceptives inside EDP kits could commence within 24 months of project start-up.

5.0 MANAGEMENT INFORMATION SYSTEMS. The above discussion on contraceptives, warehousing, and transport does not assure an adequate and reliable supply of contraceptives. Nurses must know when their stock is insufficient. Distributors must know what quantities to deliver. The supplies officer must know what quantities to order. Managers and donors need to assess performance, and measure the effectiveness of interventions.

To accomplish these objectives, an FP MIS will be implemented in four phases:

- PHASE I: A SENTINEL SYSTEM
- PHASE II: SERVICE DELIVERY INFORMATION
- PHASE III: MIS INNOVATIONS
- PHASE IV: EVALUATION

5.1 PHASE I: A SENTINEL SYSTEM. The easiest way to achieve a contraceptive MIS baseline, might be to mimic the existing EDP sentinel system.

EDP maintains a sentinel reporting system in which two dispensaries and one health centre in each district (more than 300 facilities) submit a one sheet commodity report monthly. The forms are included in the kits. This report is collected as the SDP staff receive the kit and is sent from the district directly to the central level.

The columns included on this form are identical to those required for family planning contraceptives. Using exactly the same format for family planning commodities the form would appear as illustrated in the following figure.

Because staff are already trained in the use of this format, and because the format is very simple, no additional training should be required.

Upon receipt at the Health Planning Department, the contraceptive sheet could be forwarded to the FP office for entry into a computerized database.

Although the sampling represented by 300 facilities (all HCs and Dispensaries) will not generate CPRs, it will provide information about the success of the contraceptive distribution system.

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FIGURE 7. CONTRACEPTIVE SENTINEL REPORTING FORM.

CONTRACEPTIVE MONTHLY STOCK RECORD (please submit with EDP form D.3)	
MONTH & YEAR: _____	DISPENSARY: _____ GRADE: _____
REPORTED BY: _____	HEALTH CENTRE: _____
REPORTING DATE: _____	DISTRICT: _____
SIGNATURE: _____	REGION: _____

	Unit	B/F	Rec'd	Used	Ret'd	Date Finish	Bal
Oral Pills	cycle						
Condoms	piece						
IUDs	piece						
Depoprovera	10cc						
Diaphragms	piece						
Spermicides	tubes						
Spermicides	tab						

PRE-PROJECT IMPLEMENTATION. This sentinel system could be implemented as a pre-project activity. The EDP sentinel system is in place. The FP computer is expected soon. The FP Administrative Assistant is capable of programming an appropriate database.

Required implementation steps are as follows:

1. The FP Programme Manager should assure appropriate authorization.
2. Five thousand copies of the photo-ready version of the above form (in the appendix) should be printed (3 SDPs x 110 districts x 12 months = 3,960).

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3. The forms should be sent to zonal warehouses with instructions that the forms should be given only to designated EDP sentinel reporting sites (perhaps a list from the Health Planning Department should be attached). Twelve copies should be given to each designated site.

Distribution to zones should occur in the following quantities:

DISTRIBUTION: CONTRACEPTIVE SENTINEL REPORTING FORMS	
ZONE	number
DSM N	905
DSM S	890
TABORA	817
IRINGA	711
MTWARA	418
MWANZA	1259
TOTAL	5000

4. The provision of a computer for the FP Programme must be assured to process the submitted forms. The simplest and most useful report generated by the computer might look like the following figure.

# OF REPTING SITES WITH <u>NO</u> STOCKS				
	ORALS	CONDOMS	IUDs	OTHERS
DODOMA REGION				
KONDOA DIST				
MPWAPWA DIST				
....				
DODOMA REG TOTAL				
ARUSHA REGION				
MONDULI DIST				
ARUMERU DIST				
....				
ARUSHA REG TOTAL				
NATIONAL TOTAL				

5.2 PHASE II: SERVICE DELIVERY INFORMATION. The Sentinel system provides only information that measures success in distribution. Programmatic performance, contraceptive projections, and the assessment of interventions require a more complete system.

Such a system will include the following elements:

- o review of the FP CLIENT CARD to assure clinical requirements for quality of care issues, and referral information,
- o revisions of the FP REGISTER to assure the ability to calculate continuation rates and number of acceptors,
- o introduction of TALLY SHEETS to facilitate time-saving calculations,
- o revision of the MCH-3 Form to assure complete information on contraceptives issued.

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- o identification of managerial interventions at the central and local levels that use the aggregated information to support achievement of programmatic and project objectives.

The revised system will produce the following indicators:

- o CONTRACEPTIVE PREVALENCE RATES, by district, region and for the programme. These rates will be compared to indicate relative performance. They will be displayed across time to indicate progress toward objectives.
- o the number of NEW ACCEPTORS will be similarly organized to illustrate programmatic growth.
- o CONTINUATION RATES will be used as an indicator of quality of care.
- o SOURCE OF REFERRALS will serve as an indicator of the success of selected interventions.

CLISWG. Review of the above forms in order to assure the above indicators and the appropriate local use of these indicators can be best undertaken by select representatives from the MOH, UMATI, and NGOs. Representatives will be chosen for their familiarity with service delivery.

Preliminary discussions have suggested the name for this group might be the Contraceptive Logistics Management Information Systems Working Group (CLISWG).

Terms of Reference and anticipated membership for this group is included in the appendix, but in summary the process for this group will include:

- o fact finding tours to at least two areas of the country to identify strengths and weakness of current logistics and MIS,
- o an examination of working FP MIS in two countries within the region,
- o design of appropriate formats, curriculum, and exercises to be used in implementing the new MIS,
- o field testing of formats, curriculum, and exercises, and

revision as required,

Portions of this process will be assisted through a Technical Coordination between Developing Countries (TCDC) process. Consultants will be brought in from other countries in the region that have been particularly successful in elements of this process.

It is anticipated that at the completion of this process, selected Tanzanian CLISWG members will have reached a level of competence that will enable them to provide consultancy services to other countries.

CLISWG will also undertake responsibility for periodic assessment of the adequacy of contraceptive distribution. As data becomes available, this working group will assume a technical role in planning for the inclusion of contraceptives in EDP kits.

PRE-PROJECT IMPLEMENTATION. In 1988, the MOH was able to achieve 95% submission of the MCH-3 forms. After the processing of this form was computerized, the submission rate declined. Also, districts tend to omit information on FP commodities.

It is best to begin early in working back toward complete submission rates and the inclusion of FP commodity information.

The MCH/FP National Nursing Coordinator should resume this responsibility.

5.3 PHASE III: MIS INNOVATIONS. During the middle and later portions of the project, CLISWG will continue problem solving activities regarding the distribution of contraceptive and the implementation of the FP MIS. It will also monitor the effects of including contraceptives in the EDP kits.

WOMEN'S REPRODUCTIVE CARD. FP record-keeping often fails to respect the role of family planning in the continuing relationship between the acceptor and the clinician. The choice of an appropriate contraceptive is often dictated by longer term information.

Whereas the FP MIS discussed in the above section is similar to other activities in neighboring countries, the development of a Women's Reproductive Card provides Tanzanians with an opportunity to initiate and test a new approach to FP and women's health

care.

Such cards could be designed and tested by CLISWG.

DHS SOCIAL IMPACT PROJECTIONS. CLISWG will use FP MIS data, the results of Demographic Health Survey (DHS), and census data to project the impact of population growth rates on the cost of providing social services. This analysis will be undertaken at the regional level and be available for use during FP promotional activities with local decision makers.

5.4 PHASE IV: EVALUATION. During the middle and later phases of the FPSS project CLISWG will turn its attention to a more in depth analysis of the available data.

FP COST BENEFIT ANALYSIS. As the FPSS project and the UNFPA project progress, data will accumulate on FP achievements in Tanzania. Data will also accumulate on the cost of service delivery.

CLISWG will assist the MOH and UMATI in quantifying FP achievements and dividing these by the aggregate costs. This analysis will be focused on programmatic issues relevant to decisions on new FP interventions.

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APPENDIX: PRELIMINARY BUDGET FOR LOGISTICS AND MIS									
		(thousands of USD)							TOTAL
		1991	1992	1993	1994	1995	1996	1997	
1	CONTRACEPTIVE PROCURE	\$392	\$584	\$737	\$911	\$1,106	\$1,326	\$1,570	\$6,626
2	VEHICLE PURCHASE	\$270	\$50	\$285					\$605
	MAINTENANCE	\$50	\$11	\$61	\$11	\$11	\$11	\$11	\$166
	PETROL	\$39	\$39	\$59	\$59	\$59	\$59	\$59	\$374
3	WAREHOUSE CENTRAL	\$4	\$5	\$5	\$6	\$7	\$7	\$8	\$42
	WAREHOUSE ZONAL	\$4	\$5	\$5	\$6	\$6	\$7	\$7	\$40
4	CLISWG ACTIVITIES	\$19	\$24	\$18	\$18	\$18	\$18	\$12	\$127
5	MIS PRINTING COSTS	\$250	\$10	\$10	\$10	\$10	\$10	\$10	\$310
6	NATIONAL MIS IMPLEMENT		\$201	\$20	\$20	\$20	\$20	\$20	\$301
7	TRAINING ESAMI			\$21	\$11	\$11	\$11	\$11	\$74
	TRAINING US-BASED		\$30		\$30				\$60
8	STDY TRS ZAMBIA		\$11						\$11
	KENYA			\$6					\$6
9	TCDC ZAMBIA	\$2							\$2
	TCDC KENYA		\$2						\$2
	TCDC TO OTHERS			\$2	\$2	\$2	\$2	\$2	\$10
10	EQUIPMENT								
	COMPUTER & SOFTW		\$28		\$28				\$56
	CALCULATORS		\$21						\$21
	CUPBOARDS & CARDS		\$184						\$184
	DESKS AND CHAIRS		\$184						\$184
11	ADDITIONAL STAFFING								
	MON&EVAL OFFICER, MOH	\$5	\$5	\$5	\$5	\$5	\$5	\$5	\$35
	DATA ENTRY CLERK, MOH	\$2	\$2	\$2	\$2	\$2	\$2	\$2	\$14
	HEALTH PLANNING, MOH	\$2	\$2	\$2	\$2	\$2	\$2	\$2	\$14
	WAREHOUSE MANAGER, UM	\$2	\$2	\$2	\$2	\$2	\$2	\$2	\$14
12	OFFICE SP (26 SQ MTRS)	\$2	\$2	\$2	\$2	\$2	\$2	\$2	\$13
	TOTAL	1,043	\$1,423	\$1,232	\$1,124	\$1,262	\$1,483	\$1,722	9,291

APPENDIX: ANNUAL SUMMARY BUDGET LOGISTICS AND MIS						draft 22 May	
	(thousands of USD)						
	1991	1992	1993	1994	1995	1996	1997
ANNUAL SUMMARY:							
CONTRACEPTIVES	\$392	\$584	\$737	\$911	\$1,106	\$1,326	\$1,570
VEHICLES	\$359	\$100	\$405	\$70	\$70	\$70	\$70
WAREHOUSING	\$8	\$10	\$10	\$12	\$13	\$14	\$15
OTHER ACTIVITIES	\$284	\$729	\$80	\$131	\$73	\$73	\$67
TOTAL	\$1,043	\$1,423	\$1,232	\$1,124	\$12	\$1,483	\$1,722
TA	\$80	\$60	\$60	\$80	\$40	\$20	\$20
PROJECT SUMMARY:							
CONTRACEPTIVES						\$6,626	70%
VEHICLES						\$1145	10%
WAREHOUSING						\$82	1%
OTHER ACTIVITIES						\$1,438	15%
TA	# mos	18	\$360	4%			
TOTAL						\$9,651	100%

APPENDIX: BUDGET NOTES		
1	CONTRACEPTIVES	see projection spreadsheets, based on PID target CPR, phased implementation of Lo_F, and assumes UNFPA seven yr duration, includes GSA fee and freight, does not include safety stock at end of project.
2	VEHICLE PURCH	45 Suzukis x (\$8,000+\$1,000 shipping) plus one ten ton truck based on UNFPA purchase order from SCANIA
	VEHICLE MAINTEN	17% x annual purch on five year life \$50,000 for mobile maint units at zones in 1991 & 1995.
	PETROL	91% X purchased annualized over five yr life
3	WAREHOUSE central	CPR generated volume calc x T/S 565 / SQ MTR (source NACP, 22/5; Bimji)
	WAREHOUSE, ZONE	(same as above, slightly reduced)
4	CLISWG	T/S 6,000 X 8 persons x 30 days x 3 events
5	MIS PRINT COST	SEE SUPPORTING SPREADSHEET
6	NAT MIS IMPLMTA	1992, Zambian cost data x quadrip pop 1993-1997 innovation, monitoring, eval
7	TRAINING ESAMI	FP LOG & MANAGE, partic= '91 = 6, '93 = 3; tuition = \$2,500 + \$1,000 air & other
	TRAINING USA	MICRO COMP IN H & FP, (tuition = \$8,000 + air = 4,000 + 3,000 PD) x parti = 2('91) + = 2('93)
8	STUDY TOUR, ZAM	8 part (400 air +(7 days x 135 PD)
	STUDY TOUR, KEN	6 part (400 air +(6 days x 120 PD)
9	TCDC	400 air + 14 days (150 fee + 105 PD)
10	EQUIP, COMPUTER	2 x 14,000 (see supporting spreadsheet)
	CALCULATORS	3,500 SDPs x \$6
	CUPBOARDS	3,500 x T/S 5,000
	CARDS	AVG CPR x 7yrs x .8 NA x \$0.15
	DESKS & CHAIR	3,500 x T/S 10,000
11	STAFF, M&E OFF	T/S 83,000 /mo
	DATA ENTRY CLRK	T/S 33,000 /mo
	HEALTH PLANNER	T/S 66.000 /mo
	WAREHOUSE MANGR	T/S 33,000 /mo
12	OFFICE SPACE	40 sq mtrs x \$4 x 12 mo

APPENDIX: CONTRACEPTIVE PROCUREMENT PROJECTIONS

project year =		1	2	3	4	5	6	7	
	1990	1991	1992	1993	1994	1995	1996	7	
POP (millions)	24.7	25.4	26.1	26.8	27.6	28.3	29.1	29	
WIFA (23%)	5.7	5.8	6.0	6.2	6.3	6.5	6.7	6	
CPR	5.3%	8.3%	10.3%	11.0%	11.8%	12.5%	13.2%	10	
# ACCEPT(1,000)	301	485	618	679	748	814	883	9	
METH MIX		ACCEPTORS (1000s)							
ORALS	70%	211	339	433	475	524	570	618	6
combined	63%	190	305	390	427	471	513	557	8
lo-dose	7%	21	34	43	47	52	57	62	7.6
IUCD	10%	30	48	62	68	75	81	88	6.9
INJECT	15%	45	73	93	102	112	122	133	4
CONDOMS	4%	12	19	25	27	30	33	35	9.3
OTHER	1%	3	5	6	7	7	8	9	0.1
		CONTRACEPTIVE QUANTITIES (1000s)							
ORAL PILLS	13	2740	4412	5627	6175	6806	7409	8039	8
COMB OTHER	13	1918	2647	2813	2470	2042	1482	804	
COMB USAID	13	822	1765	2813	3705	4764	5927	7235	8
lo-dose	13	274	441	563	617	681	741	804	8
IUCD	0.4	12	19	25	27	30	33	35	9.3
INJECTABLES	4	181	291	371	407	449	488	530	5
CONDOMS	100	1204	1940	2473	2714	2992	3257	3534	8
OTHER	100	301	485	618	679	748	814	883	9
		US\$ COST (\$1,000)							
ORAL	0.135	\$370	\$596	\$760	\$834	\$919	\$1,000	\$1,085	\$1.15
C OTHER	0.135	\$259	\$357	\$380	\$333	\$276	\$200	\$109	0.5
C USAID	0.135	\$111	\$238	\$380	\$500	\$643	\$800	\$977	\$1.15
lo-dose	0.135	\$37	\$60	\$76	\$83	\$92	\$100	\$109	8
IUCD	1.047	\$13	\$20	\$26	\$28	\$31	\$34	\$37	6
INJ	0.760	\$137	\$221	\$282	\$309	\$341	\$371	\$403	7
CONDOMS	0.048	\$58	\$93	\$119	\$130	\$144	\$156	\$170	5
OTHER	0.100	\$30	\$48	\$62	\$68	\$75	\$81	\$88	8
		SUMMARY COST BY DONOR							
USAID			\$352	\$524	\$659	\$818	\$991	\$1,183	\$1.28
OTHER			\$687	\$800	\$794	\$783	\$753	\$708	5
TOTAL		\$645	\$1,038	\$1,324	\$1,453	\$1,602	\$1,743	\$1,892	\$2.02
UNFPA/IPPF	USAID								
\$5,178	\$5,935	= SEVEN YEAR COMMODITY COST							
	\$89	= GSA FEE 1.5%							
\$518	\$593	= ESTIMATED FREIGHT COST (10%)							
\$5,696	\$6,617	= TOTAL COST							

APPENDIX: LMIS PROCUREMENT TABLE					
DATE INIT'D	ITEM	DATE REQ'D	SOURCE OF SPECIFIC	PROCURE METHOD	COST
CONTRACEPTIVES:					
annually Sept-Nov	contracep tives	shipmt's arriv twice yearly	specified in annual CPT projection s		life of project = \$6.6 million
VEHICLES:					
QTR 2; 1991	30 SUZUKI PICKUPS	QTR 4; 1991	model MG 410? confirm # & model w/ IPHCTC	purch via UNIPAC (cheaper) or direct USAID mission	30x(\$8,00 0 + \$1000 shipping) = \$270,000
QTR 1; 1993	15 SUZUKI PICKUPS	QTR 3; 1993	above	above	15 x (\$8,000 + \$1000 shipping) = \$135,000
annually	SPARE PARTS	annually	as per advic of IPHCTC (17% x purch price / 5 yr life of vehicle)	above	life of proj = \$166,000
QTR 1; 1992 QTR 1; 1993	MOBILE MAINTENAC E UNITS	QTR 3; 1992 QTR 3; 1993	Land Rover specificall y equipped as per advic of IPHCTC	above	2 x \$50,000
QTR 1; 1993	10 TON TRUCK1	QTR 3: 1993		above	\$50,000

APPENDIX: LEVEL OF EFFORT
BUY-IN
LOGISTICS AND MANAGEMENT INFORMATION SYSTEMS
FAMILY PLANNING SUPPORT SERVICES
TANZANIA

BACKGROUND. The Family Planning (FP) Logistics and Management Information Systems (LMIS) activities included in this buy-in are a component of the bilateral Family Planning Support Services (FPSS) project. LMIS activities undertaken under FPSS include:

- o CONTRACEPTIVE PROCUREMENT,
- o WAREHOUSING SUPPORT,
- o TRANSPORT SUPPORT, and
- o MANAGEMENT INFORMATION SYSTEMS.

The USAID mission will retain responsibility for contraceptive procurement, the expenditure of warehousing support funds, and the purchasing of vehicles.

Activities included under the buy-in will include technical assistance and limited other expenditures to support the development and implementation of a FP MIS plus technical support for the projection, warehousing, and transport of contraceptives.

SPECIFIC ACTIVITIES: These activities are discussed in greater detail in the project paper and the January and May, 1990 LMIS team reports completed during the project preparation phase.

1. CONTRACEPTIVE PROJECTION. Projection of quantities of contraceptives required for regions and district.
2. LOGISTICS. Technical Assistance to the MOH through the Integrated PHC Logistics and Commodities Committee. Assistance will be required in assuring the inclusion of contraceptives in the integrated warehousing and transport of Essential Drug Programme (EDP) kits and Extended Programme on Immunization (EPI) vaccines.

Assistance will be required in assuring the inclusion of contraceptives in the integrated warehousing and transport of Essential Drug Programme (EDP) kits and Extended Programme on Immunization (EPI) vaccines.

3. SENTINEL REPORTING SYSTEM. Technical Assistance in the implementation of a contraceptive sentinel reporting system that uses the same formats, facilities, and submission protocols of the EDP system. This needs to be implemented as soon as possible.
4. FP MIS DESIGN AND IMPLEMENTATION. Technical Assistance will be provided to an ad hoc joint working group which includes representatives from the MOH and UMATI (IPPF-affiliated FPA) plus a representative from an NGO.

The joint working group will advise the MOH and UMATI. The working group will debrief the USAID mission, MOH Officers, and UMATI on each of the following steps. The group will produce a report on each step in the process.

Consultants who have worked with the contractor in similar tasks in neighboring countries will be used in addition to staff from the contracting agency. Funds are included to support the placement of selected participants in consultancy roles for neighboring countries.

- o fact-finding tours to two districts to assess logistics, distribution, record-keeping, reporting, and the managerial use of contraceptive data,
- o study tour to Zambia to examine, in particular, clinic based record-keeping and reporting. During the study tour participants will design preliminary client cards, tally sheets, registers, reports, instruction manuals, case study exercises, and training curricula.
- o field testing of all of the above listed elements in at least two districts. This field testing will include testing of the instruction manual, the case studies, and the curricula. The field testing will be concluded with post-test debriefing sessions.
- o redesign based on results of the field testing,

- o implementation through a cascade, tiered, training of trainers (TOT) approach. Working Group participants will train MCH coordinators and UMATI coordinators who will, in turn, train FP service providers.
 - o monitoring and evaluation of this training,
 - o the provision to the MOH of advise on the feasibility of including contraceptives inside EDP kits,
 - o a study tour to Kenya will facilitate the EDP kit feasibility study and assess the appropriateness of installing the Contraceptive Commodity MIS (CCMIS) software in Tanzania,
 - o the design of innovative MIS techniques including Women's Reproductive Cards,
 - o the execution of a FP financing study to establish the cost of FP services in Tanzania,
 - o assessment and evaluation timed to coincide with a mid-project review and the project completion evaluation.
5. SHORT TERM TRAINING. Training will be provided for select individuals at ESAMI (FP Logistics and Management Information Systems) and in the United States (Microcomputers for Health and Family Planning).
6. EQUIPMENT. Computers and software, calculators, cupboards and cards, and desks and chairs will be purchased under the buy-in. These items will be placed with assistance of the joint working group.
7. ADDITIONAL STAFFING. An MOH Monitoring and Evaluation officer, data entry clerk, health planner, and a warehouse manager, plus office space will be provided under the buy-in.

APPENDIX: PROJECTED BUY-IN BUDGET

(thousands of US\$; exclusive of overhead and fees)

	'91	'92	'93	'94	'95	'96	'97	total
JT WKING GRP	19	24	18	18	18	18	12	127
MIS PRTING	250	10	10	10	10	10	10	310
MIS IMPL TRNG		201	20	20	20	20	20	301
<u>TRNG</u> : ESAMI		21	11	11	11	11	11	76
USA		30		30				60
<u>STUDY TRS</u> : ZAM		11						11
KENYA			6					6
<u>TCDC</u> : ZAM	2							2
KENYA		2						2
TO OTHERS			2	2	2	2	2	10
<u>EQUIP</u> : COMPs		28		28				56
CALCULATORS		21						21
CUPB & CRDS		184						184
DSKS & CHRS		184						184
<u>ADD STAFF</u> : MON & EVAL	5	5	5	5	5	5	5	35
DATA ENTRY	2	2	2	2	2	2	2	14
HLTH PLNER	2	2	2	2	2	2	2	14
WAREH MANG	2	2	2	2	2	2	2	14
OFFICE SPACE	1	1	1	1	1	1	1	7
SUBTOTAL	283	728	79	131	73	73	67	1,434
TECH ASSIST; MONTHS	4	3	3	4	2	1	1	18
COST	80	60	60	80	40	20	20	360
ANNUAL TOTAL	363	788	139	211	113	93	87	1,794

APPENDIX: PROJECT START UP NOTES FOR LMIS

The following is a narrative summary of those LMIS activities most important for implementation as soon as possible after project signing.

1. CONTRACEPTIVE PROJECTIONS. The following information should be reviewed to assure that adequate contraceptive supplies are available and on order. These apply to all three donors: USAID, UNFPA, and IPPF.
 - o stocks in warehouses at the central level,
 - o stocks presumed to be at regional stores based on recent distribution data,
 - o shipments en route, and
 - o orders placed.
2. WAREHOUSING needs to be identified for any contraceptives stored inappropriately or en route.
3. TRANSPORT needs to be identified for moving contraceptives out of Dar es Salaam.

Ideally, warehousing and transport and warehousing will be arranged in a manner consistent with the MOH emphasis on an integrated PHC distribution system.

Once such a system has been clearly defined, vehicles should be ordered. "Clearly defined" means knowing where the vehicles will be assigned, who will assume responsibility for the vehicles, who will maintain the vehicles, and how the petrol funds will be expended. These are all clearly defined in proposals before the MOH but acceptance of these proposals will be required.
4. SENTINEL REPORTING SYSTEM. Implementation of this system is described in detail, including formats, in the May LMIS report. This system is intended to provide information, within 60 days of implementation, on which districts have contraceptives.
5. CLISWG. The membership of this committee must be identified, orientation undertaken, and the first field trip initiated.

PP/LMIS
19 May
page 38

solicit their assistance with study tour arrangements. Also
the Zambian TCDC consultant should be secured.

APPENDIX: CLISWG TERMS OF REFERENCE

The Contraceptive Logistics Information Systems Working Group (CLISWG) will assume responsibility for reviewing current FP MIS practices, designing a revised MIS (including manuals, exercises, and curricula), field test all of these, and monitor implementation.

CLISWG will be composed of representatives from the MOH and UMATI and work under the supervision of the MOH FP Programme Manager with:

- o funding from the USAID FP project, and
- o technical support from the UNFPA programme officer and a USAID technical advisor.

ACTIVITIES:

1. Fact-finding field tours to two diverse regions to assess current practices.
2. Interviews with MOH and UMATI managers to determine managerial information requirements and the state of current work on integrated PHC MIS activities.
3. Design client cards, registers, tally sheets, and reporting formats, plus write manuals, exercises, and curricula for the implementation of the revised FP MIS.
4. Field test all of the above (including the manual, exercises, and curricula) in at least two districts, providing complete pre-test training and post-test debriefing workshops.
5. Redesign based on results of the field test.
6. Conduct study tours to Kenya and Zambia to examine FP MIS accomplishments at these two sites.
7. Conduct a Dissemination Workshop for FP decision makers at which the revised MIS is presented for review.
8. Participate as resource persons in the training of trainers for nationwide implementation of the revised FP MIS, monitor this training to assure quality of instruction, and evaluate results of the training.
9. Participate in FP MIS TCDC activities, incorporating consultants from neighboring countries when appropriate, providing CLISWG members to share Tanzanian FP MIS experiences in other countries within the region.

findings to appropriate officers.

11. Monitor and evaluate the implementation of the revised FP MIS.
12. Conduct field tests of innovative integrated MIS techniques such as a Woman's Fertility Card.

PROPOSED CLISWG MEMBERSHIP:

- o MOH MCH Unit PNO, chairperson
- o UMATI headquarters officer,
- o an MCH/FP Coordinator,
- o an UMATI Coordinator, and
- o a MOH FP staff member will be included upon joining, and
- o an NGO representative.

HC

APPENDIX: CLISWG IMPLEMENTATION TIMELINE													filename = cwg_tm1n								draft 21 MAY						
	1991				1992				1993				1994				1995				1996				1997		
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3
ORIENT	X																										
FACTFIND	XX																										
INTERV MANGRS		X																									
STUDY TOUR ZAM			X																								
INITIAL DESIGN			X																								
TOT TRAINING				XX																							
FIELD TEST					XXX	XXX																					
REDESIGN							XX																				
PRINTING & PROD								XXX	XXX																		
IMPLEMENT														>	>>>	>>>	>>										
MONITORING														X	X	X											
EVALUATION																											
STUDY TOUR KENYA																X	X										
EDP FACTFINDING					XXX							XX	X											XX			
WOMN'S REPRO CRD																											
DHS IMPACT EVAL																											
EVALUATION PHASE																											

5/0

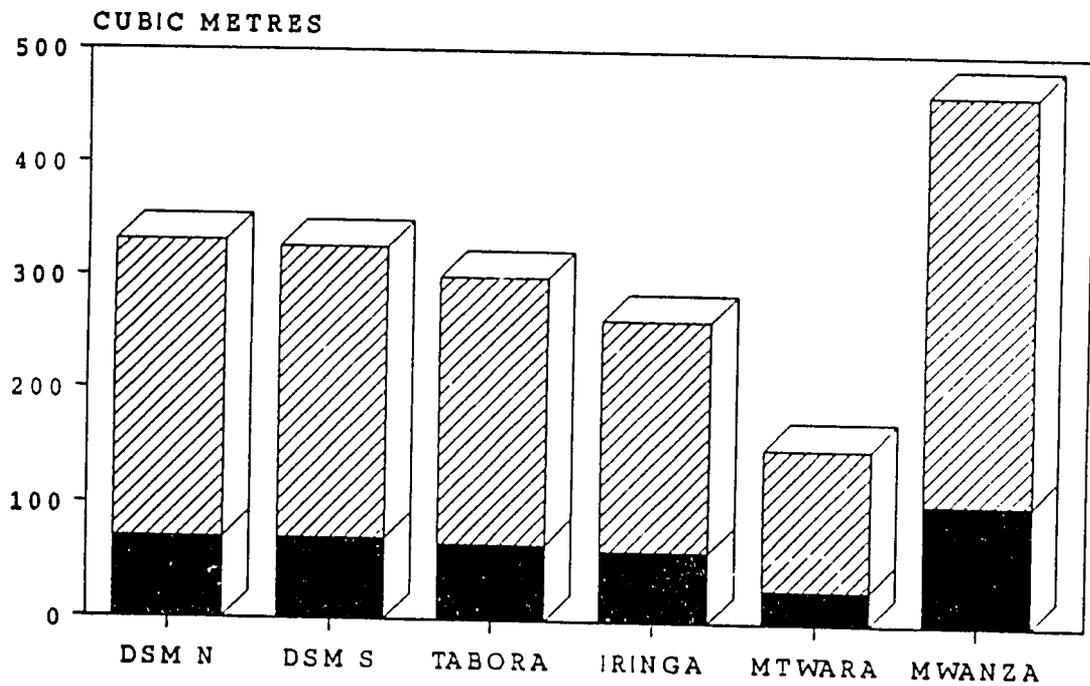
APPENDIX: TRANSPORT CALCULATIONS

I. TRANSPORT COST	PER ANNUM	COST
VEHICLE PROCUREMENT		
DISTRICT & REGIONAL SUZUKIS		\$163,200
136 districts x \$6,000 / 5 year life		
ANNUAL MAINTENANCE COSTS		
17% of procurement costs		\$27,744
FUEL COSTS		
SUZUKIS		
2,500 ltrs x 136 suzukis x \$.50 per ltr		170,000
TOTAL: ZONE TO HU COMBINED DISTRIBUTION		\$360,944 =====
II. SPACE REQUIREMENTS		
COLD CHAIN BOX SPACE REQUIREMENTS		
50 x 70 x 55 cm = 0.19 cu mt		
3106 EDP SDPs/ 5 per tour = 621.5		
0.19 CU MTRs x 621.5 tours		118 CU MTRs
EDP KITS		
YELLOW = 3000 X 0.09		288 CU MTRs
BLUE = 106 X 0.17		

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APPENDIX: VOLUME OF EDP KITS BY ZONE

VOLUME OF EDP KITS SIX MONTHS SUPPLY



UNICEF, 3 JUNE 1990

APPENDIX: ESTIMATED FP MIS STATIONARY REQUIREMENTS

filename=A_STATIO
draft 27 Jan 90

CLIENT CARDS		total =	26,100,000 cards
1990	4.9 million		
1991	5 million		
1992	5.2 million		
1993	5.4 million		
1994	5.6 million		
REGISTERS		total =	4,252 regis.
one per service delivery desk			
dispensaries =	3500		
health centres	250		
district hosp	85		
reg hosps	17		
PVOs	200		
others	200		
TALLY SHEETS		total =	567,120 sheets
per month: x 5yrs			
1 x disp	3500		
4 x hcctr	1000		
8 x disth	680		
16 x regh	272		
10 x PVO	2000		
10 x othr	2000		
INSTRUCTION MANUALS		total =	4,252 manuals
one / FP desk	4252		
CURRICULA MATERIAL		total =	63,780 sheets
15 pgs x FP desk			
FP REPORTS			255,120 sheets
1/month/facilityx5yrs			

APPENDIX: PROPOSAL FOR COMPUTER PURCHASE
FOR FAMILY PLANNING OFFICE
MINISTRY OF HEALTH, TANZANIA

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- 1.0 PROPOSED APPLICATIONS. The Family Planning Office proposes to use a desktop microcomputer for at least the following applications:
- o financial accounting including documentation of expenditures,
 - o word processing, including reports to donor organizations,
 - o the processing of Family Planning (FP) reports, as available, to generate key indicators of programmatic performance (e.g. Contraceptive Prevalence Rates (CPRs) by programme, zone, and district, across time).

- 2.0 STAFFING. The administrative assistant is experienced in word processing (Word Perfect), financial spreadsheets (LOTUS), database management (DBASE), and the use of operating systems and utility packages.

The secretary has experience in word processing.

- 3.0 ALTERNATIVES. The MCH computer is backlogged with the entry of MCH reports. It is a Wang computer with a processor two generations out of date. It uses very low density 5 and 1/4 inch disks. There is no printer. Printing requires that the material be moved to a disk which is hand carried to the other end of the Ministry for printing at the convenience of other non FP staff members.

- 4.0 ESTIMATED COSTS. Although the FP office does not have precise information regarding current list prices for the items included on the technical specifications list, very rough estimations of US based list prices might approximate:

Hardware (including UPS)		\$5,000
Software	1,300	
Supplies	<u>700</u>	
TOTAL (not including airfreight)		8,000 USD

- 5.0 PROPOSED TIMING. Given that recently-hired computer-skilled staff are underutilized without a computer, the hardware and software should be airfreighted as soon as possible.

4/6

6.0 TECHNICAL SPECIFICATIONS.

IBM PS\2, or compatible, with:

386 processor
3 (three) megabytes of RAM¹
one 3.5" High Density 1.4 mg floppy drive
one 40 MG hard disk drive

one Colour Monitor

one external 5 1/4" floppy disk drive²

Uninterruptable Power Supply³

Printer: dot-matrix
wide carriage
sheet feeder option

Printer cable!

Software: DOS 4.0 or better
Word Perfect version 5.1
Lotus 1-2-3, version 3.0
DBASE IIII
PC Tools⁴
FASTBACK⁵
Harvard Graphics⁶

Other Start-up Supplies:
plastic dust cover for: computer,
external drive, and
printer
computer cleaning supplies
diskette storage box; 3.5" floppies
diskette storage box; 5 1/4" floppies
5 (five) boxes of 10@: 1.4 mg 3.5" floppy disks
2 (two) boxes printer ribbons
3 (three) boxes of continuous feed computer paper

7.0 Supporting Notes:
Technical Specifications

1. Three megabytes of RAM will enable full use of the "windows-environment" and eventually multi-tasking. Given the data and reporting intensive work of FP office, this capacity is well worth the expense for the additional memory.
2. The 5 1/4" external drive will provide compatibility with other older computers serving the MOH.
3. The additional expense of a UPS is justified by the frequency of power surges and power outages in Dar es Salaam. Without the UPS, the system would be at considerable risk.
4. Although a number of utility packages would serve this purpose, the current staff has experience with PC Tools.
5. The working environment and the importance of the data will require the capacity to back up frequently and quickly.
6. Harvard Graphics will enable the FP Office to provide feedback to service delivery personnel and improve presentations to donors and supervisors.

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APPENDIX: PHOTO READY SENTINEL REPORT FORM

CONTRACEPTIVE MONTHLY STOCK RECORD (please submit with EDP form D.3)		
MONTH & YEAR: _____	DISPENSARY: _____	GRADE: _____
REPORTED BY: _____	HEALTH CENTRE: _____	
REPORTING DATE: _____	DISTRICT: _____	
SIGNATURE: _____	REGION: _____	

	Unit	B/F	Rec'd	Used	Ret'd	Date Finish	Bal
Oral Pills	cycle						
Condoms	piece						
IUDs	piece						
Depoprovera	10cc						
Diaphragms	piece						
Spermicides	tubes						
Spermicides	tab						

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APPENDIX: PROPOSED PROJECT PAPER NARRATIVE
LOGISTICS AND MANAGEMENT INFORMATION SYSTEMS

CONTRACEPTIVE PROCUREMENT. In order to meet FPSS project CPR objectives, contraceptives will be procured to supplement supplies from other donors, UNFPA and IPPF. Funds budgeted for contraceptive procurement under the project assume continuation of UNFPA and IPPF supplies.

No less than annually, contraceptive use data will be compared with existing stocks to project shipping schedules for all contraceptive donors for the following three years.

CONTRACEPTIVE LOGISTICS. The current warehousing capacity for contraceptives is limited to 72 square meters. This is far less than current requirements and about half of what will be required at project commencement.

A single three ton truck is available for distribution from the port through central warehousing and out to the regions. Reliance on commercial transport has proved difficult. The current contraceptive distribution system extends only to regions. Movement of contraceptives from region to service delivery points is ad hoc and relies on a "pull effect."

SHARED DISTRIBUTION COSTS. Both the Extended Programme on Immunization (EPI) and the Essential Drug Programme (EDP) have distribution systems that include warehousing and transport. The EPI programme, in particular, has a reputation for a well executed preventive maintenance programme that keeps its vehicles functioning longer than those in other programmes.

These two programmes have begun discussion on the savings that would accrue from a shared distribution system. The inclusion of contraceptives in such a shared system would require only 4% of the combined space requirements of the three programmes.

The three programmes agreed in principle on the adoption of a shared approach during the development of the FPSS project paper. MOH endorsement of this plan is anticipated prior to project commencement.

FPSS assistance for warehousing and transport expenses will be expended in support of a shared distribution programme. Technical assistance will be provided, when and if required to assure the appropriateness of the these expenditures.

INFORMATION SYSTEMS. Although both the MCH unit of the MOH and UMATI have systems that collect data on family planning, both have rather severe limitations. UMATI collects primarily acceptor information. On the MOH forms, 94% of those submitted in 1989 failed to report on contraceptive commodities. Stockoutages are discovered repeatedly when programme staff undertake field visits.

The most immediate need is for a SENTINEL REPORTING SYSTEM. By modeling on the existing EDP system, - by using the same form design, the same facilities, and the same submission procedures, - it is possible to implement quickly and, within 60 days, have information on which districts are without contraceptives.

A more lengthy process will design and implement the elements of a FAMILY PLANNING MANAGEMENT INFORMATION SYSTEM. These elements include a revised client card, tally sheets, a FP register, and periodic reports. These will be accompanied by an instruction manual, case study exercises, and a curriculum to be used during implementation and pre-service training.

These elements will focus on those indicators most important to the Tanzanian Family Programme: contraceptive prevalence rates, adequacy of contraceptive supplies, and continuation rates.

These indicators will be used at each level of management to assess performance against expectations, and to identify relative performance between districts and regions.

A joint working group of representatives from the MOH and UMATI will advise the MOH in the design, testing, and implementation of this system. The FPSS project will provide technical assistance to this working group.

APPENDIX: HOST COUNTRY COMMITMENT NOTES

Within LMIS, the following evidence of host country commitment may be noted:

1. CONTRACEPTIVES. USAID contraceptives will be phased in during the project. The MOH has identified other sources of contraceptives.
2. WAREHOUSING. UMATI currently provides storage at the central level. In addition, the MOH warehouse at Mabibo and MOH zonal and district stores are used.
3. TRANSPORT. UMATI and MOH vehicles are used for transport throughout the system.
4. MAINTENANCE. MOH systems (via EPI) provide maintenance.
5. PETROL. Much of the petrol is provided through existing govt. fuel votes.
6. STAFF TIME. MOH and UMATI staff supervise the projection of contraceptive need, the warehousing, and the distribution of contraceptives. They also submit and process reports on contraceptive availability.

APPENDIX: ADVISORY COMMITTEE PRESENTATION

MAY 14, 1990

FORODANI HOTEL

DAR ES SALAAM

COMMODITY LOGISTICS MANAGEMENT INFORMATION SYSTEMS

- CONTRACEPTIVE COMMODITIES
- WAREHOUSING
- TRANSPORT
- MANAGEMENT INFORMATION SYSTEMS

14 MAY 1990

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CONTRACEPTIVE COMMODITIES

- ASSUMPTIONS:
 - Prevalance Rates
 - PID budget
 - other donor budgets
 - method mix
- PRODUCT:
 - QTY by year
 - QTY by method
 - Budget by year
 - Budget by method

14 MAY 1990

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WAREHOUSING

- ASSUMPTIONS:
 - UMATI at Central Level
 - Zonal Warehousing
 - District EDP Warehousing

- PRODUCT:
 - Space and cost, Central level
 - Space and cost, each Zone
 - Requirement at Districts
 - Capacity at SDPs
 - cupboards, desks, chairs,
 - calculators, stationary

14 MAY 1990

TRANSPORT

- ASSUMPTIONS:
 - UMATl from port to warehouse
 - UMATl from warehouse to Zones
 - EDP from Zones to Districts
 - EDP from Districts to HC/Disp
- PRODUCT:
 - SIZE AND NUMBER OF VEHICLES:
 - UMATl requirements
 - EDP, Zone to District requirements
 - Suzukis, District to HC/Disp

14 MAY 1990

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MANAGEMENT INFORMATION SYSTEMS

- ASSUMPTIONS:
 - Reports follows contraceptive distribution
 - Reports support management & supervision
 - Reports enable commodity projections
 - Reports provide FP programmatic monitoring

- PRODUCT:
 - Fact-finding & design
 - Field Testing
 - Material Production
 - Training & Implementation

PID VS PROJECT PAPER TASK COMPARISON

<u>PID</u>	<u>PROJECT PAPER</u>
<ul style="list-style-type: none">o Level of detail to support INCLUSION of proposed activities.	<ul style="list-style-type: none">o Level of detail to support IMPLEMENTATION of these activities.

14 MAY 1990

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APPENDIX: TERMS OF REFERENCE FOR FP CHIEF
MONITORING AND EVALUATION
OFFICER (MA, RESEARCH AND
EVALUATION, EXETER)

The Family Planning Research and Evaluation Officer will assume responsibility for assuring the MOH FP Programme Manager information required to enable optimal management of the FP programme. Indicators such as prevalence rate, new acceptors, and continuity rates will be periodically presented in formats that compare district, regional, and zonal performance, and illustrate progress across time.

The Officer will also assist the FP Programme manager in using Management by Exception techniques to direct resources toward the identification and resolution of problems restraining growth and quality of the FP programme.

Information will be shared with UMATI, donors, and other organizations and agencies participating in and providing assistance to the FP programme.

The Family Planning Research and Evaluation Officer will report to the FP Programme Manager, and will, in turn, supervise the FP Demographer and data entry clerk.

Training in Contraceptives, FP MIS, and computer management will be provided for the Research and Evaluation Officer.

SPECIFIC ACTIVITIES WILL INCLUDE:

1. Preparation of periodic reports assessing programmatic performance as measured the key indicators.
2. Preparation of periodic reports identifying districts with poor performance as measured by these indicators.
3. Directing personnel within the MOH and coordinating with personal from UMATI and other agencies in the investigation and resolution of poor performance.
4. Reporting periodically on the frequency with which major problems are identified and the success achieved in resolution of these problems.
5. Providing reports to UMATI, donors, and other agencies relevant to their concerns.

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APPENDIX: TERMS OF REFERENCE FOR FP
PRINCIPLE MONITORING AND
EVALUATION OFFICER
(DEMOGRAPHER)

The FP Demography Officer will assist the Research and Evaluation Officer in the maintenance of the FP MIS and in assuring the optimal managerial use of the MIS.

The Demography Officer will visit districts reporting poor performance and/or a lack of progress as measured by indicators determined by the FP programme.

The Demography Officer will join ClISWG members in assuring the introduction of managerial and supervisory techniques through which MCH/FP Coordinators and UMATI Coordinators will identify local constraints and design interventions to eliminate these problems.

The Demography Officer will report to the Research and Evaluation Officer. This position will require considerable travel.

Specific Activities will include:

1. Assuring completeness of reporting from districts.
2. Assuring the managerial use of data by MCH/FP Coordinators and UMATI Coordinators.
3. Investigation at poor performance sites of issues likely to cause the poor performance and identification of resources required to resolve these problems.

APPENDIX: PERSONS CONTACTED

Dr. A. Mzige	Director MCH/FP	MOH
Dr. F. Mrisho	FP Programme Manager	MOH
Dr. A. Kimambo	SMO, EDP	MOH
Dr. K. Msambichaka	EPI Manager	MOH
Dr. K. Nyamryakunge	NCAP Manager	MOH
Ms. E. Mbatia	Statistician	MOH
Ms. Massila	SNO, MCH/FP	MOH
Mr. B. Malgaard	Advisor	MOH
Mr. H. Hansen	Project Ccoordinator, EPI	MOH
Ms. Nsekela	Executive Director	UMATI
Mr. Upangile	Director of Operations	UMATI
Mr. W. Mbunda	Research and Evaluation	UMATI
Mr. P. Mushi	Supplies Officer	UMATI
Dr. A. Arkutu	Res Rep and Sr. Advisor on Population	UNFPA
Dr. F. Magari	National Programme Officer	UNFPA
Ms. A. Ekpo-Comvalius	NACP TEch Officer	WHO
Dr. H. Van Asten	NACP Epidemiology Officer	WHO
Ms. L. van den Assum	Country Director	UNICEF
Ms. June Ward	Programme Officer	UNICEF
Mr. A.P. Senegama	Supply Officer	UNICEF
Mr. James Lee	Asst. Programme Officer	UNICEF
Mr. Per Larsen	Health Officer	DANIDA

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PROJECT PAPER RECOMMENDATIONS

TRAINING AND SERVICE DELIVERY TEAM

30 May, 1990

TEAM MEMBERS:

DR FATMA MRISHO
Director, National FP Programme, MOH

MS JENNY HUDDART
Initiatives Inc./USAID Consultant

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EXECUTIVE SUMMARY

1. The recommendations contained in this report are based upon the following considerations:
 - (a) USAID/Tanzania's desire to assist the MOH to achieve the goals it has set for the National Family Planning Programme as outlined in its Plan of Operations;
 - (b) the need for the proposed FPSS Project to complement the support to be provided for family planning training by UNFPA;
 - (c) the agreements reached with the MOH during the PID development process on a framework for the training component of the FPSS Project.
2. The main purpose of the training component of the proposed FPSS Project is the establishment of an effective family planning training system in support of the National Family Planning Programme. This will be achieved through efforts to strengthen the capacity of the MOH and UMATI to plan, organize, monitor and evaluate basic and in-service family planning training programs. The local participant costs for the implementation of the in-service training courses are to be covered by the UNFPA Project.
3. The proposed FPSS Project support should cover the assessment of training needs; the development of training strategies and implementation plans; the development/procurement of the necessary curricula and training materials; the design and implementation of training management information system/s; and the design and implementation of systematic trainee follow-up and evaluation procedures. The FPSS Project should also fund the salaries of additional training staff for MOH and UMATI and assist in the development of training skills through short-term fellowships and in-country training programs.
4. In addition to the above, it is recommended that the FPSS Project also support the implementation of family planning training for special groups of service providers, namely: tutors from basic paramedic training institutions; and hospital-based clinicians.

5. Finally, it is recommended that the FPSS Project should contribute towards the equipping of the planned National Family Planning (Training and Research) Centre to be constructed with NORAD funds. During the interim period prior to the commissioning of the Centre, the FPSS Project should lease suitable office accommodation for the central MOH/FP Programme staff and for the UMATI Training Unit.
6. The MOH will be responsible for training policy, for training strategy development and planning, and for coordinating all family planning training activities, including the coordination of family planning training with other MOH PHC training programs. The UMATI Training Unit will provide the basis for the Central Family Planning Training Team, and will be responsible for the training of family planning trainers at the zonal/regional and district levels of the MOH.
7. The development of the family planning training system will fall into three main phases:
 - Phase 1 (Year 1): Recruitment of training staff, development of family planning service policies and protocols, and identification of training needs and strategies.
 - Phase 2 (Year 2): Development of training curricula and teaching/learning materials.
 - Phase 3 (Years 3-7): Phased implementation of decentralised in-service training program.
8. The development of a new, nationwide and decentralised training programme is an ambitious undertaking, and there are likely to be many unanticipated factors influencing implementation. As part of the mid-term Project evaluation at the end of Year 3, progress in the implementation of the training component will be carefully reviewed and, if necessary, a revised plan of activities will be developed for the remaining years of the FPSS Project.

FAMILY PLANNING TRAINING

1. BACKGROUND

1.1 Training Requirements of the National Family Planning Programme

The National Family Planning Programme's main strategy for the expansion of services, as laid out in the Plan of Operations, is the provision of in-service training for large numbers of service providers operating out of government MCH clinics at hospital, health centre and dispensary facilities.

The main service providers have been defined as MCH Aides, with support to be given from Doctors, Medical Assistants, Rural Medical Aides, Public Health Nurses and Nurse/Midwives. Health Officers and Health Assistants are also targetted for training to enable them to participate in client motivation. The total number of trainees nationally is estimated to be around 7,500, with a target completion date of December 1993. In addition to clinic-based service providers, the programme calls for the training of 2 Village Health Workers, Traditional Birth Attendants or Community Development Assistants from each village to a total of 34,000 by 1993.

The strategy laid out in the Plan of Operations for the achievement of the in-service training targets is to develop FP Training Teams at the central, zonal/regional and district levels. The central team will train zonal/regional trainers. The zonal/regional training teams will train district trainers teams who, in turn, will be responsible for training service providers at the clinic level. The zonal, regional, and district trainers will be selected from existing nursing officers or public health nurses and will be expected to devote at least 75% of their time to FP training during the first phase of the decentralised training programme. It is intended that responsibility for the training of CBDs will lie with service providers (largely MCHAs) from the health centre and dispensary levels.

1.2 UNFPA Support for Family Planning Training

The only significant donor support for the achievement of the training targets outlined in the National Family Planning Programme Plan of Operations is that of UNFPA. The single largest training component of UNFPA's \$6.5m Project, spanning the four years 1990-1994, is the funding for local participant costs for the training of zonal, regional and district training teams and 6,500 service providers. The UNFPA Project assumes that UMATI will be responsible for the training of the zonal/regional training teams; the training of district trainers and of

service providers will be the responsibility of the MOH.
TRAINING
PAGE 2

Other training components of the UNFPA Project's training budget include participant costs for the training of institutional tutors from each of the paramedic basic training school, the local training of regional and district medical officers in programme management, several local training courses in contraceptive technology update and communication/motivation skills to be provided by CAFS, and a number of long-term training fellowships for FP programme staff.

1.3 Decisions Reached During the PID Development Process

As outlined above, the focus of the training component of the UNFPA Project is the implementation of in-service training courses. UNFPA is eager for training of service providers to commence as soon as possible and will be pushing for an early start to training in a small number of Districts. On the other hand, it was agreed, during the PID stage, that the proposed USAID FPSS Project would complement that of UNFPA by supporting, over the long term, the development of institutional capacity, within the MOH and UMATI, to plan, organize, monitor and evaluate a national training programme for family planning. FPSS Project support would assist the National FP Programme to identify training needs, to develop relevant curricula and training materials, to establish systems and skills in the management of a training function, and to evaluate training effectiveness. Thus, the FPSS Project would assist in ensuring the effectiveness of the in-service training courses which will be implemented with UNFPA support.

The PID Team recommended that a full-time central training team for family planning was required to fulfil the ambitious training targets of the National Family Planning Programme and to ensure that the training provided is of consistent quality. Furthermore, it was agreed that, given the lack of resources within the MOH headquarters, and based on UMATI's previous training experience, the UMATI training unit should form the foundation for the development of the central family planning training team, at least for the first phase of in-service training activities.

The second phase of family planning training, which should aim at greater integration with other decentralised PHC in-service training activities through the zonal continuing education centres, may demand a change in the respective training roles of the MOH and UMATI. In addition, the establishment of the proposed National Family Planning (Training and Research) Centre will provide an opportunity to formulate a longer-term strategy for family planning training in Tanzania.

1.4 The Current Family Planning Training Situation

(a) Service Guidelines:

A recent INTRAH training needs assessment, conducted in February 1990, stresses the lack of clearly defined service policies, service policies and job descriptions relating to family planning responsibilities. Thus there is little guidance for the design of either basic or in-service training curricula and little basis for proper supervision.

(b) Pre-Service Training:

The basic curricula for nursing, MCHA, medical assistant and rural medical aides were revised in 1987 and the MCH component, including family planning, was strengthened. However, the curricula require updating in line with the new policies promulgated under the National Family Planning Programme.

In addition, an initial training needs assessment carried out by INTRAH in February, 1990, confirmed that the family planning component of the basic training programmes for MCH Aides, Public Health Nurses and Medical Assistants remains inadequate. Little, if any, funds are available for the field practicums and supervision of the field practicums is not well organized. Furthermore, few of the tutorial staff have received any training in family planning and in many institutions, the latest curricula have not even been implemented. No formal evaluation of the effectiveness of pre-service family planning training has ever been conducted.

All pre-service health training institutions are critically short of family planning teaching/learning materials. No basic family text or manual, wall-charts or teaching models are available.

- USAID/Tanzania have provided funding for JHPIEGO to assist UMATI to provide family planning training for tutors from the nursing and MCHA training schools to supply these schools with reference materials and teaching aids. \$160,640 has been obligated for the period November 1989 through April 1991 to cover the training and provision of teaching/learning materials of 50 nurse tutors from 25 schools.

USAID/Tanzania have also provided funding for JHPIEGO to assist the Association of Gynaecologists and Obstetricians of Tanzania (AGOTA) to hold a continuing education workshop in safe mother-hood and to follow up this workshop with a seminar for the review and strengthening of the family planning component of the undergraduate medical curriculum. It is intended that the new curriculum will be implemented in 1990, with the first group of students graduating from the new curriculum in 1994.

(c) In-Service Training

In the past, UMATI have been the major providers of family planning training for MOH staff and they conducted this training without any financial reimbursement from the MOH. Up until 1987, UMATI trained service providers directly. During 1987 and 1988, UMATI trained the zonal and regional MCH Coordinators and regional UMATI Coordinators as family planning trainers. Each of the 20 regional family planning training teams conducted at least one course for service providers. It is estimated that approximately 800 MCHAs were trained in this way before lack of funds halted the training process. Due to the lack of any systematic information system, it is difficult to track the number of courses conducted by the regional trainers and impossible to determine which staff have been trained, their cadre, when they were trained, or whether those trained are still deployed in MCH clinics.

UMATI currently have a team of 10 trainers; all have basic nursing qualifications, 3 have had training as nurse tutors. None of the trainers have had training in needs assessment, curriculum design or trainee evaluation.

UMATI have developed two basic training curricula for FP: one for clinical & communications skills, the other for training family planning trainers. The same curricula have been used regardless of the cadre or skill levels of trainees. The recent INTRAH assessment found that there is little, if any, coordination between basic and in-service training and, as a result, the in-service curricula do not address relevant skills and competencies for service delivery. Since the cessation of service provider and TOT training for the MOH, UMATI have conducted FLE training for youth leaders under funding from SIDA and have run family planning TOT and clinical & communication skills courses for their own staff.

UMATI have few teaching aides for their family planning training and no reference materials/manuals which can be kept by trainees for future guidance and reference. GTZ have funded the development of two informational texts for village health workers and for MCH Aides, together with a flip chart for community motivation. However, neither of the texts provide the service provider with "how to" information. A preliminary inventory of family planning training materials and curricula was conducted by CEDHA at the request of the MOH Family Planning Unit. However, neither the scope of the inventory nor the items recommended for use was found to be adequate to the needs observed by the recent INTRAH assessment.

The MOH Department of Manpower Development and Training (DMDT) maintain a core team of training management staff at head office, covering pre-service and continuing education. DMDT is intending to develop a network of zonal continuing education centres and to decentralise the implementation of in-service training.

At the present time, 24 vertical PHC programs are operating their own series of in-service training activities, and the goal of the DMDT is to encourage integration of all PHC in-service training activities through the medium of the zonal centres and zonal continuing education coordinators. However, they recognise that to initiate a new program such as family planning, the first round of training will have to use a vertical approach, with better integration sought through the decentralized zonal training centres as a second phase.

The new UNFPA project includes a significant training component, covering local participant/UMATI trainer costs for the training of zonal/regional trainers, district training teams and service providers (MCHAs, RMAs, MAs to a total of 6500).

Considerable effort has been made by the MOH to establish a village health worker programme. This programme includes the development of PHC/VHW training teams at zonal, regional and district levels. Approximately 3100 VHWs are currently working, out of a planned 1995 goal of 17,000. Family planning is not included in the present curriculum, although there are plans to include this in the near future. VHWs are front line workers and can play an important role in informing communities about family planning and motivating them to seek services from the clinics.

(d) The National FP Centre

A National Family Planning Centre (NFPC) is to be constructed on the site of the Muhimbili Medical Centre (MMC). The role of the NFPC is intended to be that of a training and research base for reproductive health, including family planning. The Centre will utilise the clinical base provided by the MMC Maternity Unit to provide training in family planning and reproductive health for undergraduate and graduate doctors and other senior health personnel. In the longer term, it is intended that the NFPC will act as a regional training centre for training tutorial staff from paramedical training institutions. It has been agreed that the NFPC will be managed by UMATI, and that a Director of Training be appointed to oversee training activities. It is anticipated that the NFPC will be commissioned within during 1993.

Based upon the original specifications for the NFPC, NORAD agreed to provide \$800,000 towards the cost of constructing and equipping the NFPC, and to contribute towards the first four years' running costs. Since that agreement was reached, it has been proposed that the staff of the central MOH family planning division should also be housed at the NFPC, together with the UMATI central training unit. This decision means that additional donor support will be required to complement NORAD's contribution.

At the present time, the MOH family planning division have a total of two offices, currently accommodating 4 staff, with another 3-4 staff anticipated to be joining the Programme over the next 6 months. The 9 UMATI trainers based in Dar es Salaam are currently working out of 2 offices, with no space for meetings or for storage of equipment and materials. Neither the MOH or UMATI have the funds to rent sufficient office accommodation, and the situation will be critical until the NFPC building is commissioned in 2-3 years' time.

(e) Management of the Family Planning Training Programme:

Whilst considerable efforts have been made to define the volume of training required, less attention has yet been given to how the training targets can be achieved. The UNFPA project will support local participant costs for courses, but little support has been allocated to developing training capacity. The volume of training envisioned by the National FP Programme requires careful planning and preparation to ensure effectiveness. At the present time there are no clearly defined service policies or protocols upon which to base decisions on who needs training for what responsibilities. Curricula need to be developed and teaching and learning material needs have to be defined. A realistic and phased implementation plan needs to be developed, taking into account the need for adequate support and follow-up to the decentralised training process.

The staffing of the central family planning unit within the MOH is currently planned to consist of the following posts: a Director, a Deputy Director, a Research/Evaluation Officer, an Administrative/Finance Officer, and a Secretary. While it is intended that each of these positions will eventually be established MOH posts, full or partial (top-up) funding will be provided by UNFPA for a period of four years. UNFPA are not presently intending to support any position related to family planning training.

The overall management structure for the FP training programme has not yet been formally determined. The relative roles of the MOH FP Unit, the proposed Training Director of the NFPC, of the UMATI central training team, and the zonal, regional and district family planning trainers have yet to be clearly defined and agreed.

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2. RECOMMENDED PROJECT COMPONENTS

2.1 Development of an In-Service Training Programme for Family Planning

The National Family Planning Programme requires the establishment of a comprehensive in-service training system with careful preparation to ensure that the training is both relevant and effective. UNFPA support is targetted at training course implementation. The FPSS Project should aim to develop the institutional capacity to manage an effective training program through the provision of technical assistance, training, material support and additional staffing.

The development of a strong in-service training programme programme for family planning will require the following steps:

(a) Development of Service Standards and Protocols:

The FP services to be offered at each type of service site need to be defined and documented and service protocols developed as a basis for curriculum development, supervision and training. Based on the service protocols, the family planning responsibilities of each relevant cadre/position need to be defined and incorporated into the job descriptions. A supervisory checklist and guidelines need to be developed. The FPSS project should support the development of the necessary documentation, and the costs of printing, duplication and distribution. The service standards, protocols, job descriptions and supervisory checklist should be distributed to all service providers, supervisors, basic training institutions and in-service training teams.

(b) Inventory of Current FP Activities:

There are currently various existing and planned projects relating to family planning in different parts of the country but there is no comprehensive information on these projects available to the central FP Unit of the MOH. For the development of a training implementation plan for the National FP Program, which avoids duplication and builds upon other initiatives, the FPSS Project should support an inventory of projects related to FP needs to be conducted to collect data on project objectives, timescales, client population, training, and resource inputs.

(c) Inventory of Clinic Needs:

To enable service providers to implement the skills developed during training, the necessary equipment must be available at the clinics.

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The FPSS Project should support the development of a checklist of essential equipment (including such items as screens for client privacy) for each type of service site should be developed by the MOH FP Unit and the printing of sufficient copies for each MCH clinic (at hospital, health centre and dispensary levels). The FPSS Project should then fund an inventory of each service site to determine clinic needs and the procurement of the necessary items.

(d) Definition of Training Needs:

Based on the service standards, protocols and job descriptions, the skill and knowledge requirements for each staff category should be defined. The content areas will include, but not be limited to: family planning appreciation; clinical family planning skills; client motivation/ communication; counselling; record-keeping; use of information for work planning and client follow-up; supervision; and training skills.

(e) Determination of In-Service Training Strategy:

The strategy for training implementation will need to be determined. This strategy must cover: a) the format of the curricula. eg. should record-keeping be taught as one component of an integrated family planning course, or should it be taught as a separate, stand-alone module; b) the composition of the trainee groups. eg. clinic teams, uni-disciplinary, etc.; the phasing of training of the different groups. eg. within a District, should the District Management Team receive training first, followed by FP trainers and preceptors, and lastly service providers. Both Government and NGO representatives should be involved in the strategy development process.

(f) Selection of Practicum Sites:

To improve the field practicum components of training, a small number (one or two) practicum sites should be selected within each District, based on their location, physical structure, client load and staff availability. The number and designation of preceptors to be trained from each of the sites will also need to be determined. Specifications of the equipment and other materials (including teaching and IEC materials) required at each of the practicum sites should be developed, an inventory conducted to determine the current situation at the selected sites, and the necessary items procured and installed.

75.

(g) Determination of Trainer Requirements:

The responsibilities of each of the family planning training teams (i.e. at central UMATI and MOH, zonal/regional and district levels), together with their relationship to each other, need to be defined and documented.

The composition of each of the training teams, covering numbers of trainers, qualifications/position, and their full-time or part-time status, must also be specified. The skills required of the family planning training program should be specified and a plan developed for the acquisition of these skills through short-term fellowships, secondments, etc.

(h) Development of a Master Training Implementation Plan:

An overall implementation plan for in-service family planning training should be developed. This plan should cover materials development, trainer preparation, the geographic phasing of training, trainee follow-up, course scheduling etc., for both Government and NGO sectors. The plan should also include an evaluation schedule, covering the types of evaluation to be conducted, by whom and when, and cover an annual review and replanning exercise.

The decision on the phasing of the implementation of the in-service training will be taken by the MOH, with assistance from the Central Training Team (CTT) based at UMATI. However, in drawing up the recommendations for FPSS assistance, certain assumptions have been made. It has been assumed that training will proceed in groups of four regions at a time, with the following sequence followed for each group of regions:

- (1) Training of zonal/regional trainers from the first 4 regions. During their training, each zonal/regional team will be required to develop a training implementation plan.
- (2) The zonal/regional trainers, in two groups of 2 regions each, train preceptors from selected practicum sites (2 per district) within the regions. This training will both prepare preceptors in readiness for the district training teams, and will provide the zonal/regional trainers with practical training experience. Each of the combined zonal/regional training teams to be supported by at least one trainer from the CTT;
- (3) The zonal/regional trainers, in regional teams, train one group of service providers as training practice. The trainees will undergo their field practicums under the supervision of the previously-trained preceptors. Each of the four zonal/regional training teams to be supported by a trainer from the CTT.

- (4) The zonal/regional trainers, in regional teams, train district training teams from the districts within their regions. Each of the four zonal/regional training teams to be supported by a trainer from the CTT. At the end of the training, each district team will develop their own training implementation plan.
- (5) Each District training team train service providers from their district. On average, each district training team will have to train staff from 30 clinic sites.

As outlined above, effective decentralisation of training responsibilities and maintenance of training quality will require considerable support from the CTT and zonal/regional training teams. It is recommended that the FPSS Project support the local costs of transportation and per diem to enable trainers from the central and zonal/regional levels to supervise and support the training activities of the next level training teams.

Based on the above phasing, (5 groups of 4 regions), it is estimated that national coverage could be achieved within 5 years from the date of commencement of training. During this period, and approximately 12-18 months following completion of training, a follow-up evaluation of service provider performance should be conducted and plans developed to provide refresher training to meet identified shortcomings. For this second generation of in-service training, efforts should be made to integrate family planning training with other training in primary health care, through the medium of the zonal continuing education centres.

(A summary of the above format for phased implementation of training is given in Annexes 1(a) and 1(b)).

(i) Training Management Information System:

In order to monitor the implementation of the training plan and to keep track of training resources, a training information system should be designed as soon as possible following completion of the training implementation plan. The information required for managing the training program will need to be determined, covering inventories of materials and equipment, budgets and expenditures, courses implemented and individuals/cadres trained, etc.; and a system designed for data collection, aggregation and analysis. The responsibilities of the decentralised training teams for maintaining the MIS and the use of the data will form part of the TOT training curriculum. (Preliminary discussions with UNFPA indicate that the design of the training MIS might be supported by the Royal Tropical Institute of Holland.)

(j) Development of Training Curricula:

Based on the skill and knowledge requirements as defined in (4) above, and upon the training strategy selected (5), existing basic training curricula basic training should be revised as necessary, and in-service curricula for each content area developed.

The proposed UNFPA-funded TOT course in communication and motivation skills to be run by CAFS in July 1990 will assist in the development of that component of the service-provider curriculum. The Contraceptive Logistics and Information System Working Group (CLISWIG), to be supported by FPSS, will be responsible for developing the client and logistics MIS component of the service provider curriculum. EMAU are intended to assist in the development of the counselling component. FPSS should support the development of the necessary curricula, their pre-testing, finalisation, printing and distribution.

(k) Development of Teaching/Learning Materials:

Based on the service standards, protocols and job descriptions, and upon the family planning curricula for pre-service and in-service training, a comprehensive teaching/learning materials needs assessment should be conducted, covering both basic and in-service training, and resulting in a specification of basic requirements. Existing materials from the region should be collected and, wherever possible, adapted and/or translated for use in Tanzania.

The FPSS project should support the costs of collecting existing regional materials, their review and adaptation, and the printing and distribution costs. It is estimated that a total of two service provider manuals and 4 teaching posters/flipcharts will be supported. In addition, the FPSS Project should supply each FP training team and basic training institution (both Government and NGO) with a small collection of reference texts for use by the teaching staff and students.

2.2 Strengthening the Family Planning Training Staff

Preliminary estimates of trainer requirements for the central UMATI training team, based on assumptions on training strategy and phasing, upon current information regarding possible secondments to the program of trainers from other organizations, and upon the potential for UMATI to allocate their own trainers to the program, result in the need for the FPSS Project to fund the salaries of up to 4 trainers for a period of 7 years. These salaries would be based upon existing UMATI terms and conditions.

2.3 Training of Institutional Tutors

The UNFPA Project includes funding for the participant costs of training tutors from the basic training institutions. However, UMATI, with support from JHPIEGO, is currently implementing a project for the training of 50 nurse tutors in family planning from 25 nursing and MCH Aide basic training schools. In order to allow UNFPA Project funds to cover the local participant costs for a larger number of service providers, and to ensure continuity, it has been agreed that the FPSS Project should continue USAID's support to UMATI for the training of tutors from the basic training schools.

Once the curricula for the basic training of service providers have been revised, the training of institutional tutors should be extended beyond the 25 nursing and MCH Aide schools to all the relevant training institutions. There are 91 paramedic schools covering the basic training of nurse tutors, public health nurses, nurse/midwives, MCH aides, assistant medical officers, medical assistants, rural medical aides, health officers, and health assistants. Assuming that two tutors from each institution should be trained in the new FP curriculum, a total of approximately 150 additional tutors (to those already trained by UMATI) will require training.

It is recommended that a team of 4 trainers be formed, within the UMATI central training team, to take responsibility for the development of appropriate TOT curricula, for the implementation of training, and for trainee follow-up evaluation and support, including assistance in strengthening the student field practicums. The tutors' training needs will vary according to the family planning role defined for the cadre being trained in the school, but it is anticipated that training courses of between 2-5 weeks will be required. Allowing for curriculum development, course preparation, course implementation and trainee follow-up, the first round of institutional tutor training should be able to be completed within 3 years.

A long-term goal is for the planned National Family Planning Centre (See 2.4 below) to develop into a regional centre for the training of tutors from basic training schools in family planning. The tutor training to be conducted within Tanzania over the first 3 years of the FPSS Project will form a base of experience for such development. Following the mid-term evaluation of the FPSS Project, an assessment of the steps required to develop the NFPC's regional training capacity will be carried out.

2.4 Development of a National Family Planning (Training & Research) Centre

NORAD's contribution of \$800,000 for the NFPC was originally comprised of approximately \$350,000 for construction, with the balance intended for equipment and four years' operating costs. The expanded specifications for the NFPC will mean that a greater proportion of NORAD's funding will be required for construction. It is proposed that the FPSS Project supplement NORAD's support by contributing \$200,000 towards equipment and operating expenses.

During the interim period prior to the commissioning of the NFPC, the central MOH/FP Unit and the UMATI Central Training Team require adequate office accommodation. It is recommended that the FPSS Project fund the costs of renting office space for a period of up to 3 years for a total of between 20-25 persons, including space for meetings and for storing training equipment and materials.

2.5 MCH/FP Concepts and Skills for Interns

To bridge the transition until medical students graduate from the new MCH/FP curriculum, it is recommended that interns be provided with a brief, 3-day family planning update, including a practicum consisting of a prescribed list of procedures to be performed during their internship. A total of 60 interns would receive this training each year for the four year transition period.

The responsibility for this training would lie with the Obstetrics and Gynaecology and Community Health Departments of the Faculty of Medicine, which have been involved in the development of the revised undergraduate curriculum. Since internships are conducted in each of the four teaching hospitals in the country, a plan for bringing the interns to Dar es Salaam for the family planning training will need to be developed.

The FPSS Project should provide technical assistance and basic teaching materials and equipment. It is anticipated that the transition training would continue for four years.

2.6 Contraceptive Technology Update for Medical Staff

To support the FP service providers working out of the MCH clinics, and to provide clinical back-up for referral of complications, it is important that medical staff in the field are informed of the goals of the National FP Programme and are brought up to date with current FP policies and practices. Currently, there are no provisions within the UNFPA Project to provide training to hospital-based physicians.

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In the longer term, this function will be taken over by the NFPC planned for the Muhimbili Medical Centre. Prior to the establishment of the NFPC, it is recommended that the Department of Obstetrics and Gynaecology be responsible for the training of regional gynaecologists. In turn, each of the regional hospital gynaecologists would organize and implement a 5-day training program for selected medical staff from the government and NGO hospitals within their regions. A total of 20 regional courses would be implemented for 10 doctors each.

As preparation for this training, Obstetrics and Gynaecology Faculty members from each of the four teaching hospitals, will themselves receive update training in reproductive health and family planning. A total of 16 faculty members will be sent to the University of Nairobi (in two groups of 8 each) for two weeks training. Their training will include an update on the full range of contraceptive technology and clinical practicums, including VSC under local anaesthesia and insertion of the IUCD (TCU 380A and post-partum). In addition, participants will develop modules for a training manual on family planning for use by medical students, interns and other medical officers.

Following this FP update training, each participant will receive a further two weeks training in modern teaching techniques, including student assessment, interactive teaching methods and clinical research methods. Training will be conducted by the Centre for Educational Development in Health (CEDHA) in Arusha in two groups of 8-10 participants each. Each teaching hospital will be provided with teaching equipment, including slide projector, overhead projector, screen, video player, and videos on STDs, IUD, and VSC. Each regional hospital will be provided with a slide projector, overhead projector and screen.

FPSS Project support to this activity will cover technical assistance for curriculum design, participant and trainer travel and per diem, training materials printing and reproduction, Nairobi University and CEDHA costs, and procurement of teaching equipment for the teaching (4) and regional hospitals (16).

2.7 MCH/FP Seminars for Members of Professional Associations

The annual meetings of Tanzanian professional associations (for example the Association of Gynaecologists and Obstetricians of Tanzania, the Tanzanian Public Health Association, the Tanzanian Home Economics Association, etc.) provide an opportunity for members to discuss the development of MCH/FP practices and services within the country. Following the AGOTA model supported by JHPIEGO in 1990, short workshops could be attached to the end of these meetings to promote knowledge and debate in family planning.

5/1

Responsibility for the planning and preparation for these seminars will vary according to the audience, but may variously lie with the MOH/FP Training Coordinator, the UMATI Training Officers, the ObGyn.Faculty at MMC, or one of the NGOs involved in the National FP Programme. It is recommended that the FPSS Project support 2-day workshops for members of various professional associations, linked to the scheduled annual meetings of members. A total of 7 workshops, each for an estimated 50 persons, should be supported over the life of the project.

2.8 Laparoscopy Training

Since 1977, JHPIEGO has trained 10 Gynaecologist and nurse teams in laparoscopy and has supplied 13 laparoscopes to 9 regional hospitals. Only five teams now remain intact and the laparoscopes are only rarely used. Should funds be available, the FPSS Project has been requested to fund the costs of two 2-week courses for 6 gynaecologists each at MMC. The training will update trainees with new developments in laparoscopy, train them in surgical contraception under local anaesthesia, and train them in how to service laparoscopy equipment. Trainers will be drawn from the Obstetrics and Gynaecology faculty at MMC. Project inputs would include technical assistance, provision of laparoscopy parts, and training implementation costs.

3 IMPLEMENTATION OF PROJECT ACTIVITIES

3.1 Summary of Organizational Responsibilities

The MOH, as the agency responsible for the development and implementation of the National Family Planning Programme, must be responsible for the establishment of service policies and protocols, the development of training policies and strategies, for oversight of all family planning training activities conducted by other agencies, and for ensuring that family planning training activities are coordinated with other MOH PHC training programs. Therefore the role of the MOH/FP Training Coordinator at this stage in the development of the programme, will primarily be that of training management.

Completion of the preparatory activities for in-service training will, of necessity, involve the combined efforts of a number of persons from various agencies, including the MOH Continuing Education Unit, the MOH/MCH Division, the MOH/FP Unit, UMATI Training Unit, EMAU, the Faculty of Medicine, etc.

The determination of which agencies need to be involved and of their contribution to the training activities, will need to form part of the early planning for the training program.

It is proposed that the Central Training Team for the National Family Planning Programme be built upon the foundation already laid by the UMATI Training Unit. In relation to in-service training, one section of the CTT will be responsible for the training of zonal/regional family planning trainers and for supporting these trainers during the early stages of their own training activities with District Training Teams and service providers. A second section of the CTT will be responsible for the training of tutors from the basic training institutions. (Refer to draft organizational chart given in Annex 4.)

It is anticipated that over time, as the first, vertical round of in-service family planning training is completed, and as the National Family Planning Centre begins to commence operations, the respective roles of UMATI, the MOH and the NFPC will require revision. In-service family planning training should begin to be better integrated with other in-service training programs for front-line health workers, the zonal training centres will be playing a significant role in the decentralised training process, and basic training in family planning will have affected the requirements for in-service training.

Given the anticipated changes in organizational responsibilities for the training needs of the National FP Programme, and the consequential impact on the organizations involved, to the extent possible, secondments of appropriately qualified staff should be effected as a means of increasing the size of the CTT. Failing this, appointments on contract should be made.

3.2 Phasing of Implementation of the Training Component

The development of the family planning training system will fall into three main phases:

- Phase 1 (Year 1): Recruitment of training staff, development of family planning service policies and protocols, training needs assessments, and development of in-service training strategies.
- Phase 2 (Year 2): Development of training curricula, training materials needs assessment, and the development, adaptation or procurement of teaching/learning materials.

Phase 3 (Years 3-7): Phased implementation of the first round of the decentralised in-service training program, trainee follow-up and performance evaluation, and planning and implementation of second-round, refresher training.

In addition to the above, a number of discrete training courses will be conducted for special groups of service providers, namely: the training of tutors from the basic paramedic training institutions; the training of hospital-based doctors; and the implementation of seminars on family planning for members of professional associations.

An implementation schedule for the training and VSC components of the proposed FPSS Project is given in Annex 5.

3.3 Monitoring, Evaluation and Re-planning

The training MIS will assist the MOH/FP Training Coordinator and the UMATI CTT to monitor the implementation of the training program against the targets established in the training plan.

Pre-test and post-test evaluations will be conducted during all training courses. In addition, 12-18 month post-training performance evaluations will be conducted for samples of trainees. Periodic FP Program situation analyses will also provide feedback on the effectiveness of training on the quality of service delivery and on client behaviour.

The development of a new, nationwide and decentralised training programme is an ambitious undertaking, and there are likely to be many unanticipated factors influencing implementation. As part of the mid-term Project evaluation in Year 3, progress in the implementation of the training component will be carefully reviewed and, if necessary, a revised plan of activities will be developed for the remaining years of the FPSS Project.

3.4 Training Component Budget

A detailed budget (draft) for the training component of the FPSS Project is given in Annex 6. A summary of this budget by major activity is given in Annex 7.

EXAMPLE OF PHASED IMPLEMENTATION PLAN FOR IN-SERVICE FP TRAINING: ASSUMES 5 PHASES EACH COVERING 4 REGIONS

TRAINEES	FROM	NO. OF TRAINEES	CONTENT	COMP. DAYS	TOT. TIME	TRAINERS/COURSE FROM	#	SUPPORTED BY:
(1) ZONAL/REG'AL FP MANAGERS/SUPERVISORS eg. RMOs, MCH COORD'S/DEPUTIES, ETC. (2/Region + 2/Zone)	4 REGIONS	10	FP OVERVIEW	2	1 WK	CTT	2	MCH FP PROG. UMATI REG.COORDS
	1 ZONE		FP PRG.MGMT.	2				
			SUPERVISION	2				
(2) ZONAL/REG'AL FP TRAINERS (2/Region + 2/Zone)	4 REGIONS	10	CLINICAL	12	5 WKS	CTT	2	MCH FP PROG. UMATI REG.COORDS OTHER RESOURCE PERSONS
	1 ZONE		MOTIV/COMM.	3				
			COUNSELLING	3				
			REC-KEEPING	2				
			TEACHING SKILLS	5				
			TRAINING MGMT. + REG.IMP.PLANS	3 2				
(3) PRECEPTORS FROM PRACTICUM SITES FROM 1ST 4 REGIONS, 2 REGIONS AT A TIME (2 practicum sites/Dist.x 1 preceptor/ site x 5 Dists/Reg x 2 Reg's)	2 REGIONS	20	CLINICAL	12	4 WKS	2/RTP	3	CTT x 1
	2 REGIONS	20	MOTIV/COMM.	3				
			COUNSELLING	3				
			REC-KEEPING	2				
			PRECEPTOR SKILLS	4				
(4) SERVICE PROVIDERS FROM AREAS ADJACENT TO PRACTICUM SITES, 1 COURSE/REGION (3 S-PS/Clinic x 4 Clinics/Dist)	1 REGION	12	CLINICAL	15	4 WKS	2/RTP PRECEP'S	3 10	CTT x 1
	1 REGION	12	MOTIV/COMM.	3				
	1 REGION	12	COUNSELLING	3				
	1 REGION	12	REC-KEEPING	3				
(5) DISTRICT FP TRAINERS FROM 1ST 4 REG'S, 1 COURSE/REGION. (2 Trainers/Dist x 5 Dists/Region + 2 MCH Trainers from CMBT)	1 REGION	12	CLINICAL	12	5 WKS	2/RTP PRECEP'S	2-3 10	CTT x 1
	1 REGION	12	MOTIV/COMM.	3				
	1 REGION	12	COUNSELLING	3				
	1 REGION	12	REC-KEEPING	2				
			TEACHING SKILLS	5				
			TRAINING MGMT. + DIST.IMP.PLANS	3 2				
(6) SERVICE PROVIDERS FROM 4 1ST.PHASE REGIONS/DISTRICTS, TRAINED IN GPS OF 12-15 FOR ADEQUATE PRACTICUMS.	1 DISTRICT	15	CLINICAL	15	4 WKS	DTP PRECEP'S	2 2	2/RTP x 1
	(6 courses)	(90)	MOTIV/COMM.	3				
	x		COUNSELLING	3				
	(20 Dist's) (1800)		REC-KEEPING	3				

OUTLINE SCHEDULE FOR PHASED IMPLEMENTATION OF IN-SERVICE FP TRAINING PROGRAM
(2 YEARS ONLY SHOWN)

ACTIVITY	1991												1992											
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
TRG.ZON/REG FP MANAGERS/SUPVS	x												*									+		
TRG.ZON/REG TRAINERS				xxx									***									+++		
TRG.OF PRECEPTORS BY Z/R (1)						xx								**								+		
(2)						xx								**								+		
TRG.S-Ps(Z/R PRACTICE) (1)							xx								**									
(2)							xx								**							etc.		
(3)							xx								**									
(4)							xx								**									
Z/R TRAIN DIST.TRAINERS (1)								xxx								***								
(2)								xxx								***								
(3)								xxx								***								
(4)								xxx								***								
DIST TEAM 1 TRAIN S-Ps (1)										xx								**						
(2)											xx								**					
(3)												xx										*		
(4)													xx											
(5)														xx										
(6)															xx									

NOTES:

- (1) Assumes ~~phased~~ implementation of family planning in-service training program with 4 Regions covered in each phase.
(Schedule above only shows example of first two years)
- (2) Assumes a Central FP training team of at least 4 persons, full-time.

DRAFT JOB DESCRIPTION FOR FP PROGRAMME TRAINING COORDINATOR

POSITION: National FP Programme Training Coordinator
REPORTS TO: Director, Family Planning Programme

ROLE:

To provide leadership for the training component of the National Family Planning Programme through planning, coordinating, supporting and monitoring the inputs of all the implementing agencies (MOH, UMATI and the National Family Planning Centre) towards the achievement of the National Programme goals.

SPECIFIC RESPONSIBILITIES

1. To organize and facilitate the development of service policies and protocols, the definition of family planning roles, and the revision of job descriptions.
2. To facilitate the development of training strategies and implementation plans according to the goals of the National Family Planning Programme.
3. To organise and participate in curriculum and training materials development activities.
4. To organise and participate in regular evaluations of training effectiveness and for ensuring that the evaluation results lead to appropriate adjustments to the training programme.
5. To coordinate, support and monitor the family planning training activities of UMATI and the National Family Planning Centre.
6. To **liaise** with CLISWIG on the logistics and MIS components of all family **planning** training activities.
7. To **liaise** with the MOH Training Division on the implementation of family planning pre-service and in-service training activities and on the development of a long-term strategy for the integration of family planning training with overall MCH/PHC training.
8. To establish and maintain a training management information system.
9. To assist the Programme Director in the selection of candidates for training fellowships.

DRAFT JOB DESCRIPTION FOR PROGRAMME OFFICER B: TRAINING
(FP CENTRAL TRAINING TEAM MANAGER)

POSITION: FP Central Training Team Manager
REPORTS TO: UMATI Programme Officer A : Training

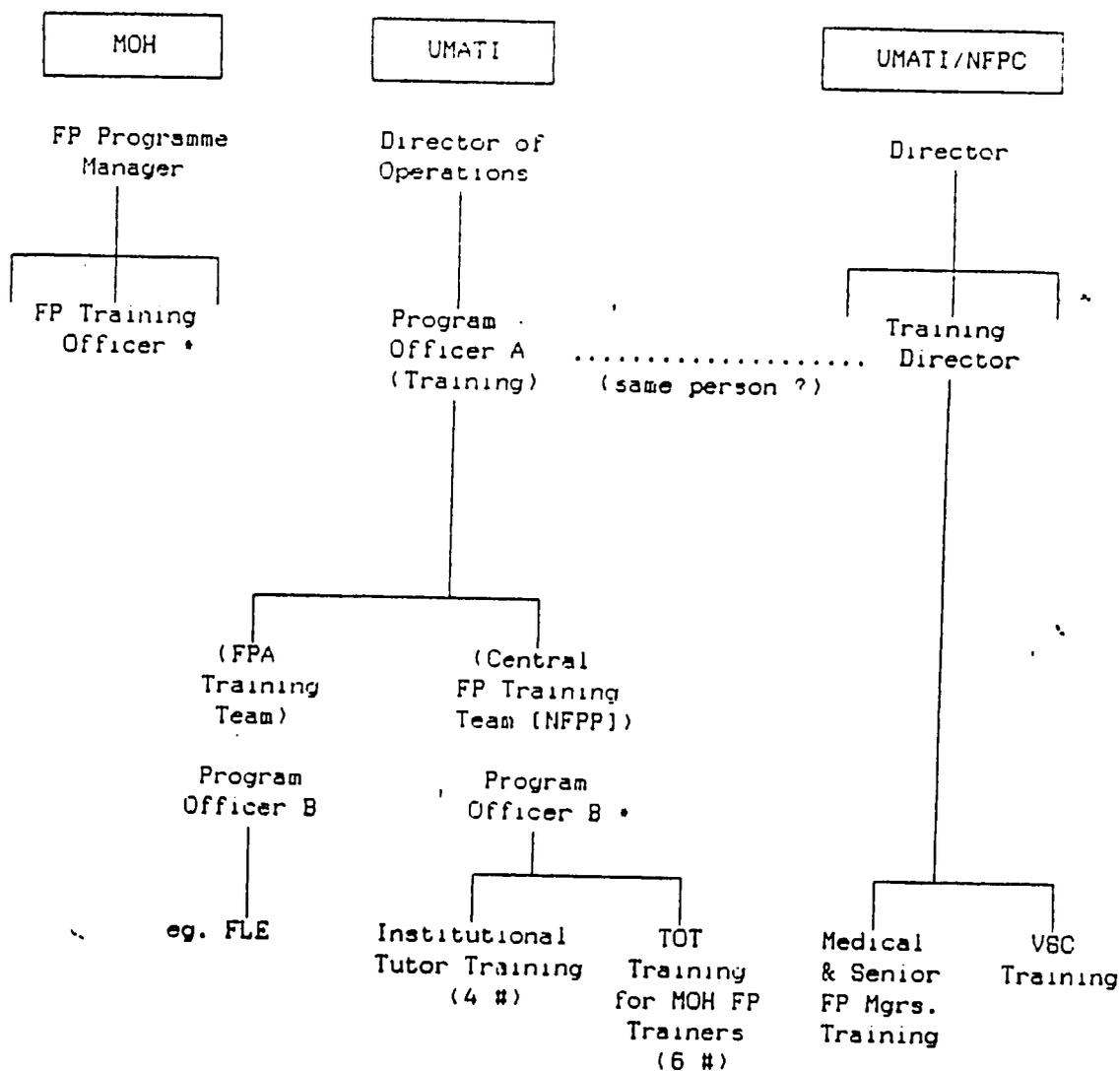
ROLE:

To manage the activities of the Central Training Team for the National Family Planning Programme in line with the agreed training policies and plans.

SPECIFIC RESPONSIBILITIES

1. To direct, organize and supervise the activities of the two sections of the central training team, namely: the Institutional Tutor Training Unit and the In-Service Training Unit.
2. To participate, under the guidance of the MOH FP Training Coordinator, in the development of FP service policies, protocols and job descriptions, and in the development of the training implementation plans.
3. To participate in training needs assessments, curriculum development, training materials needs assessments, and training material development as agreed with the MOH Training Coordinator and the UMATI Programme Officer A: Training.
4. With the members of the CTT, to develop team and individual workplans for the implementation of the FP Programme training plans.
5. To support the CTT Units in the implementation of training courses, with particular attention to the trainer allocations, budgetting and logistics.
6. To ensure the accurate and timely reporting of training activities as agreed with the MOH FP Training Coordinator for the maintenance of the Training MIS.

DRAFT ORGANIZATIONAL CHART FOR FP TRAINING



Notes:

- * Proposed for FPSS funding for 7 years
- # To be provided through secondments (4), from existing UMATI trainers (2-4), and through FPSS funding (2-4)

Assumed that the UMATI Training Unit would be subsumed under the NFPC once the latter is operational

IMPLEMENTATION SCHEDULE FOR TRAINING AND VSC COMPONENTS OF PHASED FPB PROJECT

TRAINING ACTIVITY	1990	1991	1992	1993	1994	1995	1996	1997
A. DEVELOPMENT OF IN-SERVICE FP TRAINING PROGRAM:								
Develop Service Stand's, Protocols, Job Desc's	XXXX							
Inventory of Gov't, NGO and Donor FP Activities	XXXXX							
Clinic Inventory, Equip. Needs Assess't, Proc't	XXXXXXXXXXXXXXXXXX							
Define Trg. Needs, Trg. Strat'y, Trainer Needs	XXX							
Develop Master Training Implementation Plan	XXXXXX							
Design Training Management Information System		XXX						
Dev'p/Revise Basic and In-Service Trg. Curricul		XXXXXX						
Training Materials Needs Assessment/Dev't Plan		XXXX						
Adaptation/Dev't/Procurement of Trg. Materials			AAAAA	AAAAA				
Phased Implementation of TTT Training			XXXXXX	XXXXXX	AAAAA	AAAAA	AAAAA	
Phased Implementation of Service-Provider Trg.				XXXXXXX	XXXXXXX	XXXXXXX	XXXXXXX	XXXXXXX
Trainee Eval./Needs Ass't/Refresher Trg					AAAAA	AAAAA	AAAAA	AAAAA
B. STRENGTHENING THE FP TRAINING STAFF								
Recruitment of Training Staff to MCH & FPI	XXXXXXXXXX							
Short-Term Fellowships for Trg. Staff		X X		X X X X X	X X X X X	X X X X X	X X X X X	X X X X X
In-Country Trg. Courses for FP Training Staff				AAA		AAA		
C. TRAINING OF SPECIAL STAFF GROUPS								
VSC Clin. & Couns. Trg. for Service Extension	.....		.....	.....	.....	.....	.....	.....
Trg. of Tutors of basic for medic Trg. Schools	.....		.....	.....	.....	.....	.....	.....
MCH/FP Concepts for Interns	XXX	XXX	XXX	XXX				
Contraceptive Tech. Update for Medical Staff		XXXXXXXXXXXXXXX						
MCH/FP Seminars for Prof'l Assoc's		X	X	X	X	X	X	X
D. OTHER								
Office Space rental for MCH/FP Unit/UNICEF CT	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX							
Development of National Family Planning Centre								
Assess't of Reg'l Tutor Trg. Capacity Dev't				XXXXXX				
Mid-Term Project Evaluation/Replanning					XXXXXXXXXX			

... = funded under previous project

ANNEX 6: DETAILED FPSS BUDGET FOR PROPOSED TRAINING ACTIVITIES

ACTIVITY	PROJECT FUNDING (\$000)							TOTAL
	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	
A. DEVELOPMENT OF IN-SERVICE FP TRG. PROGRAM								
1. Develop Service Standards/Protocols/ FP Role Definitions & Job Descriptions								
a) TA (external)(1 mth x 25000)	25,000							25,000
b) Workshop to review/finalise								
-Per diem: (20 personsx5 daysx\$20)	2,000							2,000
-Travel: (10 personsx\$155)	1,550							1,550
-Workshop materials: (20x\$10)	200							200
-Secretarial support:(20 daysx\$10)	200							200
-Hire of facility:(5 daysx\$50)	250							250
c) Printing, mailing:								
-Printing: (5000 copiesx\$2)	10000							10000
-Mailing: (5000x\$0.1)	500							500
Sub-total	39,700							39,700
2. Inventory of FP Activities								
a) TA (local)(30 daysx\$60)	1,800							1,800
b) Secretarial (10 daysx\$10)	100							100
Sub-Total	1900							1,900
3. Inventory of Clinic Equipment Needs								
a) Checklist of clinic equipment								
-Printing: (150 copiesx0.5)	75							75
-Mailing: (1.0x0.1)	15							15
b) Procurement of equipment								
-Screens: (3000 clinicsx\$40)		120,000						120,000
-MCH Kits (3000x\$50)		150,000						150,000
-Practicum site equip: (250x\$50)		12,500						12,500
-Shipping/handling:(@5%)		14125						14,125
-Distribution of equipment:(@1%)		1,766						1,766
Sub-Total	90	298,391						298,481
4. Training Strategy Development								
a) TA (external)(1 mth.x\$25000)	25,000							25,000
b) Workshop:								
-Per diem: (25 personsx5 daysx\$20)	2,500							2,500
-Travel: (15 personsx\$155)	2,325							2,325
-Workshop materials: (25x\$10)	250							250
-Secretarial support:(20 daysx\$10)	200							200
-Hire of facility:(5 daysx\$50)	250							250
-Printing/duplication:(50x\$5)	250							250
Sub-Total	30,775							30,775

ACTIVITY	PROJECT FUNDING (\$000)							
	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	TOTAL
5. Development of Training Master Plan								
a) TA (KIT)								
b) FPSS Mgmt./planning visit (1mth x \$25000)	25,000							25,000
c) Planning Retreat:								
-Per diem: (15 persons x 5 days x \$20)	1,500							1,500
-Travel: (15 persons x \$155)	2,325							2,325
-Materials (15 persons x \$10)	150							150
-Hire of facility: (5 days x \$50)	250							250
-Printing/duplication: (50 x \$5)	250							250
Sub-Total	29,475							29,475
6. Design/develop Training MIS								
a) TA (KIT)								
b) Provision of computer, printer (1 x 15000)	15,000							15,000
c) Computer supplies (6 years x \$50/yr)	350							350
d) Computer trg for MOH Trg. Coordinator (1 month (local) x \$2500)		2,500						2,500
e) Form Printing: (6 forms x 130R/D x \$2)		1,560						1,560
Sub-Total	15,350	4,060						19,410
7. Development of Training Curricula								
a) TA (external) for review: (1mth x \$25000)		25,000						25,000
b) Dev't costs (5 teams x 5 persons x 10 days x \$50)		12,500						12,500
c) Pre-testing costs (5 courses x \$200)		1,000						1,000
d) Workshop for review:								
-Per diem: (20 persons x 10 days x \$20)		4,000						4,000
-Travel: (15 persons x \$155)		2,325						2,325
-Materials (20 persons x \$10)		200						200
-Hire of facility: (10 days x \$50)		500						500
-Secretarial: (20 days x \$10/day)		200						200
e) Printing: (5 courses x 500 cc x \$3)		7,500						7,500
Sub-Total		53,225						53,225

ACTIVITY	PROJECT FUNDING (\$000)							
	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	TOTAL
8. Teaching/Learning Materials								
a) Collection of Reg'al Materials:								
-TA (external): (1mthx\$5000 [no trav/pd])		5,000						5,000
-Procurement costs: (30x\$15)		450						450
b) Materials needs assessment:								
-TA (external): (1mthx\$25000)		25,000						25,000
c) Workshop for materials review/planning:								
-Per diem: (20 personsx10daysx\$20)		4,000						4,000
-Travel: (15 personsx\$155)		2,325						2,325
-Materials (20 personsx\$10)		200						200
-Hire of facility: (10daysx\$50)		500						500
-Secretarial: (20daysx\$10/day)		200						200
d) Materials procurement:								
-Teaching posters: (3postersx250x\$5)		3,750						3,750
-Teach. models: (250x\$200)		50,000						50,000
-Refer. texts: (10 booksx100schsx\$15)		15,000						15,000
-Refer. texts: (5 booksx150TTsx\$15)		11,250						11,250
e) S-P Manual development:								
-Dev't costs (3mthsx\$1500/mthx2 manuals)			9,000					9,000
-Printing costs: (10000ccx2x\$5)			100,000					100,000
-Distribution costs (@1%)			1,000					1,000
f) Flipchart development:								
-Dev't costs (3mthsx\$1500x2 flipcharts)				9,000				9,000
-Printing: (250 TTsx\$20)				5,000				5,000
-Distribution: (@1%)				50				50
Sub-Total		117,675	110,000	14,050				241,725
9. Training Supervision/Follow-up:								
a) Trg. zonal/reg'al managers (5 courses):								
-CTT travel: (4persx5coursesx\$155)		620	620	930	930			3,100
-CTT P-D: (4 pers.x6dysx5coursesx\$20)		480	480	720	720			2,400
-Trainee travel: (10persx5coursesx\$50)		500	500	750	750			2,500
-Trainee P-D: (10persx6dysx5coursesx\$20)		1,200	1,200	1,500	1,800			6,000
-Trg. Materials: (10persx5coursesx\$10)		100	100	150	150			500
b) Support for Trg. of Z/RTTs:								
-CTT travel: (4persx5coursesx\$155)		620	620	930	930			3,100
-CTT P-D: (4 pers.x3dysx5coursesx\$20)		2800	2800	4200	4200			14,000
c) Support for Trg. of Preceptors:								
-CTT Travel: (1 personsx10coursesx\$155)		310	310	465	465			1,550
-CTT P-D: (1 pers.x10dysx10coursesx\$20)		1200	1200	1800	1800			6,000
-Z/RTT Travel: (6personsx10coursesx\$50)		600	600	900	900			3,000
-Z/TRR P-D: (6persx30dysx10coursesx\$20)		7200	7200	10800	10800			36,000
-Trainee Trav: (20persx10crs.x\$50)		2000	2000	3000	3000			10,000
-Trainee P-D: (20persx30dysx10crsx\$20)		24000	24000	36000	36000			120,000
-Materials: (200persx\$5)		200	200	300	300			1,000
d) Support for S-P Training (Z/RTT Pract):								
-CTT Travel: (1 personsx20coursesx\$155)		620	620	930	930			3,100
-CTT P-D: (1 pers.x30dysx20coursesx\$20)		2400	2400	3600	3600			12,000

ACTIVITY	PROJECT FUNDING (\$000)							
	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	TOTAL
e) Support for DTT Training: -CTT Travel:(1 persx20coursesx\$155) -CTT P-D:(1 pers.x35dysx20coursesx\$20)		620	620	930	930			3,100
f) Support for S-P Training: -Z/RTT Travel:(1 persx650coursesx\$25)		2800	2800	4200	4200			14,600
g) Support for Trainee follow-up/eval: -DTT Travel:(1 persx3000 SPPx\$25) -DTT P-D:(1 persx2dysx30SDPx105Dsx\$20) -Z/RTT Trav:(1 persx105 distsx\$25) -Z/RTT P-D:(1 persx6dysx105 distsx\$20) -CTT Trav:(1 persx105 distsx\$155) -CTT P-D:(1 persx7dysx105 distsx\$20)		1,073	3,218	5,395	4,323	2,145		16,153
				15,000	15,000	15,000	30,000	75,000
				24,000	24,000	24,000	48,000	120,000
				525	525	525	1,050	2,625
				2,520	2,520	2,520	5,040	12,600
				3,255	3,255	3,255	6,510	16,275
				2,940	2,940	2,940	5,880	14,700
Sub-Total	0	49,343	51,488	126,040	124,968	50,385	96,480	498,703
10. Training Management								
a) TA/Mgmt. Visits(external):(2 mths/year)	50,000	50,000	50,000	50,000	50,000	50,000	50,000	350,000
b) Training Coordinator/MOH		6,000	6,000	6,000	6,000	6,000	6,000	36,000
c) Training Administrative Asst.:MOH		4,000	4,000	4,000	4,000	4,000	4,000	24,000
d) Training Officer B: UMATI		2,000	2,000	2,000	2,000	2,000	2,000	12,000
e) Trainers (4): UMATI		4,000	4,000	4,000	4,000	4,000	4,000	24,000
Sub-Total	50,000	66,000	66,000	66,000	66,000	66,000	66,000	446,000
11. Trainer Skill Development								
a) S-T Fellowships (5/yr @ \$5000)		25,000	25,000	25,000	25,000	25,000	25,000	150,000
b) In-Country Training Skill Dev't Courses -Trainers costs (@\$50,000x2) -Participant costs (@\$8000 for 20) -Materials (@ \$25/participant)			50,000			50,000		100,000
			8,000			8,000		16,000
			1,000			1,000		2,000
Sub-Total		25,000	84,000	25,000	84,000	25,000	25,000	268,000
12. Office Accommodation								
a) Rental for Central MOH/FP Unit Staff -@500/month x 36 months	6,000	6,000	6,000					18,000
b) Rental for Central Training Team -@700/month x 36 months	8,400	8,400	8,400					25,200
Sub-Total	14,400	14,400	14,400					43,200
13. Vehicles for Central Training Team								
a) 2x12-15 seater minibus (for in-service and tutor training teams):(@ \$30000)	60,000							
b) 1xsuzukis for each team (2x\$9000)	18,000							
c) Spare parts (@17% of cost)	2,652	2,652	2,652	2,652	2,652			
Sub-Total	80,652	2,652	2,652	2,652	2,652			
TOTAL: DEVELOPMENT OF IN-SERVICE TRG PROGRAM	262,342	630,746	328,540	233,742	277,620	141,385	187,480	2,061,854

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ACTIVITY	PROJECT FUNDING (\$'000)							
	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	TOTAL
B. TRAINING OF INSTITUTIONAL TUTORS								
1.TA (external) for Trg.Imp./Supervision: -2 trips/year @ \$25000/trip		25,000	50,000	50,000	50,000			175,000
2.Implementation of Courses:								
-Trainee travel:(15 persx12 coursx\$155)		4,650	9,300	9,300	4,650			27,900
-Trainee P-D:(15 persx30dysx12 coursx\$20)		18,000	36,000	36,000	18,000			108,000
-Trainee Materials:(180x\$15)		450	900	900	450			2,700
-Didactic Honoraria: (45 sess/coursex 12 coursesx\$5/sess)		450	900	900	450			2,700
-Resource persons:(10 persx12 coursx\$10)		200	400	400	200			1,200
-Course admin:(@750/coursex12 courses)		1,500	3,000	3,000	1,500			9,000
-Trainer Subsis:(2 Tsx30dysx12coursx\$10)		1,200	2,400	2,400	1,200			7,200
3.Trainee Follow-up/Evaluation:								
-CTT Travel:(1 persx90 schoolsx\$155)			2325	4650	4650	2325		13,950
-CTT P-D:(1 persx5dysx90schsx\$20)			1500	3000	3000	1500		9,000
4.UMATI overhead:(@15% of imp.costs)		3,968	8,509	9,083	5,115	574		27,248
TOTAL: TRAINING OF INST'TUTIONAL TUTORS	0	55,418	115,234	119,633	89,215	4,399	0	381,898
C. MCH/FP CONCEPTS FOR INTERNS								
1.Training costs:								
-Didactic (21 hrs/coursex4coursex\$5)	105	105	105	105				420
-Res.Pers.Trav:(3/coursex4coursex\$155)	465	465	465	465				1,860
-Resource Pers.P-D:(2persx3dysx4cour.x\$35)	210	210	210	210				840
-In-country admin:(\$1000x4courses)	1,000	1,000	1,000	1,000				4,000
-Participant materials:(240 persx\$25)	1,500	1,500	1,500	1,500				6,000
-Trainee travel(180persx\$155)(1 gp DSM)	6,975	6,975	6,975	6,975				27,900
-Trainee P-D:(180 persx4dysx\$20)	3,600	3,600	3,600	3,600				14,400
2.TA (external):								
-1 mth/year for 4 years @ \$25000	25,000	25,000	25,000	25,000				100,000
-EOP Evaluation: 1mth @\$25000				25,000				25,000
3.Trg.Equipment for Teaching Hospitals (4)								
-IUD B/U Kits:(8x\$1200)	9,600							9,600
-pelvic models:(4x\$400)	1,600							1,600
-slide projectors:(4x\$750)	3,000							3,000
-O/H Projectors:(4x750)	3,000							3,000
-Transparencies/pens:(4x\$50)	200							200
-Video players:(4x\$1200)	4,800							4,800
-Videos [IUD/STD/VSC etc.]:(12x\$50)	600							600
-Projector screens:(4x\$500)	2,000							2,000
-Computer for MMC/Popline/Index Medicus	15,000							15,000
-Shipping/handling:(@25%)	9,950							9,950
-Indir.costs of Procurement Agency (@15%)	13,291	5,828	5,828	9,578				34,526
TOTAL MCH/FP CONCEPTS FOR INTERNS	101,896	44,683	44,683	73,433	0	0	0	264,695

ACTIVITY	PROJECT FUNDING (\$000)							TOTAL
	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	
D. CONTRACEPTIVE TECH.UPDATE FOR MEDICAL STAFF								
1.CTU for ObGyn.Faculty:								
-Participant costs/NBI:(16persx\$1700)		13,600	13,600					27,200
-Nairobi Univ.Costs:(\$4500x2)		4,500	4,500					9,000
-Admin.costs:(\$5000)		2,500	2,500					5,000
-TA (external):(2mths)		25,000	25,000					50,000
-Participant materials: (16x\$50)		400	400					800
-Shipping/handling costs @25%		100	100					200
2.Printing/reproduction of Manual:(300x\$10)			3,000					3,000
3.Didactic Update for ObGyn Faculty:								
-Part.P-D:(16persx14dysx\$20)		2,240	2,240					4,480
-Partic.travel:(16x\$155)		1,240	1,240					2,480
-CEDHA tuition fees @ \$5,500/course		5,500	5,500					11,000
-Admin.@ \$1000/course		1,000	1,000					2,000
-Participant materials:(16x\$20)		160	160					320
4.Training of Regional Gynaecologists:								
-Partic.Travel:(18 persx\$155)			2,790					2,790
-Part.P-D:(18x6x\$20)			2,160					2,160
-Part.Materials:(18x\$20)			360					360
-Trainer Honorariums:(3x5x\$35)			525					525
-Admin.Costs:(\$1000)			1,000					1,000
5.Training of Hosp.Based Physicians:								
-Part.Travel:(10 persx20coursesx\$25)				2,500	2,500			5,000
-Part.P-D:(10persx6dysx20coursesx\$20)				12,000	12,000			24,000
-Part.Materials:(200 persx\$20)				2,000	2,000			4,000
-Trainer Honorariums:(20persx5dysx\$35)				1,750	1,750			3,500
-Admin.Costs:(20 coursesx\$250)				2,500	2,500			5,000
6.Training Equipment for Regional Hospitals:								
-IUD B/U Kits:(18x\$150)			2,700					2,700
-pelvic models:(18x\$400)			7,200					7,200
-slide projectors:(18x\$750)			12,750					12,750
-O/B Projectors:(18x750)			12,750					12,750
-Transparencies/pens:(18x\$50)			900					900
-Projector screens:(18x\$500)			9,000					9,000
-Shipping/handling:(@25%)			11,325					11,325
7.-Indir.costs of Procurement Agency (@15%)		8,436	18,405	3,113	3,113	0	0	33,066
TOTAL CONTRACEPTIVE TECH.UPDATE FOR MEDICAL STAFF	0	64,676	141,105	23,863	23,663	0	0	253,506

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ACTIVITY	PROJECT FUNDING (\$000)							
	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	TOTAL
E. MCH/FP SEMINARS FOR MEMBERS OF PROF. ASSOCS								
-Facility rental: (2daysx\$100x6sem)		200	200	200	200	200	200	1,200
-Resource Persons Trav: (3 persx\$155x6sem)		465	465	465	465	465	465	2,790
-Resource Pers. P-D: (3persx3dysx\$20x6sem)		180	180	180	180	180	180	1,080
-Res. Pers. Honorarium: (3persx2dysx\$35x6sem)		210	210	210	210	210	210	1,260
-Partic. P-D: (50persx3dysx\$20x6 seminars)		3,000	3,000	3,000	3,000	3,000	3,000	18,000
-Materials @2000/seminarx6		2,000	2,000	2,000	2,000	2,000	2,000	12,000
-Admin @ \$1000/seminarx6		1,000	1,000	1,000	1,000	1,000	1,000	6,000
-Share of Part. Travel: (50persx\$155x6)		7,750	7,750	7,750	7,750	7,750	7,750	46,500
TOTAL MCH/FP SEMINARS FOR MEMBERS OF PROF. ASSOCS	0	14,805	14,805	14,805	14,805	14,805	14,805	86,830
F. LAPAROSCOPY TRAINING FOR GYNAECOLOGISTS								
-Part. Travel: (6persx2coursesx\$155)				930	930			1,860
-Part. P-D: (6persx2coursesx14dysx\$20)				1,680	1,680			3,360
-Trainer Honorarium: (21hrsx2coursesx\$5)				105	105			210
-Practicum Fees: (120patientsx\$20)				1,200	1,200			2,400
-Part. Materials: (12 persx\$25)				150	150			300
-TA (external): (2wks @ \$15000)					15,000			15,000
-Laparoscope parts (@ \$10000)					10,000			10,000
-Indir. costs of Procurement Agency (@15%)				610	4,360			4,970
TOTAL LAPAROSCOPY TRAINING FOR GYNAECOLOGISTS	0	0	0	4,675	31,425	0	0	36,100
GRAND TOTAL: TRAINING COMPONENT	364,238	610,120	644,367	470,150	438,927	160,569	202,125	3,090,362

NB Costs at constant 1990 prices

ANNEX 7

SUMMARY BUDGET FOR TRAINING COMPONENT

ACTIVITY	PROJECT FUNDING (\$000) (CONSTANT 1990 PRICES)							
	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	TOTAL
DEVELOPMENT OF FP IN-SERVICE TRAINING PROGRAM	262,342	630,746	328,530	233,742	277,620	141,385	187,355	2,061,854
TRAINING OF INSTITUTIONAL TUTORS	0	55,418	115,234	119,633	89,215	4,399	0	383,899
MCH/FP CONCEPTS FOR INTERNS	101,896	44,683	44,683	73,433	0	0	0	264,695
CONTRACEPTIVE TECH.UPDATE FOR MEDICAL STAFF	0	64,676	141,105	23,863	23,863	0	0	253,507
MCH/FP SEMINARS FOR MEMBERS OF PROF.ASSOCs	0	14805	14805	14805	14805	14805	14805	88,830
LAPAROSCOPY TRAINING FOR GYNAECOLOGISTS	0	0	0	4,675	33,425	0	0	38,100
TOTAL: TRAINING COMPONENT	364,238	810,328	644,367	470,150	438,927	160,589	202,285	3,090,882

RP

IEC COMPONENT

EXECUTIVE SUMMARY

A. Purposes of the IEC Component

The IEC component of the project will focus on improving the acceptance and continued use of modern family planning methods. IEC activities are planned to keep step with the logistics, management, private sector, and training components of the project. In order to do this, IEC efforts will concentrate during the first five project years on improving the exchange of information and counseling that clients and other clinic attenders receive at both Ministry of Health and selected private sector service delivery points. Once the logistics, management information system, and training components are well underway, modest IEC efforts will aim at increasing the demand for family planning services through intensified outreach activities in four selected areas of the country and through a national radio program.

A secondary purpose of IEC efforts is to elicit support for the National Family Planning Programme among Regional and District level policy-makers. These IEC activities will also disseminate regionally-relevant data from the 1991 DHS with the purpose of improving policy-makers' planning skills.

Finally, the IEC component is designed to create a core of family planning IEC expertise in UMATI and the Health Education Unit of the Ministry of Health.

B. Major IEC Activities

IEC activities will take place in three phases:

PHASE I (3 Years): During the first three years, the Health Education Unit of the Ministry of Health will oversee the production of large volumes of print materials to support family planning counseling, and for distribution to clinic attenders at Ministry of Health hospitals, health centers, and dispensaries. The Health Education Unit is already planning such a project in collaboration with the Johns Hopkins University Population Communication Services through a \$600,000 buy-in from USAID/Tanzania. FPSS will build on that project by funding additional quantities of print materials and expanding the distribution of print materials from one pilot area to all Ministry of Health family planning service delivery points during the third project year. Simultaneously, UMATI will develop and procure supportive IEC materials for private sector clinics and motivators. All materials produced by UMATI and the Health Education Unit will also be distributed to other Tanzanian organizations active in family planning IEC and family life education.

PHASE II (2 Years): During the fourth and fifth project years, the Health Education Unit will turn its attention to developing, producing, and distributing a second round of print materials for service providers, MCH clinic attenders, and family planning clients. UMATI will organize and conduct regional seminars for district and regional policy-makers. UMATI will also develop and produce a colorful and easily understood brochure depicting major DHS findings to be distributed to seminar participants and other government leaders.

PHASE III (2 Years): During the final two project years, the Health Education Unit will produce an entertaining and educational radio drama series with family planning messages. UMATI will organize and monitor intensified outreach activities in four small areas of the country. Areas for concentration will be either towns, cities or catchment areas around private sector programs where outreach activities are likely to have the greatest impact on contraceptive prevalence. The Health Education Unit will assist with materials development for these activities. At the end of the seventh year, UMATI will conduct an impact evaluation of the outreach activities.

Throughout the seven years, IEC personnel from organizations active in family planning IEC and family life education will attend short courses in family health communication. Beginning the second project year, USAID will fund two participants per year to attend short-term external training courses.

C. Project Execution

The IEC component will be executed through a series of buy-ins to a cooperating agency with expertise in family planning IEC. The cooperating agency will be responsible for 1) assisting the Health Education Unit and UMATI design each phase of the IEC component, 2) monitoring IEC activities on an ongoing basis, 3) reporting progress to USAID/Tanzania, 4) providing technical assistance to project activities as needed, and 5) administering IEC project funds to the Health Education Unit and UMATI.

D. Budget Summary

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	TOTAL
I. SALARIES	1,800	1,300	1,800	1,800	1,800	6,600	6,600	22,200
II. CONSULTANTS	2,300	0	3,380	2,900	15,460	4,200	4,200	32,440
III. TRAVEL AND ALLOWANCES	5,515	24,000	63,650	80,515	73,715	63,115	63,115	373,625
IV. EQUIPMENT AND SUPPLIES	92,900	7,000	8,300	14,300	54,200	8,400	3,400	193,500
V. OTHER DIRECT COSTS	- 24,500	273,700	73,400	515,000	270,150	26,900	26,900	1,210,550
VI. SUBCONTRACTS	50,000	50,000	0	5,000	0	0	30,000	135,000
VI TECHNICAL ASSISTANCE	42,240	42,240	42,240	42,240	42,240	42,240	48,340	302,280
TOTAL	219,255	398,740	192,770	661,755	457,565	151,455	168,055	2,269,595

I. Background

Tanzania presents a great communication challenge. The largest country in East Africa, Tanzania's 23 million people are concentrated around the country's perimeter with only rugged roads connecting Dar es Salaam and outlying centers. Communications are further hampered by unreliable telecommunications and a poorly maintained public transportation system. With its widely scattered population and poor transportation and communication infrastructure, any nationwide IEC effort will be time consuming and costly.

Fortunately, Tanzania has a well-developed health system. The Ministry of Health has 152 district and regional hospitals, 260 rural health centers, and 2,644 local dispensaries. Some 90 percent of the population live within 10 kilometers of one of these facilities. The Ministry of Health Maternal and Child Health and Family Planning Programme (MCH/FP) provides family planning services in 2,413 of the 3,056 health facilities (79 percent) on the mainland and 24 of the 85 (28 percent) MCH/FP clinics in Zanzibar. The Family Planning Association of Tanzania (UMATI), the Tanzanian Red Cross (TRCS), and a number of private clinics also provide services in urban areas.

Despite these efforts, contraceptive prevalence is low. In the last decade, there has been no national survey on contraceptive prevalence. However, a 1988 UNFPA analysis of service statistics estimated use of modern methods at 7 percent of married women of reproductive age; an estimated 15 percent are using traditional methods.

There are several commonly cited reasons why acceptance of modern family planning methods is so low. First, there are indications that general knowledge about family planning methods is not widespread. For example, a recent KAP survey conducted in Morogoro by UMATI found that only 30 percent of the adults surveyed could name one modern method. Second, those who have heard of family planning may have inaccurate and incorrect information. A number of qualitative studies report that some women and men think that modern contraceptives cause infertility, illness and promiscuity. Third, in some areas of the country, men and the community at large may disapprove of family planning.

Oral contraceptives are the most popular method in Tanzania. According to a 1987 study of service statistics from 25 family planning clinics in five regions, approximately 75 percent of family planning clients used oral contraceptives. UNFPA estimates, however, that half of these clients discontinue pills after one cycle. The reasons for this high discontinuation rate are not known. The unreliable distribution system for contraceptives certainly is a major contributor to the problem. Also, many service providers have not been trained in counseling. It is well documented in other countries that discontinuation is often high when clients are not properly counseled about possible side effects, and when they are not given the contraceptive of their choice. Both these situations are likely in Tanzania.

In the same study, 25 percent of family planning clients used IUDs, condoms, or spermicides. Although injectables and tubal ligations are available at some district and regional hospitals, the number of clients who

avail themselves of these services is unknown. The government policy until recently allowed only gynecologists to provide injectables. Recently, the Ministry of Health has issued a circular announcing that now any doctor may provide injectables.

A national household survey to explore knowledge, attitudes and practices related to AIDS is currently underway and will give useful information on contraceptive knowledge and use. Results should become available in late 1990. Also, the Bureau of Statistics plans to field a Demographic and Health Survey in 1991. Results should be available late in 1992.

The Government of Tanzania has recently recognized the need to educate people about population issues and family planning. Tanzania is now in the process of adopting a population policy. The Chairman of Chama Cha Mapinduzi (CCM - Tanzania Central Party), Dr. Julius Nyerere, has publicly endorsed family planning and the need for smaller families. As the government has become more favorable toward family planning, MOH NCH/FP has expanded its role.

In 1989, the MCH/FP Program developed a four year plan of operations to improve family planning services. The plan includes training for MCH/FP staff at regional, district, and village levels, and an improved contraceptive logistics system and management information system. The plan also includes a countrywide IEC program directed and managed by the MOH Health Education Unit (HEU).

FPSS plans to support the logistics, MIS, IEC and training components of the MCH/FP Program over a seven year period. This document lays out the plan for the IEC component of the FPSS Project.

Family Planning IEC

To date UMATI has been the organization primarily responsible for disseminating information about family planning. In 1974, when the government of Tanzania was less favorable toward family planning, the MOH gave UMATI the mandate to disseminate information about family planning. Unfortunately, UMATI's three-member IEC Unit as yet has not developed an organized IEC strategy. The Unit has focused on seminars and print materials for policy-makers, service providers and family planning clients; it has not conducted formative or evaluative research. Partly because UMATI lacks information about family planning KAP, most messages aim at showing why family planning is important rather than educating the public about family planning methods or refuting common misconceptions.

UMATI has a large staff whose main function is to educate and inform people about family planning. In each region, UMATI employs a full-time Regional Coordinator. These coordinators are responsible for holding meetings and seminars for UMATI volunteers, regional and district-level policy makers and religious leaders, and representing UMATI at the regional level. In addition to the Regional Coordinators, UMATI also employs more than 60 District Coordinators. These coordinators assist the Regional Coordinators at

the District level. Unfortunately, many of the regional and district coordinators have never received training in motivation and counseling. Although they are responsible for conducting family planning outreach work, they rarely receive family planning updates through UMATI. Virtually none of these Coordinators have audio-visual aids such as flipcharts, posters, or leaflets to support their work. All regions have film projectors. However, their supply of films is small and most of the available family planning films in Kiswahili are out-dated.

GTZ has also concentrated on family planning IEC in one district. The program will now be replicated in four other districts. GTZ has, in fact, been the most active producer of family planning support materials. Materials such as calendars, posters, flipcharts, leaflets, and occasional radio programs have been produced. Most print materials have been produced in very small numbers and at a considerable cost. GTZ also relies heavily on village-level meetings and filmshows. Unfortunately, they also have the problem that the supply of family planning films in Kiswahili are limited and mostly out-dated.

Several other non-governmental organizations and organizations within the government and CCM party train extension workers and produce materials about responsible parenthood, childspacing, or population issues. Organizations that include this type of information usually ask UMATI to contribute resource persons and review materials and curricula for accuracy. Many of these organizations have produced their own print materials. None have really exploited the radio for disseminating information. Several of the organizations rely heavily on films to open discussions about family planning. Although most organizations have film projectors, the supply of relevant films in Kiswahili is limited.

Most population and family planning messages have fallen into three thematic categories:

1. UMATI and GTZ materials stress improved maternal and child health through childspacing. Some GTZ materials describe the modern methods. Target audiences are couples and women of reproductive age.
2. WAZAZI, POPFLEP, ENAU, TRCS and the school family life education program messages stress responsible parenthood, the dangers of teenage pregnancy and irresponsible behavior such as smoking, drinking, and taking drugs. Target audiences are parents, workers, and school-age youth.
3. POPFLEP, the Population Planning Unit and UMATI have developed materials with messages stressing the social and economic benefits of population planning. These messages are targetted at policymakers.

Despite these efforts, there are serious gaps in IEC materials and activities. There is a serious dearth of support materials for use by service providers or for distribution to clients. Most family planning clinics have only one family planning poster and almost no clinics have family planning leaflets or booklets for clients. Although the radio reaches almost every

corner of the nation, it has been largely unused to disseminate family planning information. There are few outreach workers dedicated to family planning who are trained in communication and motivation. Also, there is very limited research on which to base messages, target priority audiences, or evaluate the effectiveness of communication activities.

IEC efforts have been further weakened by a pressing need for more qualified communication personnel, functioning printing and radio production equipment, and funds to sustain activities. In the area of print materials, there are few graphic artists trained or equipped to produce color separated materials. Also, while typesetting and desktop publishing equipment is available at several facilities, few people are trained to operate it. Finally, there are no printing facilities capable of producing large quantities of multi-colored materials and paper is often expensive, low quality, or unavailable.

Planned IEC Projects with the Health Education Unit and the Institute of Adult Education

The United Nations Population Fund is planning to fund a four-year IEC project that will coordinate population awareness, responsible parenthood, and family life education messages. The Institute of Adult Education (IAE) and the Johns Hopkins University Population Communication Services will manage that project. The project will begin in late 1990. The first two years of the project will focus on training for IAE staff and preparations for three regional campaigns. Regional campaigns featuring village-level meetings and regionally developed materials, will be conducted on a rolling basis during the third and fourth project years. Messages and materials developed under the project will refer people to MOH facilities for family planning information and services.

The Health Education Unit of the Ministry of Health also plans to begin a two year family planning IEC project in 1990, funded through a USAID buy-in to the Johns Hopkins University Population Communication Services. This project includes a small KAP survey in five regions of the country; a one year weekly radio drama series to be broadcast during the second project year; print materials for clients, service providers, and potential clients which will be distributed in one small pilot area; and development of a family planning logo, identifying badges for MCH-Aides, and stickers to identify family planning services. A follow-on KAP will be conducted in the pilot area to assess project impact.

Both projects include some equipment support to IAE and HEU. The HEU project includes two vehicles, a studio quality audio recorder, and graphic art equipment and supplies. The IAE project includes equipment to upgrade printing capabilities to include color separation and improve printing efficiency.

The following strategy for the IEC component of the FPSS project builds on these two projects. The objectives and interventions described below aim at filling the most immediate IEC needs. They were planned to keep pace with the project's training and logistics components. That is, the aim is to

improve the quality of client-provider interactions while the logistics and training programs are gearing up. Then, when quality services are in place, the IEC component will begin very modest efforts in selected areas of the country to generate an increased demand for family planning services.

II. Seven-Year Family Planning IEC Strategy

A. Communication Objectives by Audience Segments

1. Current users of modern methods: Maintain continuing users by decreasing dropout rates of temporary and semi-permanent methods.
2. MCH clinic attenders who do not practice family planning: Shift to use of family planning services and acceptance of modern family planning methods.
3. Traditional and non-users who do not attend MCH clinics: Increase the demand for family planning services once services are upgraded to offer a full range of modern methods.
4. Husbands: Increase knowledge about and acceptance of modern family planning methods.
5. District and Regional level policy-makers: Gain support for the National Family Planning Programme.
6. IEC personnel: Develop a critical mass of IEC expertise among HEU, UNATI, and other organizations active in family life education and family planning IEC activities.

B. Major Strategic Interventions

1. Improve the quality of information and counseling provided to clients at family planning services through counseling and communication training and through the provision of illustrated support materials at clinics.

Family planning services are mainly available through Ministry of Health and private clinics. There are indications that the drop-out rate at these clinics may be high. Improving the quality of information exchange between clinic providers and clients could help prevent rumors and misinformation from spreading, allay concerns about health and side effects, and help reduce drop-out rates.

Satisfied acceptors also become credible sources of information and often become unobtrusive but effective referral agents for relatives, neighbors, and friends. Active promotion of family planning services will not have significant impact in the long run if the clients' experience at the point of contact is not altogether wholesome and satisfying.

Hence it is essential that immediate attention be focused on developing

key IEC interventions that improve provider-client face-to-face interactions.

The National Family Planning Program plans to include counseling and communication training in their country-wide training for family planning providers. Hence, training is not included in the IEC plan.

The Health Education Unit of the Ministry of Health already has plans for a two year Family Planning Communication Project aimed at providing accurate information to providers and clients at MCH/FP clinics and, to a limited extent, to the general public. FPSS will strengthen and expand project activities as indicated below.

Key activities:

a) Materials support for family planning providers. The Health Education Unit will provide family planning providers with reference guides, visual aids and print materials that they can share with clients. This activity is planned under the Family Planning Communication Project. FPSS will expand this activity by increasing quantities of materials produced during the second project year and by funding a second round of print materials production during the fourth year.

b) Materials support for family planning clients. The Health Education Unit will also provide illustrative wallcharts, posters, and leaflets for clinic attenders and family planning clients under the Family Planning Communication Project. FPSS will provide supplemental funding to increase quantities of these materials and to add a second round of materials production during the fourth year.

2. Strengthen motivational and counseling activities at selected private-sector programs through provision of print and audio-visual materials.

As FPSS strengthens family planning services at selected industries and private clinics, there will be a need to generate a demand for these services. The FPSS Private Sector Component makes provisions for training motivators and family planning service providers. However, these motivators and service providers will need print and audio-visual materials to support their motivational and counseling activities.

A number of organizations in Tanzania already have family life education and family planning IEC programs. Many of these programs rely heavily on films to motivate industry employees, church groups, government, party and religious leaders, parents' groups, and the general public. Films are reportedly a very effective means of broaching the subject of family planning. Unfortunately, no family planning films have been produced in Tanzania since 1979. Although these old films are still popular, there is a need to produce more up-to-date films and to make films developed in other countries available in Kiswahili to organizations in Tanzania.

Key Activities:

a) Audio-visual materials support for private-sector motivators and counselors. Motivators and counselors will be provided with print materials and films that they can share during motivational activities and clinic visits. Two educational and entertaining films will be developed under the FPSS project and distributed to private sector motivators. Materials produced to support Ministry of Health services can also be used by private-sector family planning providers. In addition, materials produced by POPFLEP in support of industrial-based family planning IEC can be produced in support of FPSS efforts.

b) Film support for ongoing outreach work by other organizations. Films developed under the project and available from other sources outside Tanzania will be distributed to organizations active in family life education and family planning IEC such as UMATI, Regional Coordinators, POPFLEP, WAZAZI, Institute of Adult Education, EMAU, ELCT, CNBT, UNICEF, JTC and others. Additional copies will be sold to organizations in order to recover some of the production and duplication costs.

3. Disseminate the 1991 DHS results and elicit support for the National Family Planning Programme among regional and district planners and policy-makers.

In order for the National Family Planning Programme to serve the largest number of people, it is important to gain support from District and Regional level planners. These representatives of the government and CCM can greatly influence the opinions and actions of community level leaders. Also, many government extension workers have already been trained in family planning. However, their ministries have not stressed family planning motivation and education as an integral part of their jobs. Local government leaders are also responsible for making decisions concerning monetary allocations among the ministries. These leaders are therefore an important gateway to mobilizing regional, district and community resources in support of the family planning efforts.

UNFPA is supporting a project with the Institute of Development Training to train District and Regional Medical Officers of the Ministry of Health in management. This training will include an orientation to the National Family Planning Program. Training is scheduled to begin in August, 1990.

Results from the 1991 DHS should become available in 1992. Results of the DHS can be useful to regional and district planners. In order to help government planners incorporate the results into planning activities, there is a need to disseminate the results in a useable and understandable manner.

Key Activities:

a) Regional seminars for district and regional level policy-makers. Once results of the 1991 DHS become available, seminars will be organized regionally to inform policy-makers of the National Family Planning Program activities in their regions. During these seminars, leaders will also

be informed about DHS findings relevant to their regions.

b) Materials support to regional seminars. Colorful brochures depicting the relationship of DHS and census findings to the national family planning effort will be produced and distributed to seminar participants. These brochures will reinforce major seminar messages and act as reminders to policy-makers after seminars are finished.

4. Once contraceptive supplies are reliable, and service providers are adequately trained and supplied with supportive IEC materials, expand the demand for family planning services through intensified outreach activities in selected areas.

By the fifth project year, there will be a need to expand IEC efforts beyond clinic walls. Many family planning providers will have completed training. The logistics and MIS systems should be in place, and IEC materials should be available at all clinics. Consequently, during the fourth, fifth, and sixth project years, demand generation activities should be strengthened.

Because Tanzania is a large country and because family planning is better accepted in some locations than others, expanded outreach activities should be focused on selected areas where they will have the greatest impact. These areas may be urban centers or catchment areas around industrial-based family planning programs or other private sector services. Simultaneously, the radio can be harnessed to reinforce outreach activities as well as spread motivational messages to areas where services are available but intensified outreach activities are not planned.

Key Activities:

a) Expanding and strengthening local initiatives. Local organizations and volunteers active in family planning and family life education will be mobilized and enabled to conduct outreach activities such as meetings with community elders, motivational talks, filmshows, concerts and home visits. Where appropriate, local folk media performers may be commissioned to create and present songs, poems, or dramas about family planning.

b) Training for outreach workers. Outreach workers will receive training in motivational techniques, use of available materials support/visual aids, and major outreach themes and messages.

c) Audio-visual support to outreach activities. Films, posters, leaflets, booklets, and flipcharts produced under FPSS or other programs will be procured and distributed during outreach activities. Other supportive materials will be developed or reproduced as needed.

d) Extending national radio drama series with family planning messages. FPSS will fund the extension of a family planning radio drama produced by the Health Education Unit during the first four project year.

During the final two project years, the radio drama show will reinforce messages and themes of intensified outreach activities so that even those who do not live in one of the four outreach areas can benefit from the messages.

d) Unifying messages and themes throughout outreach areas. In order to maximize the impact of any combination of IEC activities, all IEC messages will reinforce each other and will be repeated at different levels of exposure. Themes and messages will be based on the objectives of the FPSS IEC component as outlined above:

- Messages that help sustain acceptance
- Messages that motivate traditional and non-users to practice modern family planning
- Messages that inform and motivate men to endorse and practice modern family planning
- Messages that elicit support for modern family planning among community leaders

5. Throughout the seven years of the FPSS project, develop a critical mass of IEC expertise among UMATI, HEU, and other organizations active in family planning communication and family life education.

Most IEC activities in the past years are best described as materials production and population awareness seminars that promote childspacing, responsible parenthood, and a small family norm. There are few professionals who have been exposed to systematic research-based communication approaches. IEC activities are also seldom evaluated in terms of project impact.

There is very little experience in the area of IEC strategies linking services with clients or creating demand for existing services. Hence, the dearth of expertise and experience in the area of IEC for service delivery.

Key Activities:

a) Training for IEC professionals. IEC professionals within HEU, UMATI, EMAU, WAZAZI, POPFLEP, and IAE will receive training through short external and internal courses in the methodology of the communication process:

- Developing and executing formative research (both qualitative and quantitative)
- Interpreting research as it relates to project design, strategic, creative message development and media planning
- Development, pretesting, and revision of materials

- Implementation and monitoring strategies
- Process and impact evaluation
- Replanning

b) Use of private sector resources. IEC personnel from UMATI and HEU will be exposed to the use of private sector professionals in advertising, development communication, production houses, and research firms, both as experienced in Tanzania and in other countries with the end in view of reconceptualizing their role more as managers of the IEC process rather than actually producing materials.

c) On the job experience for key IEC personnel. Develop a mechanism whereby key IEC personnel are trained by engaging them in "learning by doing" work in the development, production, monitoring and evaluation of the materials that are needed for the FPSS project.

d) Family planning update and training in motivational techniques for UMATI Regional and District Coordinators. Training workshops for UMATI Coordinators will be conducted to improve their motivational skills such as planning motivational activities, clearly and convincingly presenting family planning information, countering common misconceptions and rumours about family planning, and using IEC support materials in the most effective manner.

III. THREE-PHASE STRATEGY IMPLEMENTATION PLAN

The strategy outlined above will be implemented in three phases. Timing has been planned to keep pace with training, logistics and MIS components of the National Family Planning Programme. Strategies for developing a critical mass of IEC expertise will start in phase one and continue through phases two and three.

PHASE ONE (3 YEARS): While the training and logistics components of the National Family Planning Programme are gearing up, phase one will address the most pressing and important IEC needs. This involves strengthening the "front line" of the family planning program. That is, improving the quality of client/provider face-to-face interactions. Many of the activities during this phase are already planned as part of the Health Education Unit Family Planning Communication Project. During this phase, FPSS will build on the foundation of the HEU project by funding an expansion of proposed project activities. HEU will produce print materials in support of clinic providers, clients, and potential clients. Near the end of the second year, the Health Education Unit Family Planning Communication Project will conduct an evaluation of the impact of IEC activities in one pilot area. FPSS will provide supplemental funding to HEU for increased volumes of some of the materials produced and expanded distribution. Simultaneously, UMATI will coordinate the production and distribution of materials in support of private sector motivators. UMATI will also oversee the production of two entertaining family planning films and will

distribute them widely to organizations active in family planning IEC. During the last year of phase one, UMATI will begin planning and developing materials for regional seminars. Also during this first phase, four IEC staff from UMATI, HEU or other organizations active in family life education or family planning communication will attend short-term external training courses to enhance their communication skills.

PHASE TWO (2 YEARS): Phase two will focus on preparations for more intensified outreach in selected areas. HEU will produce and distribute a second round of print materials for clients and potential clients. UMATI will continue distributing films. Seminars for policy-makers will be conducted in all regions. Four areas will be selected for intensified outreach activities. Formative research, strategy design, training, and materials development for intensified outreach activities will begin. Another four IEC personnel from organizations active in family planning IEC will attend short-term external training courses in family health communications.

PHASE THREE (2 YEARS): During phase three, IEC activities will expand beyond clinic walls to recruit new clients. Intensified outreach activities will take place in four selected areas of the country. These will be supported by production and broadcast of a weekly radio drama series promoting family planning services. During the last year of this phase, an evaluation will be conducted to measure the impact of outreach activities. Another four IEC personnel will attend short-term external training courses in communication.

III. MECHANISM OF IMPLEMENTATION

Overall coordination of IEC activities will be facilitated by an IEC Coordinating Committee. The committee will be chaired by the Ministry of Health MCH/FP Division. UMATI will act as secretariat, scheduling Coordinating Committee meetings and recording and distributing minutes of the meetings. Members of the Coordinating Committee will include representatives of the Health Education Unit, ENAU, POPFLEP, WAZAZI, the Institute of Adult Education, Tanzania Red Cross Society, GTZ, and the Christian Medical Board of Tanzania. The purpose of the committee will be to assure accuracy of information and consistency of messages among family planning materials produced by various organizations.

The Health Education Unit of the Ministry of Health and UMATI will be the major implementers of family planning IEC activities. During the first three project years the Health Education Unit will focus on IEC activities in support of public sector family planning services and UMATI will direct its attention to activities in support of private sector family planning programs. During the second and third phase of activities, UMATI and HEU will work together to prepare for and implement intensified outreach activities in selected areas. UMATI will also have principal responsibility during phase two for conducting regional level seminars for policy-makers.

FPSS will strengthen the capabilities of HEU and UMATI to fulfill their roles through the provision of equipment, supplies, and some salaries.

A. FPSS support to the Health Education Unit FPSS will support the Health Education by building on the foundation of the Family Planning Communication Project. FPSS will fund an expansion of the proposed project to include:

1. expanding the project for five additional years to include nation-wide distribution of materials, and a second round of print materials production during the fourth project year.
2. increasing quantities of leaflets and posters produced during the first two year.
3. picking up funding for the radio program during the fifth, sixth, and seventh FPSS project years.
4. improving project management capabilities of the Health Education Unit by upgrading their office equipment and storage facilities. Specifically, HEU needs an office dedicated to project personnel, a room with space enough for storage of print materials, a photocopy machine, an air conditioner, and a typewriter.
5. improving the quality of print materials produced by the project by training the HEU graphic artist in manual color separation techniques and providing color separation equipment and supplies.

Under the Family Planning Communication Project, the Health Education Unit will contribute one full-time project manager for two years. The Family Planning Communication Project also includes the full-time assistance of a Research and Evaluation Officer and an Assistant Project Manager. Both positions are funded for one year under the project with the understanding that their salaries will be picked up by the Ministry of Health during the second project year. FPSS will need Ministry of Health assurance that these three staff members will remain available to FPSS for an extension of the Health Education Unit project for five additional years.

B. FPSS support to UMATI. UMATI will coordinate and manage IEC activities in support of the private-sector family planning program, seminars for policy-makers, and during the third phase intensified outreach activities. The IEC Unit of UMATI is currently staffed with three full-time employees. All manage at least one project. None have sufficient time to manage an IEC project of this magnitude. FPSS will therefore fund one full-time project manager for seven years at an UMATI Programme Officer salary. During the sixth and seventh years, FPSS will pay the salaries of four Assistant Outreach Managers to assist with intensified outreach activities.

While the IEC Project Manager will have day-to-day responsibility for management of project activities, the UMATI Chief IEC Officer will be named Project Director. The IEC Project Manager will be responsible for coordinating all UMATI IEC activities under the FPSS project. To facilitate the coordination and implementation of project activities, FPSS will supply one vehicle to the Project Manager.

UMATI will contribute 50% of one IEC staff member's time to act as assistant project manager. Other UMATI staff will be made available to assist with project activities on a part-time basis. Regional UMATI Coordinators will conduct regional seminars, and some Coordinators may act as Outreach Managers during the intensified outreach activities in their regions. To assist Outreach Managers with intensified outreach activities, FPSS will fund four Assistant Outreach Managers for the final two project years.

The UMATI Research and Evaluation Unit will be responsible for coordinating and assisting the Project Manager with formative and evaluative research. FPSS will provide one vehicle for the UMATI Research and Evaluation Unit to assist with data collection and research management.

FPSS will also facilitate IEC activities through provision office space for the IEC Unit, and some equipment. FPSS will provide four 220 Volt generators for use by UMATI Regional Coordinators during intensified outreach activities. FPSS will also provide a telephone, desk and chair, typewriter, and file cabinet for the Project Manager.

C. Technical assistance to the Health Education Unit and UMATI. Technical assistance will be provided through a series of buy-ins to a centrally-funded cooperative agency with expertise in family planning IEC. When possible, in-country technical assistance will be provided by qualified Tanzanians. The buy-in will provide for:

1. Technical assistance to UMATI and HEU to design detailed implementation plans for each phase of project activities.
2. Regular monitoring visits and reporting every six months to USAID/Dar es Salaam.
3. Technical assistance with formative and evaluative research design, analysis, and reporting.
4. Technical assistance as needed with message design and materials development.
5. Technical assistance as needed to film directors and producers.
6. Procurement and shipping of necessary equipment and supplies.
7. In-country training for IEC personnel in recent advances in family health communication.
8. Provision of sample family planning IEC materials developed in other countries, such as videos, films, leaflets, and posters.
9. Assistance dubbing films into Kiswahili.

IV. DETAILED DESCRIPTION OF KEY ACTIVITIES

A. Development, production, and distribution of high quality print materials for providers and for clients. Most of the print materials will be developed under the Family Planning Communication Project.

1. Materials for providers: Illustrative list of materials to be developed under the Family Planning Communication Project.

a) Handbooks for MCH-Aides. Written in Kiswahili, this illustrated handbook will give information in simple non-technical language about the various family planning methods and other primary health care interventions. The project will procure or produce 10,000 copies.

b) Buttons or badges for family planning providers. Badges or buttons containing the family planning logo will be produced and distributed to MCH-Aides and other health workers who have complete the National Family Planning Programme in-service training course on family planning.

2. Materials for family planning clients and clinic attenders: Illustrative list of materials to be developed under the Family Planning Communication Project.

a) Wallcharts for clinics. Colorful wallcharts, showing the various family planning methods available in Tanzania will be distributed to all family planning clinics. Four thousand copies of this wallchart will be produced.

b) Posters for clinics. Four attractive color posters will communicate important family planning messages aimed at reinforcing family planning behavior, combatting rumors, and convincing non-users to practice family planning.

c) Method-specific leaflets on the pill, IUD, injectables, and voluntary surgical sterilization. One page illustrated leaflets will provide basic information about each of the permanent and semi-permanent methods. The Family Planning Communication Project will fund 300,000 copies of each leaflet. FPSS will fund an additional 200,000 copies each to be produced and distributed during the fourth and fifth project years.

3. Materials for potential clients: Illustrative list of materials to be developed under the Family Planning Communication Project.

a) Leaflets on family planning. Single-paged colored leaflets will provide information on the benefits of family planning and brief illustrated descriptions of the family planning methods available in Tanzania. The Family Planning Communication Project will produce and distribute 200,000 copies. FPSS will fund production and distribution of 300,000 additional copies during the second project year and 500,000 additional copies during the fourth and fifth project years.

b) Posters directing people to family planning services. Four posters will be developed and distributed with convincing and appealing messages such as the benefits of family planning, the caring attitude of family planning service providers, and answers to common questions about modern family planning methods. The Family Planning Communication Project will fund 10,000 copies each of these posters. FPSS will fund the production of 10,000 additional copies of each poster. Posters will be distributed through organizations with outreach programs such as GTZ, the Institute of Adult Education, CCT, Tanzania Red Cross Society, WAZAZI, UMATI, and UNICEF.

4. Development process. All materials development will begin with a thorough assessment of materials support needs of clients, service providers, and motivational workers. Messages and themes will be developed based on the results of a national KAP survey, an inventory of existing studies, and focus group discussions with clients and potential clients.

Print materials will be designed and draft materials prepared by an outside graphic artist hired by HEU. The draft materials will be presented to the IEC Coordinating Committee for comments and revisions. Revised materials will be pretested and revised two times and presented to the IEC Coordinating Committee for final approval before printing. Materials will be printed by an outside printer through a subcontract. Materials will be distributed according to a distribution plan developed by the IEC Coordinating Committee.

The second round of print materials may either involve reprinting materials produced during the first phase of the project, or may involve developing new materials. The IEC Coordinating Committee will decide what type of materials are needed based on an evaluation of print materials conducted during the second project year. New materials will be produced based on a second round of qualitative research, and repeating the development process described above.

5. Distribution of print materials. Print materials will be distributed through two channels. Packets of print materials will be distributed in packets through the mail to organizations with family planning communication programs. For distribution to MOH service delivery sites, HEU will contract a handling and shipping agent to deliver packets of print materials with instructions for use to each dispensary and health center with family planning services.

6. Evaluation of Print Materials: HEU will subcontract UMATI Research and Evaluation Unit to design and conduct an impact evaluation of all Family Planning Communication Project components, including print materials. This evaluation will take place at the end of the second project year. The evaluation will include baseline data collection to determine clients' exposure to print materials and the accuracy of clients' family planning knowledge. After distributing the materials in one area of the country, final evaluation data will be collected to determine clients' exposure to project materials, the clarity of the materials' messages, and the accuracy of clients' family planning knowledge. Baseline and final evaluation data will

be compared to determine impact of print materials and to direct future materials development and distribution.

A similar evaluation process will take place during the seventh project year to assess impact of the second round of print materials.

B. Development, production and distribution of two entertaining films with family planning messages.

1. The 30-minute dramatic films: During the first three project years, UMATI will manage the production of two films with family planning messages. One copy of each film will be distributed to each UMATI Regional Coordinator, POPFLEP, ELCT, EMAU, ST2, WAZAZI, THEA, the Institute for Adult Education, HEU, UNICEF, the Audiovisual Institute, and CNBT. Additional copies will be made available to organizations for the cost of duplication and shipping.

2. Film production process: UMATI will subcontract a film production house and commission a scriptwriter to produce two entertaining films. Scripts will be based on findings from a series of focus group discussions conducted among men and women in several areas of the country. Scripts will be reviewed by members of the IEC Coordinating Committee for accuracy of information as well as clarity and appropriateness of messages. Films will be pretested and revised before multiple copies are made and distributed.

3. Evaluation of films: As part of the overall evaluation of the IEC component, audience research will assess how many people were exposed to the films, whether the messages were clear, and how many people could recall the program's characters and messages. The evaluation will also collect information about clients' sources of referral.

C. Procurement and production of high quality print materials in support of private-sector family planning programs.

1. Materials for employment-based motivators: Illustrative list of outputs:

a) Posters promoting family planning services. Colorful and eye-catching posters referring people to family planning services will be posted throughout workplaces with private-sector family planning programs. One poster will be produced for employment-based programs. Other posters will be provided by the HEU project.

b) Booklets for industrial workers. The POPFLEP Organized Sector program has produced booklets and a photonovel for industrial workers with information about the benefits of family planning. UMATI will procure copies of relevant booklets from POPFLEP and distribute in industrial-based family planning program sites.

c) Training manual for employment-based motivators. A small manual outlining the curriculum that motivators should follow during

discussions and talks with employees will be distributed to motivators during their training. Some training manuals have already been produced by POPFLEP and the Family Planning Private Sector program in Kenya, and other employment-based family planning projects. UMATI will adapt these manuals for use by employment-based motivators.

d) Films with family planning messages. Films produced under the FPSS project will be shown during motivational talks in industries. Other films produced outside Tanzania will be identified. UMATI will contract a film production house to dub particularly effective films into Kiswahili. Films will also be distributed through the Audiovisual Institute. The Audiovisual Institute can arrange to have films played at commercial cinemas throughout Tanzania.

2. Materials for employment-based family planning providers:
Illustrative list of outputs:

a) Leaflets on pills, injectables, IUDs, and Voluntary Surgical Contraception. In order to provide clients and their spouses with accurate information about the more effective temporary and permanent family planning methods, HEU will produce leaflets on each of these methods. UMATI will distribute copies of these leaflets to private-sector service providers. Clinic providers can give these leaflets to clients who express interest in or choose to use one of these methods.

b) Flipcharts showing male and female reproductive organs and the various contraceptive methods. Flipcharts produced by the Ministry of Health Training program, or procured from other programs in Africa, will be given to employment-based family planning providers. Providers can use flipcharts when explaining the methods to clients.

3. Materials development process: Before materials are developed or procured, UMATI will conduct focus group discussions with employees to determine their informational, motivational, and materials needs. Based on these discussions, UMATI will decide which materials to develop and which to procure. All materials to be used in the private-sector program will be pretested with employees.

4. Evaluation of private-sector IEC materials: As part of the overall evaluation of the private sector component, audience research will assess how many people were exposed to the materials, whether the messages were clear, and the accuracy and completeness of employees' family planning knowledge.

D. Seminars for regional and district-level policy-makers.

1. Assessment of Informational Needs: In preparation for regional seminars, UMATI Regional Coordinators will conduct interviews with a sample of regional and district level government and party officials to assess their knowledge and attitudes toward family planning, its relation to population growth and the impact of population growth on regional and national development. This information will guide UMATI in planning content, appeals,

and priority messages for regional seminars.

2. Workshop for Curriculum Design: UNATI will organize a workshop for Regional and District UNATI Coordinators and representatives of the Bureau of Census, the Population Planning Unit, and the Ministry of Health to discuss DHS results and the findings from interviews with regional and district level leaders. Priority messages will be identified and the UNATI Coordinators will develop curricula, visual aids, and plans for seminars in their regions.

3. Print Materials Development: Based on DHS results and the informational needs of policy-makers identified during interviews with leaders, UNATI will develop a colorful illustrative brochure for distribution to seminar participants. The brochure will reinforce seminar messages and serve as a reminder of important issues once participants return to their work.

4. Regional Seminars for Policy-makers: UNATI Coordinators will be responsible for organizing one-day seminars for government and party leaders in their region. Seminars will follow the plans developed during the curriculum design workshop.

5. Evaluation of Seminars: Once seminars have been completed, UNATI Regional Coordinators will once again conduct interviews with a sample of Regional and District level officials who attended the seminars. The results of pre- and post-seminar interviews will be compared to determine the impact of seminars.

E. Intensified outreach activities in four selected areas of Tanzania.

1. Selection of areas for concentration: After the first three years of the bilateral project, the IEC Coordinating Committee will meet with USAID to identify four areas of the country for intensive demand generation activities. Efforts will concentrate on those areas where IEC is expected to have the greatest impact. Areas may be cities, towns, or catchment areas around industrial-based family planning programs or other private sector clinics. Areas will be selected based on results of a situation analysis conducted after the third project year, DHS results, and other relevant research and will meet the following criteria:

All family planning service delivery sites have well functioning logistics systems,

A variety of family planning methods are available to the majority of people in the area,

Family planning service providers have been trained in family planning service provision, counseling and motivation, and

A supportive community environment for family planning exists as indicated by a continuous increase in contraceptive clients.

2. Management and organization of intensified activities: UMATI will coordinate the intensified outreach activities. While UMATI will have overall responsibility for coordinating activities, HEU will continue to assist with this portion of the project, possibly through a subcontract.

In each of the four selected areas, the HEU Regional Health Education Officer or the UMATI Regional Coordinator will act as the IEC outreach manager. This manager will be responsible for mobilizing support and cooperation from UMATI volunteers and one or more organization active in family planning and family life education in the area. UMATI will subcontract with local research organizations to conduct qualitative research aimed at identifying audiences, themes, and priority messages. Cooperating organizations and volunteers will work with UMATI and HEU to design a strategy for informing and motivating people in the area about family planning services.

Each of the cooperating organizations will help organize outreach activities such as meetings with community elders, motivational talks, filmshows, concerts, or home visits. All activities will incorporate the agreed-upon themes and messages and will aim at reaching as many people in the area as possible.

Outreach managers will be supported in these activities by the UMATI and HEU Project Managers in Dar es Salaam who will make frequent visits to the area. They will be further supported during the sixth and seventh project years by Assistance Outreach Managers funded through the FPSS project.

3. Audio-visual support to outreach activities: UMATI will supply outreach managers with posters, leaflets and films produced under the FPSS project. UMATI will also procure and distribute flipcharts produced by other projects. Some special materials will also be developed for local area activities. An illustrative list follows:

a) Contraceptive sample kits. Outreach workers will be supplied with canvas bags sporting the family planning logo. Outreach workers can carry their contraceptive supplies, leaflets, and other visual aids in these bags.

b) Flyers promoting family planning services. Inexpensive one-page flyers will give basic information about modern contraceptives, their advantages, and where services are available. Outreach workers can distribute these flyers to adults during home visits and motivational talks. A blank space can be provided on the back where health workers can write the address of the dispensary or health clinic, thus "personalizing" the material.

c) Kangas with family planning messages. Colorful and attractive kangas with a family planning slogan and the family planning logo will be developed and distributed to outreach workers, folk media performers, and may even be sold in shops.

4. Materials development process: All materials will be developed based on results of formative research in the intensified outreach areas. HEU

and UMATI will design materials and contract local graphic artists to prepare draft materials. All materials will be pretested and revised two times with the target audiences before production.

5. Training for outreach workers: Training support for this phase of project activities will begin during the first phase with training in motivational techniques and a family planning update for UMATI Regional and District Coordinators. During the third phase, outreach managers in each area will be responsible for training outreach workers in family planning, motivation and communication techniques. UMATI and HEU Project Managers will assist with designing the curriculum for training. Outreach workers will be trained in 2-week courses in family planning information, how to use audio-visual equipment and materials, priority messages and themes of the outreach activities, and presentation skills. Outreach workers will receive contraceptive sample kits and other support materials during the training. In larger cities with many outreach workers, each organization participating in the intensified outreach activities will be responsible for training their own outreach workers. The outreach manager will train one trainer from each organization who will be responsible for training their organization's outreach workers.

6. Folk Media performances with family planning messages: Where appropriate, UMATI may contract folk media groups to create and perform songs, dramas, or poems with family planning messages. The performances will be accompanied by an outreach worker who will provide information about family planning and the location of family planning services.

7. Community filmshows and discussions: A central component of the intensified activities will be community filmshows. Family planning films will be shown by outreach workers. Following the films, outreach workers will conduct discussions about modern family planning and direct people to services. Entertaining family planning films may also be shown in commercial cinemas, and to organized groups such as youth groups, womens' groups, church groups, etc.

8. Meetings with community leaders: Before outreach activities get underway, the IEC Outreach Managers will hold meetings with local government, party, medical and religious leaders to enlist their support for the family planning program in general and for the intensified outreach activities in their regions or districts. Managers will also inform clinic staff in the area of the upcoming activities and elicit their support and participation.

9. Evaluation of intensified outreach activities: During the seventh project year, UMATI will conduct an impact evaluation of the outreach activities. Success will be measured by 1) evidence that a large percentage of the target audience has been exposed to outreach messages, 2) an increased demand for contraceptive services following the intensified outreach activities, and 3) an indication that the outreach activities have been a major source of referral to family planning services.

BUDGET FOR IEC COMPONENT

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	TOTAL
I. SALARIES								
UMATI IEC Manager	1,800	1,800	1,800	1,800	1,800	1,800	1,800	12,600
4 UMATI Assistant Outreach Managers	0	0	0	0	0	4,800	4,800	9,600
SUBTOTAL SALARIES	1,800	1,800	1,800	1,800	1,800	6,600	6,600	22,200
II CONSULTANTS								
Research assistants for focus group discussions	1,000	0	0	0	2,000	1,000	1,000	5,000
Resource persons for Regional Seminars	0	0	900	1,500	0	0	0	2,400
Resource persons for Outreach Worker Training	0	0	0	0	8,960	0	0	8,960
Resource persons for UMATI Coordinator training	0	0	1,680	0	0	0	0	1,680
Graphic Artist for materials development	1,000	0	500	1,000	1,000	0	0	3,500
Editor for print materials	300	0	300	400	300	0	0	1,300
Radio scriptwriter	0	0	0	0	1,200	1,200	1,200	3,600
Actresses and actors for radio drama	0	0	0	0	2,000	2,000	2,000	6,000
	2,300	0	3,380	2,900	15,460	4,200	4,200	32,440
III. TRAVEL AND ALLOWANCES								
Travel and per diem for workshop to prepare regional seminars	0	0	15,000	0	0	0	0	15,000
Travel and per diem for regional seminars	0	0	0	55,000	0	0	0	55,000
Travel and per diem for focus group research	1,115	0	0	1,115	1,115	1,115	1,115	5,575
Travel and per diem for pretesting materials	400	0	200	400	400	0	0	1,400
Travel and per diem for Intensified outreach strategy design meetings in 4 areas	0	0	0	0	3,600	0	0	3,600

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Travel and perdiem for 2 week training course for 120 outreach workers in 4 areas	0	0	0	0	36,600	0	0	36,600
Travel and perdiem for 3 2-week training courses for UMATI Coordinators in motivation	0	0	24,450	0	0	0	0	24,450
Perdiem and travel allowance for outreach motivators to hold one meeting/week X 6 months	0	0	0	0	0	30,000	30,000	60,000
Perdiem and fuel for Monitoring visits by UMATI Project Manager	2,000	2,000	2,000	2,000	2,000	2,000	2,000	14,000
Fuel for Outreach Managers to supervise outreach activities	0	0	0	0	8,000	8,000	8,000	24,000
Fuel for HEU Project Manager to supervise focus group discussions, materials distribution, and evaluation	2,000	2,000	2,000	2,000	2,000	2,000	2,000	14,000
Transportation, travel allowance and tuition for short-term external training--2 people/year	0	20,000	20,000	20,000	20,000	20,000	20,000	120,000
	5,515	24,000	63,650	80,515	73,715	63,115	63,115	373,625
IV. EQUIPMENT AND SUPPLIES								
2 vehicles for UMATI IEC Project Manager and Research Officer (includes 17% for maintenance)	22,000	0	0	0	0	0	0	22,000
4 vehicles for Outreach Managers	0	0	0	0	44,000	0	0	44,000
8 tape recorders for focus group discussions	800	0	0	0	0	0	0	800
Audio cassette tapes for focus group discussions	100	0	0	100	100	100	100	500
Batteries for tape recorders	100	0	0	100	100	100	100	500
Supplies for HEU graphic artist	500	0	0	500	0	0	0	1,000

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Plates and film for printing	500	0	0	500	500	0	0	1,500
Typesetting paper	0	0	0	100	0	0	0	100
Reel-to-reel tapes	0	0	0	0	200	200	200	600
Typewriter for UMATI IEC Manager	600	0	0	0	0	0	0	600
Camera for producing print materials at HEU	50,000	0	0	0	0	0	0	50,000
Photocopy machine for HEU	3,500	0	0	0	0	0	0	3,500
Air conditioner for HEU	1,600	0	0	0	0	0	0	1,600
Telephone for UMATI IEC Manager	200	0	0	0	0	0	0	200
Office equipment for UMATI IEC Manager	1,000	0	0	0	0	0	0	1,000
Stationery and supplies	1,000	1,000	1,000	1,000	1,000	1,000	1,000	7,000
Optical camera for dubbing films	5,000	0	0	0	0	0	0	5,000
Supplies for workshop in preparation for regional seminars	0	0	1,000	0	0	0	0	1,000
Supplies for Regional seminars	0	0	0	2,500	0	0	0	2,500
Supplies for outreach strategy design meetings	0	0	0	0	400	0	0	400
Supplies for training workshop for outreach workers	0	0	0	0	400	0	0	400
Supplies for workshops for UMATI Coordinators	0	0	300	0	0	0	0	300
Office rental for UMATI IEC Manager	6,000	6,000	6,000	6,000	6,000	6,000	6,000	42,000
Four 220 volt generators	0	0	0	3,000	0	0	0	3,000
Other outreach supplies	0	0	0	0	1,000	1,000	1,000	3,000
Graphic arts supplies	0	0	0	500	500	0	0	1,000
SUBTOTAL	92,900	7,000	8,300	14,300	54,200	8,400	8,400	193,500
V. OTHER DIRECT COSTS								
Postage and packing for distribution of print materials to NGOs	0	0	2,000	0	2,000	0	0	4,000

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for distribution of print materials to MCH clinics and dispensaries	0	0	40,000	0	40,000	0	0	80,000
Postage and packing for distribution of films to organizations active in family planning IEC	0	0	5,000	0	0	0	0	5,000
Hall rental for workshop in preparation of regional seminars	0	0	200	0	0	0	0	200
Hall rental for regional seminars	0	0	0	500	0	0	0	500
Hall rental for strategy design meetings	0	0	0	0	250	0	0	250
Hall rental for training UPTI Coordinators in Motivations & interpersonal communication	0	0	200	0	0	0	0	200
Communications--telex, fax, express mail, phone	4,000	4,000	4,000	4,000	4,000	4,000	4,000	28,000
Printing costs								
Posters	0	40,000	0	75,000	40,000	0	0	155,000
Leaflets	0	150,000	0	415,000	100,000	0	0	665,000
Brochure	0	0	1,500	0	0	0	0	1,500
Flyers	0	0	0	0	45,000	0	0	45,000
Kangas, buttons, carrying bags	0	0	0	0	5,000	0	0	5,000
Flipcharts for outreach workers and private sector service providers	0	1,200	0	0	8,400	0	0	9,600
Dubbing films into Kiswahili (50 copies)	0	28,000	0	0	0	0	0	28,000
Booklets, posters, flipcharts from other organizations	0	5,000	0	0	5,000	0	0	10,000
Bank charges	500	500	500	500	500	500	500	3,500
UPTI overhead @ 15%	20,000	20,000	20,000	20,000	20,000	20,000	20,000	140,000
Procurement of films	0	25,000	0	0	0	0	0	25,000
Commission for folk media troupes	0	0	0	0	0	2,400	2,400	4,800
SUBTOTAL	24,500	273,700	73,400	515,000	270,150	26,900	25,900	1,210,550

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VI. SUBCONTRACTS

Subcontract film production for 2 30-minute color films	50,000	50,000	0	0	0	0	0	100,000
Subcontract evaluation	0	0	0	5,000	0	0	30,000	35,000
SUBTOTAL	50,000	50,000	0	5,000	0	0	30,000	135,000
SUBTOTAL IN-COUNTRY COSTS	177,215	353,500	150,520	419,515	415,315	103,215	159,215	1,967,315
VI TECHNICAL ASSISTANCE								
Monitoring visits every six months x 7 years @ \$10,000/VISIT	20,000	20,000	20,000	20,000	20,000	20,000	25,000	145,000
Other technical assistance one time/year	10,000	10,000	10,000	10,000	10,000	10,000	10,000	70,000
Communications--telephone, fax, telex, express mail	2,000	2,000	2,000	2,000	2,000	2,000	2,000	14,000
Overhead @ 32%	10,240	10,240	10,240	10,240	10,240	10,240	11,840	73,250
SUBTOTAL	42,240	42,240	42,240	42,240	42,240	42,240	48,840	302,290
TOTAL	219,255	395,740	192,760	461,755	457,555	151,455	198,055	2,269,595

: VOLUNTARY SURGICAL CONTRACEPTION

The purpose of the voluntary surgical contraceptive (VSC) component is to expand the availability of voluntary surgical contraception services in Tanzania in order to enhance the well being of Tanzanian families by reducing the rates of maternal and infant mortality and morbidity. A secondary purpose is to allow more Tanzanian families the opportunity to choose a safe and effective permanent method of family planning if they so desire.

Estimates of the numbers of women who are dying each year in Tanzania in childbirth or for causes related to childbirth, range from 2200 to 4400. Evidence from elsewhere in Africa indicates that most of these are older women with six or more children and that many of these deaths could be avoided if safe tubal ligation services were more readily available. Furthermore, some 223,000 infants die each year in Tanzania and again evidence suggests that many of these infants are born to older women of higher parity.

Over the last three years, VSC services have begun to be offered for family planning reasons, and there is some evidence to suggest a growing interest in this method of contraception, although demand is still low. Reported constraints concerning tubal ligation include women's fear of the operation, lack of surgical supplies, and lack of knowledge among service providers and potential clients. A recent USAID/Tanzania buy-in to the Association for Voluntary Surgical Contraception (AVSC) will support the expansion of VSC sites from the current two in Dar es Salaam to a further 17 locations. As part of the Family Planning Services Support Project, VSC services will be further expanded to a total of 45 sites by 1996/97. By the end of the project, it is estimated that a total of 22,750 clients per year will be served, as compared to a current total of 650/year.

The VSC component will include the training of clinical teams and FP/VSC counsellors, orientation seminars for health workers and program managers, minor renovations to service clinics, provision of expendable supplies, and technical support for program planning, supervision and quality assurance. AVSC will provide technical assistance, equipment, supplies and support towards institutional operating costs. AVSC will also support MOH, UMATI and USAID in managing the FPSS support. The GOT and NGOs will provide facilities, staff and other operating support. This component will be effected through a buy-in to AVSC for a total of \$1,577,500 covering years 2 through 7 of the Project.

ANNEX ___ : VOLUNTARY SURGICAL CONTRACEPTION

1. Purpose and Summary Description: The purpose of expanding the availability of voluntary surgical contraceptive services in Tanzania is to enhance the well being of Kenyan families by reducing the rates of maternal and infant mortality and morbidity. A secondary purpose is to allow more Tanzanian families the opportunity to choose a safe and effective permanent method of family planning if they so desire.

Estimates of maternal mortality in Tanzania range from 185 to 370 per 100,000 live births (2200-4400 maternal deaths per year). Evidence from elsewhere indicates that maternal mortality is highest among older women with six or more children. Many of these deaths could be avoided if safe tubal ligation services were more readily available. Furthermore, some 16% of the infants born each year in Tanzania are dying (approximately 223,000 each year). Again, findings in other African countries indicate that most of these infants are born to older women of higher parity.

This component of the Tanzanian family planning project will extend the availability of voluntary surgical contraception services from the present two sites to a total of 45 sites by the end of year 7 (1996/7), with an expected increase in the numbers of clients served each year from an estimated current level of 650 to a total of 22750.

Support for expansion of voluntary surgical contraception services will include the training of clinical teams and FP/VSC counsellors, orientation seminars for health workers and program managers, minor renovations to service clinics, provision of expendable supplies, and technical support for program planning, supervision and quality assurance. The Association for Voluntary Surgical Contraception (AVSC) will provide technical assistance, equipment, supplies and support towards institutional operating costs. AVSC will also support MOH, UMATI and USAID in managing the FPSS support. This component will be effected through a buy-in to AVSC for a total of \$1,577,500 covering years 2 through 7 of the Project.

II. Background: Of the women opting for family planning in Tanzania at the present time, it is estimated that 76% use oral contraceptives, 19% use the IUCD, and less than 1% have selected sterilization. Many multiparous women who want no more children and who might opt for permanent contraception have no access to this service. In the past, voluntary surgical contraception (VSC) for women has been offered in Tanzania for health reasons only, and access to these services has been extremely limited. More recently, there is some evidence of growing interest in VSC for family planning reasons, although demand is still very low. The reported constraints concerning tubal ligation include: a) women's fear of the operation; b) lack of surgical supplies in the hospitals; c) lack of knowledge among service providers and potential clients; and, in some regions, d) opposition to permanent contraception by husbands. Service providers believe that client fears would be significantly reduced if VSC were available as an out-patient procedure under local anaesthetic. The MOH and UMATI have requested USAID to assist in making VSC services more accessible and available in Tanzania.

Between 1982 and 1985, AVSC provided grants to UMATI for information and education activities, including the training of volunteers in communication skills and contraceptive technology, including VSC. In 1987, two surgical teams were trained in minilaparotomy using local anaesthetic (ML/LA) at the Family Planning Association of Kenya (FPAK), and subsequently ML/LA services were set up at the Muhimbili Medical Centre (MMC) in Dar es Salaam. More recently, UMATI began to offer ML/LA services at their own clinic at the MMC site. Since 1985, more than 2360 clients have received tubal ligation at these two centers. UMATI had developed a quality training program for surgical teams and FP/VSC counsellors, and both the clinical and the training skills so developed will now play a key role in the expansion of services from these initial two sites to other regions in the country.

During 1989 and early 1990, at the request of the MOH and UMATI, AVSC, together with representatives of MMC and UMATI, visited 8 regions to assess the demand for VSC and the needs for service development in order to develop a program for the extension of VSC services in Tanzania. The results of this assessment supported the view of a growing demand for family planning in Tanzania, whilst indicating considerable regional differences in demand for tubal ligation (with demand highest in Kilimanjaro and Arusha Regions, as well in the major urban centers).

III. Description: Based on the assessment, a plan to launch a 2-phase program for the gradual extension of VSC services was developed. The first phase will extend services to an additional 17 sites; the second phase will cover a further 26 sites to a total of 45 sites by the end of seven years. The majority of sites will be in government facilities, with the second largest number planned for Mission hospitals. In areas of high demand, VSC services may be considered for UMATI clinics based on the model of Dar es Salaam, and private clinics will be considered where the mission or government facility is not easily accessible. Areas where there is already a critical shortage of land, where the population is already heavily involved in cash economy, and where education levels are higher, are more likely to be areas where demand for permanent contraception will be greater. These factors, together with an assessment of the motivation and interest of the hospital staff and previous demonstrated demand for temporary contraception, will be considered in prioritizing the initial expansion sites.

From January 1990, a \$200,000 Mission buy-in to AVSC has been effected to support a two-year project as the first phase of the seven-year program. This first phase will extend VSC ML/LA services beyond the two MMC clinics to 17 new sites. The Ob/Gyn surgeons and VSC counsellors previously trained by FPAK and AVSC will be responsible for the training of clinical teams and FP/VSC counsellors from 13 hospitals within Dar es Salaam and neighbouring regions. The doctors to be trained in ML/LA under the project will also receive an update their role in supporting IUCD (380 A) insertion and the management of complications related to IUCD use. Support will also be provided to the Kilimanjaro Christian Medical Centre (KCMC) to develop ML/LA services, to train clinical and counselling teams from 3 adjacent district hospitals, and to assist KCMC to evolve into a technical

assistance/quality assurance center for the future expansion of VSC services in the north eastern part of the country. UMATI will remain responsible for program development, quality assurance, and technical assistance in the North Western and Coast Regions. The project will also be covering the cost of a full-time Tanzanian consultant to the program for needs assessments, training, supervision and quality control. The consultant, together with a FP/VSC counsellor from UMATI, will also provide trainee follow-up for all surgical teams and counsellors when they return to their home sites, and will assist KCMC to take over these functions in their own regions.

During the second phase of the program (years 3-7), and as part of the Tanzanian Family Planning Services Support Project, USAID/Tanzania will effect a further buy-in to AVSC for \$1.578m. for the further extension of VSC services to a total of 45 sites. The project will cover the training of additional surgical teams and FP/VSC counsellors; the provision of expendable supplies; and the delivery of at least two orientation seminars in each expansion area to inform administrators, health care providers, and family planning workers about the availability of family planning including VSC and how to obtain services. Special assessments will be conducted in the Mbeya and Mwanza regions in the early part of the project to identify their potential to join Kilimanjaro and MMC as VSC training and quality assurance centres for VSC.

The approach planned for the expansion of VSC services is intentionally aimed at the development of services that can be sustained over the long term. This is part of the rationale for ML/LA as opposed to laparoscopy. Any doctor with experience in female abdominal surgery can be trained to perform ML/LA. The equipment is simple, and local anaesthesia is safer, more cost effective, and (according to local health professionals) more acceptable to Tanzanian women. In addition, VSC counselling will be integrated into general counselling for all family planning methods, and refresher training in IUCD insertion and the management of complications will be included into the ML/LA training.

Details of the phasing of the extension of VSC services, together with the associated costs for the years 1990/91 through 1996/97, are given in the Annex.

ACTIVITIES AND COSTS FOR VSC COMPONENT 1990/1-1996/7

	1990/1	1991/2	1992/3	1993/4	1994/5	1995/6	1996/7	TOTAL
Service Sites - New	8	9	6	5	5	5	5	43
Service Sites - Cumulative	10	19	25	30	35	40	45	45
ML/LA Doctors	10	26	26	36	36	40	40	214
ML/LA Nurses	10	26	26	36	36	40	40	214
FP/VSC Counsellors	34	50	50	60	60	70	70	394
Orientation seminars	5	13	15	15	12	12	10	82
Minor clinic renovations	8	9	6	5	5	5	5	43
Clients served annually	650	1200	2000	3000	4200	5200	6500	22750
COSTS (\$000)								
Equipment (AVSC)	*	30.0	70.0	70.0	65.0	65.0	50.0	350.0
Equipment (Local Purchase)	*	12.0	24.0	30.0	30.0	30.0	25.0	151.0
Expendable Supplies	*	9.6	16.0	27.0	42.0	50.0	40.0	134.6
Medical Training (\$700/trainee)	*	*	36.4	57.0	56.0	61.0	70.0	200.4
Counsellor Training (\$500/trainee)	*	*	27.5	36.0	39.0	45.5	5.0	153.0
Orientation seminars	*	6.5	7.5	7.5	7.0	7.5	7.0	43.0
Clinic renovation (\$2000/site)	*	8.0	12.0	12.0	12.0	12.0	14.0	70.0
Quality assurance/TA (local)	*	*	18.5	20.0	22.0	24.0	26.0	110.5
Operations	*	*	3.5	4.0	4.5	5.0	5.5	22.5
AVSC Direct cost	*	*	34.5	40.5	44.5	48.5	44.5	212.5
TOTAL	*	66.1	249.9	301	322	351.5	287.0	1577.5

Notes:

- (1) * Costs covered by current USAID/Tanzania buy-in to AVSC
 (2) Unit costs increased over 7 years to reflect estimated inflation

1-385
 (1997)

TANZANIA PARASTATAL/PRIVATE SECTOR
FAMILY PLANNING PROJECT

CONSULTANCY REPORT FOR
USAID MISSION
TANZANIA

N.A. KEYONZO - THE PATHFINDER FUND
REHEMA MWATEMBA - UMATI

MAY 10-29, 1990

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PARASTATAL/PRIVATE SECTOR FAMILY PLANNING

EXECUTIVE SUMMARY

Tanzania is experiencing one of the highest population growth rates in the world. The goal of this project is to help slow Tanzania's high growth rate by increasing the institutional capacity of parastatal/private sector organizations to provide sustainable programs for the delivery of family planning and related Maternal and Child Health (MCH) services. Parastatals are those institutions owned jointly/wholly by government, while private is defined as non-governmental and refers to institutions and facilities that are not largely financed by the central government. Currently, the major strategy in Tanzania has been to offer family planning services in all government facilities. However, this approach will not cover the whole country and not all potential users will prefer to use or have easy access to public health facilities.

This project will increase the range of options available to potential family planning users (female and male) and other family planning related services. Under this project, family planning service delivery will be added to or improved in selected parastatals/private enterprises (factories & plantations) which employ significant numbers of workers and provide basic health care to employees, their families and surrounding communities. Support will also be given to health care facilities/services sponsored by religious organizations, national private and voluntary organizations whose support for activities will include community based distribution of contraceptives. It is anticipated that by the end of this seven-year project, feasibility of parastatal/private supported family planning service delivery will have been demonstrated on a national basis and a significant number of clients will be using family planning services provided by the project-supported organizations.

In accordance with Government of Tanzania (GOT) and USAID overall strategy, the project will aim to increase service delivery without increasing recurrent cost and administrative burden for the government. Emphasis will be placed on programs that are innovative and self-financing. Programs will be established in viable and autonomous institutions with the intention that family planning service delivery will continue following the project without external donor support. Monitoring, evaluation and selected operations research activities and national seminars will be funded to assess and disseminate lessons learned.

The US \$ 1.9 million USAID contribution will support a series of sub-projects to be identified and developed by UMATI/implementing agency. Training of service providers, monitoring, evaluation, IEC, operations research and commodities will be provided. Sub-projects will be developed by UMATI/implementing agency based on criteria established by MOH and UMATI, in consultation with a Technical Advisory Committee to the project.

1. PROJECT RATIONALE

1.1. Country Strategies and Programs:

Public Sector Programs

Tanzania's population was 23.2 million in 1988 with an annual increase of about 3% which would cause the population to double in 25 years if the current population growth rate continues. The growth rate reflects the high total fertility rate of 7.1%, low contraceptive prevalence rate estimated at 5% for all methods, and an infant mortality rate of 107/1000. Estimates of maternal mortality range from 185-370 per 100,000 live births. The low prevalence rate for modern contraception places Tanzania at the beginning of the pre-emergent stage according to the USAID typology. Eighty percent of the population live in the rural areas and the literacy rate for both men and women is high by African standards at 65%.

The Party and top levels of GOT have long been supportive of child spacing activities in the country. UMATI, a non-governmental organization and an IPPF affiliate, was established in 1959, and in 1973 the CCM directed MOH to assist the organization in the provision of child spacing services. In 1986 the government established a population unit within the Ministry of Finance, Planning and Economic Affairs and is currently in the process of finalizing a population policy. Most of family planning services are integrated with the MCH and are available in most of government health care facilities throughout the country. UMATI's role since 1974 has been to procure and distribute contraceptives, to train health workers and to motivate Tanzania to use family planning services. Currently, limited services in two clinics are also available through UMATI and in some church facilities.

In March 1989, MOH launched a National Family Planning Programme (NFPP) with the publication of its 5-year plan of operations (1989-1993). At the same time most of the key policy constraints to the use of family planning were removed. The ultimate objective of NFPP is to improve maternal child health through reduction in the fertility rate. Currently UNFPA/MOH are implementing a 4-year (1990-93) National Family Planning Program.

1.1.2. Private Sector/Parastatal Activities

Private sector/parastatals play an important role in easing the Government's burden in the provision of health care services. About 48% of all hospitals on the mainland are operated by non-governmental organizations (NGOs), most of which are affiliated to religious organizations, and some private companies which provide a lot of health care. A substantial amount of recurrent cost in church hospital/clinics are financed through service fee (curative) and drug charges. Some GOT support (staff secondment) and overseas donations, bridge the remaining gap in recurrent cost financing.

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Tanzania's economy is entering the second phase of the Economic Recovery Programme and will have difficulties staying ahead of the population growth rate.

1.2 The Problem Statement

The constraints to the delivery of family planning are both of a demand and supply nature. These constraints/problems include:

- Lack of an effective and efficient contraceptive procurement and distribution system limiting access to family planning services.
- Poor quality of family planning services related to lack of contraceptive supplies and shortage of adequately trained service providers. There is also lack of understanding of family planning benefits and methods among the health workers.
- Because of the cultural, traditional and religious beliefs, a large section of Tanzanian population still have large families, especially with 80% of the population living in the rural areas. One third of the Tanzanians women are co-wives and approximately 2/3 of the population are Catholics or Muslims. In spite of this, IEC work in progress is very inadequate resulting into lack of awareness of availability of services.
- Few non-governmental organizations are involved in provision of family planning services and have weak institutional capacity to deliver family planning mainly due to lack of resources. Access is limited mostly to government services which are mostly clinic based, poorly managed and rarely supervised.

One of the major constraints to increased effective family planning services in Tanzania is lack of easy access to family planning services by potential users. GOT through MOH is currently tackling the issue of increased effective access to family planning services in all government health facilities. Some of the efforts will be through the MOH/UNFPA National Family Planning Programme (1990-93) and also the proposed GOT/USAID Family Planning Services Support Project (1990-1997).

Additional efforts complementary to the provision of family planning services at existing government and non-governmental facilities are needed to increase availability of family planning services in various institutional catchment areas in Tanzania, especially those in which people already have access to some health services. MOH/UMATI have explored a number of alternatives to increase the delivery of family planning services. Three major potential delivery systems are underutilized or unexploited: the health facilities operated by religious organizations, the parastatal facilities and the health care facilities operated by private enterprises for their employees. These facilities, including the Peoples' Defence Forces, Police and Prisons, have been identified in the MOH/UNFPA National Family Planning Programme as potential areas of family planning service delivery.

The MOH statistics for 1989 indicate that government supports an estimated 2941 health facilities on the mainland (102 Hospitals, 239 health centers and 2600 dispensaries), of which 70% are providing MCH services while over 50% of the MCH clinics provide a reasonable range of family planning services. The church organizations support 44 hospitals and a big number of health centers and dispensaries. However, data from UMATI indicate that the number of hospitals/dispensaries operated by CCT member churches to be over 155. The number of parastatal and private companies supported are also unknown. UMATI's report on Industrial FP activities in Dar es Salaam indicate that out of the 147 companies they had contacted, 83 (56.4%) had a health facility (health center or dispensary) and about 6 facilities were offering some limited family planning. (1) A review conducted by Pathfinder and UMATI for MOH/USAID in May 1990 in Dar es Salaam and Morogoro revealed that of the 22 companies visited, all of them except one had a company-owned health facility. The one that did not have a health facility of its own (plus medical staff) had access to an organized health service. With regard to family planning, only two companies offered family planning services. However, those two offered family planning to a limited extent due to lack of trained staff, lack of equipment or contraceptive supplies.

The unmet potential for adding family planning services to existing company-supported health facilities is significant. For example, some dispensaries provide health services to 200-500 sisal workers, and 23 surrounding villages. Other facilities under National Development Corporation in Dar es Salaam provide health care to about 15,000 employees, plus their families from 45 companies. Sugar-processing factories in Morogoro region provide for 8000 employees, their families and surrounding villages. Also, in Dar es Salaam, Tanzania Occupational Health Services reported having about 300 affiliated factory dispensaries that can provide an effective base for family planning. Based on the Pathfinder/UMATI team assessment for the MOH/USAID private sector review in Dar es Salaam and Morogoro, it was determined that companies strongly welcomed assistance in provision of family planning to improve the health status of their employees, provide additional benefits to the firm in reducing days lost due to maternity leave, improve productivity, reduce absenteeism and reduce turnover (and retraining). In the 9 companies that were visited in Morogoro, most employees were between ages 17-30 and over half of them were females.

Church-related facilities also have a potential that has not been fully exploited. In Kenya, this potential has been

(1) Data obtained from UMATI, E&R Division - April, 1990

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evidenced in hospital-based Protestant health systems offering family planning services, for example in Chogoria and Tumu Tumu. In Tanzania, the Seventh Day Adventists (SDA) in Arusha have been actively involved in the delivery of family planning services for the more than seven years. Other potential in Tanzania might exist: for example, in Mvumi Hospital Community Health Care Programme - Anglican Diocese, Central Tanganyika, Masai Lutheran in Arusha and the Morovian Church in Mbeya, and Tabora Regions. The 1986 Church MCH Programme in Tanzania (CCT) Report indicated that most mothers (85% of the low-risk and 60% of the high-risk group) appeared well aware of the need to plan their families, but their knowledge lacked precision and there were many stories circulating about possible complications. The report further stated that: "Most mothers showed a strong interest in receiving more information about family planning methods. Several high risk mothers wanted at all costs to stop giving birth even wishing a sterilization because they felt under the present circumstances unable to feed more mouths."

The unexploited potential for provision of family planning services in the non-clinical non-government context is also considerable. The two examples are seen through the current UMATI CBD pilots efforts in 2 Districts of Dar es Salaam Region and the SDA church in Arusha.

2. PROJECT DESCRIPTION

2.1 Goals and Purpose of the Project

To make family planning, child survival and primary health care services available, accessible and affordable to the parastatal/private sector that are not covered by MOH services.

The purpose of the project is to demonstrate and increase the institutional capacity of the private sector/parastatal organizations to undertake sustainable programs for the provision of family planning. Methodologies for donor assistance to for-profit and parastatal organizations are not developed. Because of the potential demand of the unmet needs in these organizations, the project will emphasize this aspect of these organizations.

2.2 Project Design and Implementation Strategy

The project intent is to design and implement a series of demonstration sub-projects with parastatal/private enterprise organizations. This will be done in three phases. Phase I (1990/91): Detailed assessment & design. Phase II (1991-93): Development of Sub-Project, implementation and operations research. Phase III (1995-97): To be designed in year IV after the mid-term evaluation in 1994.

The initial three-year sub-projects will be designed to demonstrate that with relatively small infusion of additional resources, parastatal/private organizations' can add and maintain family planning services within their organizations health services and that the added services will be perceived by the organizations to be beneficial. The demonstrations will cover organizations of widely varying employee/client size, different service provider mixes, different delivery systems and varying contraceptive methods provided.

The end of the project status achievements will include:

- 70 institutions operating new or improved family planning programs.
- An institutional capacity within UMATI/Implementing Agency to support participating institutions with dependable and ready access to adequate contraceptive supplies, supervision and follow up.
- The capability and commitment of participating organizations to maintain or expand the level of family planning service delivery upon termination of external assistance.
- Created family planning need by other organizations not directly supported by the project.
- Determination of the potential contribution of this project to the national family planning acceptors rate will be done during the mid-term evaluation.

It is assumed that a significant number of acceptors of family planning will use the services to limit their births rather than simply to space births according to the prevailing patterns in Tanzania. This will be addressed by operations research.

2.3 Project Beneficiaries

Project beneficiaries are parastatal/private organizations' employees, their dependants and surrounding communities/villages. The number of the population to be covered will be determined during the assessment before the start of sub-projects. The project will focus on workers and their families at the lower end of the wage scale in companies who earn minimum salaries, bordering on the poverty line. Some of the workers in companies visited by the design team were between the ages of 18-30, with the same proportion of sexes. It is assumed that a big proportion of the beneficiaries will be in their prime reproductive ages. In church health facilities, most of the beneficiaries are likely to be rural, peasant farmers.

2.4 Project Elements

There are seven major elements of the project, briefly described below. Responsibility for establishing or overseeing these elements and ensuring their direct linkages to goal attainment lies with UMATI/Implementing agency.

2.4.1 Design & Development of 60 Sub-projects, Implementation & Evaluation

During the 7 years of the project, a total of 70 demonstration sub-projects delivering family planning services will be developed. For the number of projects to be developed each year, see Annex I. The selection of the sub-projects should ensure that projects are selected from for-profit organizations, parastatals, NGOs, and church-related NGOs. Most of the sub-projects will be initiated in year II and year IV in order to permit completion and evaluation. A list of potential projects identified by the design team in Dar es Salaam and Morogoro is in Annex.

VII. However, a comprehensive inventory of potentially interested organizations will be developed during year I.

The sub-projects will be selected on the basis of the following criteria of appropriateness which should be reviewed before it is adopted.

- Criterion I: The availability of other health services at the project site.
- Criterion II: The willingness of the organization management to:
- include family planning with other health services,
 - commit staff and other resources such as clinic space for services.
 - show commitment to continuing the services and purchasing contraceptives when funding ends.
- Criterion III: The potential for the project to reach a large number of people of child-bearing age who are not currently served because there are no other family planning services in the area or easily accessible.

2.4.2 Ensuring Efficient Contraceptive Supply and Management System

The contraceptives to be utilized in the sub-projects will be supplied directly by UMATI through its existing logistics system. Established MOH/UMATI procedures to provide a full range of contraceptives to the parastatal/private sector organizations which utilize service providers certified as appropriately trained by UMATI, and are recognized as family planning service delivery points (SDPS), will be followed. MOH/UMATI has assured full availability of contraceptives for the parastatal/private sector. Also, the private sector will use the same forms as UMATI. The relatively small number of added service delivery points planned for this sector should not seriously burden the existing system.

As in most logistics systems, there are periodic shortages. MOH/UMATI will be taking steps to effectively address this problem through the planned USAID/MOH project. In addition, back-up arrangements will be made to facilitate availability and access by the project facilities. Funds will be budgeted in the sub-projects to provide carrier transportation of contraceptives from UMATI stores to the sub-projects in the event of emergency or temporary disruption of the UMATI transport system.

Some aspects of technical assistance on logistics supply and management have also been incorporated in the project in case need arises. The system will be closely monitored, identifying any problems early on and helping to mobilize resources for action.

2.4.3 Training

Three different training activities to be conducted during this project are given below:

- training of service providers
- orientation courses/seminars for the senior management of parastatal/private organizations
- training of existing UMATI POPLEP etc. private sector related staff.

2.4.3.1. Training of 140 Medical Assistants Nurse/Midwives, MCH Aides in Family Planning motivation, clinical services and management

One of the key barriers identified to increased effective family planning in Tanzania is the shortage of trained staff to deliver services at the health facilities. Nurse/midwives are mainly responsible for MCH/FP and are authorized to prescribe pills, provide depo-provera (injection), insert IUDS, distribute condoms and foam jellies. Medical assistants are in-charge of dispensaries/health centres and provide services. Because basic training for nurses/midwives and medical assistants is deficient in clinical family planning skills, both staff must undergo in-service family planning courses before being certified as competent in family planning service delivery.

In implementation of training for parastatal/private organizations health service providers, the following constraints must be considered.

- (a) Initially 2 participants will be selected from each sub-project or participating organization. Training design will therefore take the needs of individual working conditions, institutions and the socio-cultural characteristics of the recipient population into account while providing cost-effective courses for a reasonable number of people. Seven 2-month courses for 20 persons are planned. A total of 140 persons will be trained over the life of the project.
- b) Clinical facilities for practice of techniques are essential. The training will therefore require access to facilities with sufficient number of clients to provide an acceptable level of practice for all participants, UMATI has two model clinics in Dar es Salaam.
- c) Training should be accomplished in-country by UMATI.
- d) Provision of training must be preceded by provision of contraceptives.

- e) Because of the need to conduct some motivational activities within the work place, service providers will have to be trained in IEC motivation and counselling and marketing family planning.

2.4.3.2. Orientation Seminars/Workshops for Senior Level Management of Parastatal/Private Organizations

It is important to involve parastatal/private organizations' senior level management in the project if greater company participation is expected. The focus of these workshops/seminars will be:

- 1) the rationale for family planning;
- 2) the relationship between birth spacing/family planning to absenteeism, productivity, turnover, and health care cost;
- 3) the impact of government regulations on the provision of family planning; and
- 4) the cost of providing family planning and other preventive health care measures using private care providers.

Participants will be selected from each participating organization. Seven one-day seminars of 20 people will be conducted.

2.4.4 Development, Testing and Implementation of Training Methodology/Curriculum

UMATI, in consultation with MOH, will prepare a detailed plan for training of family planning service providers in the parastatal/private sector. The existing UMATI family planning training curriculum will be reviewed, tested and implemented. The main objectives of the training program are to provide certified staff for the sub-projects capable of providing family planning services and to develop a model of training activity, parts which may be adopted for future training.

The training design will be influenced partly by the following factors:

- the need to meet MOH/UMATI standards for certification;
- the need to address identified short comings in the existing health workers training; and
- the need to extend family planning programs beyond the clinic-based services to other approaches that will respond to community and cultural needs.

2.4.5 Operations Research Activities

The parastatal/private sector project aims at exploring new family planning programmatic territories and demonstrating operational aspects of the project. An opportunity has been provided to conduct, report and

disseminate results of operational research activities in order to clarify specific actions or document experiences which impact on the attainment of the project objectives. During the first project year, the UMATI/Implementing Agency in consultation with the Technical Advisory Committee for the project implementation, will identify three to five operational research activities in the areas such as contraceptive logistics/management, management information system, perceptions of management, methods preferences, management inputs, client flow analysis etc. If technical assistance is desired, Population Council, who are already conducting operations research activities in family planning in the country with the Board of Internal Trade (BIT) clinic or Tanzania occupational Health Services (TOHS), can be approached.

2.4.6 Monitoring, Evaluation and Dissemination

UMATI/implementing agency will be responsible for ensuring that an adequate Management Information System (MIS) is developed, including record-keeping forms. The system developed should be to a large extent uniform to the one being used by MOH and UMATI. UMATI will also be responsible for reporting on the project result to MOH and USAID, disseminating results through at least two seminars, and other activities as appropriate. The participants of the seminars will be parastatal/private sector personnel related to the on-going or completed demonstrations sub-projects, parastatal/sector personnel representing potential organizations for sub-projects, Government of Tanzania policy-makers/personnel and related donor representatives (for example, UNFPA). The purpose of the conferences will be exchange information on project experience -- progress of the sub-projects, operational research reports, and to stimulate additional parastatal/private sector family planning activities in potential grantees or organizations.

2.4.7 I.E.C. Activities

A major constraint identified to family planning acceptance in Tanzania is the lack of understanding of family planning benefits and methods for both the health workers and the potential users. Through this project support educational materials targeted at the parastatal/private sector will be designed, developed, tested and produced by UMATI's IEC department. The IEC Manager will ensure that private sector support educational materials are produced. A review of existing relevant materials at UMATI, Kenya's Planning Private Sector project (FPPS), etc., will be conducted in order to determine what materials can be adapted. For those materials that need to be designed, developed, and tested, this should be completed within the first eighteen months of the project.

For materials development, if technical assistance is desired, UMATI should explore the possibility of bringing in advisors from the Family Planning Private Sector in Kenya.

3. COST ESTIMATES

The total estimated project cost is US \$ 1.9 million of which USAID will finance most of it. UMATI share will include inputs in staff time from top level management. USAID's share will be in grant funds. The tables in the Annexes indicate the estimated project costs by specific categories.

Budget Assumptions

- Salaries and Benefits - 10% inflation and additional staff in years three and four
- Vehicles and Insurance - 10% inflation rate
- General administration and travel-associated expenses - Takes into account the increased volume of administration and travel costs.
- Sub-projects - No inflation is built-in
- Training - No inflation is built-in
- T.A - Assumes that for every month scheduled, it will cost U.S. \$ 10,000.

4. Project Implementation & Management (chronogram Annex II)

The project will be implemented and managed by UMATI which will be responsible to a Technical Advisory Committee (TAC) comprising MOH as Chairman, UMATI as secretary, USAID, UNFPA and other appropriate related agencies/organizations to be determined. During the first two years of the project, the Committee will meet at least quarterly and/or as need arises. During the remaining period, the Committee will meet twice a year.

For the management of the parastatal/private sector project, UMATI in consultation with TAC, will recruit initially 3 staff: 1) a Senior family planning management specialist; 2) Evaluation research/management information system specialist; and 3) an Administrative assistant/secretary. During the second an accountant and for the third and fourth years of the project, two additional staff will be hired - Administration Procurement Specialist and a Training/Service Delivery Specialist. Details of qualifications and experience of all the personnel to be recruited will be worked out by UMATI in consultation with the TAC.

Prior to the implementation of the project, UMATI will initiate the setting up of the Technical Advisory Committee. UMATI will be responsible for completing the sub-project agreement format to be designed and agreed upon in consultation with USAID. It will also ensure that relevant departments in Ministries of Health, Finance and Economic Planning are informed through our the life of the project. UMATI will take guidance from TAC which will review sub-projects and play an overall guidance role to the project.

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5. PROJECT PROCUREMENT ACTIVITIES PLAN

The following goods and services are to be obtained locally or from abroad under the project.

5.1. Study Tour for Project Staff

Immediately the core project staff are recruited, they will undertake a one month study tour most likely to Kenya, to review the on-going family planning activities of the private sector there. UMATI will liaise with the host and agree on a programme. The two likely organizations to organize the study tour in Kenya are the Family Planning Private Sector (JSI) Kenya and The Pathfinder Fund.

5.2. Technical Assistance

It is expected the project will receive Technical Assistance (TA) from the main MOH/USAID project. However, 40 person-months of back-up technical assistance is probably necessary. TA in the areas of management, logistics/MIS, medical/service delivery, operations research, IEC and evaluation is proposed and included in the project. Preference will be given to competent Tanzanians. Other organizations that can provide T.A. include FPPS Kenya, The Pathfinder Fund, The Population Council, and SEATS.

5.3. Training

The project training component includes provision of clinical, motivation and management training for about 2 months to approximately 140 health service providers, the development and testing of new training methodologies for these personnel and materials production. Training will be provided by UMATI directly or through a sub-contract, subject to approval of the Technical Advisory Committee.

5.4. Commodities Procurement

Five vehicles will be provided by project funds, three for the project staff and two mini-buses mainly for training activities. Two vehicles will be purchased in year I of the project, one in year III and two in year IV. The vehicles needed will be right-hand drive models such as Toyota Land Cruiser, Minivans or equivalent. UMATI will procure these vehicles.

5.5. Other Project Related Commodities

UMATI will be responsible for procurement of equipment and supplies for the office and for equipment and supplies to be used in an estimated 70 sub-projects. Office equipment will be standard types of equipment found in a commercial office facility and will include a micro-computer with supporting hardware and uninterruptable power supply, a photo copier. The project will receive MCH/FP clinical equipment and supplies and necessary record-keeping and storage facilities. A detailed commodity list will be produced by UMATI.

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5.6. Project Premises

USAID/private sector support to UMATI should include enabling UMATI to acquire permanent offices by granting permission to the Association to purchase an ordinary residential house of 3-4 bedrooms and renovate the place to project premises using funds allocated for office rent. Acquisition of own premises is one sign of project inbuilt efforts towards sustainability after project life is over.

5.7. Contraceptives

Contraceptives used by the project will be provided by UMATI, through its logistics system. MOH/UMATI will call upon IPPF, The Pathfinder Fund, etc., in case of emergency.

6. Project Evaluation Plan

At the beginning of the project, project-specific baseline data will be conducted and analysed to establish a basic against which parastatal/private sector family planning activities can be measured as the project progress. The project staff will be responsible for conducting the baseline survey. Where desired, the services of a local consultant will be engaged. The baseline survey reports will include data on the following:

1. Total population served by each sub-grantee and sex/age estimates.
2. Capacity to provide family planning services by each sub-grantee.
3. Sub-grantee staffing and their family planning and maternal and child health needs.
4. Sub-grantees record-keeping system.
5. The number of parastatal/private sector health facilities offering family planning services to their workers and dependants and surrounding villages.
6. Monthly average family planning users by method.
7. Stock of contraceptives and source of supply.
8. Some information on knowledge, attitude and practice of the workers in each catchment area.

In consultation with TAC, project staff will develop a comprehensive project evaluation plan during the first year of the project activity. The project will be evaluated at two levels -- the project and sub-project levels. The project will build in internal evaluation and monitoring to ensure that the implementation process conforms to plan in terms of inputs, work schedules, and target outputs. The project staff will provide sub-grantees with relevant forms, charts and plans of action that are time and target specific and which will serve as a yardstick to measure on-going or completed project activities. On a quarterly basis, the sub-grantees will submit a report to UMATI which will include the number of family planning acceptors and users, contraceptives supplied and distributed, financial expenditures, problems encountered and suggested/possible solutions.

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At the project level, an external mid-term and final evaluation will be conducted. The mid-term evaluation is scheduled for third quarter in year IV while the final one will be second quarter in year VII of the project.

The purpose of the mid-term evaluation will be to examine the project implementation process and suggest possible action. The main aim of the final evaluation will be to determine whether the project has achieved its purpose. The status of the project will be assessed against the project baseline survey report and the intended end-of-the-project status. This evaluation will provide recommendations which will help determine future follow-up activities.

7. Policy Decisions/Issues

A policy issue to be decided on during the life of the project is whether to introduce cost-sharing with parastatals/private companies that can afford to pay for items such as contraceptives, training and transportation costs. As indicated in the review report by the design team, most of the parastatals/private companies were economically viable and would have no problems with cost-sharing. Most of them would pick up their own contraceptives supplies if they knew where to obtain it.

It is recommended that further investigations be made on this issue during the in-depth assessment of this sector during year one of the project in order to obtain more information. This issue should also be discussed during parastatal/private sector management orientation seminars.

In addition, to enable UMATI/private sector to attain sustainability, the Association should ensure that the project have channels for generating income from the beginning. A separate bank account should be kept for the money generated by the project. The kind of bank account preferable would be fixed deposits.

Annex I

NO. OF SUB PROJECT PER YEAR AND STAFF

	1	2	3	4	5	6	7
1 STAFF							
1. FP MANAGEMENT SPECIALIST	1						
2. E & R/MIS SPECIALIST	1						
3. ADMIN ASSISTANT/ SECRETARY	1						
4. ACCOUNTANT		1					
5. PROCUREMENT SPECIALIST			1				
6. TRAINING/SERVICE DELIVERY SPECIALIST				1			
2 SUB PROJECTS	5	20	5	20	10	10	5

TECHNICAL ASSISTANCE PLAN

TYPE OF T.A.	TIME IN MONTHS							TOTAL
	1	2	3	4	5	6	7	
MANAGEMENT	4	2	2	2	1			11
LOGISTIC/MIS	1	1	1	1	1			5
TRAINING	1	2	1	1	1	1		7
MEDICAL/SERVICE DELIVERY		1	1	1	1	1		5
I.E.C	1	1	1	1	1			5
OPERATIONS RESEARCH	1	1	1	1	1			5
EVALUATION				1			1	2
TOTAL	8	8	7	8	6	2	1	40

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Annex II

PARASTATAL/PRIVATE SECTOR CHRONOGRAM

ACTIVITIES	TIME						
	1	2	3	4	5	6	7
1 Establishment of Technical Advisory Committee (TAC). TAC Meetings	-	-	-	-	-	-	-
2 Securing of office space	-						
3 Purchase equipment	-	-	-	-	-	-	-
4 Recruit Project Staff	-						
5 Project staff study tour	-						
6 Conduct review/assessment of sector and prepare a detailed Implementation plan	-						
7 Identification and development of sub projects. Collection of Baseline Data/KAP Surveys.							
8 Set up Monitoring and Reporting procedures.							
9 Identification and Schedule of Technical Assistance (T.A)							
10 Develop, Test and Implement training methodologies	-						
11 Begin arrangements for Commodities procurement and MIS forms.	-						
12 Training, supplying equipment and contraceptives							
13 Service Delivery and Supervision							
14 Development of I.E.C support materials	-	-	-	-	-	-	-
15 Operations Research activities	-	-	-	-	-	-	-
16 Evaluation				-			-

Annex III a

COST ESTIMATES - SUMMARY

CATEGORIES	YEARS							TOTAL
	1	2	3	4	5	6	7	
1 SALARY & BENEFITS	7000	8000	10000	15000	16000	18000	18000	92000
2 EQUIPMENT AND SUPPLIES	77000	6000	58500	123000	18000	18000	18000	318500
3 GENERAL ADMINISTRATION	5000	5000	6000	6000	7000	8000	8000	45000
4 TRAVEL & ASS. EXPENSES	10000	10000	10000	15000	20000	20000	20000	105000
5 SUB PROJECTS	25000	100000	25000	100000	50000	50000	25000	375000
6 OPERATIONS RESEARCH		15000	15000	22500	22500			75000
7 TRAINING	42800	94200	39800	74200	99800	44800	14800	410400
8 RENTAL	10000	10000	10000	15000	20000	20000	20000	105000
9 DISSEMINATION SEMINARS				9000			9000	18000
10 T.A.	80000	80000	70000	110000	60000	10000	40000	450000
TOTAL	256800	328200	244300	489700	313300	188800	172800	1993900

Annex III b

COST ESTIMATES - SUMMARY

CATEGORIES	YEARS						
	1	2	3	4	5	6	7
1 | SALARY & BENEFITS	7000	8000	10000	15000	16000	18000	18000
2 | EQUIPMENT AND SUPPLIES							
|.OFFICE EQUIPMENT |(CHAIRS, DESKS, |AIR-CONDITIONERS ETC.)	10000		25000	10000			
|.VEHICLES							
|3-4 WHEEL DRIVE	25000		25000	60000			
|2 MINI BUSES	30000			35000			
|.VEHICLE INSURANCE/ |MAINTENANCE (10% OF VALUE)	6000	6000	8500	18000	18000	18000	18000
3 | GENERAL ADMINISTRATION							
|POSTAGE, TELEX, FAX, |STATIONERY PHOTOCOPIER	5000 6000	5000	6000	6000	7000	8000	8000
4 | TRAVEL & ASS. EXPENSES							
|PER DIEMS, PETROL, ETC.	10000	10000	10000	15000	20000	20000	20000
5 | SUB-PROJECTS							
CLINIC EQUIPMENT, KAP/BASE LINE SURVEYS (@ \$500 PER PROJECT)	25000	100000	25000	100000	50000	50000	25000
6 OPERATIONS RESEARCH							
5 @ 15000 EACH		15000	15000	22500	22500		

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Annex III c

COST ESTIMATES - SUMMARY

CATEGORIES	YEARS						
	1	2	3	4	5	6	7
7 TRAINING	42800	94200	39800	74200	99800	44800	14800
|.STUDY TOUR FOR 4 PEOPLE | @ \$8000 PER PERSON	28000		10000		20000		
|.SERVICE PROVIDERS | 20 X 60 X NO/PART.	12000	48000	12000	48000	24000	24000	12000
|.TRAVEL @ \$80 X NO. | OF PARTICIPANTS	800	3200	800	3200	16800	16800	800
|.MANAGEMENT SEMINARS | @ \$200 PER PERSON | (TRAVEL 150, PER DIEM 50)	2000	8000	2000	8000	4000	4000	2000
|.CONTRACEPTIVE TECHNOLOGY | COURSE FOR 20 DOCTORS | @ \$5000 PER COURSE		35000	15000	15000	35000		
8 RENTAL OF OFFICE SPACE	10000	10000	10000	15000	20000	20000	20000
9 REPORTS DESSEMINATION SEMINARS FOR 3 DAYS 160 PEOPLE @ \$50 PER DAY				9000			9000
10 TECHNICAL ASSISTANCE							
|.MANAGEMENT	40000	20000	20000	20000	10000		
|.LOGISTICS/MIS	10000	10000	10000	10000	10000		
|.TRAINING	10000	20000	10000	10000	10000		
|.MEDICAL/SERVICE DELIVERY		10000	10000	10000	10000	10000	
|.I.E.C	10000	10000	10000	10000	10000		
|.OPERATIONS RESEARCH	10000	10000	10000	10000	10000		
|.EVALUATION				40000			40000
TOTAL	256800	328200	244300	489700	313300	188800	172800

TOTAL US \$ 1993900

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PROJECT PAPER TEAM

INSTITUTIONAL ANALYSIS:
Ministry of Health
UMATI

May 1990
Mr. Michael Hall
Dr. Gottlieb Mpangile

ORDER OF REPORT - INSTITUTIONAL ANALYSIS

- I EXECUTIVE SUMMARY

- II MOH
 - MOH PROJECT ACTIVITIES & LOG FRAME
 - MOH PROJECT ACTIVITIES WITH BUDGET

- III UMATI
 - UMATI PROJECT ACTIVITIES & LOG FRAME
 - UMATI PROJECT ACTIVITIES WITH BUDGET

- IV ANNEX 1-7

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I. EXECUTIVE SUMMARY

A. Summary

This project has been designed to reinforce the commitment of the Government of Tanzania to developing and managing a revitalized National Family Planning Program (NFPP). The development of the Plan of Operations 1989-1993, detailing for the first time the operational strategy and the goals of the Program, clearly evidences that renewed commitment. In addition, Chama Cha Mapinduzi (CCM), the national political party, has recently approved a long-awaited draft population policy for the country.

Over the life of the project the two principal institutions responsible for the NFPP, the Ministry of Health and the Family Planning Association - UMATI, will be the targets of a considerable investment in institutional resources, staffing capabilities and operational systems. The size and scope of those inputs will require a phased approach that is coupled with specific and significant institution-building activities to ensure that they can be adequately absorbed and managed. Those inputs will also be best utilized in a phased approach of concurrent institution-building if they are carefully integrated into existing programs and systems and other donor activities. Such an approach would also address the issue of sustainability which is of major concern for both institutions.

Much of the project activity will require extensive institutional and component-building technical assistance. It is of particular interest to the Government of Tanzania to utilize and develop local talent in those various areas. It will therefore be important for the project to develop a specific, phased strategy for identifying, developing and, ultimately utilizing local talent during the life of the project. Such a strategy, in itself, would also be a significant long-term contribution to the National Family Planning Program.

B. Ministry of Health

1. Background

The principal, relevant entity in the Ministry of Health is the Family Planning Unit which is located in Maternal and Child Health Section under the Department of Preventative Services. At present it is a small office consisting of a Unit Manager, Administration and Finance Officer and a Secretary. An Assistant Manager will be added shortly and all positions and present activities are supported by a \$ 6.5 million dollar UNFPA grant (1990-93) that has an ambitious goal of increasing contraceptive prevalence rates from 7% to 25% through a variety of activities in expansion of services, training, logistics and research. The USAID project will complement those activities with specific support in logistics, training, IE&C, research and overall administration and planning.

Exclusive of the Family Planning Unit, family planning services, including service delivery and supervisory personnel, delivery points and the GOT budgetary contribution, are total integrated with all Maternal and Child Health services. There are no exclusively family planning personnel outside the Family Planning Unit and even those responsible for MCH service delivery and supervision, namely Medical Officers and Nurses, have a parallel chain of command reporting to the Chief Medical Officer-MOH and the Senior Medical Officer-MCH Services respectively. Yearly health planning, including MCH and family planning services under the MOH decentralized approach, will be done by the District Medical Officer and District-level, local government representatives of the Primary Health Care Committee (PHC). It will set yearly family planning targets for the entire District but not for individual service delivery points.

2. Conclusions and Recommendations

The Ministry of Health could more accurately reflect its already considerable commitment to family planning by finalizing the National Population Policy and creating a separate line item in its budget to reflect MOH contributions.

To further reinforce its commitment to family planning and to lessen the problem of parallel lines of authority of field planning, supervisory and service delivery personnel, it would also be most helpful to have the Family Planning Unit report directly to the Assistant Chief Medical Officer-Department of Preventive Services.

The USAID project has been designed to assist and complement GOT and other donor (principally UNFPA) inputs. An important first step of the project will be for the Family Planning Unit to develop one integrated, MOH Family Planning Program. This should be closely followed by a thorough task analysis and workplan to ensure a comprehensive approach.

Project-related activities are considerable and varied and will include additional management staff and administrative support systems in the Family Planning Unit. The additional management staff and operational systems, and the technical assistance to develop them, need to be provided in a systematic, phased multi-year approach that realistically reflects the absorptive capacity of the relatively new and small unit.

As phased institution-building occurs at the Family Planning Unit, it will be increasingly important for it to have field supervisory personnel exclusively for family planning that report directly to the Unit. The MOH should identify Public Health Nurses in the system at the District level, preferably who have been trained in family planning, who can supervise quality of care issue at service delivery points.

For monitoring and supervision purpose it will become increasingly important for District Medical and District PHC Committees to set specific family planning targets for each service delivery point in their District.

C. UMATI

1. Background

UMATI, established in 1959, is the oldest International Planned Parenthood Federation (IPPF) affiliate in Africa. Its policies and programs are decided on by a volunteer structure which includes 800 Branch Committees, 83 District Committees, 20 Regional Committees and a National Executive Committee. It has a paid staff headed by an Executive Director with the principal divisions of Operations and Finance. UMATI has a annual budget of approximately one million dollars; two-thirds of which is from IPPF and the remaining amount from various international donors. Over the years the vast majority of UMATI program activity has been in informational and motivational work in population and family planning. Much of this work has been done through its network of 20 Regional and 23 District Coordinators. It also has forecasted MOH commodity needs, transported commodities to MOH Regional Warehouses, and is the only organization during significant clinical training in the country.

As part of USAID project, UMATI will have extensive responsibilities in training, IE&C, private sector and, to a lesser degree, research. These activities, over the life of the project, could more than double its present budget. Because of the financial resources needed to support its present network of Regional and District Coordinators. Management-level supervisory and systems support personnel are already stretched very thin and several key positions remain vacant.

2. Conclusions and Recommendations

Given that UMATI is a volunteer, non-governmental organization with its own family planning projects, it needs to do comprehensive Strategic Planning that integrates USAID project activities with existing ones into an integrated program. The Strategic Planning should also thoroughly examine the impact of project activities on the volunteer and management structures, operational systems, personnel needs and the problems of supervision and accountability.

The size and scope of project activities, given the already heavily burdened management personnel and systems will require a carefully phased multi-year approach to requisite institution-building activities that carefully monitors and reflects absorptive capacity of UMATI.

A number of component, supervisory and systems-related personnel will be added to UMATI as part of the project. In addition to paying attention to absorptive capacity, it will be very important to consider the issue of sustainability. As an IPPF affiliate under increasing pressure to generate more of its income, UMATI will probably have to hire project-related staff under a life-of-the-project contract and as such, they will not be permanent employees of the organization. The salaries for those positions will also have to fall within existing salary scales.

GOVERNMENT OF TANZANIA - MINISTRY OF HEALTH

1. Policy Level

The substantive involvement of the Government of Tanzania (GOT) in the provision of family planning began in 1973 when the national political party, Chama Cha Mapinduzi (CCM), directed the Ministry of Health (MOH) to assist UMATI in the provision of child-spacing services. The following year the MOH incorporated child-spacing into its Maternal and Child Health (MCH) services in its extensive service delivery structure throughout the country. In 1985, a three year National Child-spacing Program was launched with the support of the United Nations Fund for Population Activities (UNFPA). Two years later, following a series of seminars on population and development, the CCM directed the Government to prepare a national population policy. That policy has been submitted in 1990 to the Government for final clearance. Meanwhile, the MOH has launched a National Family Planning Program including a Plan of Operations for 1989-93 defining the strategies and responsibilities for program development and implementation. Much of the support for this plan will come from a four year (1990-93), 6.5 million dollar grant from UNFPA.

FINDINGS

As of May, 1990 there is not approved or operative National Population Policy.

Reflecting the integral approach to MCH services, there is no specific line item in the MOH budget for family planning.

RECOMMENDATIONS

It would be important to identify what steps in the national decision-making process remain to achieve final approval of the National Population Policy and to encourage and help facilitate, to the degree possible, that process.

Once the National Population Policy is approved, it will be important to encourage a continuing dialogue among top level decision-makers in the relevant Ministries as to the implications of the policy in terms of financial and manpower planning, management structures, program planning, etc.

While the financial contributions of the Government to the family planning program, both in-kind and personnel expenditures, may be considerable, the integrated nature of MCH services makes them difficult to identify. It may prove helpful in terms of program planning, management and accountability, as well as the involvement of foreign donors, to develop a separate line item in the MOH budget for family planning.

2. MCH - Headquarters (see Annex 5)

The Family Planning Unit of the Ministry of Health is located within MCH Services in the Department of Preventative Health. Its present Manager is a physician and former senior lecturer at the Faculty of Community Medicine, Medical College, University of Dar es Salaam. She has held that position for two years. Her immediate supervisor is the Senior Medical Officer MCH Services who in turn reports to the Assistant Chief Medical Officer (ACMO) Department of Preventative Services. Also reporting to the ACMO Preventive Services, and with responsibilities in the USAID-proposed project, are the Health Education Section and that of Public Health Nursing Care. The Regional Medical Officers, and therefore the District Medical Officers, who have prime responsibility for program planning and supervision at the Regional and District level (see Section 3), are supervised by the Chief Medical Officer. The Chief Medical Officer is also the immediate supervisor of the ACMO Preventive Services.

The Family Planning Unit, in addition to the Manager, presently includes a Secretary and a Finance and Administration Officer. An Assistant Manager will be added upon return from her studies in September 1990. All these positions are funded by the UNFPA grant. In addition, the USAID-proposed components of Training and Logistics and MIS are recommending the addition of a Training Officer, FP Chief Monitoring and Evaluation Officer and a Data Entry Clerk (see Annex 6).

FINDINGS

While it is helpful for planning, coordination and general management purposes that the Family Planning Unit and the Health Education and Public Health Nursing Care Sections have a common line of supervision to the ACMO Preventive Services, only the Family Planning Unit must go through another Section (MCH) to get there. As the Family Planning Program grows, this may prove to be time-consuming and burdensome for both the MCH Section and the Family Planning Unit. There are presently examples of other MCH vertical programs that report directly to the ACMO- Preventive Services.

The parallel chain of command of Regional Medical Officers, and therefore District Medical Officers, Medical Assistants, Rural Medical Aides, and MCH Coordinators to the Chief Medical Officer makes coordination and common supervision among the key cadres of workers involved in family planning difficult. Regional Medical Officers, and their subordinates, play crucial roles in program planning and target setting and the supervision of service delivery points (SDP), other supervisory and service personnel and vehicles.

The Family Planning Unit has no supervisory authority over anyone in the field. It must rely on the good will and interest of field supervisory, site and service personnel, who are overburdened with other responsibilities, to plan, oversee and deliver family planning services.

The Family Planning Unit, when it has its full complement of UNFPA and USAID-funded staff, will have management staff in all the key component areas of family planning. But it will need to coordinate and integrate the various GOT, UNFPA, USAID, NORAD projects into one coherent Tanzanian Family Planning Program.

RECOMMENDATIONS

As the program grows in size and scope, careful consideration should be given to moving the Family Planning Unit out from under the MCH section and have it report directly to the ACMO-Preventive Services. In addition to facilitating more direct coordination among the crucial elements necessary for a successful program, symbolically it would represent the relative priority given to it by the Government of Tanzania.

It will be difficult to address the problem of the parallel chain of command of the Regional Medical Officers. It is suggested that a small working group from the Family Planning Unit and the offices of the ACMO Preventive Services and the Chief Medical Officer be formed to identify the responsibilities, to agree on how to monitor them, of Regional Medical Officers, and their subordinates, in the National Family Planning Program.

The Family Planning Unit needs personnel in the field, under its direct authority, to monitor and assist the various components of its program including logistics, MIS, quality assurance and client care, supervision, etc. It should be a public health nurse at the Regional and District Levels (ones already in the MOH systems). In addition to greatly improving the chances of program success, it would clearly indicate the commitment of the MOH to family planning.

As the Family Planning Unit begins to formulate one integrated program from various project and MOH inputs, it will be necessary to do a task analysis of the total program in order to appropriately and completely assign responsibilities and tasks to the Unit's staff. It may also identify additional staffing needs. As a companion to the task analysis, a Unit workplan must be developed that identifies all tasks, persons responsible and timelines for their completion. (This should occur for every year of the project.) It will no doubt also indicate that the Unit is understaffed, especially in the Finance and Administration areas, oversight of the USAID-project (especially in the IE&C component in the Health Education Unit and data entry and clerical support positions. Its important that the task analysis lead to self-discovery of these needs, but it can probably be assumed that an IE&C Program Officer will be needed, two Program Officers II Finance and Administration (one administration, one finance) and at least two clerical positions. Extensive technical assistance will be needed in Finance and Administration to develop the department procedures manual for budgeting and reporting, inventory, purchase orders, vehicles, etc. All Program Officers I and Program Officers II should be computer literate, which may require training, and at least two more computers should be added to the office.

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3. Regional and District Level (see Annex 7)

There are 20 Regions and 106 Districts in the country, all having a similar MOH administrative structure. Each Region has a Regional Medical Officer (RMO), reporting to the Chief Medical Officer - Dar es Salaam, who is responsible for all MOH activities in the Region. Related to family planning and under his direct supervision is the Regional Nursing Officer (RNO) and the In-Charge of the Regional Hospital. The RNO supervises the Regional Maternal and Child Health Coordinator (RMCHC) who is responsible for the technical supervision of all MCH services, of which family planning is one, in the Region. The Regional Hospital has an MCH clinic In-Charge (Public Health Nurse) who is under the overall supervision of the Hospital In-Charge.

Each District has a District Medical Officer, (DMO) who reports to the RMO, and a similar deployment of District Nursing Officers and District MCH Coordinators, District Hospital In-Charge with an MCH clinic In-Charge. In addition, Districts have Health Centers, with Medical Assistants reporting directly to the DMO who are in charge, and Dispensaries, supervised by Rural Medical Assistants (RMAs) who report to the Medical Assistants in their areas. While supervised through a direct chain of command from the DMO, Medical Assistants and RMAs are placed and paid by units of local government.

The District level, and the DMO, is of particular importance because it is at this level that decentralized, overall health planning (including family planning) has been recently instituted by the MOH. The DMO is responsible for facilitating a District Level Primary Health Care Committee (DHC Committee) comprised of District level representations of other Ministries and Local Government. The PHC Committee and the DMO are charged with the responsibility of developing an annual plan that specifies and sets targets for all health care activity in the District.

FINDINGS

The chain of command issues raised earlier (see section 2) are most apparent at this implementation level with key supervisory staff often self-identifying two or three immediate supervisors. Nursing staff (clinic In-charge, RMCHC, DMOCHC, RNO, DNO) tend to self-identify the primarily female and technical nursing chain of command, while males tend to identify individuals in the predominately male/physician chain (RMA, MA, Facility In-charge, DMO, RMO). Technical supervision and site visits of clinics and personnel is most often done by the DMCHC and is therefore generally considered the supervisor most immediately responsible for family planning services.

Management issues of technical competence of providers, treatment of clients, quality assurance, logistics and MIS trouble shooting, patient flow, staff utilization, if identified at all, are split among the clinic or facility In-charge or the MCHC, many of whom have had no such training generally or specifically related to family planning. While some of

these responsibilities have been nominally assigned to the MCHC, who may or may not have been trained in family planning, the size of many Districts and the continuous problems with transportation make this nearly impossible in most cases. It must be remembered that even when and where some of that kind of supervision is possible, it must be done by the MCHC in the context of similar responsibilities in all MCH services at a given clinic or facility. Little time can therefore be devoted solely to family planning.

Almost no attention has been paid to the on-site managerial responsibilities of an MCH clinic or facility In-Charge person to creating high quality, user-sensitive and friendly family planning services. These cadres have a crucial role in the overall image, quality and therefore marketing of family planning services. The reticence of people to use these services, their general poor reputation and high drop-out rates are in large part due to the lack of recognition of this crucial management role.

Decentralized, District planning is an important step to institutionalizing the importance of family planning both among District MOH staff and in local Government. Family planning targets will be set for the entire District as a result of this process. But they must also be set for each service delivery point if they are to be a useful internal management tool for monitoring and evaluating site, personnel and program performance.

RECOMMENDATIONS

This is little that can be done about the parallel chain of command of MCH staff and Regional and Medical Officers without reforming the entire MOH structure. Since this is unrealistic, and perhaps would have little effect at the service delivery level, it would seem most useful to highlight and concentrate on the responsibilities of MCH Clinic In-Charges at Regional and District Hospitals and Health Centers and Rural Medical Aides at Dispensaries. Those are key people to shape and supervise the daily quality of family planning services at the SDP. The Regional and District Training Teams should include these key cadres in their training and curricula development should include all aspects of clinic management (see Training Component). Job descriptions for these positions need to be reviewed to ensure that family planning clinical management is included.

A Public Health Nurse already in the field at the Regional and District level should be assigned to work with the respective MCHCs to do site supervision and training specifically in family planning. They should be directly responsible to the Family Planning Unit in the MOH and represent their informational and authority link with the field (see Section 2 Recommendations).

District Health Plans should contain specific targets in family planning for each SDP. Only with such targets can effect monitoring and supervision take place. It will also send a strong message as to the high priority given to family planning by each District.

PROJECT ACTIVITIES - MINISTRY OF HEALTH FAMILY PLANNING UNIT

Year I

Activities

1. a) Integration of Projects into one Family Planning Program - 1 week
b) Task Analysis - 2 weeks
c) Annual Workplan Development - 1 week
 1 Expatriate Consultant; 1 Local Consultant (Institute for Development Management) for 6 weeks
2. Establishment of Inter-departmental Working Group - MOH
 Identify duties, agreements, benchmarks - 2 weeks (half days)
 1 Local Consultant (Institute for Development Management)
3. Development of FP Unit Finance and Administration Manual - 3 months
 1 Expatriate - 2 weeks; 1 Local Consultant (Institute for Development Management) - 3 months
4. Develop job descriptions and hire additional staff identified in activity # 1 (probably to include - IE+C Program Manager, Monitoring and Evaluation Officer, 2 Program Officers II Administration and Finance, Data Entry Clerk, 2 Clerical positions) - 6 months
 1 Local Consultant - 1 month
5. Develop plan for long and short-term training of staff - 2 weeks
 1 Local Consultant - 3 weeks
6. Computer purchase and training
 2 Computers; training for 5 staff - 3 months
7. Year end review of workplan and project, development of Year II Workplan - 2 weeks
 Expatriate and IDM Consultant (same as Activity # 1) - 1 month
8. MOH Work Group review of agreements, make adjustments - 3 days
 1 Local (IDM) Consultant (same as Activity # 2) - 1 week

Year II

Activities

1. Computer Training for newly hired staff - 2 months (approximately 4 staff)
2. Long-Term Training - 1 staff
3. Short-Term Management Training - 3 staff
 (IDM, Center for African Studies, USA)

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4. Year end Review, Development of Year III Workplan (same as Activity # 7 Year I)
5. MOH Work Group Review (same as Activity # 8 year I)

Year III
Activities

1. Review Task Analysis - identify additional staffing needs/requirements - 3 weeks
1 Local (IDM) Consultant - 3 weeks
2. Develop Personnel and Procedures Manual - 6 weeks
Local Consultant - 6 weeks
3. Continue long and short-term Management Training - 3 staff
4. Year end review, development of Year IV workplan - 2 weeks
5. Plan for Mid-Project Review Year IV - 2 weeks
1 Expatriate and 1 Local (IDM) Consultant - 2 weeks

Year IV
Activities

1. Mid-Project Review - component assignments and performance, staffing, future manpower and technical assistance requirements, financial analysis - 6 weeks
1 Expatriate and 1 Local Consultant - 6 weeks (2 weeks preparatory; 2 weeks follow-up)
MOH and UMATI review - 2 weeks
2. Continue Long-Term Training - 1 staff
3. Continue Short-Term Training - 3 staff
4. Annual year end workplan review, development of Year V workplan

Years V + VI
Activities

Continue annual activities in planning, evaluation, Short-Term Training and Long-Term Training

Year VII
Activities

1. Project Evaluation (same criteria as Mid-Project Evaluation), - 6 weeks
1 Expatriate and 1 Local Consultant - 6 weeks
(2 weeks preparatory and 2 weeks follow-up)
MOH and UMATI - 2 weeks

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- 2+3. Long and Short-Term Training
- 4. New MOH Program Goals and Objectives - Design - 8 weeks
 - 2 Expatriate and (2) Local Consultants - 8 weeks
 - (2 weeks preparation and 3 weeks follow-up)
 - MOH and UMATI - 3 weeks

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MOH ACTIVITIES

Activities	Y E A R						
	1	2	3	4	5	6	7
- Integration of Projects							
- Task Analysis, and Review of							
- Job Description, Hiring							
- Workplan Development + Review							
- MOH Interdepartment Taskforce							
- Finance + Admin. Procedures Manual							
- Financial Computer Purchase + Training							
- Develop Plan for Long and Short-term training							
- Long-term Training							
- Short-term Training							
- Personnel Policies + Procedures Manual							
- Mid-Project Review							
- Project Evaluation, Development of New Project							

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PROJECT ACTIVITIES BUDGET
MINISTRY OF HEALTH FAMILY PLANNING UNIT

Year I

Activity 1 Integration of Project, Task Analysis, Workplan

a)	2 Consultants (Expatriate @ \$25,000/mo; 1 Local @ \$60/day) 6 weeks	\$ 39,300
b)	3 Week Workshop (10 participants)	
	- Per Diem (10 persons x 15 days x \$ 20)	\$ 3,000
	- Facility (15 x \$50/day)	\$ 750
	- Materials, Secretarial Support (15 x \$ 15/day)	\$ 225
	Sub-Total	\$ 43,275

Activity 2 MOH Indepartmental Working Group

a)	1 Consultant (15 x \$60/day) -3 weeks	\$ 900
b)	Workshop (5 participants - half day)- 2 weeks	
	- Per diem (5 persons x 10days x \$20)	\$ 1,000
	- Facility (10 x \$50/day)	\$ 500
	- Materials, Secretarial support (10 x \$15/day)	\$ 150
	Sub-Total	\$ 2,550

Activity 3 Development of FP Unit Finance and Administration Manual

a)	1 Consultant (local 60days x \$60/day)-3 months	\$ 3,600
b)	Materials, Secretarial Support (10 x \$15/day)	\$ 150
c)	Printing (10 copes @ \$20/day)	\$ 200
	Sub-Total	\$ 3,950

Activity 4 Develop Job Descriptions, hire staff identified in Activity # 1

a)	-IE+C Program Manager (600/mox.12x7years)	\$ 50,400
	- Monitoring and Evaluation Officer (in Logistic and MIS Component Budget)	
	- Program Officer II Administration (500/mo x 12 x 7 years)	\$ 42,000
	- Program Officer II Firance (500/mo x 12 x 7years)	\$ 42,000
	- Data Entry Clerk (In Logistics and MIS Component Budget)	\$ 42,000
	Yearly	\$ 25,200
b)	1 Consultant (Local @ \$60/day x 20 days) 1 month	\$ 1,200
	Sub-Total - First year	\$ 26,400
	(Subject to Year IV Mid-Projext Review Adjustments) life of project	\$ 176,400

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Activity 5 Develop Long and Short-Term Training Plan - 3 weeks
I Consultant (Local @ \$60/day x 15 days) Sub-Total \$ 900

Activity 6 Computer purchase and training (5 staff for 3 months)
a) 2 Computer, software, consumables, Insurance \$ 15,000
b) Training (part time for 3 months x 5 staff)) \$ 3,000
Sub-total \$ 18,000

Activity 7 Year End Review of workplan and project, develop Year II Workplan
a) 1 Consultant (Expatriate @ \$25,000/mo, Local @ \$ 60/day) - 1 month \$ 26,200
b) Workshop - 2 weeks 10 participants
- Per diem (10 persons x 10 days x \$20) \$ 2,000
- Facility (10 x \$50/day) \$ 500
- Materials, Secretarial Support (10x\$15/day) \$ 150
Sub-Total \$ 28,850

Activity 8 MOH Working Group Review
a) 1 Consultant (Local @ \$ 60/day) - 1 Week \$ 300
b) Workshop
- Per diem (5 x 3 days x \$ 20) \$ 300
- Facility (3 x \$50/day) \$ 150
- Materials, Secretarial Support (5x\$15/day) \$ 75
Sub-Total \$ 825

Year I Total \$ 124,750

Year II

Activity 1 Computer Training for New Staff
- 4 staff partial days for 3 months Sub-Total \$ 2,400

Activity 2 Long-Term Training
- 1 staff person Sub-Total \$ 30,000

Activity 3 Short-Term Management Training
- 1 USA Training (2 months) \$ 20,000
- 2 Regional (1 months) \$ 10,000
Sub-Total \$ 30,000

Activity 4 Year End Review, Development of Year II WorkPlan
(see Year I Activity # 7) Sub-Total \$ 20,850

Activity 5 MOH Work Group Review
(see Year I Activity # 8) Sub-Total \$ 825
Yearly Sub-Total \$ 92,075
Yearly Reoccurring Personnel Costs \$ 25,200
Year II Total \$ 117,275

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Year III

<u>Activity 1</u>	Review Task Analysis - identify staffing needs/requirements 1 Consultant (Local 15 x \$60/day) - 3 weeks	Sub-Total	\$ 900
<u>Activity 2</u>	Develop Personnel Policies and Procedures Manual		
a)	1 Consultant (Local 30x\$60/day) - 6 weeks		\$ 1,800
b)	Print 20 copies @ \$20/copy		\$ 400
	Sub-Total	\$ 2,200	
<u>Activity 3</u>	Short-Term Management Training		
	1 USA Training (2 months)		\$ 30,000
	2 Regional Training (1 month)		\$ 10,000
	Sub-Total	\$ 40,000	
<u>Activity 4</u>	Year and Review, Development of Year IV Workplan (See Year I Activity # 7)	Sub-Total	\$ 28,850
<u>Activity 5</u>	MOH Working Group Review (See Year I Activity # 8)	Sub-Total	\$ 825
<u>Activity 6</u>	Planning for Mid Project Reveiw Year IV		
	2 Consultants (Expatriate @ 25,000/mo, Local @ \$60/day) - 2 weeks	Sub-Total	\$ 13,100
	Yearly Sub-Total		\$ 85,875
	(Subject to Year III Activity 1. Findings) - Reoccurring Personnel Costs		\$ 25,200
	Long-Term Trainee		\$ 30,000
	Year III Total		\$ 141,075

Year IV

<u>Activity 1</u>	Mid Project Review		
a)	Consultants (1 Expatriate @ 25,000 mo; 1 Local @ 60/day) - 6 weeks		\$ 39,300
b)	Workshop - MOH and UMATI (20 participants) - 2 weeks		
	- Per diem (20 persons x 10 days x \$20)		\$ 4,000
	- Facility (10 x \$50/day)		\$ 500
	- Materials, Secretarial Support (20 x \$15/day)		\$ 300
	Sub-Total		\$ 44,100
<u>Activity 2</u>	Long-Term Training		
	1 staff person (new)	Sub-Total	\$ 30,000
<u>Activity 3</u>	Short-Term Management Training		
	1 USA Training		
	2 Regional Training	Sub-Total	\$ 40,000

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<u>Activity 4</u>	Annual Year End Review and Workplan Development	
	Sub-Total	\$ 28,850
	Yearly Sub-Total	\$ 142,950
	Yearly Reoccurring Personnel Costs	\$ 25,200
	Year IV Total	\$ 168,150

Year V

Continuous Activities	
Evaluation and Planning	\$ 28,850
Long-Term Training	\$ 30,000
Short-Term Training	\$ 40,000
Yearly Sub-Total	\$ 98,850
Yearly Reoccurring Personnel	\$ 25,200
Year V Total	\$ 124,050

Year VI

Same Activities as Year V	Total	\$ 124,050
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Year VII

<u>Activities 1 + 2</u>	Long and Short-Term Training	Sub-Total	\$ 70,000
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<u>Activity 3</u>	Project Evaluation		
	(see Year IV Activity # 1) - 6 weeks	Sub-Total	\$ 44,100

<u>Activity 4</u>	New MOH Program Goals + Objectives - Design	
a)	Consultants (2 Expatriate @ 25,000/mo/)	
	Consultant) - 8 weeks)	\$ 104,800
	(2 Local @ \$60.day/)	
	Consultant))	
b)	Workshop - MOH and UMATI 20 participants	
	for 2 weeks	
-	Per diem (20 persons x 10days x \$20)	\$ 4,000
-	Facility (10 x \$50/day)	\$ 500
-	Materials, Secretarial Support	
	(30 x \$15/day)	\$ 450
	Sub-Total	\$ 109,750

Year VII Sub-Total	\$ 223,850
Yearly Reoccurring Personnel Costs	\$ 25,200
Year VII Total	\$ 249,050

Budget Summary

		\$
Year	I	124,750
Year	II	117,275
Year	III	141,075
Year	IV	168,150
Year	V	124,050
Year	VI	249,050
Project Sub-Total - MOH		1,048,400

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UMATI

1. ORGANIZATION

1.1 Decision Making

UMATI, the oldest African affiliate of the International Planned Parenthood Federation (IPPF), was established in 1959 in response to the need for family planning information and services in Tanzania. Until 1974 when the Ministry of Health (MOH) incorporated child spacing in its MCH services, it was one of the few national organizations working in the field of family planning.

As a non-governmental organization (NGO), UMATI's policies and programs are decided upon by its volunteer leadership. There are over 200,000 members of the organization throughout Tanzania who, through purchase of an annual membership, are entitled to participate in the volunteer structure. Starting from the grassroots village level, there is a tiered system of volunteer committees, elected bi-annually by the membership in the respective areas. As such, there are 800 Branch Committees, 86 District Committees, 20 Regional Committees and a National Executive Committee. While the volunteer leadership is principally responsible for determining policy and program issues which are carried out by a professional paid staff (see sections 2&3), they also assist in motivational activities at all levels of the organization.

1.2 Planning

As with all IPPF affiliates, UMATI is guided by the development of a volunteer approved, "rolling" three year plan. The plan sets out a series of broad strategies that are a shared agreement as to the best way to achieve its mission given available human and financial resources. Each strategy has a series of specific project activities which detail how identified resources will be used to implement the given strategy. (see annex 1 & 2)

For the operative year of the three year plan, a detailed Work Program Plan and Budget is developed and approved by the volunteer leadership. It specifies in detail the activities to be carried out in each project, all inputs and expected outputs. As such it is the detailed guide for all paid staff as to their specific program responsibilities and provides financial and programmatic parameters sufficient for monitoring and evaluation. In addition to monthly intend reporting to management staff, quarterly financial and program reporting on the progress of the Work Program Plan and Budget is required by both the National Executive Committee and IPPF.

1.3 Funding

Approximately two thirds of UMATI funding comes from IPPF. Prior to developing the Work Program Plan and Budget each year, IPPF gives UMATI a target total dollar figure available for planning purposes.

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The funds are used primarily to fund the core management, administrative and program staff, and associated costs, and to facilitate the volunteer structure. It also funds a number of the specific projects under each strategy. In addition, UMATI solicits funds from other donors to fund other projects in support of each strategy. Presently UMATI is receiving approximately one-third of its funding from a variety of donors including the Norwegian International Development Agency (NORAD), the Swedish International Development Agency (SIDA), the Association for Voluntary Surgical Contraception (AVSC), the United Nations Development Program (UNDP), Pathfinder, the Japanese Organization for International Cooperation in Family Planning (JOICFP) and Johns Hopkins Program Information and Education in Gynecology and Obstetrics (JHPIEGO). In addition to these funding sources, UMATI raises a small amount of funds through its membership fees and limited product sales. As with all Family Planning Associations (FPA), UMATI is under increasing pressure to address the issue of long term financial sustainability through increased emphasis on income generating activities. To that end, UMATI has formed a private, for-profit organization to generate income for the organization. It has already purchased a building in Dar es Salaam housing UMATI training and Regional staff to which UMATI pays rent for its use. The front portion of the building is being converted into a pharmacy. It will be run by the for-profit organization, the income from which will be given to UMATI.

FINDINGS

1.1 Decision Making

Any activities proposed in the Project Paper to be carried out by UMATI will have to be approved by the volunteer leadership of the organization. Much of that leadership (District, Regional and National Executive Committees) has been with the organization for a long time and are accustomed to a certain type and level of activities to support the mission and strategies of the organization. They are also accustomed to having IPPF as their principal donor which has allowed them broad flexibility to identify and implement projects which the volunteers decide are the most appropriate for the organization. USAID-funded activities as proposed in the Project Paper will be considerable and will be quite specific in detailing the nature and content of the various activities and therefore, how the funds will be used. Policy and program decision making in the context of USAID funding will be a much less independent, autonomous exercise.

1.2 Planning

Present management, support and implementation staff are entirely funded by IPPF and other donor-funded activities. The staff is stretched very thin and several positions remain vacant due to lack of adequate financial resources (see Section 2&3). This is particularly true at the management/supervisory level. Even with the inclusion of adequate administrative costs, the addition (or the considerable expansion) of USAID-funded activities will almost certainly require a reorganization

of the management structure with significant additional staff. This reality, and its implications in terms of mission program planning, staffing and finances will be considerable.

1.3 Finances

The mix of funding sources will be affected by the inclusion of USAID-funded activities. In addition to new documentation and reporting requirements, there will be little flexibility as to how these funds are used and the amount of management/supervision and support staff they will require. Administrative and supervisory personnel and systems are already overburdened and therefore will need to be carefully considered in calculating adequate administrative costs to properly manage and monitor USAID-funded activities.

The issues of financial sustainability of projects and personnel and of income generation are very important for UMATI. They will need to analyze and understand the impact of USAID-funded projects on those two related issues and to programmatically and financially plan accordingly.

RECOMMENDATIONS

UMATI will need to do comprehensive Strategic Planning to thoroughly evaluate the requirements and implications of their role in family planning in Tanzania as specified in MOH National Family Planning Programme Plan of Operations 1989-1993 and as further clarified at the Morogoro Retreat March 1990. Some of the important elements of the Strategic Planning process should be:

- . Analysis of the external environment to include a detailed understanding of their role and specific responsibilities as outlined in the national document and further clarified at the Morogoro Retreat.
- . Analysis of the internal strengths and weakness of the organization to include the volunteer structure and roles, management structure, personnel and systems, program and financial planning monitoring and evaluation and the systems and personnel to support these activities. The strengths and weaknesses of field staff needs to be assessed. Space and equipment are other important considerations.
- . The Mission of the organization, and its strategies and projects will need to be carefully reviewed in light of the internal and external environmental analyses. There needs to be a thorough discussion and understanding of the impact of the National Program and the proposed USAID-funded activities on the focus, direction, staffing, systems, present projects and general financial sustainability of UMATI.

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. The strategic planning process should be done as soon as possible and will take three months to complete. It is of extreme importance that it is done with the active involvement of the top levels of management and volunteer leadership and not for them by a third party. Those responsible for facilitating the process should be familiar with both the country situation relative to family planning and with the IPPF structure and system. Ideally at least one of them would have been through a strategic planning process with an IPPF affiliate. UMATI will need to feel completely confident in whomever is chosen.

. The strategic plan should be a five year document and progress should be formally evaluated after year two. The process, depending on changes in the internal and external environment, should be repeated in an abbreviated form in year five.

2. MANAGEMENT STRUCTURE - DAR ES SALAAM (see organization chart Annex 3)

2.1 Executive Director

The Executive Director is the highest paid staff persons in the organization and as such is its Chief Executive Officer. She is hired by and reports to the National Executive Committee and is responsible for the successful implementation of all programs of the organization. She is a teacher by training and has served in the position since 1969.

2.2 Deputy Executive Director

Under the Executive Director, and at the direction of IPPF, the post of Deputy Executive Director has recently been created. It is filled by an Ob/Gyn physician who had previously held the position of Director of Operations with UMATI. His principal responsibilities are to fill-in if the Executive Director is away and to oversee the areas of personnel and maintenance of vehicles. To assist him in these responsibilities, he has an assistant, Administrative Officer I. There is an Administrative Officer III Personnel who has a clerk. The positions of Administrative Officer II Manpower Development and that of Maintenance are vacant.

2.3 Finance

The next level of management includes the Director of Finance and the Director of Operations. The Director of Finance is responsible for all money matters including financial planning and budgeting, accounting, monitoring and reporting. She has both a BA in accounting and an MBA from the University of Dar es Salaam. The ordering, transporting and accounting for contraceptives, a national responsibility assigned to UMATI, is also her responsibility. To perform her financial duties, she is assisted by two accountants, three assistant accountants and one accounts clerk. The organization to date has not reorganized the support staff to the planned goal of one Senior Accountant, four Accountants, two Assistant Accountants, one Accounts Clerk primarily due to lack of funds. In the financial area there is also one Chief Internal Auditor that reports directly to the Executive Director.

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In overseeing the management of commodities, the Finance Director supervises a Program Officer I Supplies who in turn supervises a Program Officer II Stores and a Warehouseman.

2.4 Operations

The Director of Operations is a physician who has done post-graduate studies in Human Fertility at the University of Exeter and in Public Health at the University of Dar es Salaam. Previously he was the Director of UMATI's Integrated Family Planning, Nutrition and Parasite Control Project for one and a half years and assumed his present position in May, 1989. As Director of Operations he is responsible for supervising all projects other than commodities. The Program Officer I Training position has been empty for four years due to lack of funds which means he must pay particular attention to these projects although he is assisted by Program Officer II Training. The Program Officer I, II and III Innovative Projects have never been filled as they are newly conceived and no funds have been identified for them. The Program Officer IE&C is responsible for more daily supervision of projects in this area. Eight projects have Program Officer II Coordinators who, along with 20 Regional Coordinators and 23 District Coordinators, all report directly to the Director of Operations. There will be nine more District Coordinators added this year who will also report to the Director of Operations (See Section 3).

2.5 Research and Evaluation

These functions are supervised and in many cases implemented, by the Program Officer I Research and Evaluation who reports directly to the Executive Director. He has a BA in statistics and an MA in Demography from the University of Dar es Salaam and has worked with UMATI since 1983. He receives all project reporting data from the Director of Operations where it is initially sent by project and field staff including all information relating to commodities from all over the country. He is responsible for compiling all project data into monthly (internal) and quarterly reports (internal and donors) for project monitoring and evaluation purposes. He also provides the Program Officer I Supplies with commodities data necessary for forecasting and shipping to regional MCH warehouses throughout the country.

In the area of research, he is responsible for the design, oversight and analysis of all research called for in the Work Program Plan and Budget. These are usually area and project specific research regarding knowledge, attitudes and practices. In performing both the research and evaluation duties, the Program Officer I is assisted by Program Officer II Research and Program Officer II Data Analysis.

FINDINGS

2.1 Executive Director

The Executive Director has served for many years in that capacity and has indicated a desire to retire in the next several years. Most of

what UMATI is has been due to her efforts and the organization will have very big shoes to fill.

2.2 Deputy Executive Director

The Deputy Executive Director has a very narrow area of supervision and perhaps due to the newness of the position, it has been difficult for the organization to know how best to utilize the position. It is also most unusual to have junior positions (Directors of Operations and of Finance) reporting around him directly to the Executive Director.

2.3 Director of Finance

The Director of Finance, with the inclusion of commodities under her supervision, is very short staffed. The sheer number of projects and donors, all with different reporting requirements, is difficult for her to handle. One of the things that suffers is the quantity and quality of internal financial reporting for supervision purposes. It also makes it hard for her to quality control the imprest funds managed by Regional and District Coordinators in the field.

2.4 Director of Operations

Having more than 60 people that he must supervise, in addition to writing grants, responding to donor requests, visits, etc. is far beyond anyone's capability. This is one of the most serious management issues that the organization faces. This problem is compounded by the fact that as with the other departments, key mid-level management positions are vacant due to limited funds.

2.5 Research and Evaluation

The staff of this department is barely able to keep up with the donor requirements for program reporting. It is not able to produce enough of a variety of evaluation project data to supervise, but especially to analyze, project performance or impact. All of this leaves even less time for comprehensive or quality research.

RECOMMENDATIONS

Executive Director

Careful consideration needs to be given to the replacement of the present Executive Director. The results of the strategic planning process, the issue of sustainability and income generation, the size and scope of USAID-funded activities, etc. should all be taken into careful consideration.

2.1-2.5 Executive Management Positions

The present numbers and deployment of senior and mid-level management staff is clearly inadequate to properly supervise, monitor and

evaluate projects and project staff. The addition of USAID and NORAD funded national activities will compound this serious problem even further (see Section 4). This inadequacy also exists in the administrative support activities of program and financial reporting and analysis, clerical support and even in physical space. One result of the Strategic Planning process should be the reorganization of the management structure and the organogram to better address the management issues of supervision and administrative support. That structure should be the result of a process that senior management and volunteers participate in. (See annex 4 for one example.) Some of the following concepts should be taken into consideration:

- Broadening the span of authority and responsibility of the Deputy Executive Director.
- Removing commodities from the extensive responsibilities of the Director of Finance. Perhaps raising the head of it to a higher level and putting maintenance of all vehicles under him or her also.
- Regionalizing responsibility for all projects in a given area and making those individuals the program link (only supervisory) to the Director of Operations. They will need to be of commensurate quality.
- Creating more departments at the level of the Directors of Operations and Finance that have mid-level managers who provide technical assistance and support to projects but who do not supervise them. (Supervision being done by Regional Coordinators.) Such departments might include Research and Evaluation, Training, IE&C (to include youth programs, motivational activities, etc.) and Client Services (CBD, Clinics, VSC, Norplant, etc). Cost considerations are very real but given the existing problems in supervision and the projected scope of existing and new projects (see section 4) there is no real alternative. It also creates a much more experienced and knowledgeable "horizontal" management team to deal with organization-wide and national issues of UMATI.

3. Regional Level

Presently UMATI has Regional Coordinators in all 20 Regions in the country and District Coordinators in 23 of the 106 Districts. Next year that number will increase to 32. These Coordinators have three basic responsibilities. Most of their time (and funding) is spent on giving motivational seminars and health talks to local community and government leaders. They also are responsible for collecting client user data, mostly from MOH Maternal and Child Health (MCH) Coordinators, for all facilities, governmental and non-governmental, in their area. This data is given to Headquarters to check against commodities distributed to those areas and to help forecast future commodity needs. Coordinators are also responsible for membership drives and for facilitating the UMATI volunteer committees in their area. The majority of Regional Coordinators are either nurses, social workers or medical assistants while most District Coordinators have been trained as teachers. All report to the Director of Operations.

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In addition to the two types of Coordinators, some Regions have project-specific staff. Most projects have Project Coordinators, who report to the the Director of Operations, and project staff who are under their supervision. Projects include a wide variety activities (see Annex 2) such as CBD, Clinics (3), Integrated Family Planning + Parasite Control, out-of-School growth, Family Life Education, pre-service and in-service clinical training, adolescent mothers, etc. few of which are national in scope.

FINDINGS

- . Many Regional, and especially District, Coordinators are long-term employees of UMATI who have specialized in motivational seminars and little else. In terms of skills, there is little flexibility to broaden their technical or supervisory responsibilities without extensive training.
- . Most Regional and District Coordinators, given their present motivational and volunteer related activities, have little time to take on large, new tasks in their areas.
- . Project Coordinators in Regions all report to the Director of Operations. Given that he must also supervise all the area Coordinators, it is not possible for him to give them the pro-active, problem-solving kind of supervision they need.
- . Given the number of mid-level management positions that are vacant, it is impossible for projects and Project Coordinators to get much technical assistance from Headquarters.

RECOMMENDATIONS

- . Chain of command and supervisory problems can be addressed by the reorganization of management staff as outlined in the recommendations of section 2. Of course the funds for such a reorganization is a major issue and have not been identified and which must be addressed by the proposed USAID project.
- . Regionalizing supervision of all activities must be seriously considered. But the qualifications of the present Regional and District Coordinators may not be entirely appropriate for such a task. This will create ~~some~~ difficult decisions for UMATI especially when it comes to their long term District Coordinators.

4. IMPACT OF COMPONENT ACTIVITIES ON UMATI MANAGEMENT AND FIELD STAFF (See Annex 4)

4.1 Research and Evaluation Unit

In addition to all researched evaluation duties associated with existing UMATI projects, the department will have a number of added responsibilities as a result of the proposed component activities of the USAID-funded project.

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. Logistics and MIS - The Program Officer I will be a member of the Advisory Committee and participate in the design of the new MIS. The Program Officer II Data Analysis will continue to input aggregate MIS information obtained from the MOH pertaining to commodities.

. IE&C and OR - The Program Officer I will be responsible for designing and carrying out the KAP survey in five regions in years 1-2 and 5-6 (abbreviated) and the situational analysis years 1,3,6. Presumably his assistance will also be required to format information from the DHS in year 4 and to structure and input evaluative information for the DHS Dissemination and Demand Generation (years 6+7) activities. Operations Research activities will be better understood when the Research and Evaluation Committee, of which he will be a member, clarifies the number and extent of that research:

. Private Sector - the Program Officer I will have to assist in the design of any further MIS needed for this component and the Program Officer II Data Analysis will have to input and analyze that information.

FINDINGS

As mentioned earlier, this Unit is already overburdened and is not producing enough quantitative or qualitative data for existing project supervision, let alone project impact analyses. The added responsibilities of USAID-funded component activities, especially the KAP surveys, situational analysis, operations research and new MIS designs will be extremely time consuming.

RECOMMENDATIONS

. The Unit should be raised to the level of a department with the Program Officer I concentrating on the new activities.

. The Program Officer II Research will require a Data Entry Clerk to input and retrieve research and DHS information.

. The Program Officer II Data Analysis will require a Data Entry Clerk to input and retrieve existing project data and new component activities information.

. There needs to be at least one computer in the Unit so that research and project (existing and new) and commodity information can be inputted and retrieved simultaneously.

4.2 IE&C Unit

This Unit will have extensive new activities as a result of the USAID-funded project component. (See IE&C Component description.) It will include the development of materials for the Private Sector

component, and the DHS dissemination (year 4) and Demand Generation (years 6-7) activities. The component is funding a new position in the Unit at the Program Officer I level which will oversee these activities and serve on the IE&C Coordinating Committee. It will also fund 50% of Program Officer II Press position to assist with those activities.

FINDINGS

While the proposed new staff appear sufficient to handle the component activities, their scope, together with existing UMATI IE&C activities, further exacerbates the extreme scope of supervision of the Director of Operations.

RECOMMENDATIONS

It is suggested that the Unit be elevated to departmental status and removed from the span of supervision of the Director of Operations. This would also require the Head of the Unit to become a departmental Director.

4.3 Private Sector

This is a new unit developed specifically to manage and implement the component activities of the USAID-funded project. It would contain a Program Officer I who would be a member of the Technical Advisory Committee, develop proposals, budgets and implementation plans and supervise the component activities. There would also be a Program Officer II who would assist in private sector contacts and plan and implement necessary linkages with existing training, commodities and MIS systems. He or she would also be responsible for the baseline surveys and troubleshooting at operating sites. A high quality secretary has been added given the clerical load with the public he or she will do considering how much both Program Officers will be out of the office.

FINDINGS

The recommended staffing appears sufficient to cover component activities. If the component is successful in reaching its targets, by years 6 and 7 it will have a considerable number of companies participating throughout the country. Supervision and general servicing of so many sites could be a problem.

RECOMMENDATIONS

Given that this component is basically a service delivery project, it is suggested that it be grouped with other existing service delivery projects in UMATI and that a separate department be formed. Once again, the Director of Operations is in no position to take on the supervision of a new project.

4.4 Regional & District Coordinators

UMATI Coordinators will have the added responsibilities in IE+C of the DHS dissemination (year 4) and the Demand Generation (years 6-7) which should take approximately 30% and 50% of their time respectively. For the Demand Generation activities, the project is funding Assistant Coordinators for two years. They will also certainly have to bear some responsibility of implementation of the KAP studies and situational analyses.

FINDINGS

Depending on how extensive their responsibilities are for the KAP studies and situational analyses, they should be able to handle these added responsibilities. If they are to assume responsibility for supervision of all existing UMATI activities in their respective areas, as recommended in this Institutional Analysis, that would be a significant amount of additional work.

RECOMMENDATIONS

It is recommended that Regional and District Coordinator become responsible for all UMATI projects in their respective areas. They would then be the sole supervisory link to Headquarters and specifically to the Director of Operations.

It is recommended that a thorough review of the qualifications and job descriptions of these positions occur taking into consideration this important new responsibility.

4.5 Commodities and Vehicle Maintenance

The responsibilities and activities of these units will remain largely the same. The positions of Administrative Officer II Maintenance and Program Officer II Purchases are to be filled and a Warehouse Manager is to be added. Rental money for additional storage space has also been included.

FINDINGS

The organizational separation of maintenance and commodities seems artificial and unnecessary. The positioning of commodities under the supervision of the Director of Finance overburden an already busy department.

RECOMMENDATIONS

The activities of commodities and maintenance of vehicles should be combined and removed from the Finance Department. Serious consideration should be given to placing the combined unit under the Deputy Executive Director.

4.6 Training

Training activities, with the addition of the USAID-funded component and the NORAD-funded National Family Planning Center (NFPC), will expand dramatically and will include a diverse number of responsibilities that will be national in scope. It will include all the preparatory steps for launching a natural pre-service and in-service training program. The NFPC will include a Center Director, Training Director and Senior Nurse, and the USAID-funded component will call for the filling of the vacant position of Program Officer I Training at UMATI. The present Program Officer II Training will oversee the pre-service and in-service training and UMATI will have to add another Program Officer II Training to oversee the training needs of its own projects.

FINDINGS

It is obvious that the training unit will expand dramatically and will be involved in a much broader range of activities on a national scale. It is impossible to have the Director of Operations continue to supervise such an expanded unit.

RECOMMENDATIONS

The unit should be elevated to a department that is no longer under the supervision of the Director of Operations.

The management of the NFPC and all the other training activities of UMATI need to be coordinated and combined in an integrated system of supervision, strategy development, implementation plans, MIS, etc.

The qualifications for the new positions of Departmental Director, NFPC Director must be carefully analyzed. Strong emphasis should be put on the management skills and experience necessary for such a large and complex undertaking.

4.7 Finance and Administration

This department will be responsible for accounting for all project funds, as well as existing projects, and for producing external reports for donors and internal reports for project monitoring evaluation and analysis. It will also be responsible for developing job descriptions for the many new project positions.

FINDINGS

The department is already seriously understaffed and the quality of internal reports for existing project monitoring and evaluation is not sufficient. In addition, all tasks are done by hand making it a labor-intensive operation.

RECOMMENDATIONS

The department needs to be immediately staffed up to reflect the existing organizational chart (see Annex 3). Even this may not be sufficient and a thorough study needs to be made of total staffing needs once the project begins.

There needs to be extensive technical assistance provided to develop an integrated financial MIS system for both internal and external reporting. It should include plans, equipment and training to computerize it.

Once the systems are established, a Financial Policies and Procedures Manual needs to be developed describing all such functions of the department.

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PROJECT ACTIVITIES
UMATI

Year I
Activities

1. Review specifics of assigned component activities with MOH
3 days 1 Local Consultant - 1 week

2. Strategic Planning - 3 months
 - Internal & External Environment
 - Mission
 - Volunteer and staff structure, qualifications
 - Financial and Programmatic Information Systems evaluation
 - 1 Expatriate Consultant (2 weeks at beginning) 2 weeks at end)-1 month
 - 1 Local Consultant (same schedule + 2 weeks in middle) - 6 weeks
 - 2 Workshops (one week for each at beginning and end) for Senior Volunteers and Management.

3. Begin hiring process for Project-related management staff:
 - a) (expected from Strategic Planning Process)
 - Director IE&C
 - Director Training
 - Director Service Delivery
 - Senior Accountant
 - 2 Accountants
 - 1 Assistant Accountant
 - Program Officer II IE&C (funds in IE&C Component)
 - 4 clerical Positions

 - b) Partial Project funding for
 - Director Research and Evaluation
 - Program Officers II Research, Evaluation
 - 2 Data Entry Personnel - Research and Evaluation

 - c) Provide Technical Assistance to develop new organogram and job descriptions for steps a+b.

4. Long-term Training
 - 1 management staff

5. Short-term Management Training
 - USA (2 month course) based
 - Regional (1 month course) based

6. Technical Assistance to develop financial information systems - 2 months
 - 1 Expatriate Consultant for 1 month
 - 1 Local Consultant for 2 months

UMATI ACTIVITIES

Activities	Y E A R						
	1	2	3	4	5	6	7
- Review Assigned Component Activities with MOH							
- Strategic Planning							
- Review of Strategic Plan							
- Develop Job Descriptions, Hire Staff							
- Long-Term Training							
- Short-Term Training							
- Develop Financial MIS							
- Develop Financial Procedures Manual							
- Computerize Financial Reporting							
- Develop Integrated Program MIS							
- Develop Dept. Workplans							
- Participate in Mid-Project Review							
- Participate in Project Review, Development of New Project							

7. Develop Departmental Workplans - 2 weeks
1 Local Consultant for 1 month

Year II
Activities

1. Technical Assistance to develop Financial Procedures Manual
1 Local Consultant (same as year I Activity 6) - 2 months
2. Purchase computer and begin training for Finance Department
1 computer - training for 3 staff
3. Convert financial reporting to computer
1 Expatriate Consultant - 1 month
1 Local Consultant - 1 month
4. Technical Assistance to develop computerized, integrated programmatic information reporting system - 3 months
1 Expatriate Consultant - 1 month
1 Local Consultant - 2 months
5. Short term Management Training
1 USA-based - 2 months
2 Regional based - 1 month
6. Review Year II Activities and develop Year III Departmental Workplans - 2 weeks
1 Local Consultant (same as Year I Activity 7) - 2 weeks

Year III
Activities

1. Long-term Training - 1 Management Staff
2. Short-Term Training
1 - USA based 2 months
2 - Regional based 1 month
3. Review and update Strategic Plan - 6 weeks
1 Expatriate Consultant (same used in original process)- 1 month
1 Local Consultant (same used in original process)- 6 weeks
Workshop for Senior Volunteers and Management - 1 week
4. Develop Workplaces for Year VI

Year VI
Activities

1. Short-term Training
- 1 USA based (2 months)
- 2 Regional based (1 month)
2. Review Year VI Activities Develop Workplaces for Year VII

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Year VII
Activities

1. Short-term Training - 3 participants
2. Strategic Plan Review - Senior Volunteers & Management - 3 days
1 Local Consultant - 2 weeks
3. Participate in MOH Project Review and Development of New Goals + Objectives (see MOH Activities Year VII and Budget)

Project Activities Budget - UMATI

Year I
Activities

1. Review specifics of assigned Component Activities with MOH - 3 days
 - a) Local Consultant (5 x \$ 60/day) - \$ 300
 - b) Workshop (3 Participants-MOH, 3-UMATI) - 3 days
 - Per diem (6 x 3 days x \$ 20) - \$ 360
 - Facility (3 x \$50/day) - \$ 150
 - Materials, Secretarial Support (5 x \$ 15/day) - \$ 75

Sub-Total \$ 885

2. Strategic Planning - 3 months
 - 1 Expatriate (1 month @ \$25,000 month) \$ 26,800
 - 1 Local (30 x \$ 60/day) -
 - 2 Workshops of 1 week (1 at beginning, 1 at end)
 - Per diem (20 x 10 days x \$20) - \$ 4,000
 - Facility (10 x \$50/day) - \$ 500
 - Materials, Secretarial Support (10 x \$15/day) - \$ 150

Sub-Total \$ 31,450

3. a) Technical Assistance to develop new Organogram and Job Description - 1 month
 - 1 Local Consultant (20 x \$60/day) Sub-Total \$ 1,200

b) Fill the identified positions:

 - Director IE&C - \$ 150/mo 2 Accountants -\$100/mo
 - Director Training - \$150/mo 1 Assistant Accountant - \$75/mo
 - Director Service Delivery \$150/mo 4 Clerical Positions - \$40/mo
 - Senior Accountant - \$125/mo

Partially Fund:

 - Director Research + Evaluation - \$50/mo 2 Program Officer II Res.+Eval. - \$ 50/mo.

Yearly recurring personnel/costs Sub-Total \$ 13,920

4. Long-term training - 1 staff @ 30,000/year Sub-Total \$ 30,000

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5. Short-term training -		
- 1 staff -USA based training (2 months) - \$20,000		
- 2 staff -Regional Training (1 month) - \$10,000		
	Sub-Total	\$ 30,000
6. Technical Assistance to develop Financial Information Systems - 2 months		
- 1 Expatriate (1 month @ \$25,000/mo)		
- 1 Local (2 months @\$60/day)		
	Sub-Total	\$ 27,400
7. Develop Departmental Workplans		
- Local Consultant (1 month @ \$60/day)	Sub-Total	\$ 1,200
		<u>\$136,055</u>
	Year I Activities Total	

Year II
Activities

1. Technical Assistance to develop Financial Procedures		
Manual - 1 month		
- 1 Local Consultant (1 month @ \$ 60/day)	Sub-Total	\$ 1,200
2. Purchase Computer, Train 3 Financial Staff		
- Computer - \$9,000; Training for 3 months - \$ 2,000	Sub-Total	\$ 11,000
3. Convert Financial Reporting to Computer - 1 month		
- 1 Expatriate (1 month @ \$25,000/month)	Sub-Total	\$ 25,000
4. Technical Assistance to develop computerized programatic MIS - 2 months		
- 1 Expatriate (1 month @ \$25,000) 1 Local (2 months @ \$60/day)	Sub-total	\$ 26,400
5. Short-term Management Training (Same as Year I Activity II 5)	Sub-total	\$ 30,000
6. Review Year II Activities and Develop year III Workplans - 2 weeks		
- 1 Local Consultant (2 weeks @ \$60/day)	Sub-total	\$ 600
		\$ 30,000
Yearly Long-Term Training		\$ 13,920
Yearly Recurring Personnel Costs		<u>\$138,120</u>
	Year II Total	

Year III
Activity

1. Review Progress of Strategic Plan - Volunteers+Management - 1 Week		
a. 1 Local Consultant (2 weeks @ \$ 50/day)		\$ 600
b. Workshop (20 participants)		\$ 2,000
- Per diem (20 x 5 days X \$20)		\$ 250
- Facility (5 x \$50/day)		\$ 75
- Materials, Secretarial Support (5x\$15/day)		\$ 75
	Sub-Total	\$ 2,925
2. Short-term Management Training	Sub-Total	\$30,000
3. Long-Term Training	Sub-Total	\$30,000
Yearly Reoccurring Personnel Costs		<u>\$13,920</u>
	Year III Total	<u>\$76,845</u>

Year IV
Activity

1. Short-Term Training	Sub-Total	\$ 30,000
2. Long-Term Training	Sub-Total	\$ 30,000
Yearly Recurring Personnel Costs		\$ 13,920
Year IV Total		\$ 73,920

Year V
Activity

1. Short-Term Training	Sub-Total	\$ 30,000
2. Long-Term Training	Sub-Total	\$ 30,000
3. Review and Update Strategic Plan - 6 weeks		
a) Expatriate (1 month @ \$25,000/mo)		
1 Local (6 weeks @ \$60/day)		\$ 26,800
b) Workshop - volunteers and Management - 1 week		
- Per diem (20 x 5 x \$20)		\$ 2,000
- Facility (5 x \$50/day)		\$ 250
- Materials, Secretarial Support (10x\$15/day)		\$ 150
Sub-Total		\$ 29,200
Yearly Recurring Personnel Costs		\$ 13,920
Year V Total		\$ 103,120

Year VI
Activities

1. Short-Term Training	Sub-Total	\$ 30,000
2. Long-Term Training	Sub-Total	\$ 30,000
Yearly Recurring Personnel Costs		\$ 13,920
Year VI Total		\$ 73,920

Year VII
Activities

1. Short-Term Training	Sub-Total	\$ 30,000
2. Long-Term Training	Sub-Total	\$ 30,000
3. Review of Strategic Plan		
a) Local Consultant (2 weeks @ \$60/day)		\$ 4,000
b) Workshop - Volunteers & Management - 3 days		
- Per diem (20x3x\$20)		\$ 1,200
- Facility (3x\$50/day)		\$ 150
- Materials, Secretarial Support (5x\$15/day)		\$ 75
Sub-Total		\$ 2,025
Yearly Recurring Personnel Costs		\$ 13,920
Year VII Costs		\$ 75,945

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SUMMARY

Year I	-	\$ 136,056
Year II	-	\$ 138,120
Year III	-	\$ 76,645
Year IV	-	\$ 73,920
Year V	-	\$ 103,120
Year VI	-	\$ 73,920
Year VII	-	\$ 75,945

UMATI - Institutional Development Total = \$ 677,925

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ANNEX 1

Strategies of UMATI

1. To promote awareness of the benefits and rationale for family planning and responsible parenthood among special population groups in selected areas of the country.
2. To increase the availability of contraceptives and family planning delivery points and services for eligible couples and individuals in selected areas.
3. To increase family planning skills and knowledge for service providers through training.
4. To increase skills and managerial capacity of UMATI staff and volunteers.
5. To convince policy-makers of the need to promote and protect the human rights concept of family planning for all citizens.

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ANNEX 2

The Projects of each Strategy of UMATI

Strategy I

- a) Family Planning IE&C and motivational program on the Mainland
1990 - TShs. 39,904,504
1991 - TShs. 69,320,786 (IPPF)
- b) Promoting family planning awareness and practice in Zanzibar
1990 - 1,941,189
1991 - 2,823,898 (IPPF)
- c) Radio program for educating men in family planning
1991 - 3,395,400 (proposed to UNFPA)
- d) Training of Trainers in family life education
1990 - 6,669,840
1991 - 8,631,490 (SIDA)
- e) Motivational seminars for Regional Planners and Policy-Makers
1990 - 3,429,700
1991 - 5,132,460 (SIDA)
- f) Family Planning Women in Development-cottage industries
1990 - Evaluation of past program
1991 - 4,637,068 (NORAD)

Strategy 2

- a) UMATI Family Planning Clinics (3)
1990 - 3,761,723
1991 - 5,623,770
- b) Integrated Family Planning, Nutrition and Parasite Control Project
1990 - 6,442,524
1991 - 8,870,053 (IPPF, JOICFP)
- c) Rural Community-based Distribution Project
1990 - 4,457,770
1991 - 4,662,061 (PATHFINDER)
- d) Voluntary Surgical Contraception
1990 - 6,867,180
1991 - 6,367,700 (AVSC)

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- e) Procurement and Distribution of Contraceptions
1990 - 2,829,492
1991 - 5,136,801 (IPPF)

Strategy 3

- a) Family Planning Clinical and Communications
skill course
1990 - 1,560,230
1991 - 3,022,750 (IPPF)
- b) Contraceptive Technology Update Course
1990 - 4,420,450
1991 - 4,439,760 (IPPF)
- c) Training of Trainers (Nurse Tutors)
1990 - 4,457,470 (IPPF)
1991 - 5,883,286 (JHPIEGO)

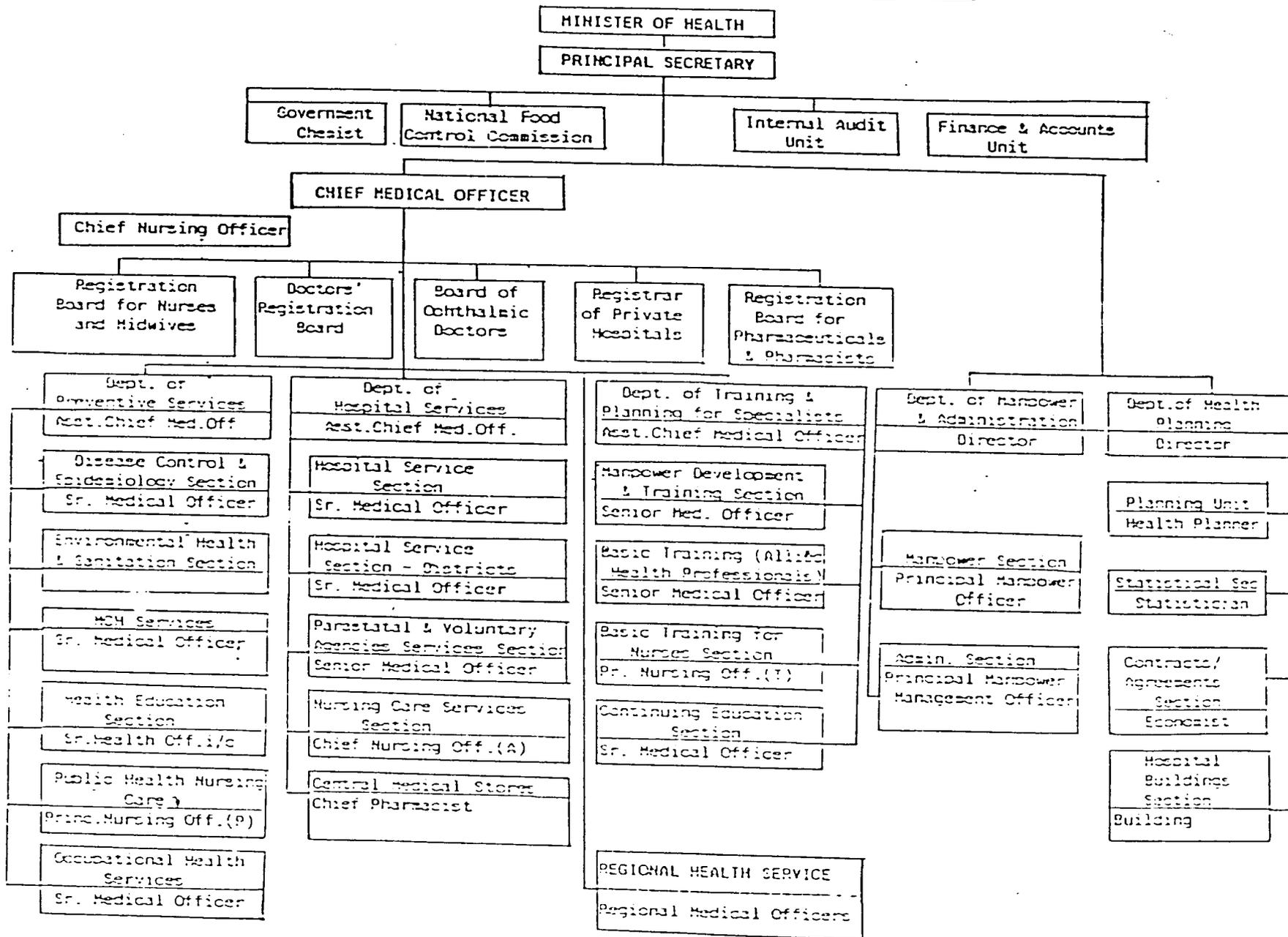
Strategy 4

- a) Training of UMATI staff (8) at Center
for African Studies (CAFS)
1990 - 1991 - US \$ 36,000 (SIDA)
- b) Achievement workshop for staff and
volunteers
1991 - 2,000,000 (NORAD)

Strategy 5

- a) Pilot Project for Teenage Dropout Mothers
1990 - 7,617,900
1991 - 8,357,100 (RFSU-Swedish FPA)
- b) Youth Development through Vocational
training and Family Life Education
1990 - 11,803,500
1991 - 12,393,728 (NORAD)
- c) Sensitization Seminars on Family Planning
as a human right
1990 - 7,339,779 (NORAD)

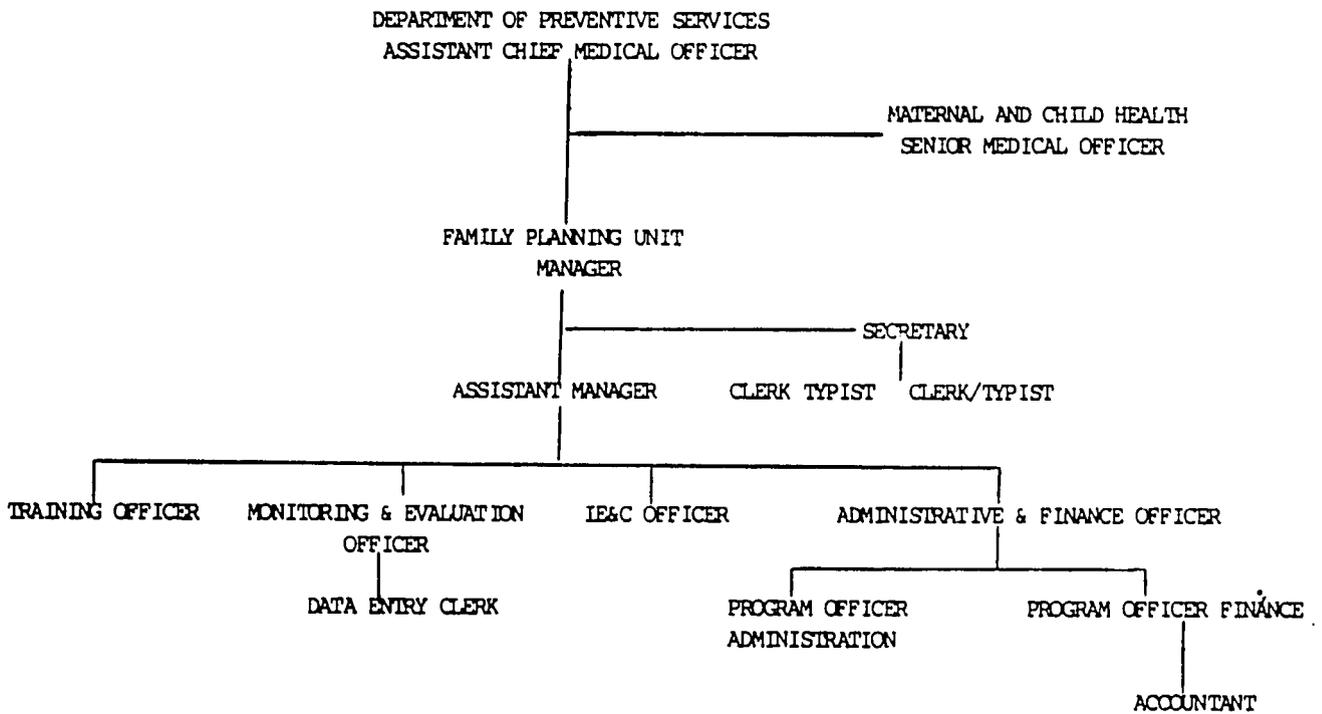
The Organization Structure of the Ministry of Health



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ANNEX 6

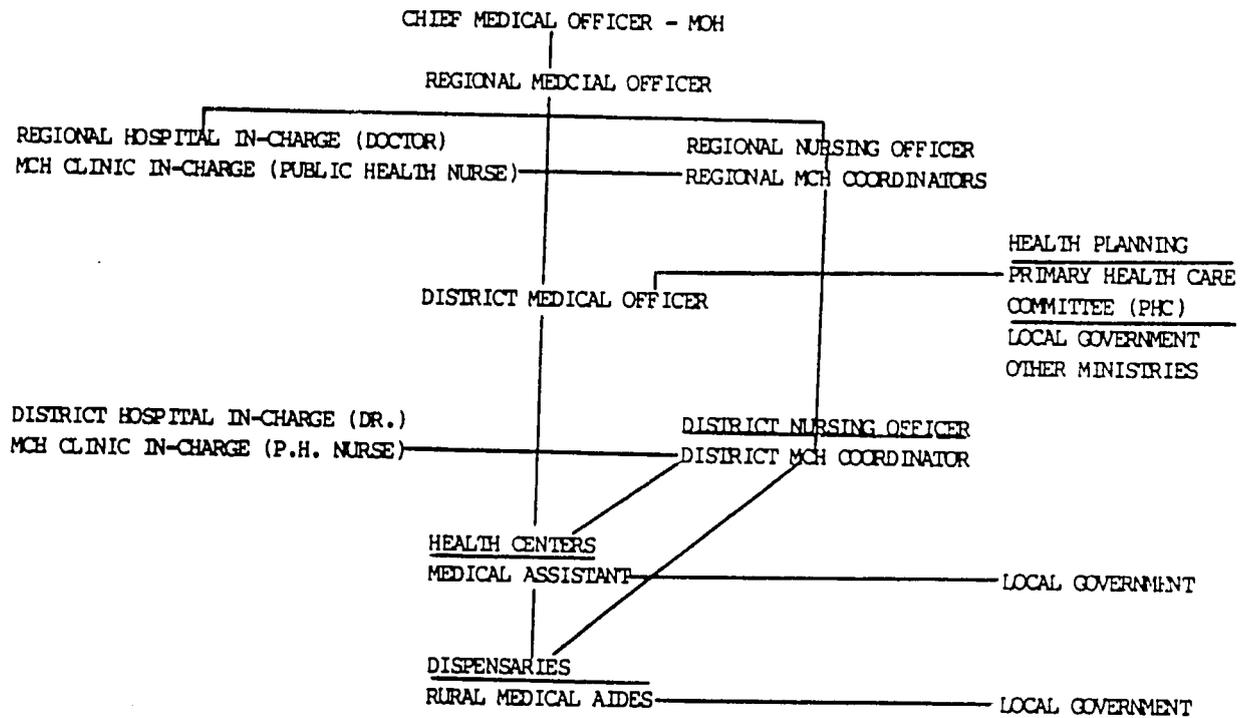
MOH FAMILY PLANNING UNIT - PROPOSED ORGANIZATIONAL STRUCTURE



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ANNEX 7

MOH - REGIONAL AND DISTRICT ORGANIZATIONAL STRUCTURE AND SERVICE DELIVERY POINTS



THE SOCIAL SOUNDNESS OF SUPPORTING FAMILY PLANNING
IN TANZANIA

for

USAID

by

David Scheirman
Christine Hongoke
Jeremiah Mshana

11 June 1990

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CHAPTER 1
INTRODUCTION

This report presents the findings of a study commissioned by the United States Agency for International Development (USAID). The purpose of the study was to assess the compatibility of family planning within the context of the sociocultural environment of Tanzania. The main objective of the study was to determine the cultural and social acceptability of family planning and to ascertain whether the proposed project has a reasonable chance of succeeding.

The population of Tanzania is currently 23.2 million and if the present annual growth rate of 3.0 percent is sustained the population is expected to reach nearly 50 million in 25 years. This rapid growth places a heavy burden on land, water, and forest resources and overtaxes an already weakened infrastructure. Unchecked population growth also strains the capacity of the social services to provide quality educational and health services to all Tanzanians. Economic recovery in Tanzania depends upon increasing agricultural production and creating employment opportunities for the 500,000 Class Seven leavers who join the labor force annually. Unchecked population growth clearly constrains Tanzania from achieving its development objectives. In recognition of this, the government is presently preparing a national population policy. The Ministry of Health has already devised a family planning strategy to improve maternal and child health through reducing the fertility rate. USAID is presently considering ways to assist the Ministry of Health to implement this strategy. Prior to making this commitment it is important to gauge and understand what the people of Tanzania - the future participants of this program - think and feel about family planning. For example, is the time right for introducing family planning and if so, where and to whom? What are the perceptions, attitudes, and beliefs of people living in rural and urban areas? Are people interested in receiving and accepting family planning services and if so, what is the best way to provide them? Are there constraints and obstacles to overcome and if so, what are they? Are there different levels of awareness amongst the several groups and classes of potential participants? Are the values and beliefs of potential participants consistent with the concept of family planning? How will the project communicate with participants? What is the likelihood that family planning will be accepted by different groups and what benefits will accrue from practicing family planning?

Since the answers to these questions were either unknown or just assumed, USAID commissioned this Social Soundness Analysis to determine the sociocultural feasibility and implications of supporting family planning in Tanzania.

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1.1 Approach to the Study

The study was carried out between May 7 and June 16, 1990. In order to complete the objectives of the study, the following persons, groups, institutions, and entities were visited, questioned, and if appropriate, observed:

- Women and men from rural and urban areas practicing family planning
- Women and men representing different tribes, areas, income levels, marital status, age, religion, and educational attainments
- Health and family planning professionals
- Village health workers
- Traditional birth attendants and traditional healers
- Teachers
- Religious leaders
- Political leaders
- Village elders and leaders
- Bar customers
- Taxi drivers
- Key informants with relevant information, insights, or experience
- MCH Clinics
- Dispensaries
- Ongoing family planning and health projects

A literature review was carried out and pertinent reports, articles, documents, and publications were consulted.

Field work was carried out in Dar es Salaam, an urban area, and in Pangani and Lushoto Districts in Tanga Region, both rural areas. Pangani is a lightly populated predominantly Moslem district located along the coast approximately 75 miles north of Dar es Salaam. Lushoto is a densely populated district which contains Christians and Moslems and is located in the Usambara Mountains. Vegetables for urban markets are intensively cultivated in the fertile valleys of these mountains.

1.2 The Research Team

The team was composed of the following members:

David Scheinman, Sociologist
Christine Hongoke, Ministry of Education Research Specialist
Jeremiah Mshana, Rural Research Specialist

1.3 Methodology

Informal interviews and focused group discussions were used to elicit information from people concerning their beliefs, practices, attitudes and perceptions to enable us to describe, explain, and predict the implications of introducing family planning. We wanted to confirm or deny assumed trends and patterns of human behavior and at the same time identify any new ones. This was accomplished by utilizing our background

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knowledge of the Tanzanian sociocultural landscape and relying on the many contacts which team members have built up over the years. Mr. Scheinman has lived in Tanzania since 1980 while Ms. Hongoke and Mr. Mshana are Tanzanian citizens with extensive knowledge of the sociocultural environment.

Much useful information was collected during meetings and interviews held with the people and groups listed in Section 1.1. Respondents were encouraged to air their views and questions like "what is your view regarding..., what do you know about..., what do men and women feel about..." were successfully used to stimulate discussion. Establishing a dialogue and obtaining information was surprisingly not difficult considering the subject matter. In addition, thirty females and twenty males were interviewed using a checklist based on the Scope of Work. Twenty-five of the females were current family planning acceptors but none of the men regularly practiced family planning. Females practicing family planning were generally met at MCH clinics and the men were randomly chosen. These interviews produced some basic quantitative data which is introduced in the text where appropriate.

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CHAPTER 2

CONDITIONS AND FACTORS CAUSING HIGH FERTILITY IN TANZANIA

2.1 Demographic Overview

Tanzania's 23.2 million inhabitants are unequally divided over 945,000 square kilometers of land. The population density is 24.6 people per kilometer and population pressure exists in congested fertile pockets which include Arusha, Kilimanjaro, Lushoto, and Mwanza plus many urban areas. Approximately 71 percent of the population lives in rural areas and 29 percent are urban residents. The urban population is growing at 11.3 percent annually and rural-to-urban migration accounts for half to two thirds of the rapid urban growth which occurred in the 1970's and 80's. Approximately 55 percent of the land is cultivable under rainfed conditions but presently only about eight percent is being farmed. Fifty-four percent of the population is under 15 years old, 51 percent is female, and there are approximately 5.3 million women of child bearing age. Life expectancy for children born in 1987 is 55 years for females and 51 for males. Approximately 80 percent of all one-year-olds are fully immunized against tuberculosis, DPT, polio, and measles.

Though the mortality rate has fallen through the years, the fertility rate has remained consistently at seven for the past thirty years. Total fertility is a bit higher than this along the western, southern, and northern border regions where the rates correspond with high figures recorded in neighboring regions of Kenya, Uganda, Rwanda, Burundi, Zambia and Malawi. The coastal and central regions have fertility rates lower than seven. Though latent demand for contraception seems high, the total number of acceptors in Tanzania includes no more than five percent of the women capable of bearing children. This positively correlates with the total number of couples in Sub-Saharan Africa practicing modern contraception, which is thought to be three to four percent of all couples. Though these figures are discouraging, pockets of demand are slowly emerging in response to the economic, social, and cultural changes occurring throughout Sub-Saharan Africa and within urban and rural Tanzania. The fact that 25 to 50 percent of all maternity related deaths in Sub-Saharan Africa are associated with illegal abortion suggests that a large unmet need exists for family planning information and materials.

2.2 Traditional Values, Beliefs, and Attitudes

There are many traditional values, beliefs, attitudes, and practices which cause, contribute to, and support high fertility. These are as follows:

- Status and prestige attained by having children.
- Having many children confirms ones virtue.
- Self-image enhanced by producing children.
- A man's lineage is continued through his children.
- Proof that one has been favored by spiritual forces and deceased ancestors.

- Short-term economic gain provided by children through farm labor.
- Long-term economic gain provided by children through caring for parents when they are old.
- Lack of forward planning and belief in fatalism.
- Polygamy.
- Taboo against husband and wife discussing sexual issues.
- Fostering children.
- Early Marriage for women.
- Infant mortality and the fear of children dying or becoming disabled.

Having many children confers status and prestige on parents and earns them the respect of their peers. It confirms the fact that they are following the right or correct behavior and is clear evidence that the parents have been favored by spiritual forces and deceased ancestors. High fertility brings joy, fulfillment, self actualization, and contentment. It creates a positive self-image for the parents since the self-identity of people is strongly linked to their reproductive abilities.

High fertility also assures males that their lineage and that of their ancestors will be preserved. It appeases the ancestors since they can now rest assured that the line will continue, and this should bring joy and contentment to the parents. Perpetuating one's line through male children is so important that parents will continue trying to produce males late in their reproductive lives if they perceive an imbalance between their male and female progeny.

The contribution children made to farm productivity is another important reason why fertility levels, particularly in rural areas, remain high. Increasing farm productivity and efficiency on subsistence farms depends on having access to labor, and families achieve this by producing more children. Children farm the land, herd livestock, carry water, fetch wood, and watch their younger brothers and sisters. Women depend on their children to assist them with the many domestic and farm chores they are responsible for carrying out. Children are also valued for the security they represent to parents as the parents become older. Children earning money are expected to contribute to the upkeep of their parents and the wealth is traditionally expected to flow upwards to the parents from the younger generation. If elderly parents are still living on the family farm they will require assistance tilling the land, carrying water, and hewing wood. They will also require assistance when ill and also want to be assured of a proper burial. Dying without children is a horrible thought and parents take solace and comfort knowing their children will perform the appropriate rites when continuing onward to what they perceive will be their next life.

The infant mortality rate in Tanzania is at least 12 percent and could be even higher in some rural areas. Parents know they are raising children in a high risk environment, and this impacts on fertility in two ways. First of all, parents want to replace a deceased infant or child

as soon as the mother's health allows her to become pregnant again. Secondly, the fear of children dying or becoming disabled is pervasive and extends far beyond infancy. Some parents with five or more children remarked that all their offspring could be lost in a catastrophe so it was necessary to ensure against perceived future losses by continuing to have children. Parents also expressed concern that their children could become disabled through polio, crippled, or that they would be bewitched and consequently become a liability to the family instead of an asset.

Fertility is also high due to the lack of forward planning and the strong influence of fatalism in peoples lives. People generally tend to react to events which have already occurred as opposed to initiating action to cause or prevent something from happening. Many people believe that events occur due to the will of god and feel people have no real business influencing the outcome of their actions. Having children is a very natural and cherished phenomena and interfering with that process is still a bit peculiar or awkward for many people. There is also sometimes a taint of evil associated with disturbing life's natural rhythms by preventing conception from occurring.

Linked to fatalism is the idea of "riziki" which is a Swahili word representing the wealth each child brings into the world when he or she is born. Due to this widespread belief some couples continue procreating even though they know they cannot clothe or educate their children properly. Some rural men told us they wanted to continue having children since the more they had, the greater the chance one would become rich. Parents also believe that as the children develop, the older ones will reduce the parent's burden by taking care of the younger ones. Early marriage is another cause for high fertility. A young female who begins bearing children at 15 or 16 will have a much longer reproductive life than a woman with a secondary education who probably won't begin bearing children until her early twenties.

High fertility in Tanzania is also sustained by fostering, a very widespread phenomena whereby children are cared for by relatives of their biologic parents. This an important support structure for maintaining high fertility because it reduces the penalty one would normally pay for having more children than one can support. There is usually a pool of care-givers in the extended family or clan who will happily take over responsibilities normally carried out by the biological parents.

High fertility is also supported by polygamy. Wives try winning favor with the husband by producing children so consequently competition between them may be an important factor in sustaining high fertility. If these polygamous wives maintain separate households, they will all require children to assist them in carrying out domestic tasks and running the farms. The taboo against husband and wife or close relatives discussing sexual issues also supports fertility since information on contraception or child-spacing is not easily shared or discussed. Traditionally, it would be very awkward and difficult for a wife to tell her husband, the one who controls her life, that she wants to practice

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family planning in order to avoid conception. Also, relationships between close relatives were always quite formal, so even discussing a personal and private topic like sex was quite out of the question. Since sex could not be discussed, nature followed the natural course of events. This taboo is still quite strong and change in this area will occur slowly.

As fertility is a virtue, barrenness or infertility is a dreaded curse to be avoided at all costs. Infertility impinges on a woman's self-identity and causes her to lose self-respect along with the status she would gain from her peers for having children. The identity of women is very much linked to their fecundity, so much that they are called by the first names of their children. For example, a woman named Anna with a child named Esther would be called "Mama Esther." It is important for women to be called Mama somebody as opposed to always being known by their given name because they unfortunately never gave birth. Women also fear losing children through separation, divorce, or death. Consequently, many women feel having too many children is a much lighter burden than having too few would be. Infertility problems in Tanzania seem to be greater than the three to five percent found on other continents. The 1948 Tanganyika census reported that 17 percent of the women over 45 were childless and the same figure was reported in 1957. In 1967 the figure dropped to 10.9 percent but in 1973 rose to 11.4 percent. All of these factors represent traditional customs and beliefs. Some of these are still quite important to people and some are not. A few beliefs and practices are more germane to males while others impact more on females. Differences also exist between the views of people living in rural areas and their brethren who live in the city. Many of these traditional attitudes are shifting and the interrelationships between fertility, poverty, urbanization, and rapid cultural change are complex and dynamic. Prior to analyzing the present situation, it is useful to understand fertility within the context of male and female relationships.

2.2.1 Male Beliefs and Practices

There are traditional and cultural differences in the way males and females view fertility. In a marital relationship, it is the husband and his family who control the fertility of the wife. By paying the bride price, a male and his family gain control of the woman and assume most decision making responsibilities for themselves. The role of the wife is to carry out and implement her husband's directives and since the husband is clearly the family decision-maker, a married woman cannot unilaterally decide to practice family planning and seize control of her own fertility. Men traditionally control the fertility of their wives and are the only ones who can authorize their wives to practice family planning.

It is the husband and his immediate family who control the fertility of the wife. In many tribes the husband's mother watched over the wife to make sure she was performing her duties properly. If she did not become pregnant on schedule, members of the husband's family would begin asking what her problem was and whether she required assistance.

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This still occurs in families today, and in Lushoto family planning professionals strongly urged that the wife's mother-in-law (Mama Mkwe in Swahili) be sensitized about family planning prior to initiating any activities or interventions.

Males are generally more interested in having many children than women are. This results from the weak link which exists between their reproductive act and the economic price they will have to pay for it. Men do not feel or have to endure the consequences of their conjugal act nearly as much as women do. For the traditional Tanzanian male, the benefits accrued from producing children are high and the costs low. Men have little motivation to reduce their fertility since since it is the mother who feeds, educates, supervises, and nurtures the children. The self esteem of males is strongly correlated with their virility, and this is expressed in the number of progeny they produce. Since fertility is rewarded and illegitimacy is accepted by the society, no social sanction exist which dissuade men from fathering offspring with different women. This occurs through polygamy and extra-marital liaisons. Since these liaisons were socially sanctioned through the practice of post partum abstinence, men have always enjoyed considerable sexual freedom.

Linked to self-esteem was the male belief that they had to exercise control over their wives by keeping them pregnant. The result of this was the birth of additional children which concomitantly increased the father's status, prestige, and respect. It was felt that a man's virility could be brought into question by his peers if his wife did not regularly become pregnant.

In many traditional African societies men were expected to provide land for their children. The Baganda of Uganda said that a poor man who sired many children but could not provide them with land was just raising future thieves since it was apparent the children would not be able to support themselves (Molnos, Vol. 1973). Scattered evidence indicates that in pre-colonial times much stronger social controls existed and men could not shirk the consequences of their conjugal acts as easily as they seem to today. This may be changing due to severe population pressure and congestion which is occurring today in various pockets of rural Tanzania. For example, some men in Mbaramo, a remote mountainous village in Lushoto District which is located three hours from the closest motorable road, complained they were losing control of their children because they **had** no land to give them. They said their children were undisciplined **and** spent their days lounging about the village drinking alcohol and **listening** to radio. They also complained that their children -- who were young adults-preferred living in towns -- refused to work on

family farm, and were unfamiliar with the traditional practices of their ancestors. This concept of "the rotten kid," the one who provides his parents with a negative instead of a positive return, is even forcing some males to reconsider how valuable having many children really is.

Change is occurring quickly as old beliefs and attitudes collide with new realities. The linkage between a man's self-esteem and identity and his virility is still quite strong. What's changing is that in some areas men are beginning to feel pressure from their male children because they have nothing for them. Some of these children are consequently beginning to rebel and in the process are drawn away from their cultural traditions but pulled closer to the consumer society. Though there is a tenuous linkage between a man's reproductive decisions and his economic responsibilities, this linkage may strengthen in rural areas where there is not enough land to divided amongst the sons and in urban areas where there is no land at all.

2.2.2 Female Beliefs and Practices

A woman's self esteem has traditionally been strongly linked to her child producing abilities. Women traditionally felt they would win the favor of their men and please them by bearing children. Bearing children earned women the love of their husbands and the respect of their communities.

Older people told us that traditionally a man would have one or more wives but would properly care for them and the children. We heard many complaints from respondents concerning men not assuming their responsibilities and not contributing money to help manage their family farms or clothe their families. Situations like this have prompted some women to carry their economic independence and familial responsibilities one step further by considering practicing family planning surreptitiously without the knowledge of their husbands. Some married women are beginning to see the incompatibility between their high fertility and the share of economic responsibilities they bear for raising their children. Due to the combination of economic pressure and the perceived lack of financial and material support some women receive from their husbands, more women are considering modern family planning as they become more familiar and comfortable with it.

This feeling was detected in urban areas and in rural areas experiencing shortages of arable land due to over population. Urban women, married and single, generally want to have fewer children than their rural sisters. This is because raising urban children is expensive since they attend school and require books, uniforms, and shoes. School fees must be paid and many urban children require money to pay for the transport which carries them to school. Since there is no land to farm, the economic benefit created by having free farm labor doesn't exist anymore. Another problem women identified was the physical lack of living space in urban areas. Space on farms is usually unlimited, but in the city families are cramped into one or two small rooms and must share kitchen and bathroom facilities with their neighbors.

These complaints were voiced by females since they are still the homemakers, cooks, and mothers even though many of them living in urban areas now have cash producing jobs in response to the difficult economic times they face. Many respondents in urban areas said they wanted fewer children due to the "hali ngumu", which in Swahili means difficult situation or circumstances. Though the national fertility rate is seven, the thirty female respondents we collected quantitative information from reported an average desired family size of 4.7. When asked what they thought of having five or more children, 73 percent said it would be a negative development and 27 replied it would be welcomed. The sample was not a random one since many of the women were interviewed at MCH clinics, but it gives some indication of what urban women are thinking and perceiving in 1990. Many educated women feel that just demonstrating ones ability to conceive and become a mother is enough to gain the status and prestige a woman requires to maintain her self esteem and identity. Scattered evidence indicates some women can obtain the requisite amount of status and prestige by having five or fewer children.

Conventional wisdom states that traditionally married women living in rural areas are not interested in family planning. However, scattered evidence again indicates latent demand exists from women living in land shortage areas and also from women who are just tired. In Mbaramo, seven poorly-educated married women who participated in an experimental two-day village problem and identification and planning session unanimously concluded that their biggest problem was the incompatibility between their high fertility and the disproportionate share of the burden they carried for raising the children, working in the fields and managing their homes. They complained that the contribution of their husbands was nil, yet they were expected to continue giving birth and working as hard as usual (Schaefer 1990,). Women heard there was "something" they could use to prevent becoming pregnant so often but were not sure what it was or whether it really existed or not. The women reported that in their village all the old traditional social structures were collapsing and that some husbands were even demanding that sexual relations be resumed within months after giving birth. This goes against Tanzanian traditions since most tribes practiced post-partum abstinence after a women gave birth. This system depend on cultural reinforcement, discipline, and self-restraint. The women mentioned that the old taboo preventing post-partum sex had eroded and females were now giving birth to one child after another with very little time to recover between births. These Tanzanian women said they did not have the time to give their children proper care and feed the family simultaneously.

2.2.3 Differences Between the Worlds of Tanzania Men and Women

Tanzanian men live in a word quite distinct from the one occupied by their female partners. An anthropologist once remarked that many African men regard their wives as strangers and that two separate societies exists, one male and the other female. It was also noted that the roles and activities of these two societies rarely intersected. For example, post partum abstinence certainly weakened the conjugal and emotional bond

between man and wife since they did not have sex for at least two years. Men traditionally looked at their wives as acquisitions who existed to give birth, raise the children, grow food for the household, and implement their instructions. Tanzanian women normally do not even have the rights to their children since they actually belong to the father and his relatives. Men owned the land and women were given the right to work on this land by their husbands. Traditionally the men controlled the money and the women were just supposed to concern themselves with domestic affairs.

In the pre-colonial days the system supported these roles for the following reasons:

- There were few outside influences.
- The missionaries did not wield much influence yet.
- There was enough land to distribute to the sons.
- Most men and women had initiation rites as adolescents and practiced what they were taught.
- The wives and children received more support from the men.

This sociocultural landscape is in transition and many traditional practices, attitudes, and beliefs are colliding with a deteriorating economy, consumerism, and a perceived lack of financial and material support from males. The result is overworked women developing a very untraditional interest in controlling their fertility, males caught between their old cultural values and the new realities of life, and "rotten kids" who refuse to do the dredge work children in the past did without question. The idea of "the rotten kid" is a very new one in Tanzania but these children were referred to by men and women in Dar es Salaam, Lushoto and Pangani.

A slow change has been detected in the attitudes and behavior of some Tanzanian women in the rural and urban areas we visited. Nurses working in the Lushoto MCH Clinic reported a slow but discernible change in women's attitudes towards family planning since 1986. In 1986 women would report secretly for birth control pills and did not even want to be seen waiting outside the clinic. Most even refused to have their names listed on clinic and UMATI membership cards. Women acceptors in 1990 are much more open and fewer insist on operating secretly. For example, on May 16, 1990, at least 50 women were observed waiting for gynecological examinations carried out weekly at Lushoto MCH the clinic. Clinicians reported that five years ago the women would not have been waiting their turns so openly. Many of the women still do not tell their husbands and a significant number of women spurn using their local dispensary for the perceived better service and anonymity offered at the district hospital in Lushoto. The number of acceptors is still no more than five percent, yet more women are becoming interested in and comfortable with family planning.

In Pangani the MCH Clinic reported that the number of acceptors rose from 800 in 1986 to approximately 1,500 in 1990. There are nearly 7,500

women of child bearing age in this small district and the prevalence rate there is twenty percent. This much higher than average rate is due to the efforts of the Family Health Project which has been operating since 1985.

Single men and women are also living in changing times. Fewer men have enough money to marry so many put off acquiring a wife or never officially marry. Some women do not see the advantage of having a husband and consequently choose to become single mothers instead. Some women in Pangani and Tanga complained that men used them for sex, child-making, and labor and contributed very little in return. A 56-year-old woman in Pangani with five grown children mentioned that men today were very irresponsible and neglected their families. She said the whole social fabric was unraveling partially due to the disintegration of the family.

Younger single women are also reacting to the consumer society which is gradually taking root in Tanzania. It has only been since 1985-86 that western consumer goods began reappearing in Tanzania but reaction to this has been marked. Some single women in Pangani told us that they were more interested in buying nice clothes, cosmetics, and consumer goods and were not interested in losing their freedom and being controlled by men. One 27-year-old in particular said she was very happy with her two children and could not manage any more.

Another indication of this shift in attitude is the interest women in five rural villages in Lushoto District expressed in family planning to a representative from the community development department. She was meeting with the women on non family planning topics yet the women introduced the subject themselves. Women are requesting information and assistance because their traditional methods of child spacing have eroded and no longer work well. What were these methods, and how large were families in Tanzania more than two generations ago?

2.3 Traditional Child Spacing Practices and Family Size in Tanzania

Scattered evidence indicates that pre-colonial days families were generally smaller than they have been for the past two generations. In 1859 the British explorer Richard Burton the first European to travel through Tanzania from Zanzibar to Lake Tanganyika that his main informants, the Arabs "agree in asserting that, in spite of favorable physical conditions the women are not prolific, and the impression borne away from a passing traveller is that, except in rare cases of polygamy, families are small" (Koponen 1986, 42). Similar observations are scattered throughout travel literature. The first German doctors who arrived in Tanganyika observed that the number of children and births was generally low and averaged from less than one along the coast to four or five in the upland districts. In the late 1920's and early 1930's British colonial officers assumed that certain tribes were fairly fertile and from this sprung the idea of the extremely fertile African woman. It is conceivable that in pre-colonial times the fertility rate was not seven.

Respondents reported that families of more than two generations ago were smaller than families today and that the space between births was wider also. The longer interval between births was due to the traditional child-spacing practices to ensure the health of the mother and the survival of her child. Pregnancy was avoided by abstaining from sex until the child was anywhere between two and five-years-old, depending on the traditions and practices of the tribe. This practice, known as post-partum abstinence, was a sexual restraint very traditional to most East African cultures. Its success depended, and still depends, on discipline, self-restraint, and social sanctions.

Post-partum abstinence was culturally reinforced with the widespread belief that if semen entered the body of a lactating mother, the nursing child would become retarded or disabled. In Lushoto, women whose children did not develop properly were ridiculed because it was assumed they had engaged in sex prior to weaning their infant. During the period of abstinence the couple generally stayed in separate huts and the wife and infant sometimes lived with the husband's mother. The husband was free to seek other partners during this period. In Pangani, a group of Traditional Birth Attendants (TBA's) said it was impolite for a wife to ask a husband where he had been. "The mother just wanted to be left in peace and did not care where her husband went", they chortled. In Musoma, if a woman was not prepared to resume sexual relations she told her husband to go to the lake; a subtle suggestion to find another partner there. In Lushoto: a polygamist would pass a pipe to his wife's house and if she retained it it meant he was welcome to sleep there. If she was not interested, the pipe would be returned and the man would try his luck with another wife.

Child-spacing was a cultural imperative practiced by all women regardless of their age, party, religion, or educational level. It was strongly felt that not controlling one's fertility exemplified undignified human behavior, so consequently women who allowed themselves to become pregnant while lactating were scorned by their fellow villagers. A Nyakusa man told an anthropologist the following in the 1950's: "Formerly it was a taboo to make a woman pregnant before her previous child was four or five years old. Her husband's sisters made a great case about it. The child must know how to run before a younger brother was born. We said: How can a woman carry two children? Now she becomes pregnant again when the elder is two. Of those who give birth again before that, it is said: (They kill the elder child.)" (Koponen 1986, Pg. 45).

The system worked because it was part and parcel of the pre-colonial cultural and social environment. The men and women all had initiation rites as adolescents and they all more or less respected society's rules as they knew them. In their initiation rites, boys were even taught that there are times when they should certainly not be having sex with their wives. They were also taught to respect her wishes if she did not want sexual relations.

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Traditional birth attendants said a woman who carried three children -- one on her back, another in her womb, and the third crawling on the ground - was quite a hopeless case since she could not control her fertility.

While practicing post-partum abstinence, avoiding a pregnancy was only a result of child-spacing and was not a goal unto itself. People did not really want to reduce the total number of children they had, they just wanted to ensure their survival. The idea of actually limiting the total size of one's family by avoiding becoming pregnant when not breastfeeding is alien to the cultural values practiced by most Tanzanians. In the environment of risk in which people lived, avoidance was directed at nurturing the infant instead of preventing a new pregnancy.

2.4 The Breakdown and Erosion of Traditional Child-Spacing Practices in Tanzania

Post-partum abstinence is still being practiced but in some areas the period of abstinence is shrinking to the point that it is no longer a useful child-spacing method. This is because the length of abstinence is inversely correlated with every factor of modern living. For example, most children attend school, and fewer and fewer attend initiation rites where they are taught the importance of traditional practices like post partum abstinence. These rites also instructed males to respect females when they were unable to have sexual relations. In urban areas the conjugal and emotional bonds between partners may be growing closer and the forced physical closeness makes abstinence more difficult. In the village there was always space available to throw up an additional hut or shelter, but in the city this is usually impossible. The TBAs in Pangani reported that some women don't even follow the traditional forty day period of abstinence sanctioned by Moslems.

Educated women see abstinence as a hardship and many see no reason why they should deny themselves the pleasure of their partner for two or more years. Husbands also sometimes push their wives to resume relations earlier than was traditionally prescribed. In Mbaramo, women reported that men would return home after drinking and demand sex, even a few months after giving birth. The social sanctions which used to protect women against this type of encroachment have been diluted and in many instances no longer work. In addition, AIDS has motivated many men to abandon or curtail their extramarital relationships and this puts more pressure on the female partner to resume relations.

The norms for child-spacing are very well established but the means are breaking down. Women are beginning to acknowledge this but the number of family planning acceptors is still quite low. Is this because women are uninterested in modern family planning or is it because they don't have access to family planning services? If they do have access to services, why are these services generally under-utilized?

CHAPTER 3

ATTITUDES AND PERCEPTIONS OF POTENTIAL PARTICIPANTS TOWARDS FAMILY PLANNING

Perception of the need to practice family planning differs between men, females, and different classes and groups of women. Rural men generally do not see the need for family planning. Some urban men have begun perceiving the need due to the financial and social costs of raising children in the city. Men in rural areas where there are land shortages have begun grumbling about the behavior of their children, but we doubt whether this has been translated into a felt need for their wives to practice family planning. The perception of the need to practice family planning is most acute amongst urban women.

Urban and rural women share a common perception that life in 1990 is far more difficult and complicated than it was twenty years ago. Some urban women have reacted to this by taking control of their fertility and spacing their children. Since rural women still depend on the helping hands provided by their children their awareness is different. However, health professionals working on family health projects with strong family planning components in Pangani, Bagamoyo Lushoto, and Kilimanjaro all reported very strong interest in family planning after carefully explaining and discussing it with separate groups of men and women. The conclusion was that women believe they are overworked and are giving birth too frequently but did not know what to do about it, if anything. Traditionally, especially married women in rural areas, just accepted their lot no matter how difficult it was for them. When asked about their lives they would say "navumilia tu" which means "I'll just persevere" in Swahili. This traditional lack of control or decision making power plus a strong belief in fatalism and "shauri ya Mungu" (it is the will or affair of God) all combined to keep women in their place as second-class citizens. The difference today is that some women are slowly thinking about extending their economic independence to the reproductive area. There is not a major movement by any means, but reports from the field indicate that latent demand for family planning services exists and that this can slowly be turned into active demand through counseling, awareness-creation, education, and by providing quality family planning services.

Rural women generally perceive family planning as an activity women follow who no longer want to have children but wish to continue their sex lives. These women are commonly thought to have at least seven children and are usually in their 30's. Most women met by health educators did not even know that family planning was used to space children, and was not used just to end a woman's successful reproductive career. Women also believed that contraception produced uncomfortable side effects and this further dampened their interest in that subject. Scattered evidence suggests a positive correlation exists between providing good family planning services and the number of new acceptors who will use these services.

For example, in Kilimanjaro Region, an integrated health project which combines parasite control, nutrition, and family planning components reported that attendance at family planning clinics had risen from 9

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percent to 33 percent (Mpangile 1988, 42-44). This project also trained TBAs, who were then readily accepted back into the community and enjoyed instant creditability. An integrated project in Arusha Region reported that the number of acceptors increased dramatically in two targeted villages which received intensive input and adequate contraceptives, education and service was provided cooperatively by health clinics and TBAs. A control village which was given contraceptives but did not participate in the integrated program did not register a gain in acceptors (Maro 1988, 46-50).

In Chogoria, Kenya, a rural area with a population of 200,000, a pilot project achieved an acceptor rate of 35 percent of all couples, and in Zaire a similar project achieved 25 percent. The common denominator linking the success of these interventions is good service directed at the community. The Kilimanjaro program was successful for the following reasons:

- Men could obtain condoms without having to visit the MCH Clinic.
- A constant supply of contraceptives was available.
- Regular home visits were carried out and family planning was discussed privately.
- Health workers understood the taboos and cultural values of the villagers and they subsequently used this knowledge to develop appropriate strategies and plans.

A Tanzanian medical anthropologist working in Bagamoyo District reported that women have difficulty formulating solutions for their many problems. By having village level awareness and educational meetings women were eventually able to articulate their problems of being overworked, tired, and unable to act without their husbands' approval and knowledge. It is still too early to determine whether these meetings convinced more women to practice family planning.

In Pangani, the need for that family planning counseling and services was perceived and expressed by two groups of TBAs in separate rural villages who explained that the traditional system of socially and sexually educating adolescents was crumbling and nothing existed to replace it. They said the consequences of this was an alarming number of teen pregnancies and abortions, plus drug and alcohol abuse. The pregnancies were due to the combination of poverty, ignorance, and natural circumstances.

They said adolescent females want to buy clothes, cosmetics, soap, and other consumer goods. One of the few ways to earn money was through casual sex. Unfortunately, few of them know how to prevent conceiving so consequently many become single teenage mothers. Since traditionally UMATI and the MCH clinics do not serve unmarried teenagers who never before gave birth, and because many never participated in tribal initiation rites, or were taught about sex in school, these women become young adults rather abruptly. Traditionally relatives at least two generations apart -- generally grandparents -- instructed young people concerning sexual and marital issues and behavior. The TBAs, however, reported that contemporary adolescents feel their elders are out of touch with the modern world and

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have little to teach them. TBAs felt that if they were taught how to counsel people and effectively distribute contraceptive materials in their villages, they could help reduce the rate of adolescent pregnancies. Old traditional values are eroding, but new ones like modern contraception have not yet replaced them.

3.1 Urban and Rural Attitudinal Differences Towards Family Planning

Awareness of and demand for family planning services is higher in urban areas than in the countryside. This is due to a number of interlinking factors, some of which have already been mentioned:

- Children made a lower economic contribution to the families than in rural areas where they farm, herd animals, draw water, fetch wood.
- It is superfluous to have a large child labor force in a congested urban area.
- There is limited space for children.
- Children are more expensive; one feels the economic pinch of supporting children more than in rural areas.
- Parents in urban areas want their children to be educated since this is the ticket to success.
- Children can't easily find employment in the cities.
- It is easier for a woman to anonymously visit a family planning clinic than in a rural area.
- Contraceptives can be purchased in private pharmacies.
- Urban women have access to private doctors and do not have to depend on MCH Aides.
- The desire to be modern and to participate in the consumer society is greater.
- Knowledge that future security will accrue from well-educated children, and education is very costly to provide.
- The Urban environment very heterogeneous; it is difficult to enforce social sanctions.
- Very limited living and recreational space in cities.

In Dar es Salaam, a team member reported that neighborhood children congregate outside her home until 11 or 12 each night because their parents would not allow them to play inside their cramped living quarters. A gardener reported that his wife just gave birth to their fourth child and that he wanted no more: "See these torn trousers I wear. I have to wear these so my kids can at least dress properly for school...they are always asking me for things to buy. How can I manage more than four children in the city? Back in the village near Dodoma it's fine, but not here." He mentioned that it is a poor reflection on him if he couldn't afford to dress his children properly for school. A Dar es Salaam taxi driver said he stopped at five children due to the lack of living space and fear that the paucity of employment opportunities coupled with his inability to properly support them, would drive his children to a life of crime. He explained that it would be a great embarrassment and tragedy if his children became thieves and were caught stealing. He even mentioned instances of children stealing from their parents and felt the cause stemmed from people having more children than they could care for. Again,

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this is the concept of the "rotten kid": the expected asset which became a liability. As more and more of these children surface in urban areas, it is plausible that people will begin reducing the number of children they have. Increased awareness of the expenses required and problems arising from raising children may be reflected in the fertility rate for Dar es Salaam, which is 5.7, the lowest in the country. However, fertility rates all along the East African coast from Kenya to Mozambique are generally lower than the rates found in the interiors of these countries.

Another problem in urban areas is what children can do after completing Class Seven. At most only seven percent of the Class Seven leavers go on to secondary school and the remainder make a sudden transition to adulthood and try joining the workforce.

People in rural areas have less awareness about what family planning really is. The subject is clouded by a confusing series of rumors and inaccuracies which sometimes leaves potential acceptors frightened and bewildered. Contraceptive pills are sometimes thought to cause many unwelcome side effects and some people still think they cause sterility. Aside from the lack of awareness, services in rural areas are limited. Supplies of contraceptives at village dispensaries are spotty and women are sometimes reluctant to use local facilities since then other people in the village may discover they are practicing family planning. In Lushoto, people reported that dispensaries only gave out a one-month supply of pills instead of the usual three. This, plus the lack of anonymity, motivated some acceptors to utilize the Lushoto District Hospital MCH clinic. However, travelling in rural areas is more difficult and time-consuming than in the city, so consequently there are many hurdles for a potential acceptor to overcome, especially if she does not want her husband or in-laws to discover she is practicing family planning.

Due to the homogeneous nature of village life, it would be known rather quickly if a woman did not conceive periodically. People's movements are monitored more closely and this also makes it difficult for a married rural woman to move about freely. She also has to watch her children, and this curtails her freedom of movement. In addition, Rural women have to contend with husbands who generally have not felt the economic pinch -- unlike their brethren in the city -- of having many children. Consequently, husbands cannot fathom why a woman would want to practice family planning, especially since it is the husband who traditionally controlled his wife's fertility. Husbands also feel that if their wives practice family planning they will become "loose" and will run around just like they do. Men are very threatened by this development and consequently are initially against their wives practicing family planning. This feeling is more due to ignorance and tradition than to looking pragmatically at the situation. Health educators mentioned that men were more receptive to family planning after they were accorded the respect that they expected to receive as heads of their households.

3.2 Differences in Attitude to Family Planning of People With Different Income Levels

Income is one of the socioeconomic determinants used to predict the number of family planning acceptors. Though conventional wisdom states that there is a direct correlation between rising income and lowered fertility, we did not observe this phenomena in our research. To the contrary, people said they preferred having fewer children because of their limited financial resources but that if they had more money they would certainly produce more children. We cannot argue from a statistical base, but scattered evidence indicates that from a sociocultural perspective large families were always economically and socially rewarding, especially since wealth gravitated upwards from the children to their parents. This is sometimes no longer the case in urban areas, so consequently the fertility rate in Dar es Salaam has dropped. However in our qualitative study, we detected instances -- generally in rural areas -- where men spent what extra money they had on acquiring new wives and in the process increased their progeny.

3.3 Differences in Attitude to Family Planning of People From Different Religious

Whether one is a Christian or Moslem is not a determinant in predicting who will become a family planning acceptor. Conservative Catholics generally are against contraception, but members of other major religious groups in Tanzania are free to act with the support of their religious leaders. A Moslem religious leader in Pangani said having lots of children and then not supporting them was sinful behavior. A representative of the Lutheran Church in Lushoto said their mission hospital in Bumbuli provided contraceptives and that his church supported family planning. The church supports and guides women's and youth groups which could be included in any family planning activities.

In our survey of 30 women, 14 were Moslems and 16 Christians. All respondents and key informants reported that religion was not a contentious issue vis-a-vis family planning.

3.4 Relationship Between Education and Practicing Family Planning

The World Bank states that this is a clear determinant in identifying family planning acceptors in Tanzania. They conclude that the fertility of young women with some primary school education is around 15 percent lower than those with no schooling, and that having just some secondary school education cuts fertility in half. The fertility of women working in the modern sector has also considerably reduced (World Bank 1989, 24). Our research bears out these findings. These reductions occur because educated women marry later than non-educated females, have greater awareness, and assert more control over their lives.

Education exposes people to new ideas, environments, and influences which generally cause them to initiate some action, as opposed to always reacting to events. Educated people have a higher capability for forward planing than do people who were never exposed to life outside of their village.

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3.5 Traditional Methods Used for Family Planning

Traditional methods used for family planning include the following:

- Post-partum abstinence.
- Prolonged breast-feeding.
- Tying a belt with reputed contraceptive properties around a female's waist. Called "mapande" or "pigi" in Tanzania.
- Tying special strings around a woman's finger.
- Drinking concoctions brewed from leaves, herbs and roots.
- Coitus interruptus.
- Polygamy which reinforced post-partum abstinence.

These methods generally depended on discipline, cultural reinforcement, and self-restraint. People made nebulous unspecified references to local medicines used to prevent pregnancy, yet the great number of unwanted pregnancies indicate that these medicines have either fallen into disuse or were just myths.

Practices vary among tribes, ethnic groups, couples and so forth. In some areas post-partum abstinence may still be practiced quite effectively, while in others possibly highly effective plants which have contraceptive properties are used to prevent conception. Each area differs, and it is important to learn the sociocultural terrain before trying to introduce behavioral change.

3.2 Modern Contraceptive Methods Used by Acceptors in Tanzania

The most popular contraceptive is the pill. The IUD (loop), depo-provera injections, condoms, and voluntary surgical sterilization are also used. Foams, spermicides, and suppositories are sometimes available but are not widely used. An undertermined amount of people also rely on the rhythm method.

3.2.1 The Pill

In urban and rural areas the pill is popular for the following reasons:

- Easy to take.
- Fairly easy to hide from husbands, if necessary.
- Few complications if prescribed and taken correctly.
- Does not reduce sexual desire or satisfaction for either partner.

The pill is unpopular due to the rumors which circulate about its side effects. These rumors include the following descriptions of maladies caused by taking contraceptive pills:

- They cause headaches and stomach aches.
- They cause irregular menstrual bleeding.
- They cause cancer.
- They cause future infertility.
- An acceptor will produce disabled children if she conceives again.

- Pills lower the sex drive of women.
- Pills create mental confusion.
- Pills cause high blood pressure.
- Pills cause death.
- Pills change the color of a mother's milk and cause diarrhea in nursing infant.
- Pills cause the vaginal area to swell.

Most of these accusations are rumors based on ignorance and the lack of awareness. These feeling should be overcome through information, communication, and education campaigns. Unfortunately, some side effects are very real and result from the wrong type of pill being issued or changing the type of pill an acceptor has become accustomed to. Due to the erratic supply of pills provided by different donors, dispensaries and clinics sometimes run out of one type of pill but are resupplied with yet another type. The new type may have a different or stronger concentration of hormones which may be inappropriate for the client. Another problem is that service providers sometimes distribute whatever type of pill they have on hand without first examining the client. An overweight woman with varicose veins reported that she was given an inappropriate variety of pill by a service provider. Incidents like this support, rumors and the feeling that taking contraceptive pills is dangerous for one's health. Many urban women prefer being examined by a private doctor prior to obtaining pills from an MCH clinic. This option is usually not available to rural women.

Another problem with the pill is that it is difficult for uneducated women to take it properly. They sometimes miss taking the pill for a day or two, become pregnant, and then blame the pill. It was reported that some women stop taking the pill when their husband is travelling and resume taking it upon his return. In our survey of acceptors, 64% were taking the pill, 12% had an IUD, 4% used condoms and 16% used the rhythm method.

3.2.2 The IUD (Loop)

The loop is generally unpopular for the following reasons:

- Must be professionally inserted and women - especially from rural areas -- are shy.
- Not able to insert in the dispensary due to unhygienic conditions and because service providers lack experience and skills.
- Not good for sexually active females with multiple partners who are susceptible to catching communicable STD's.
- People recall the old plastic loops which caused problems.

Rumours about the loop also abound:

- The loop will become lost inside a woman's body and it will eventually have to be surgically removed.
- The loop will cause cancer.
- The loop will begin growing toward the heart and eventually kill the woman.
- A child can be born with a loop implanted in its head.

Due to its lack of fuss and bother after insertion, the loop could be an excellent family planning method in rural and urban areas. It could be inserted surreptitiously and a woman could retain her loop for a year without having it checked by a practitioner. Since women sometimes forget to take the pill, the loop would be an appropriate alternative. It is estimated that 10-15 percent of all acceptors use loops. Only women who have already given birth are able to use this method of family planning.

3.2.3 The Condom

The condom's popularity has increased considerably due to AIDS. Women like it, but men say "it reduces the heat" and prefer using condoms only for AIDS prevention and not for family planning. The condom is popular for the following reasons:

- Easy to use.
- Easy to obtain.
- Free or relatively inexpensive.
- Do not have to see a doctor to obtain one.
- Perceived to reduce chances of contracting AIDS from an infected partner.
- Used only while sexual act is occurring. No worry about taking a pill each day or becoming anxious about a foreign object (IUD) in one's body.

Rumors about condoms are that they break and may become lost inside a woman, are not sensitive, and even contain the AIDS virus.

In a village bar in Muheza District, a quick survey revealed that four out of ten male customer were actually carrying condoms.

3.2.4 Depo-Provera Injections

Though only available in hospitals, this technique is widely known and could be very popular. Injections are well accepted throughout the country and patients sometimes feel cheated if they leave a medical facility without having been injected. The advantages of Depo-Provera are as follows: one injection lasts for three months, the method is completely undetectable, there are no pills to hide and worry about taking, and one can easily use this technique. Only women who have already given birth can use Depo-Provera.

Muhimbili Hospital in Dar es Salaam reported they give 300-400 injections of Depo-Provera per month.

3.2.5 Voluntary Surgical Sterilization

This method could be very popular amongst women who no longer want to bear children. For men, it is known as a vasectomy, and is extremely unpopular. This is due to cultural beliefs that since a vacectomy will

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render a man infertile, and this will negatively impact on his virility. Since a man's self-image is strongly tied to his virility, vasectomies will probably never be a popular method of family planning in Tanzania.

3.6. The Delivery of Family Planning Services

Awareness campaigns should be implemented only if the service points are properly supplied and equipped and the service providers are appropriately trained. Family planning services are generally located in MCH clinics which offer a number of different services for pregnant women, infants, and children. Respondents offered the following comments about these centers:

- They begin closing at 10 or 11 am instead of remaining open until 2:30pm.
- Clients are forced to listen to a lecture prior to receiving service.
- Most questions must be asked in public since there is usually no privacy.
- Many clinics are short of supplies and equipment.
- Counselling is generally not available.
- Clinicians are sometimes unable to insert IUDs.
- Staff sometimes unable to answer questions about side effects of pills.
- No facilities for men.
- Contraceptives not issued to those who have never given birth before or single women or adolescents.
- Staff members do not sometimes set good examples.

Most urban clinics are already being cleaned and prepared for closure by 11 am, and this makes it difficult for working women and others with responsibilities to attend. Many rural clinics close early also, making it inconvenient for farm women to visit since they carry out most of their chores during the cooler morning hours. Our respondents said staff closed early so they could follow their own personal agendas since they were poorly paid and had little motivation to remain in the clinic longer than necessary. People also said this was why all services were extended to groups instead of individuals: to save time so that the staff could close the clinic by 11 a.m.

It has been documented that the latent demand for family planning services **remains** just that due to the poor service offered by most clinics. **Having** regular supplies of contraceptives would probably reduce the drop-out **rate** considerably. Clinics and projects in Arusha, Kilimanjaro, and Pangani increased the number of new and continuing acceptors by providing services people like. The word spreads through informal communication channels and consequently more people began using family planning.

Good service includes the following components:

- The clinic should be clean.
- The clinicians should be friendly and courteous.

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- There should be wall charts explaining different methods of family planning.
- The service providers should be dressed neatly.
- Clients should be able to confer with service providers privately.
- Counseling should be available.
- Leaflets explaining family planning and dispelling myths should be available.
- Service providers should be able to answer all the clients' questions.
- The clinics should be adequately equipped and supplied with contraceptives.
- The clinic should be linked to the village by TBAs.
- Men should be able to obtain condoms and advice discreetly.
- Counselors should be available for women, men and adolescents.
- Staff members should set good examples by having properly spaced children.
- Service providers should learn the sociocultural landscape of their area.

CHAPTER 4

HOW TO PROVIDE FAMILY PLANNING SERVICES TO POTENTIAL PARTICIPANTS

There is still confusion over what family planning actually is and who should be practicing it. Communication strategies and techniques to deal with this issue and to reach all the target groups is presented in Chapter 5. Though many single mothers practice family planning, some respondents said they felt messages were targeted only at married couples since all the posters and literature depicted a man and woman together with three or four children. A single mother with seven children complained that the needs of single mothers were ignored by UMATI. This image of UMATI and family planning should be corrected since single mothers constitute a large group of potential acceptors.

4.1 Urban Women and Men

The project should initially target activities towards clients who have a felt need to practice family planning and do not require much or any pre-implementation awareness building. These clients will require varying degree of IEC to dispel the rumors and misinformation which still surrounds family planning, even in urban areas. The following groups of females should be targeted in the initial phasing of the project:

- Women for whom pregnancy constitutes a health risk and their male partners.
- Single, divorced, separated, and widowed females.
- Married women with two or more children.
- Educated working women.
- Prostitutes.
- All adolescents.
- All females who express an interest in practicing family planning.

4.2 Urban and Rural Men

The differences between urban and rural women are generally wider than those between urban and rural men. This is because married men everywhere feel threatened if they cannot control their wives fertility and feel they are the ones who decide whether their partners will practice family planning. Though the lack of space in urban areas has probably helped create closer conjugal and emotional bonds between couples, it is the females who **have** acted more pragmatically than the males in making the adjustment to **urban** living. Health care professionals in Dar es Salaam held widely differing opinions on the number of couples who actually discuss family planning options and make a joint decision and those in which the female just acts unilaterally without the knowledge of her partner. Sketchy evidence indicates that many women act without the knowledge of their husbands since they fear their husbands disapprove and would not allow them to practice family planning. However, evidence also indicates that some urban men are slowly realizing, due to social and

economic pressures, that having widely-spaced or fewer children makes sense. Again, society is in transition and old values are constantly colliding with new realities. For example, at the beginning of many conversations, urban women would severely criticize the males, saying they did not care about their wives and contributed very little to family welfare. However, towards the conclusion of these discussions, a number of females reflected that indeed, a few men were actually changing and did not use all of their money for drinking and womanizing.

The truth of the matter is that males are caught between their old cultural values and the new realities of life. They still feel a woman taking contraceptives will run around with other men, yet also realize that it is untenable having eight or ten children in the city. Couples are also constrained by the traditional taboo of not being able to discuss sexual issues freely between themselves. The convergence of all of these issues and problems makes it essential to include males in all urban and rural family planning IEC efforts. A programs success cannot be based on female clients secretly practicing family planning without the knowledge or approval of their husbands.

The biggest problem concerning men is that they have been ignored by family planing professionals. However, experienced family planning professionals say men can easily be approached by first reaching out and showing to them the respect and courtesy they expect to receive as males and heads of their households. Akwillina Mlay, an anthropologist working with the Family Health Project in Bagamoyo, said men were quite approachable when they met amongst themselves, had plenty of time for discussions, and were led by a confident facilitator knowlegeable in reproductive issues and the cultural background and traditions of Tanzanian males. She even said that as an older married woman with children of her own she had frank and explicit discussions with groups of rural men without anyone feeling threatened or embarrassed. (See Chapter 5 on communicating with rural men.) She said it was preferable for males to lead these discussions, but either way the facilitator should be in his or her 30's and be married with children.

Tanzanian men live in a world quite apart from their female partners and consequently rarely even think about issues which concern females. This is evident from the culturally sanctioned behavior of not having anything to do with one's wife for at least two years after giving birth. That plus polygamy and the fact that men traditionally looked at their wives as acquisitions who existed to care for their children and implement their instructions certainly weakened the conjugal and emotional bonds between man and wife. Men have also traditionally feared contraception and the taint of evil or wrongdoing attached to modern fertility control. A man in Pangani said "Those birth control pills are poison, that's just what they are. I don't put poison in my garden to stop plants from growing and I won't put poison in my wife's body to stop children from growing. Anything which stops natural growth is poison."

After understanding the cultural background, beliefs, attitudes, and fears of men, their initial resistance to family planning is quite rational. They will also highly resent a health worker trying to influence their wives' behavior without their consent. Irrate husbands have even assaulted health workers who provided contraceptives without consulting them. During discussions designed to introduce the subject and create awareness, men have responded positively to the following points:

- Child spacing practiced through post partum abstinence was/is part of their culture.
- Due to its decline, health of children and mothers are at risk.
- An unhealthy mother with many children cannot efficiently carry out her farm and household responsibilities.
- Education is the key to success, but how can one educate seven or eight children?
- Giving birth is difficult and a woman requires much time to recover.
- If there is no land to give the children, they may rebel and not provide for parents in their old age.
- Christian and Moslem leaders say caring for God's children is the responsibility of the parents and it is sinful behavior creating but not properly caring for one's children. It is the duty of parents to look after God's gift.
- Is it really prestigious to father children one cannot take care of properly?
- The more children there are, the higher the mortality rate since each one receives only limited attention. With two or three children, a sick one can be taken to the hospital but mothers with more than six children usually can't manage making a special trip just for one sick child.
- Unlike in the old days, children are exposed to how the rest of the world lives through video, magazines, radio, and now all the new cars on the streets and goods in the shops of towns and cities. Are children content to sit on the farm and just follow your instructions? Are they more acquisitive and consumer-oriented than children of twenty years ago?
- Does having many children help or damage your economic position?

Husbands' mothers and relatives can be quite influential and discussions should be initiated with them also. A man's mother comes from a generation which probably supported traditional child-spacing practices and which believes that women should continue giving birth until the natural end of their reproductive careers.

4.2 Rural Women and Men Living in Densely Populated Areas

Conventional wisdom states that people living in rural areas are not motivated to practice family planning due to the strong cultural and economic reasons explained earlier. Though men initially have little or no interest in family planning, some women do not share this view and are becoming interested in family planning for the following reasons:

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- They feel tired and worn out.
- Some are beginning to recognize the incompatibility between their high fertility and the responsibility they bear for raising and educating their children.
- They realize it is the men who push them into having so many children and who control their fertility.
- They realize that traditional taboos are no longer followed by men, and this results in successive births and impaired maternal and child health.

Based upon the complaints they voiced latent demand emanating, from married women living in areas of land shortage seems significant. In Lushoto men in some areas are beginning to convert women's traditional food crop plots into cash crop fields. These fields, which are usually located on marginal hillside land, were and are used by women to grow food for their families and for local markets. Women complained they had less food to feed their families with and concomitantly less cash with which to buy tea, sugar, oil, salt and so forth. Respondents reported that this development did not negatively impact the males since they spent their excess cash in village hotels, accumulating additional wives, and when travelling.

Separate discussions with groups of women and men revealed that they each have very different views of family and village problems. Women were very aware of the implications of giving successive births and of having too many children to care for properly while men showed absolutely no awareness at all. Men said their problems were due to the low productivity of their tired overused fields and the fact that some of their children refused to work on the family farm. Men also tended to look back at the lives their ancestors lived and remarked, "Weren't things nice in those good old days?" Women were more pragmatic and immediately focussed on problems they faced in 1990 (Schaefer 1990, -).

Based on these observations and the results of interventions gleaned from our literature review, it is proper to assume that a latent demand for family planning services exists in rural areas facing congestion and shortages of fertile land. Due to the cultural issues and factors referred to throughout the text, and since all the successful interventions were based on establishing strong relationships with the community, we feel a community-based distribution approach is the most appropriate way to provide family planning services to rural communities. Just providing technical training to service providers who will sit in a dispensary waiting for clients will probably not appreciably increase the number of new acceptors in rural areas. Interaction and dialogue must be initiated with the community in conjunction with providing good family planning services. This is why it is important to establish linkages between local dispensary, village health workers, and the community. Since the dispensary is linked to the District Health Team, a loop needs to be created which also links the District Health Team with the local dispensary, village health workers and the community.

4.3 How to Reach and Influence Potential Participants

4.3.1 Urban Participants

People in urban areas can be influenced by religious leaders, religious groups which focus on serving young people, traditional healers, traditional birth attendants, political leaders, and health care professionals. Urban residents can also be influenced by what they hear on the radio and read in newspapers, magazines, and informational literature explaining family planning. Urban men can be influenced by trained counselors who specialize in discussing family planning issues with men. Men and women can also be reached at their places of work.

Potential clients will have to be reached out to since traditionally people are not very open about discussing personal issues. Women do not like letting people know they are pregnant until there the physical evidence cannot be ignored. Due to reticence in opening up to friends, people tend to take their health problems in urban areas to doctors. Rural women discuss their health problems with trusted relatives and then consult a health professional. Health professionals are suspect these days since the widespread feeling is that they care more about earning money than providing good service. Consequently relatives are consulted about which doctor or hospital provides the best service at the most reasonable cost.

The most effective way of reaching people is by providing good service. People talk amongst themselves, and the word will certainly spread if good family planning services are available at a certain place. If good services are available, indications are that people will respond.

4.3.2 Rural Participants

Family planning should be brought directly to the people through community based distribution of contraceptives by village health workers or traditional birth attendants. The consensus of professionals presently implementing family planning programs in rural Tanzania is that one must go directly to the village to ensure success. Representatives of family health projects operating in Bagamoyo, Pangani, and Lushoto all agreed that the first step in implementing a family planning program was to meet with the villagers to gain their confidence and trust and to open a dialogue. The second step would be to quash all the rumors about contraceptives causing so many unpleasant side effects. Practitioners said that once the ice was broken and people felt comfortable, they were surprisingly candid and asked many questions about human reproduction, biology, sex, and contraception. Most people did not have the vaguest idea what occurred between the time intercourse was completed and the child was born. Facilitators reported being deluged with questions once people realized that no one would laugh at them and that the facilitator was able to competently answer all the questions. Confidence was built as the facilitators explained, with the help of an illustrated chart, how life began and also how contraception actually worked. The facilitator also explained how and why all the rumors and myths circulating about contraceptives were inaccurate.

As awareness grows and confidence is built, the CBD approach can begin being implemented by trained non-medical workers who should be residents of the village. It was reported that the best workers are TBAs. As TBAs are supposed to be trained under the Ministry of Health's Family Planning Plan of Action, integrating them into the project is feasible.

TBAs from three villages in Lushoto and 17 of the 23 villages in Pangani have been trained in preventive health strategies sanitation, ensuring safe deliveries, sterility, and identifying risky pregnancies which may require professional attention. These TBA's have credibility since they are village residents and have been working in the health sector there for most of their adult lives. They will also increase local capacity since they will remain long after the project winds up its activities.

4.3.3 How to Provide Family Planning Services to Adolescents

The transitional nature of Tanzanian society has caught adolescents in the middle. Adolescents want to be modern and join the consumer society while at the same time they are pulled by their traditional culture. Many do not go through the traditional initiation rites where they were taught how to treat their partners, yet nothing has been created to take its place. Rural children used to learn about sex from their grandparents and also from just herding animals but school and separation from home has reduced their exposure to this. TBAs in Pangani reported that, "Children today want too much too soon; they have no respect or fear and just do what they please... They even become pregnant, collect some more money, and get an abortion at the district hospital... One can do almost anything with money these days, and that is what our young people are after." The concept of the "rotten kid" was referred to earlier in the text and this is what the TBAs are referring to.

Adolescents are very vulnerable to unwanted pregnancy since they obviously know how to have sex but do not know how to avoid its consequences. The project must make a special effort to educate and provide counseling serviced for young men and women. There should be a special IEC program designed just for young people between the ages of 12 and 18. This should graphically and clearly explain the implications of having sex vis-a-vis pregnancy, AIDS, and contracting and STD which could easily lead to infertility in the future. Most infertility in Tanzania is caused by STD's which were never adequately treated and which consequently never healed properly. It is essential that these issues be taught in Primary and Secondary School. However, it may be difficult to get the approval of government officials to teach sex education in the schools.

Adults also have to be sensitized to this issue some still feel that providing sexual education for teenagers will cause the girls to become prostitutes and the boys "wahuni" (hoodlums). In our survey of 30 females, 20 (66 percent) said introducing FP to school girls was not a good idea,

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but but 23 (77 percent) said introducing Family Life Education in schools was a good idea. This means that people tend to react very emotionally when asked about providing contraceptives to young females. Family Life Education sounds less threatening since it elicits an image of learning how to cook and care for children. We feel that adults react to family planning for students the same way that males react when they hear about family planning: negatively. However, a media campaign and programs on the radio may help soften public opinion. People have a negative gut reaction based on fear, ignorance, and their cultural background. The idea of sex education in schools is a new and perhaps radical one, but the fact that an alarming number of teenagers become pregnant each year is also rather untraditional. Adults should be convinced that times have radically changed and their children are at risk. AIDS could even be used as the entry point since it is affecting many young people.

Young women today are torn between the pressure to engage in sexual relations with males and the social stigma of becoming pregnant and getting thrown out of school. It is always the fault of the girl no matter what. Even when they manage to obtain birth control pills females are at risk of getting caught since it is against the rules of most schools for them to possess contraceptive pills. Due to being caught between male teachers demanding sex and their inability to legally obtain birth control pills, many young students become pregnant and resort to illegal and dangerous abortions. This is because pregnancy is grounds for expulsion from secondary school, even if one is married. We learned that older female teachers are jealous of the younger students who are more attractive to males than themselves. They express this jealousy by carrying out surprise checks on the students personal effects in hopes of discovering banned materials like contraceptives. This behavior also serves to enhance the spread and proliferation of AIDS since condoms are also contraceptives.

Introducing sex education in schools could accomplish the following:

- reduce unwanted pregnancies
- reduce the spread of AIDS and other STDS
- teach children the benefits of small families

Even if contraceptives will not be available to young students, the project should make every effort to reach students in primary and secondary school. Possibly education will begin producing adults who see the benefits in **having** smaller families and who no longer equate success and virtue with **producing** eight or nine children. Influencing the generations of tomorrow **while** still in school could be the most important method used in reducing fertility over the next 25 years. If education and high quality FP services are available, we feel people will use these services. It may occur very slowly, but people will use FP in reaction to education and social change.

4.4 The Role of Government in Influencing People

It is crucial to gain the support of government and party officials, but this support is no guarantee that action plans will be implemented.



Again, the most effective social institution in villages are the TBAs or other indigenous residents who represent local social and political institutions. In rural areas, village governments must be evaluated on a case-by-case basis. Some are active and enjoy widespread support in the village and others are inactive and have very little support.

The biggest influence government had on family planning was restricting paid maternity leave for government employees to once every three years. Many people gave this edict credit for motivating mothers to space their children. The government also controls the two major daily newspapers, the Swahili Uhuru and the English Daily News. These papers are widely read and help to shape peoples opinions. Positive articles supporting family planning have recently appeared in both papers.

4.5 Opinion Leaders and Influential People

Opinion leaders and decision-makers vary by location, tribe, religion, and ethnic group. One should first learn which social institutions and people are the most influential. Elders are the traditional leaders yet many in the younger generation do not listen to them any more. For instance, it is hard for adolescents to relate to one 86-year-old woman who attributed her longevity to the fact that she hadn't engaged in sexual relations since her husband died in 1944. "If young people would just follow my example they could all lead long productive lives." A few coastal residents mentioned they no longer paid the high fees for initiation rites since they figured their children knew more than the teachers and wouldn't listen to them anyway. This is another example of a traditional institution falling into disuse.

Influential people in 1990 may include youth pastors, selected elderly people, financially successful business personalities, musicians, successful sports personalities, and successful business women. The nation is in transition, and more speeches from politicians will not win over new acceptors. Politicians can enable the program to succeed, but the real work should be left to local social institutions and leaders recognized by the people themselves.

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CHAPTER 5

HOW TO COMMUNICATE WITH POTENTIAL CLIENTS

The project should use the following means to communicate with clients:

- radio
- local dances (ngomas)
- choirs
- songs
- plays
- discussions
- role plays
- seminars
- poems
- posters
- calendars
- books
- pamphlets
- videos/films
- newspaper and magazine articles
- textiles with messages (khangas)

Differences approaches need to be taken in reaching urban and rural clients. Urban residents lead hectic busy lives and cannot be easily gathered for a meeting. Rural residents lead slower, more evenly-paced lives, and generally look forward to welcoming guests, provided they did not arrive to extract something or force unwanted change on the village. Role plays, discussions, seminars and other participatory activities are better suited for rural areas where awareness of family planning is lower than in urban areas. Role plays have proven highly effective in illustrating the implications of having improperly spaced or too many children. Role plays illustrating what happens to a mother overburdened with sick and hungry children, farm work, and a demanding non-supportive husband are highly effective awareness-building activities. Villagers first participate in the role play and observe what happened. Then they compare and contrast the exercise with their own experiences and try to make some generalizations. The participants eventually discuss how they would apply the principles and lessons to their own lives. Some educators said role plays were more effective than movies, since movies just tended to overwhelm people whereas role plays were catalysts in making people really think about and discuss their own situation.

Choirs are very appropriate for spreading messages and information since people in Tanzania have along oral tradition. A choir in Lushoto composed of health workers and project employees entertains villagers with songs about AIDS, family planning, and other pertinent health topics. Local dances have been used in Bagamoyo to spread the message about family planning.

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A family planning khanga currently being marketed by the private sector carries the message "Giving birth brings joy, but what about the health of the mother?"

Radio is an excellent medium particularly for urban and rural men. Men listen to the radio more than women because they control the family's assets and have more leisure time. Messages should be in the form of dramas, song operas, and stories and should not consist of do's and don'ts for the proper father. Listener participation is also an excellent way to reach men. Women's programs should also be created.

Movies and videos are excellent for cities and towns. Even in small towns like Pangani, 20-30 people gather to watch a video -- any video -- so anything which tells a story and keeps people interested would be appropriate.

Print materials should be created for service providers and clients. These should include handbooks of family planning for service providers plus posters, wall charts which illustrate family planning methods available in Tanzania, and leaflets for clients on the pill, IUD, injectables, and voluntary surgical sterilization. Posters should contain messages targeted to married women, single mothers, men, and adolescents. Materials should also be developed for potential clients on what family planning is and what its benefits are. Posters which direct people to family planning services should be strategically placed in public areas throughout the country.

Educated people in urban areas should be targeted with print media. There should also be messages endorsed by well known doctors asserting that all the family planning methods used in Tanzania are sound if applied correctly. Since most Tanzanians speak Swahili there is no need to produce materials in other languages. There is also no need to direct messages to specific ethnic groups.

It would be useful to have family planning messages authorized and endorsed by recognized Christian and Moslem leaders. These messages would reiterate the importance and duty of caring for children, God's gift. These messages should be targeted at men and women.

Communication should also be targetted at people in urban workplaces. Critical masses of potential acceptors are already gathered at these places so initiating discussions there would be much easier than calling meetings somewhere else just to discuss family planning. Employers should be amenable since fewer pregnancies mean higher worker efficiency and productivity and fewer days lost for maternity leave or health reasons. These meetings should be linked to already existing worker health programs which are implemented through the company's clinic. Other subjects should include how to prevent contracting AIDS and STD's. AIDS is an excellent entry point since awareness of it is high and virtually everyone is interested in learning more details about it. At a bar we visited in Pangani, men focused all their questions on AIDS after learning we were interested in discussing family planning. All family planning enquiries were responded to with questions about AIDS transmission and treatment.

Men can be reached and communicated to through bars and football clubs. Male health educators should be taught communication skills to enable them to discuss family planning topic with men informally.

5.1 How will the Program spread from Users to Non-Users?

The program will spread if the customers are satisfied. If good service is not available it makes little sense creating awareness in people. It has been demonstrated that latent demand can be turned into acceptance when enough time and effort is put into creating and delivering quality services to the community. Projects in Kilimanjaro, Arusha, Kenya and Zaire have already been cited. Botswana and Zimbabwe have lowered their fertility rates from 8 and 6.9 in 1965 to 5.7 and 5 in 1988 (World Bank 1989, 70). In Botswana 36 percent of all couples of child bearing age are acceptors and in Zimbabwe 32 percent of them are. These programs succeeded because they offered good service and were committed to their clients.

Additional evidence of positive response to good service comes from the Meru tribe of Kenya where a network of church based facilities has been operating since the 1950's. The quality of these services is acknowledged to be much higher than those available at government-run clinics. These family planning services are just one component of a series of community development interventions and activities which encourage husbands and wives to discuss child care, family life, and work issues with the idea of making joint decisions. This effort has won the confidence of the clients and because the service is good it has spread.

The fact that 25-50 percent of all maternity related deaths in Sub-Saharan Africa is associated with abortion suggests there is a large unmet demand for family planning services. Surveys carried out in Sub-Saharan Africa during the 1980's concluded that 30-40 percent of the women did not practice contraception due to lack of information or access and not because they were not interested (World Bank 1989, 72). The evidence shows that the availability of good family planning services raises their level of use considerably.

5.2 How to Provide Good Service to Clients in Rural Areas

The first step should be to meet with villagers to create awareness. The Bagamoyo project initiates the discussion with males by asking the elders to explain the traditional child spacing practices followed by their generation. The practices and rationale for them are fully discussed and then the conversation shifts to discuss whether these practices are still being used. Since they have eroded and most people aren't practicing extended post-partum abstinence, the question arises of why this practice has gradually fallen into disuse. Then the facilitator initiates a discussion on why these practices were good and how maternal and child health is endangered by the mother giving birth every one or two years. Though men have not consciously thought about these issues they catch on quickly. After realizing that the traditional methods aren't working as effectively as they used to, a discussion is begun on what modern

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contraceptive methods exist which can replace the old ones. During the course of the discussion, men's fears of losing possession and control of their wives, the implications of females controlling their own fertility, the socioeconomic need to have many children and all the fertility topics raised in this paper are discussed. The result is that preconceived notions, fears, and myths about family planning are replaced with the understanding that modern family planning is just a means to achieve the same ends their elders strove for two generations ago: to ensure the survival and health of the infant and her/his mother.

CHAPTER 6

RECOMMENDATIONS

Family Planning is compatible with the sociocultural environment and has a reasonable chance of succeeding. The following recommendations reflect the views of the authors and are included to assist policy-makers and implementors successfully to introduce family planning into the sociocultural landscape of Tanzania.

1. The program should initially be targeted towards urban areas and overpopulated rural pockets which have inadequate land resources.
2. Men should be included in rural and urban programs since they control the fertility of their partners.
3. Adolescents should be provided with sex education in primary and secondary school. More than half the population is below 15 years old and the number of teenage pregnancies is rising dramatically.
4. Adequate supplies of contraceptives should always be available.
5. Myths and wrong information has been extremely injurious to the concept of family planning. People's fears must be allayed before they will begin using modern contraceptives.
6. Rural services should be based on the CBD approach. TBAs should link dispensaries and villages. Just supplying contraceptives to rural clinics without raising awareness will not raise the number of acceptors.
7. Urban services should provide appropriate counseling for men, women, and adolescents.
8. Churches, NGOs, and other appropriate organizations should also have their capacities increased for providing family planning services.
9. Clinics close early because providers are poorly motivated, not because they lack skills. Motivation should be improved, and NGO organizations should be more strongly supported.
10. Clinics should provide privacy and discreet services to increase their accessibility to women whose partners object to them practicing family planning. Privacy should also be increased for men, who find it socially unacceptable to publicly mix with women and children at MCH clinics.
11. Needs assessment of service providers to determine their knowledge base should be carried out. This should be followed up by developing a curriculum for pre service and in-service practitioners.