

PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add
 C = Change
 D = Delete

Amendment Number

94684

1

DOCUMENT CODE

3

COUNTRY/ENTITY TANZANIA

3. PROJECT NUMBER
621-0173

4. BUREAU/OFFICE

AFR

06

5. PROJECT TITLE (maximum 40 characters)

FAMILY PLANNING SERVICES SUPPORT

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY
1 2 3 1 9 9

7. ESTIMATED DATE OF OBLIGATION
(Under "B" below, enter 1, 2, 3, or 4)

A. Initial FY 910 B. Quarter 4

C. Final FY 918

8. COSTS (\$000 OR EQUIVALENT \$1 =)

LIFE OF PROJECT

A. FUNDING SOURCE	FIRST FY 90			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	3040	-		30000		30000
(Grant)	(3040)	()	()	(30000)	()	(30000)
(Loan)	()	()	()	()	()	()
Other U.S.						
1. Host Country	0				3900	3900
2. Other Donor(s)						
TOTALS	3040	-				33900

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) DFA	440	440		14671		2000		30000	
(2)									
(3)									
(4)									
TOTALS									

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

460 410 450 430

11. SECONDARY PURPOSE CODE
480

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code HECS PNSD HEMH NIURE
B. Amount 13500 4800 7800 3900

13. PROJECT PURPOSE (maximum 480 characters)

TO INCREASE CONTRACEPTIVE ACCEPTANCE AND USE

14. SCHEDULED EVALUATIONS

Interim MM YY Final MM YY
0 9 9 4 0 9 9 8

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 Local Other (Specify) 935

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a page PP Amendment)

TO INCREASE LIFE OF PROJECT TO \$30 MILLION AND EXIEND THE PACD TO 12/31/99

17. APPROVED BY

Signature

Mark G. Wentling

Title

Mission Director

Date Signed

MM DD YY
10 14 21 5 9 15

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY

Family Planning Services Support Project (FPSS)
Project Paper Supplement

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Glossary

ACMO	Assistant Chief Medical Officer
AVSC	Access to Voluntary and Safe Contraception
BOS	Bureau of Statistics, Planning Commission
CA	Cooperating Agency
CAFS	Centre for African Family Studies
CBD	Community Based Distribution
CCM	Chama Cha Mapinduzi (Tanzania Political Party)
CEDPA	Center for Development and Population Activities
CPR	Contraceptive Prevalence Rate
CYP	Couple Years of Protection
DANIDA	Danish International Development Agency
DHS	Demographic and Health Surveys
EDP	Essential Drug Program
EOPS	End of Project Status
EPI	Expanded Program on Immunization
ESAMI	Eastern and Southern Africa Management Institute
FP	Family Planning
FPSS	Family Planning Services Support Project
FPU	Family Planning Unit, Ministry of Health
G/PHN/POP	Global Bureau, Pop/Health/Nutrition Centre/Office of Population
GOT	Government of the United Republic of Tanzania
GTZ	German Technical Agency for Cooperation
HED	Health Education Division, Ministry of Health
HPNO	Health, Population and Nutrition Officer
IEC	Information, Education and Communication
INTRAH	Program for International Training in Health
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JHU/PCS	John Hopkins University/Population Communications Services
KAP	Knowledge, attitudes and practices
LT/P	Long Term/Permanent Methods of Contraception
MA	Medical Assistant
MMC	Muhimbili Medical Center
MCHA	Maternal Child Health Aide
MOH	Ministry of Health
MIS	Management Information System
NGO	Non-Governmental Organization
NORAD	Norwegian Development Assistance Agency
NFPP	National Family Planning Program
ODA	Overseas Development Agency (U.K.)

PHC	Primary Health Care
PID	Project Identification Document
PIO	Project Implementation Order
POFLEP	Population and Family Life Education Programme
PP	Project Paper
PPU	Population Planning Unit, Planning Commission
PSC	Personal Services Contract
PHN	Public Health Nurse
RAPID IV	Resources for the Awareness of Population Impacts on Development
RMA	Rural Medical Aide
RMO	Regional Medical Officer
SDP	Service Delivery Point
STD	Sexually Transmitted Disease
TA	Technical Assistance
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TKAPS	Tanzania Knowledge, Attitudes and Practice Survey
TOT	Training of Trainers
TSh	Tanzanian Shilling
UMATI	Family Planning Association of Tanzania
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID/T	United States Agency of International Development/Tanzania
UWT	United Women of Tanzania
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

I. Goal and Purpose

The original goal and purpose of the Family Planning Services Support Project (FPSS) remain unchanged. The **goal** is to improve the health and well being of women and children by enhancing the opportunity to choose freely the number and spacing of children. The **purpose** is to increase contraceptive acceptance and use. These continue to be fully appropriate and operational for FPSS. This Project Paper Supplement (PPS) describes an extension of the project which will consolidate gains made to date, and expand and accelerate the implementation of the activities described in the original project paper (PP).

Relationship to the Mission's Country Program Strategic Plan (CPSP). The project's goal to improve the health status and well being of women and children directly supports the CPSP Sub-goal II of "Improved Health Status" and USAID/T's overall Program Goal of "Real growth and improved human welfare." The project's purpose (to increase contraceptive acceptance and use) is in consonance with CPSP Strategic Objective No. 3 (SO3) of "Increased use of family planning and HIV/AIDS preventive measures." FPSS output #1, "Delivery of quality family planning services," reflects Target 3.1 of SO3, "Increased knowledge of and access to family planning information and services". USAID/T has identified lower fertility as one of the two principal ways (the other being HIV/AIDS prevention) of contributing to improving health status in Tanzania as decreasing the numbers of children a woman bears in her lifetime has a direct effect on maternal health and improves chances of infant survival. The main indicator for measuring both achievement of the family planning side of the SO and the purpose of FPSS is the contraceptive prevalence rate (CPR). The goal of FPSS (which is linked to the CPSP subgoal) is measured by a decrease in maternal and infant mortality rates.

II. Background and Justification for the Supplement

The FPSS Grant Agreement was signed with the Government of Tanzania (GOT) on August 20, 1990 with a project assistance completion date (PACD) of December 31, 1997 and a life of project (LOP) funding level of \$20 million. During the initial FPSS design, USAID indicated that the project would be the first phase of an anticipated 15 - 20 years of USAID population assistance to Tanzania.

In October 1994, a **mid-term review (MTR)** of FPSS was conducted at the request of USAID/T. The purpose was to document progress to date; assess FPSS's contribution toward institutionalization of FP services; review the progress made towards the objectives; and identify gaps in the FPSS program. Although at the time FPSS was designed there were few accurate statistics to guide the development of the project paper (PP), the MTR utilized a number of important studies and assessments undertaken since 1991. These were a Tanzania Demographic and Health Survey (TDHS, 1991/92); a Tanzania Situation Analysis (TSAS, 1992); and a national knowledge, attitudes, and practices survey (TKAPS, 1994). Additionally, the various cooperating agencies (CAs) working under the aegis of FPSS periodically assess their programs, which helped the MTR team further refine the type and quantity of assistance required.

Major findings of the MTR showed that since FPSS began implementation:

- Modern method contraceptive prevalence (CPR) and overall CPR (for all women) rose much more rapidly than originally expected. Modern method CPR rose from 5.9% in 1991/92 to 11.5% in 1994 and all methods from 9.5% to 17.9%.
- New acceptors increased 40-50% between 1991 - 1994; monthly resupply client visits rose 23%.
- By mid-1994, 79% of women and 90% of men knew at least one modern method of contraception.
- Client choice has improved markedly: the proportion of facilities offering injectables, IUDs and foam has more than doubled, and almost 100% of facilities offer oral contraceptives and condoms.

Recommendations and conclusions of the MTR. The MTR team concluded that FPSS had made "exceptional progress in reaching the goal and purpose originally laid out in the Project Paper." The team felt that the momentum that had built up should be sustained and expanded with a few adjustments; however, the basic nature and outputs of the FPSS should not change. The team recommended that the Mission:

1. provide additional financial resources to continue progress toward FPSS objectives through the PACD;
2. pursue child survival funding to support the project;
3. extend the project for 2 - 3 years, to better institutionalize capacity in the public and private sectors;
4. update project indicators to improve the measurement of FPSS outputs.

The Mission agrees with the MTR report that the FPSS Project's goal, purpose and outputs are still fully relevant and are making a positive impact in family planning. This PPS forms the basis for an amendment that will (a) add \$10 million in bilateral funds (thereby increasing the LOP funding to \$30 million); and (b) extend the PACD to December 31, 1999.

Justification for use of child survival funds. The MTR report strongly recommended that child survival funds be programmed in support of FPSS activities since the FPSS directly promotes a number of child survival interventions, such as immunization, breastfeeding, use of oral rehydration therapy, as well as reducing high risk births through family planning/child spacing.

"Child survival" is the term used by USAID/W to indicate the use of simple, cost-effective interventions applied to treat and prevent the diseases that mostly afflict children under the age of five. These interventions are designed to increase global vaccine coverage; promote the use of oral rehydration therapy (ORT); treat acute respiratory infections (ARI); improve nutrition with an emphasis on breastfeeding and proper infant/child feeding; and promote

child spacing to decrease the number of high risk births¹. The Agency recognizes that there is a "synergistic effect" between child survival and family planning, and identifies specific interventions to improve the health and welfare of women of child bearing age, as their health directly affects that of their children. These interventions range from good prenatal care and improved nutrition, to use of family planning services and provision of contraceptives and promotion of breastfeeding to ensure that "high risk births" to women who are less than 18 or more than 35 years of age and/or who have more than four children are minimized.

FPSS supports child survival interventions in the following areas. For example, national surveys under FPSS (TDHS, TKAPS) not only survey child spacing practices, but also provide valuable information on national immunization levels, treatment with oral rehydration therapy, nutritional status of the under-fives, and breastfeeding practices. Such information is used for more effective program development, planning and delivery of child survival interventions other than those related strictly to child spacing. The paramedical training program supported under FPSS prepares MCH personnel to deliver high quality antenatal/postnatal care which can positively increase safe delivery of babies and reduces infant mortality. This training includes child spacing advice and services, provision of STD treatment and malaria prophylaxis for pregnant women, advice on prevention of vitamin A deficiency, promotion of breastfeeding as a child spacing intervention, and growth monitoring and correct weaning practices. Technical and material support (capacity building) to the FPU to better supervise child spacing and ancillary services helps the MOH's Department of Preventive Services/MCH Division to carry out its integrated child survival activities, since MCH Coordinators are responsible for monitoring immunization progress and promotion of nutrition and other types of services at service delivery points. Support for the logistics management system, including vehicles provided under FPSS for distribution of FP commodities, makes a direct contribution to child survival as it ensures the ready availability both of the temporary methods used for child spacing and the vaccines used in the Expanded Program on Immunization (EPI).

The National Family Planning Program (NFPP) operates within the framework of the National Health Policy. That Policy, the National Primary Health Care Strategy, and the National Population Policy (as well as USAID/T's CPSP), all identify child spacing (which is achieved largely through use of modern contraception and appropriate breastfeeding) as an intervention critical to improving child survival in Tanzania. Family planning is one component of a fully integrated maternal and child health (MCH) delivery system. However, it remains the least developed of the MCH service delivery components despite the fact that it is one of the most critical in relation to improving the health status of mothers and children and decreasing high risk births. Child spacing reduces infant mortality due to births that are too closely spaced or too frequent, and breastfeeding enables a mother to delay her next pregnancy until after she has fully weaned her youngest child, thereby increases the chances that the baby will survive. But in contrast to the many donors who provide extensive support for other child survival interventions in Tanzania (e.g., UNICEF, DANIDA), only USAID and UNFPA currently provide significant support for child spacing. They are also the

¹Child Survival: An Eight Report to Congress on the USAID Program. USAID, December, 1993, p. 4.

principal donors which support the family planning component of the National Safe Motherhood Strategy which aims to improve the reproductive health of women and reduce maternal mortality. The health of women and adolescent girls has a direct impact on infant and child mortality, so supporting this component of Tanzania's Safe Motherhood Initiative also makes a strong positive contribution to child survival.

Considering all of the activities which FPSS has supported to date, and those which will continue from 1995-1999, it is estimated that 30% can be attributed to child survival. Therefore, out of the total \$30 million LOP funds, approximately \$10 million in child survival funds will be programmed.

Update on the socio-economic environment. The technical analyses prepared as part of the project paper process for FPSS provided evidence that the institutional, socio-cultural, and economic environment in Tanzania would be supportive of efforts to implement the goal and purpose of the project. Potential existed in both GOT and NGO institutions; social and economic change were contributing to gradual change in pronatalist attitudes; family planning in Tanzania would have high returns of investment and be cost-effective. These analyses remain valid for the Project Paper Supplement, but note should be taken of the deteriorating economic situation in Tanzania and its implications for FPSS implementation.

Tanzania's economy, although recently praised by the World Bank for its outstanding performance, is in trouble. The rate of economic growth has slowed, inflation has soared, and GOT budget deficits are increasing. Real per capita income increased by only 0.7% in 1994 while inflation reached a rate of nearly 40% per annum at the end of the year. The main cause of this inflation is rapid growth of the money supply, due to excessive government borrowing. These problems are compounded by the government's failure to collect taxes, excessive revenue leakage, and corruption. As a consequence Tanzania may experience reductions in donor assistance, and lose ground painfully regained through economic reforms.

Despite this disheartening economic picture, it is not anticipated that there will be serious interference with the implementation of FPSS. The GOT has continued its commitment to its population policy and has institutionalized the Family Planning Unit within the Ministry of Health. The lion's share of FP services in Tanzania are offered through public sector facilities and are provided free of charge, although cost-sharing for curative services has now been instituted (generating more revenue for hospitals and eventually health centers). Despite their need to collect user fees, treatment at NGO or private health care facilities is often preferred, even by people who don't have much money, because the quality of their services is generally better than that provided by public sector facilities. The success of the condom social marketing program funded by USAID/Tanzania is a good indication that people have money that they are willing to spend on reproductive health care. The enormous expansion of private sector pharmacies, even in district and divisional towns, is another indication of the priority that individual Tanzanians give to health care. Tanzania also has a highly literate population which is gradually becoming aware that the economic costs of children exceed the economic costs of family planning.

Given all of the above, the wider political and economic context and the high rate of inflation

will probably not interfere seriously with project implementation. For the average Tanzanian, the economic costs of not having the program, in the long run, will far exceed any direct family planning-related expenses that individuals might incur. And the costs of not supporting FP programs will be far greater for women than for men.

III. Revised Project Description

A. Project Purpose.

The purpose of the FPSS is to increase contraceptive acceptance and use. In the original PP, the overall CPR was expected to rise from 5.9% to about 13% (modern methods) and from 9.5% to 16.5% (all methods) by 1997. The TKAPS indicated that by 1994 CPR had already reached 11.5% for modern methods and 17.9% for all methods. Given this rapid rise in CPR, the indicator for the purpose is modified so that by the end of the project (12/31/99), modern method CPR is expected to reach 18%. See Attachment 1.

B. Output #1: Delivery of Quality Family Planning Services Expanded.

This output addresses the issues of both quality and quantity of FP service delivery. FPSS defines quality from the client's perspective. It measures quality by assessing the choice of contraceptive methods (three or more methods); whether providers are competent (trained); whether information is available; extent of client/provider relations (counseling); and whether clients have easy access to services (both clinic and non-clinic based).

1. Training

Training is a major component of FPSS, and is addressed here (preparation of service providers) and in Output #2 (management of the training function and establishment of a training system). Scarcity of trained service providers was identified as a major obstacle to the delivery of quality FP services during the FPSS design. Subsequent studies (1992 TSAS) revealed that 88% of providers stated that their training in FP was inadequate and only 29% of them had been trained during the previous five years. Virtually no sites were equipped and staffed to serve as training facilities. Lack of training materials, curricula and national standards contributed to a minimal basis for FP training.

Since August 1990, FPSS (with University of North Carolina/INTRAH assistance) has provided short and long-term technical assistance (TA) and training to the FPU in the area of training management. A central training team (CTT) now provides TA to regional training teams (RTTs). A comprehensive National FP Training Strategy (updated in 1994) focusing on long term training needs and goals forms the foundation of the NFPP's inservice training system. Curricula for all six types of training course and a procedure manual, national service standards and guidelines, a trainers guide and a supervisory checklist are now in place. With UNFPA, FPSS has provided resources to prepare regional and district training teams and service providers. 60 equipment kits will have been supplied to training sites by mid-1995. The MTR showed that as a result of these efforts, a wider range of methods is now

offered and client utilization of services has increased.

From 1995 - 1999, FPSS will continue to support the decentralization of all aspects of planning, implementing and evaluating training in up to 10 regions. MCH personnel are responsible for a variety of MCH/child survival services, including promotion of immunization, nutrition counselling, malaria prophylaxis and promotion of breastfeeding. They will receive additional skills in how to identify high risk mothers and counsel/provide services that will enable them to space or limit births.

FPSS will also strengthen linkages between preservice and inservice training; further develop the training MIS (impact of training on quality and access); continue to strengthen the management functions of the FPU (at least two person years of long-term TA and continued short-term TA); prepare and update regional and district training teams, service supervisors and providers, and conduct pilot studies to determine the feasibility of using other cadres of personnel (e.g. Health Attendants) to deliver FP services; strengthen the HIV/AIDS/STD and counseling components of the training curricula; and provide clinic equipment to an additional 35 clinics. It is expected that by the PACD, over 70% of hospitals and 50% of health centers and dispensaries in the country will have at least one trained service provider.

Approximately \$1.2 million will be provided through an OYB transfer to INTRAH (under the PRIME contract) for technical assistance, equipment and other costs. Funds to support local costs will be provided through the FPSS grant to FPU.

2. Information/education/communication (IEC)

With FPSS support (and technical assistance from the Johns Hopkins University/Population Communications Support Project), the Green Star national family planning logo was developed; two and one half million leaflets, wall charts and posters were produced; KAP surveys were done to help plan IEC interventions; audio cassettes for promoting communications between social groups and couples on FP issues were developed and distributed; and a radio soap opera which carries positive messages on FP was developed and aired. To build capacity within the MOH Health Education Division (HED) FPSS supported short term TA and training of HED staff as well as KAP surveys to provide baseline information for planning and evaluating FP IEC.

During the extension period, FPSS will promote and disseminate the Green Star logo, produce additional IEC written materials and media productions to meet expanding informational needs, and provide a long term advisor to the HED to assist in the production and distribution of IEC materials. Among the expanding informational needs are IEC materials targeted to special groups, such as males and adolescents (who are a high risk group when it comes to childbearing). MCH personnel will be provided with information to enable them to counsel and inform clients on ways to space births so that newborns have a greater chance of surviving past their first birthday, and to promote other child survival interventions, such as immunization. To further build HED's capacity to implement the IEC program, FPSS will continue

to support training and short term TA for HED staff. In addition, the long term advisor will assist the HED to develop an IEC coordination mechanism for the NFPP and to work with the private sector.

The above activities will be funded from previously obligated FPSS funds. The long term advisor, technical assistance (TA) and training in IEC for HED staff will be provided through a buy-in to the G/PHN IEC project. FPSS funding for IEC materials production and development of other communications channels, such as radio and television, will be provided through the direct grant to the FPU.

3. Long-term and permanent methods (LT/P)

At the onset of the FPSS in 1991, UMATI (the local family planning association), with the Association for Voluntary Surgical Contraception (AVSC), had established two service delivery sites for voluntary surgical contraception (VSC). FPSS planned to expand these sites from two to 40 sites and perform 20,000 procedures annually by the 1997 PACD. FPSS has trained providers, refurbished facilities, provided expendable supplies, and set up supervision systems. A 1993 assessment of the LT/P program indicated extensive demand for these services. Accordingly, the number of sites to be supported through June 1996 was increased to 70. By mid-1994, LT/P services were already available at 35 sites were fully operational and 10 additional sites were being upgraded. The increase in resources provided through FPSS means that unmet demand for LT/P methods -- especially injectables and VSC -- has been met more rapidly, and female sterilization alone now accounts for 13% of modern method CPR.

Further, rapid extension of LT/P services has important implications for child survival. Most of the women coming for LT/P services are at very high risk of dying in childbirth since they are grand multiparas (i.e. have six or more children) and are well over the age of 35. These women typically have a much greater risk of complications during pregnancy and after delivery. Their babies often have low birth weights or other physical problems and are at greater risk of dying in infancy. Helping these high risk women limit births is a crucial child survival intervention.

As recommended in the MTR report, USAID/T plans to ensure that quality LT/P services expand to 112 sites by December 1999. Approximately 50% of these sites will be non-governmental/private sector. \$2.127 million has been provided for the LT/P program through June 1996. An additional \$800,000 will be required to achieve the revised objectives. To improve project management, a Michigan Fellow will be jointly supported by G/PHN/POP and FPSS, and stationed at UMATI for up to two years.

4. Community based distribution (non-clinic based services)

The MTR report found that the FPSS's community based distribution (CBD) activities had made progress in a number of areas. CBD is implemented mostly through non-governmental organizations (NGOs) which have strong roots in the local community.

Other innovative NGOs, such as the national labor union (OTTU) have begun to prepare for workplace-based activities. Support has been provided to the Seventh-Day Adventist Church (SDA), UMATI and Tanzania Occupational Health Services (TOHS) to train personnel, set up supervision and monitoring systems, and establish pilot programs to see how services can be delivered in a variety of non-clinic settings ranging from rural areas to factories. FPU was also assisted to develop a national curriculum and guidelines for CBD services.

Given the strong support evinced by communities which have received heretofore limited CBD services, the MTR team recommended that these be expanded and the group of NGOs utilized widened. Since NGOs also deliver a broad range of child survival services, FPSS-supported CBD activities will include promotion of immunization and nutrition information, prenatal counseling, STD information and counseling/referral for FP services for high risk and other clients. This will help meet the clients' preference to receive information on more than one health intervention.

Stronger management support will be requested from the major CA working in the CBD area. Other NGOs (e.g., UWT, which is the national women's organization) will be assisted to develop innovative FP activities in underserved urban areas (joint Field Support/FPSS funding). FPSS funds will also be used to support limited public sector CBD efforts, through the FPSS grant to the FPU (mainly to strengthen FPU's management and oversight of CBD activities in general). Currently FPSS has committed funds totalling \$800,000 for CBD activities to supplement centrally-funded TOHS/OTTU and SDA activities. About \$500,000 in bilateral funds will be spent to expand CBD services. One Michigan Fellow will be utilized to oversee and monitor expansion of CBD services as well as other private sector FP activities.

5. Contraceptive logistics and supplies

In 1990, lack of contraceptives in clinics was a major constraint to providing family planning services. Contraceptives supplies were limited, there were major difficulties getting available supplies to health centers and dispensaries and little information on clinic needs. The situation has improved dramatically and a major accomplishment of the FPSS has been to make contraceptives available in service sites. FPSS activities included funding for contraceptive procurement, funding of a logistics officer at the FPU, central warehouse rental, vehicle purchase, improved contraceptive logistics information systems, and the beginning of logistics training for district officers.

As a more efficient way to support both family planning and immunization services, a joint delivery system has been established between the NFPP and the EPI to enable FPSS vehicles to carry needed vaccines to service delivery points. This integrated transport system ensures that the MCH Coordinator is better able to supervise a number of child survival activities (e.g., immunization) as well as organize the transport and delivery of both vaccines and contraceptives.

USAID now prepares national Contraceptive Procurement Tables and works with the FPU to secure adequate donor funding for contraceptive needs. During the extension period, FPSS will continue to provide contraceptives to meet expanding demand, pay the rent of the central warehouse and purchase replacement vehicles for contraceptive delivery. Of critical importance will be continued support for the development of the logistics management information system (LMIS). FPSS will support TA for this as well as further training for regional and district officers. USAID/T will continue to work closely with UNFPA, ODA and most recently GTZ and the Dutch to provide funding for contraceptives.

To date, the FPSS has obligated a total of \$2,829,000 to procure contraceptives (see Section IV and Table 1). The modification adds \$3,146,000 for contraceptives through 1999 based on the annual contraceptive procurement tables (CPTs). Contraceptive logistics support will be funded from the Institutional Support grant to the FPU and from the TA budget. An estimated \$500,000 will be obligated to procure replacement vehicles for contraceptive delivery (see procurement plan) as the become worn out and need to be replaced.

C. Output #2: Tanzanian Institutional Capacity for FP Service Delivery Enhanced.

1. Support to the National Family Planning Programme (NFPP)

The MOH has established an integrated primary health care delivery system. Family planning and related MCH services (prenatal care, promotion of ORT, provision of tetanus toxoid for mothers and immunizations for babies and children) are delivered at the same service delivery points, by the same personnel. The MOH is the source of over 70% of the FP services delivered in Tanzania and is responsible for coordinating other agencies and mobilizing other donors.

The MOH has charged the Family Planning Unit (FPU) with the specific responsibility for overseeing the implementation and supervision of the NFPP. The FPU works in close collaboration with other programs within the Preventive Services Department of the MOH, especially EPI and programs concentrating on control of diarrheal disease (CDD), STD treatment and nutrition/breastfeeding promotion. In order to improve its institutional capacity for service delivery, and in conjunction with other donors, notably UNFPA and ODA (UK), FPSS will provide a variety of support to the FPU for the implementation and coordination of FP services. This continued assistance is expected to enable FPU to oversee the implementation of the NFPP Strategic Plan (1994 - 1999); ensure quality of services by monitoring and revising national policy guidelines and standards for FP service delivery; and coordinate the national training strategy and decentralization of paramedical training. FPU will also continue to actively participate in evaluations and assessments of FPSS and other donor-assisted activities.

In general, FPSS assistance falls into the following categories:

Service delivery coordination: USAID will continue to provide annual grants to FPU to implement and supervise service delivery. This will include: provision of equipment and supplies essential for FP services, establishment of a supervisory system to ensure quality services, and the expansion of CBD in selected communities.

Training: The FPU plays a critical role in the management of a decentralized system in which MCH staff are trained and periodically updated in FP knowledge and techniques. The FPU's management of the training function, especially the establishment of an overall system of inservice training will be supported by FPSS. A core team of central trainers (the CTT) is already in place and will be strengthened. In turn, the CTT will provide TA and resources to regional training teams (RTTs) which will in turn train teams and service providers at district level. Training will increasingly raise the quality of service as well as expand the range of methods available to clients. Increased assistance to link preservice and inservice institutions will be stressed, and the national guidelines and training strategy periodically reviewed and updated.² Long-term TA to help FPU institutionalize its training management capacity will be provided through an OYB transfer to INTRAH.

Logistics: Provision and management of FP supplies is a necessary part of effective service delivery. The FPU will provide essential FP equipment to FP sites to ensure quality service. In addition, FPU will be responsible for the storage and distribution of contraceptive commodities from the central warehouse to the regions. In conjunction with other sections of the MOH, FPU will further develop MIS and service monitoring tools to track the flow and use of commodities and expansion of service availability. Procurement of contraceptives is supported by USAID, UNFPA and ODA (UK).

CBD service expansion: FPSS will provide the bulk of support for CBD services through NGOs. However, in addition to private sector CBD sites, the FPU will promote CBD services in various communities in the country through FPSS funding. That will increase access of a variety of child survival services to communities, as CBD agents will provide information on nutrition, immunization and breastfeeding, in addition to family planning. Further, in some cases traditional birth attendants (TBAs) will be trained to recognize and refer women who are considered at high risk of complications related to pregnancy, practice clean/safe deliveries, and provide information on child spacing so as to further reduce the incidence of high risk births.

Policy support: To strengthen population and family planning policy development, the RAPID IV Project will continue to provide technical assistance through the MOH, the Bureau of Statistics and the Population Planning Unit of the Planning Commission. Various family planning and AIDS education packages will be developed specifically for the purpose of educating and informing cadres of leaders on family planning. The information is expected to elicit mobilize the support of local and national leaders for FP program strategies and services.

²Long-term TA to enable FPU to fully institutionalize the capacity to manage NFPP training will be provided through the OYB transfer to INTRAH.

Management support: FPSS will continue to support a limited number of positions in FPU to enable it to coordinate and manage the NFPP. We expect that by the end of the project, most of these will have been absorbed by the GOT and that additional donor support will be available. Administrative support will include rent (until the end of 1995 when the National FP Center is expected to be completed), utilities, and replacement of some office equipment. A staff training plan will be developed to be supported by FPSS and other donors. Although FPU's need for management support has lessened, during the remainder of the project FPSS will provide short-term management TA and training in response to FPU-identified needs. The estimated budget for this TA is \$100,000. Related TA provided to the FPU by other USAID/W projects will help to expand FP service delivery as well as enhance the technical capacity of FPU staff.

Since the beginning of FPSS, FPU's absorptive capacity has increased to the point where FPU can manage and disburse over twice as much as it could in 1991. A total of \$2.025 million for institutional support has been obligated to date to support management of FPU, service delivery, training, logistics management, storage and distribution of contraceptives and research, monitoring and evaluation. By the PACD a further \$3.0 million will be required, but only a small percentage of this will be for staff/administrative costs.

2. Sustainability action plan

FPSS addresses both technical and financial sustainability issues associated with the NFPP. On the technical level FPSS is working to build technical and managerial capacity with the FPU and NGOs through the provision of training, TA and commodity support to improve efficiency in management. The objective is to elevate host country personnel to the point where they can run programs with minimal expatriate TA in the future. On the financial side FPSS seeks to develop greater use of NGO and private sector clinics for voluntary surgical contraception services, with almost half of the VSC sites to be developed in the NGO or for-profit sectors.

Progress to date. FPSS has already made considerable progress in assisting the NFPP start working towards sustainability. The FPU staff and NFPP operations have been fully integrated into the MOH financially, logistically and managerially. Support for FPU staff funded by FPSS, for example, has declined markedly as a percentage of the Grant as the GOT has absorbed more positions into the regular civil service. FPU has developed a decentralized system of regional and district training teams which in time will be able to train and update service providers on a continuous basis without outside TA. This will be an ongoing, self-sustaining training system institutionalized into the overall MCH structure. FPU capabilities have been strengthened in the management of the NFPP, and short-term TA will continue to ensure that management skills are increased and refined. Pilot activities are underway to determine more effective ways of utilizing the private sector in FP service delivery and the NFPP has included social marketing in its Strategic Plan. There has been a dramatic increase in utilization of family planning services, as well as an overall shift in method mix to longer term methods which are more cost-effective. In addition,

a new National FP Center is being built by the GOT so that FPU can move out of its FPSS-rented premises in 1995.

Grant Agreement Covenants. The Project Grant Agreement includes three covenants related to GOT financial support for the Project. (1) The Government is expected to increase funding to the family planning program annually and report this information yearly to USAID/T. In 1994, USAID/T and the MOH commissioned a study to provide baseline data in this area³. Examining data from Tanzania's 175 hospitals, 276 health centers and 2900 dispensaries, the study concluded that the regional (local) government annual expenditure on service delivery staff, supplies and supervision averages \$303,000 for hospitals, \$270,000 for health centers and over \$400,000 for dispensaries. The total annual expenditure is about \$975,000 annually which far exceeds the \$250,000 estimated as the GOT contribution in the approved waiver of the 25% host country contribution (see Section IX. "Other Issues). In addition, the provision of MCH services, on which FP largely depends, is fully financed by the GOT. Although the MCH costs are not accurately documented, they are estimated to be at least three times more than the FP costs. Added to these costs are Central government expenditures which are estimated to be significant. A regular system of updating the 1994 study and regular annual reporting to USAID/T will be finalized with the FPU.

(2) The ProAg also states that over the LOP the GOT will begin to finance certain aspects of the Project's recurrent costs, including salaries, warehousing, office space and locally available commodities. The GOT has made considerable progress in these areas. With the caveat that the existing national economic crisis and shortage of resources for the health sector as a whole will continue to limit the GOT's ability to assume full responsibility for NFPP implementation, progress has been made. The GOT supports at least 35% of FPU staff, while FPSS and other donors support the rest. Regarding the warehouse, GOT and donors are working on a master plan for the central medical stores. When the new central medical stores management arrangement is finalized, it is anticipated that FP commodities will be moved to the central medical stores. However, effective implementation of the FP will continue to require increasing involvement of FPU vertically to ensure availability of commodities at every service site.

The new National Family Planning Center is under construction and is due to be completed in late 1995. USAID support for the office will end then.

The delivery of FP clinical services requires the availability of medical expendable supplies, all of which are provided by the GOT.

(3) Issues related to cost information for FP services and methods for cost recovery are in reality subsumed under the Government's cost-sharing policy for the health sector. At this point, preventive services (including MCH/FP) are exempted from

³Report on Study to Quantify the Government Contribution to Family Planning, January 3 - April 8, 1994. A. Kessy and J. Neukom, Ministry of Health.

cost-sharing. However, FP social marketing (discussed below) could contribute to cost-recovery to some extent, if it is deemed acceptable and feasible by the GOT.

Challenges. It is unlikely that GOT funding for the health sector and FP will increase substantially any time soon or be able to support the foreign exchange costs of the health program. Also, while managerial and technical sustainability have been considerably enhanced through capacity building under FPSS and training of service providers, this capacity is still far from sufficient to sustain the NFPP. Even with accelerated training of staff, it will be some years before the needed management, technical and training capabilities will be institutionalized. While the private and NGO sectors appear to offer potential for assuming an increasing proportion of the burden in providing FP services, the development of this potential will take considerable time and resources.

Even though FPSS took the long view that achieving sustainability would take decades, the MTR recommended that efforts begin now to identify and initiate the actions which the GOT should take to move in the direction of sustainability. FPSS will support these efforts in a number of ways. USAID/T will work with the FPU to develop an action plan to track progress towards achieving the Covenants discussed above in a more regular and systematic manner. We will look at and select various options that will enable the GOT to move towards a sustainable FP program (both financial and technical). This action plan will also include a review of the various NGO/private sector activities FPSS currently supports, and put them into a more cohesive strategic framework so that they may be better integrated with and supportive of the goals/objectives of the NFPP. The aim will be to bring about greater involvement of the private sector in family planning service delivery, to supplement and complement Government efforts. Training and supervision for VSC has already been delegated to an NGO; other areas may offer similar opportunities.

In addition, a separate assessment for the potential for social marketing will be carried out in FY 96. Given the success of the *Salama* condom marketed through the Tanzania AIDS Project (TAP), the possibilities for marketing an oral contraceptive or other FP commodity will be explored and possibly piloted in selected areas.

D. Output #3: NFPP Monitoring and Evaluation System Established.

The original FPSS output #3 -- "information base established" -- has been modified to be more explicit. Since 1990, activities have shifted from obtaining baseline information to development of the monitoring and evaluation system. In 1991, service statistics were poor or unavailable. A Demographic and Health Survey (TDHS) was conducted in 1991/2 and a Situational Analysis (TSAS) was carried out in 1992 to provide important baseline information. In 1994, a national knowledge, attitudes and practices survey (TKAPS) was done to measure the progress of the project. Operations research (OR) tested FP service delivery within factories and studied ways to improve quality of services.

National surveys. The need for high quality national data will continue. Therefore, FPSS will undertake a second TDHS in 1996 and a TKAPS in 1998. The TDHS will continue to

provide information on fertility changes, infant mortality rates, nutritional statuses, use of ORT, child illness and issues related to STD/HIV control. These will be used for the Mission's APIs as well as for Tanzania's national database of health information. The FPSS will fund the TDHS and TKAPS through a buy-in mechanism to a G/PHN contract.

Management information system (MIS). To date, the FPU has also made progress in establishing an MIS. It collects and uses information on service delivery, distribution and availability of commodities, staffing of health facilities and training. Zonal and regional MCH coordinators have been trained in use of the data and recent reports have been very good. The FPU has already begun MIS training for district MCH coordinators. Further short-term TA may be required to help FPU ensure that its MIS system draws on the MOH's larger data bank (the health information system, or HMIS) produces essential data for decision making. An important focus of the FPSS will be to help the FPU refine the information systems and put the logistics management information system (the LMIS which is jointly funded by FPSS and UNFPA) in place. FPSS will support TA in LMIS to enable FP managers to refine, interpret and use the data.

Operations research (OR) and special studies. A second TSAS will be carried out jointly with the TDHS in 1996. OR studies on male involvement in FP, quality of care, approaches to service delivery and IEC will be carried out during the extension period, beginning in 1995. Special studies will be undertaken to further analyze which market segments have been reached, study causes of contraceptive discontinuation and reasons for NFPP success.

Funds for the above national surveys and MIS activities are included in the Technical Assistance and Institutional Support elements of the budget. Operations research and special studies will be supported by the Global Bureau.

IV. Budget

A. FPSS Grant Agreement

The FPSS Grant Agreement has eight project elements and financing for each will continue, based on a new LOP total of \$30 million. Table 1 shows the revised LOP budget from 8/90 - 12/99. Table 2 shows the obligation schedule from FY 96 - FY 99.

Technical Assistance: The FPSS mid-term evaluation recommended that the NFPP should receive additional technical assistance to ensure a coherent and effective management of service expansion. Specifically, two Michigan Fellows will be funded partly from this project element and partly from G/Bureau funds. One fellow will assist the Senior Population Program Specialist (SPPS) with the development and monitoring of private sector and CBD activities. The second will be stationed at UMATI to assist the program manager for the long term/permanent methods program. The cost will be:

- 4 person/years of expatriate TA \$400,000

Training: The introduction of LT/P methods in public and non-government health facilities will be funded from this project element. TA in training, management and monitoring of

quality of long-term/permanent FP methods will be provided to UMATI through a Mission buy-in to AVSC and costs will be as follows:

● UMATI sub-grant	\$365,000
● Private sector program	\$180,000
● Small grants	\$ 60,000
● IEC materials	\$ 30,000
● Evaluation	\$ 25,000
● AVSC management/Technical Assistance	\$140,000
<u>Sub-total</u>	<u>\$800,000</u>

Equipment/Commodities: NFPP requires replacement of a selected number of field vehicles used for supervision of service delivery and for distribution of contraceptive commodities from the central warehouse to regional and district stores.

● 2 10-ton trucks @ \$50,000	\$100,000
● 10 pick-up trucks @ \$20,000	\$200,000
<u>Sub-total</u>	<u>\$300,000</u>

Institutional Support: The largest percentage of this element will go to support delivery and coordination of FP services. These activities include: training of service providers and supervisors; development of service delivery capability (including CBD expansion); commodity logistics management, distribution and transport; commodity warehouse/storage; program office and management staff support; MIS; program monitoring and evaluation; and office operations and communication.

● Training (providers/supervisors)	\$1,140,000
● Service delivery	\$ 680,000
● Logistics/transport	\$ 600,000
● Warehouse/Office Lease	\$ 150,000
● Management Staff Support	\$ 120,000
● Office Equipment/maintenance	\$ 100,000
● Management Information	\$ 90,000
● Monitoring/Evaluation	\$ 90,000
● Communication/Operations	\$ 30,000
<u>Sub-total</u>	<u>\$3,000,000</u>

Research/Monitoring: The GOT has greatly improved its capacity to monitor NFPP through major national surveys conducted by the Bureau of Statistics. FPSS will fund another TDHS and TKAPS in 1996 and 1998. In between will be periodic project assessments and OR activities. Because some of the costs are met by G funds, the bilateral contribution for this activity is:

● 1996 TDHS	\$600,000
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Project Management: USAID/T will maintain overall project oversight and provide technical management technical assistance to NFPP. Effective management and monitoring

of FPSS has helped the Mission make considerable progress towards its strategic objective within a relatively short time. Funds from this element will support the Senior Population Project Specialist (SPPS) and secretary:

● SPPS X 3 years	\$520,000
● SPPS secretary X 3 years	\$ 80,000
<u>Sub-total</u>	<u>\$600,000</u>

Audit/Evaluation: Program audit and evaluation is an essential element of program management and USAID has set aside funds for annual audits and a final evaluation. Audits of the grant to the FPU will be conducted by the Tanzania Controller and Auditor General or through the non-federal audit process. A final evaluation will be conducted by an external evaluation team.

● Annual audits/final evaluation	\$200,000
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Contingency: Funds in this element are used to provide for exceptional requirements.

● Contingency X 2 years	\$754,000
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B. Direct OYB Transfers

The Mission will continue to transfer funds directly from its OYB in support of selected FPSS activities. These include funds for contraceptive procurement, which will be ordered on an annual basis through G/PHN/POP'S central commodities project; and specialized technical support in the area of paramedical (PAC) training, provided through the PRIME Project (implemented by INTRAH/University of North Carolina).

Contraceptive Procurement: Funds for contraceptive procurement are transferred directly to the USAID/W central commodities procurement project and funds are required to ensure adequate and reliable supply of contraceptives through the amended LOP. Supplies are shipped directly to Ministry of Health.

● Contraceptives X 3 years	\$3,146,000
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Paramedical (PAC) Training: The training activity of the FPU has been essential for the development of quality FP services as training expands the skills necessary to provide satisfactory services. Funds will be OYB-transferred to the PRIME contractor (INTRAH) for technical assistance to improve the in-service and pre-service training capacity of the MOH. Some of the funds will be used to procure FP equipment essential for training sites in regions and selected districts.

● Supplemental training funds	\$200,000
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Table 1
FAMILY PLANNING SERVICES SUPPORT PROJECT REVISED
PROJECT BUDGET 8/1990-12/1999
(in \$000's)

Project Element	Original Grant (as amended)		This Supplement Budget		Total LOP Funding	
	USAID	GOT	USAID	GOT	USAID	GOT
Technical Assistance	4130	0	400	0	4530	0
Training	3706	100	800	150	4506	250
Equipment/Commodities	550	100	300	100	850	200
Institutional Support	2775	1400	3000	1750	5775	3150
Research/Monitoring	1310	50	600	50	1910	100
Project Management	1500	0	600	0	2100	0
Audit/Evaluation	400	0	200	0	600	0
Contingency	300	100	754	100	1054	200
Total Obligation	14671	1750	6654	2150	21325	3900
OYB TRANSFERS						
Contraceptives	2829	0	3146	0	5975	0
PAC Training	2500	0	200	0	2700	0
LOP FUNDING	20000	1750	10000	2150	30000	3900

Table 2

FAMILY PLANNING SERVICES SUPPORT PROJECT
OBLIGATION SCHEDULE
(IN \$000's)

Project Element	Obligations thru FY95	FY96	FY97	FY98	FY99	LOP GRANT
Technical Assistance	4,130	400	0	0	0	4,530
Training	3,706	800	0	0	0	4,506
Equipment/Commodities	550	200	100	0	0	850
Institutional Support	2,775	900	1,150	950	0	5,775
Research/Monitoring	1,310	500	100	0	0	1,910
Project Management	1,500	150	450	0	0	2,100
Audit/Evaluation	400	50	100	50	0	600
Contingency	300	0	754	0	0	1,054
TOTAL OBLIGATION	14,671	3,000	2,654	1,000	0	21,325
OYB TRANSFERS:						
Contraceptives	2,829	928	1,000	1,218	0	5,975
PAC Training	2,500	200	0	0	0	2,700
Total LOP Funding	20,000	4,128	3,654	2,218	0	30,000

In addition to the bilateral funds described above, the Mission will also work with G/PHN to obtain a certain amount of "field support" funds that will be used as needed to supplement FPSS activities. These amounts will be negotiated on an annual basis.

V. Implementation Plan

Implementation arrangements for the extension period will continue as planned in the original PP. A direct grant to the FPU will be developed based on a yearly workplan. Cooperating agencies (Cas) will be utilized as necessary to provide the wide variety of technical assistance required by the project. OYB transfers will be made on an as-needed basis to the central commodities project of G/PHN/POP to ensure that contraceptive commodities are delivered in a timely manner. Monies will also be OYB-transferred to the PRIME Project to ensure an adequate level of TA for the paramedical training program of the NFPP.

Occasionally, the Mission may issue purchase orders or contract for individual studies or personal services, as necessary. It should be emphasized that these would be small in nature (under \$25,000). While little commodity procurement is anticipated under the extension period, EXO assistance may be requested in obtaining bids and purchasing the limited number of vehicles that may be procured during the extension period, or other equipment needs as they arise. In addition, clearance assistance may be given to Cas which may not have separate agreements with the GOT, but who are bringing in commodities required by the FPSS under the terms of the overall Grant Agreement. Section VI describes the procurement covered by the PPS. See also Attachment 2 for an detailed implementation schedule for the extension period.

VI. Procurement Plan

To date, the FPSS has directly procured 6 program support vehicles, one photocopier and 2 minibuses for the FPU. In addition, SEATS procured 2 ten ton trucks, 20 pick-up trucks, 20 TV sets and 20 VCRs. INTRAH procured equipment for 60 clinics. A total of \$260,000 has been obligated to date for direct Mission procurement.

During the extension period, it is estimated that an additional \$300,000 will be obligated to procure additional replacement vehicles for the NFPP. These include two more ten-ton trucks and up to 10 pick-up trucks which are used for joint FP/EPI supervision and commodity delivery to the regions and districts. The exact number of vehicles will be worked out with the FPU (as well as other donors) and USAID will directly procure the vehicles for the NFPP. INTRAH will directly procure FP equipment for approximately 30 - 35 additional clinics. The Mission will assist with clearance of equipment kits, but INTRAH/FPU will be responsible for the actual procurement, inventory, checking and delivery of the goods to the warehouse and to the regions.

VII. Management Plan

The FPSS is managed by a project-funded Senior Population Program Specialist (SPPS) on a personal services contract. He is assisted by a contract secretary. Both work 100% time on FPSS. The FPSS obligations for project management, liaison and support costs through

FY 95 are \$1,500,000. This Project Paper Supplement adds \$600,000 for this component.

In addition, general supervision is provided by one USAID/T direct-hire Health and Population Officer (HPO) who is assisted by a senior Tanzanian Population Program Assistant and an OE-funded secretary. We estimate that at least \$100,000 of OE funds annually are used for project supervision and support based on the proportion of time the HPO, the HPO secretary and the Population Program Assistant devote to the project.

VIII. Evaluation Plan

The Mission has established an effective system for monitoring FPSS progress and progress towards achieving the Mission's Strategic Objective No. 3. Adequate financial and technical resources have been set aside for routine monitoring of the project and periodic evaluation of the status and achievement of FPSS within the NFPP using service statistics and mini-assessments. Individual assessments of project components (e.g., community-based distribution, training) will take place annually.

A second situation analysis study (TSAS) is planned for 1996. A second TDHS is planned for mid-1996 which will combine a detailed service availability module and quality assessment (a third TSAS will therefore not be necessary). A second TKAPS will be conducted in 1998 and will provide much of the information required for the final evaluation also scheduled for 1998.

IX. Other Issues

Gray amendment contracting. At this point, no contracting for project implementation is anticipated over the LOP, as present implementation arrangements will continue. However, FPSS has already utilized Gray amendment firms in a number of ways, and will continue to do so as appropriate. A Gray amendment firm provided consultants for the 1994 mid-term evaluation. We anticipate use of this same firm, or an equivalent, to provide consultants for the final evaluation in 1998. Training equipment is procured through INTRAH from another Gray amendment firm. One procurement had already been completed by the end of 1994; another is anticipated to be completed by mid-1995. A third procurement is contemplated. Gray amendment firms will be utilized as much as possible for any assessments that need to be conducted over the LOP (e.g., social marketing).

Waiver of 25% host country contribution. The Acting Assistant Administrator for Africa (pursuant to the authority granted to him under DOA 403) granted a waiver of the 25% host country contribution to FPSS on July 31, 1990. However, estimates were that the GOT would provide approximately 5% of the original project budget or \$250,000 per year. This contribution has been met, and is discussed in Section III.C.2. "Sustainability action plan."

Notification to the GOT of the Project Paper Supplement. Project Implementation Letter (PIL) No. 18 has been signed concurring in the modifications to the FPSS scope of work and budget.

Attachment 1

Project Paper Supplement
FPSS PROJECT LOGFRAME

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><u>GOAL</u></p> <p>To Improve the health and well being of women and children by enhancing the opportunities to choose freely the numbers and spacing of children.</p> <p><u>PURPOSE</u></p> <p>To increase contraceptive acceptance and use.</p>	<p>Decrease in maternal and infant mortality rates.</p> <p>1. Increase in modern methods contraceptive prevalence rate from 5.9% baseline to 18% of all women.</p> <p>2. Knowledge of FP methods increases from 69% (1992) to 85% among all women 15-49 years of age.</p>	<p>Demographic and health surveys.</p> <p>(1991/92) DHS: CPR, 5.9%; 94 TKAPS: CPR, 11.5%; 96 DHS/TSAS and 98 TKAPS planned.</p>	<p>Increased use of family planning leads to better health for women & children.</p> <p>1. The provision of accessible, safe and acceptable family planning services will lead to increased adoption and effective use of contraception by Tanzanians.</p> <p>2. Improvements in family planning services and information will be initiated strategically in areas of greatest need so that service availability will be reflected in increases in CPR.</p>

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><u>OUTPUTS</u></p> <p>1. Delivery of quality family planning services expanded.</p>	<p>1a. FP clients have a choice of at least 3 methods (injectables, orals and condoms) in 80% of health facilities.</p> <p>1b. 80% of hospitals and health facilities have staff trained in modern methods; 80% of dispensaries have trained staff in injectables, orals and condoms and 40% in IUD.</p> <p>1c. FP clients and providers have access to informational materials in 80% of FP sites.</p> <p>1d. LT/P sites increase from 2 (1990) to 112 in 1999 (at least 50 are private sector/NGO sites).</p> <p>1e. Community based services provided to at least 100,000 clients annually.</p> <p>1f. Reliable national contraceptive distribution system in place.</p>	<p>TSAS, DHS/SAM.</p> <p>TSAS, DHS/SAM.</p> <p>Service/training, information, assessments.</p> <p>Reports</p> <p>Project reports</p> <p>DHS/SAM, TSAS, LMIS reports.</p>	<p>1. A positive policy and program environment for family planning will continue to exist in Tanzania and the GOT will allocate increased resources to family planning over the life of the project.</p> <p>2. Improved strategies for service delivery, training and logistics will be used for more effective programming.</p> <p>3. Better means of supporting, supervising and motivating family planning service providers can be identified and implemented.</p>

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
2. Tanzanian institutional capacity for FP service delivery enhanced.	2a. An ongoing system established for pre and inservice FP training for supervisors and providers. 2b. FPU fully functioning as manager/coordinator of the NFPP. 2c. Sustainability strategy action plan developed, and being implemented.	Evaluations, assessments, and audits.	GOT continues to provide support for FP programs and increases resource allocation as necessary.
3. NFPP Monitoring and evaluation system established.	3a. National Surveys carried out. 3b. Functioning MIS provides information on service delivery, contraceptives, training and staffing. 3c. Project assessments, special studies, and operations research carried out.	DHS, TKAPS, TSAS. Service statistics reported related to training, equipment, contraceptives and clients. Assessment reports, study findings, OR reports.	Bureau of statistics carries out surveys. TA remains available.

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATOR	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><u>INPUTS (in \$000s)</u></p> <p>Tech Assistance - 4530 Training - 4506 Commodities - 850 Institutional support - 5775 Research Monitoring - 1910 AID Management - 2100 Audit/Evaluation - 600 Contingency - 1054 Direct Contracep. Proc. - 5975 Direct OYB Trans PAC training - <u>2700</u> TOTAL LOP 30000</p>	<p>Project Financial Reports.</p>	<p>Inspection, audits, evaluations and Project Implementation reports.</p>	<p>1. Other donors will supplement support for NFPP.</p> <p>2. Key staff for the NFPP can be expeditiously identified, hired and provided with the resources necessary to manage and implement project assisted activities.</p> <p>3. USAID inputs remain available.</p>

DRAFT: 1/24/95

IMPLEMENTATION SCHEDULE

ACTIVITY	TIMING					RESPONSIBLE
	1995	1996	1997	1998	1999	
1. EXPANDED SERVICE DELIVERY:						
<u>Long Term and Permanent Methods</u>						
Establish national management and medical quality assurance program in 6 area offices.	X					MOH/UMATI/AVSC
Expand LT/P service delivery sites from 48 to 112.	X	X	X	X		AVSC/UMATI/MOH
Integrate LT/P methods into national FP training and preservice medical school training.	X	X	X	X		AVSC/INTRAH/FPU
Expand coverage of SDA service delivery projects.	X	X				PATHFINDER/SDA
SDA projects targeting special client groups.	X	X	X			PATHFINDER/ UMATI/SDA
Strengthen management capacity of SDA, OTTU, TOHS.	X	X				PATHFINDER
<u>CBD:</u>						
Develop standardized CBD protocols and supervision guidelines.	X					PATHFINDER
Expand CBD services in urban areas.	X	X	X			CEDPA/OTTU/TOHS/ PATHFINDER
<u>Contraceptive Logistics & Supplies:</u>						
Contraceptives ordered	X	X	X	X	X	USAID/UNFPA/MOH
Provision of FP service equipment to 30 training sites.	X	X				INTRAH/MOH

	1995	1996	1997	1998	1999	
2. <u>INSTITUTIONAL CAPACITY ENHANCED</u>						
<u>Training:</u>						
Establish/strengthen training systems in 10 regions.	X	X				INTRAH/FPU/ REGIONAL ADMIN.
Expand services, supervisory, and training capacity in reproductive health, focusing on special client groups.	X					FPU/UMATI/ INTRAH
<u>Support to the FPU:</u>						
Develop annual workplan for FPU.	X	X	X	X	X	USAID/FPU
Annual support grant to FPU.	X	X	X	X	X	USAID
TA to FPU in training.	X	X	X	X	X	USAID/INTRAH/FPU
<u>IEC:</u>						
Materials development/production.	X	X	X	X		PCS/HED
Radio Broadcasts.	X	X	X	X	X	PCS/HED
<u>Policy Support:</u>						
Policy dissemination workshop in the regions.	X	X				RAPID/MOH/ PLANNING COM.
<u>FP Advocacy Activities</u>	X	X	X	X	X	
<u>Sustainability action plan developed.</u>	X	X	X	X	X	USAID/MOH

3. <u>ESTABLISH PROGRAM MANAGEMENT MONITORING AND EVALUATION SYSTEM</u>	1995	1996	1997	1998	1999	
<u>MIS:</u>						
LMIS Developed.	X	X				FPLM/MOH
Operation Research Studies.	X	X	X	X		POP Council/ MOH/PATHIFINDER
<u>National Information Gathering</u>						
National Situation Analysis.	X					POP Council/FPU
Zanzibar Situation Analysis.	X					POP Council/FPU
DHS			X			MACRO/BOS
TKAP				X		
4. <u>PROJECT EVALUATION</u>				X		USAID/T

ACTION MEMORANDUM FOR THE MISSION DIRECTOR

From: F. M. Mburu, Senior Family Planning Program Specialist
Thru: Dana Vogel, Population Officer
Subject: Tanzania Family Planning Services Support Project, Project Number 621-0173
Project Paper Supplement
Date: February 17, 1995

I. Problem

You are requested to approve and authorize the Tanzania Family Planning Services Support (FPSS, 621-0173) Project Paper Supplement (PPS). The PPS updates the project description and indicators (as described in Attachment 3, Project Paper Supplement); increases the life of project (LOP) funding to \$30,000,000; and extends the project activity completion date (PACD) to 12/31/99.

II. Background and Summary Project Description

The original goal and purpose of the Family Planning Services Support Project (FPSS) remain unchanged. The purpose is to increase contraceptive acceptance and use. The goal is to improve the health and well being of women and children by enhancing the opportunity to choose freely the number and spacing of children. These continue to be fully appropriate and operational for FPSS. The Project Paper Supplement (PPS) describes an extension of the project which will consolidate gains made to date, and expand and accelerate the implementation of the activities described in the original project paper (PP).

III. Justification for the Supplement

The FPSS Grant Agreement was signed with the Government of Tanzania (GOT) on August 20, 1990, with a project assistance completion date (PACD) of December 31, 1997, and a life of project (LOP) funding level of \$20 million. The FPSS PP recommended that the FPSS should be the first phase of an anticipated 15 - 20 years of USAID population assistance to Tanzania.

In October 1994, a mid-term review (MTR) of FPSS was conducted at the request of USAID/T. Major findings of the MTR showed considerable progress since FPSS began implementation. Modern method contraceptive prevalence (CPR) and overall CPR (for all women) rose much more rapidly than originally expected. Modern method CPR rose from 5.9% in 1991/92 to 11.5% in 1994 and all methods from 9.5% to 17.9%. New acceptors increased 40-50% between 1991 and 1994. By mid-1994, 79% of women and 90% of men knew at least one modern method of contraception and client choice improved markedly.

The MTR team concluded that FPSS had made "exceptional progress in reaching the goal and purpose originally laid out in the Project Paper." The team felt that the momentum should be sustained and expanded with a few adjustments; however, the purpose, goal and outputs of the FPSS should not change. The team recommended that the Mission provide additional financial resources to continue progress toward FPSS objectives through the PACD; pursue child survival funding to support the project; extend the project for 2 - 3 years, to better institutionalize capacity in the public and private sectors; and update project indicators to improve the measurement of FPSS outputs.

The Mission agrees with the MTR report that the FPSS Project's goal, purpose and outputs are still fully relevant and are making a positive impact in family planning. This amendment will (a) add \$10 million in bilateral funds (thereby increasing the LOP funding to \$30 million); and (b) extend the PACD to December 31, 1999.

Justification for use of child survival funds. The MTR report strongly recommended that USAID/W child survival funds be programmed in support of FPSS activities since many FPSS activities directly promote a number of child survival interventions, such as immunization, breastfeeding, use of oral rehydration therapy, as well as reducing high risk births through family planning/child spacing. In addition to its extensive support to the National Family Planning Programme which focuses on increasing access to family planning services for those who choose to space or limit births, FPSS supports other child survival activities. For example, national surveys under FPSS such as the Demographic and Health Survey and knowledge, attitudes and practices surveys provide valuable information on national immunization levels, treatment with oral rehydration therapy, nutritional status of under-fives, and breastfeeding practices. The paramedical training program prepares MCH personnel to deliver high quality antenatal/postnatal care which positively affects the safe delivery of babies and reduce infant mortality. This training includes child spacing advice and services, provision of STD treatment and malaria prophylaxis for pregnant women, advice on prevention of vitamin A deficiency, promotion of breastfeeding as a child spacing intervention, and growth monitoring and correct weaning practices. Other child survival interventions include joint transport arrangements with the Expanded Programme on Immunization and technical assistance to improve the management and supervision of MCH/child survival programs.

It is estimated that 30% of FPSS activities can be attributed to child survival. Therefore, out of the total \$30 million LOP funds, approximately \$10 million in child survival funds will be programmed.

IV. Revised Project Description

A. **Project Purpose**

The **purpose** of the FPSS is to increase contraceptive acceptance and use. In the original PP, the overall CPR was expected to rise from 5.9% to about 13% (modern methods) and from 9.5% to 16.5% (all methods) by 1997. The 1994 Tanzania Knowledge, Attitudes and Practice

Survey (TKAPS) indicated that CPR had already reached 11.5% for modern methods and 17.9% for all methods. Given this rapid rise in CPR, the indicator for the purpose is modified so that by the end of the project (12/31/99), modern method CPR is expected to reach 18%. See Attachment 1.

B. Output #1: Delivery of Quality Family Planning Services Expanded.

This output addresses the issues of both quality and quantity of FP service delivery. FPSS defines quality from the client's perspective. It measures quality by assessing the choice of contraceptive methods (three or more methods); whether providers are competent (trained); whether information is available; extent of client/provider relations (counseling); and whether clients have easy access to services (both clinic and non-clinic based).

1. Training

Training is a major component of FPSS, and is addressed here (preparation of service providers) and in Output #2 (management of the training function and establishment of a training system). Scarcity of trained service providers was identified as a major obstacle to the delivery of quality FP services during the original FPSS design. Approximately \$1.2 million will be provided through an OYB transfer to INTRAH (under the PRIME contract) for technical assistance, equipment and other costs. Funds to support local costs will be provided through the FPSS grant to FPU.

2. Information/education/communications (IEC)

With FPSS support (and technical assistance from the Johns Hopkins University/Population Communications Support Project), the Green Star national family planning logo was developed; two and one half million leaflets, wall charts and posters were produced; Knowledge, Attitudes and Practice (KAP) surveys were done to help plan IEC interventions; audio cassettes for promoting communications between social groups and couples on FP issues were developed and distributed; and a radio soap opera which carries positive messages on FP was developed and aired. To build capacity in the MOH Health Education Division (HED) FPSS supported short term TA and training of HED staff as well as KAP surveys to provide baseline information for planning and evaluating FP IEC. A long term advisor, technical assistance (TA) and training in IEC for HED staff will be provided through a buy-in to the G/PHN IEC project. FPSS funding for IEC materials production and development of other communications channels, such as radio and television, will be provided through the direct grant to the FPU.

3. Long-term and permanent methods (LT/P)

At the onset of the FPSS in 1991, UMATI (the local family planning association), with the Association for Voluntary Surgical Contraception (AVSC), had established two service delivery sites for voluntary surgical contraception (VSC). FPSS planned to expand these sites from two to 40 and perform 20,000 voluntary procedures annually by the PACD. FPSS has trained

providers, refurbished facilities, provided expendable supplies, and set up supervision systems. By mid-1994, VSC had nearly achieved the PACD targets: 35 sites were fully operational and 10 additional sites were being upgraded, with 70 sites planned by 1995. As recommended in the MTR report, USAID/T plans to ensure that quality LT/P services expand to 112 sites by December 1999. Approximately 50% of these sites will be non-governmental/private sector.

4. Community based distribution (non-clinic based services)

The MTR report found that the FPSS's community based distribution (CBD) activities had made progress in a number of areas. CBD is implemented mostly through non-governmental organizations (NGOs) which have strong roots in the local community. Other innovative NGOs, such as the national labor union (OTTU) have begun to prepare for workplace-based activities. Support has been provided to the Seventh-Day Adventist Church (SDA), UMATI and Tanzania Occupational Health Services (TOHS) to train personnel, set up supervision and monitoring systems, and establish pilot programs to see how services can be delivered in a variety of non-clinic settings, ranging from rural areas to factories. FPU was also assisted to develop a national curriculum and guidelines for CBD services. Given the strong support evinced by communities which have received heretofore limited CBD services, the MTR team recommended that these be expanded and the group of utilized NGOs widened.

5. Contraceptive logistics and supplies

In 1990, lack of contraceptives in clinics was a major constraint to providing family planning services. Contraceptive supplies were limited, there were major difficulties transporting available supplies to health centers and dispensaries and little information on clinic needs. The situation has improved dramatically and a major accomplishment of the FPSS has been to make contraceptives available in service sites. FPSS activities included funding for contraceptive procurement, funding of a logistics officer at the FPU, central warehouse rental, vehicle purchase, improved contraceptive logistics information systems, and the beginning of logistics training for district officers. USAID now prepares national Contraceptive Procurement Tables and works with the FPU to secure adequate donor funding for contraceptive needs.

During the extension period, FPSS will continue to provide contraceptives to meet expanding demand, pay the rent of the central warehouse and purchase replacement vehicles, as necessary, for contraceptive delivery. Of critical importance will be continued support for the development of the logistics management information system (LMIS).

C. Output #2: Tanzanian Institutional Capacity for FP Service Delivery Enhanced.

1. Support to the National Family Planning Programme (NFPP)

The MOH is the source of over 70% of the FP services delivered in Tanzania and is responsible for coordinating other agencies and mobilizing other donors. This is the basis for USAID support to the MOH Family Planning Unit (FPU) which oversees the implementation and

supervision of the NFPP. In order to improve its institutional capacity for service delivery, and in conjunction with other donors, notably UNFPA and ODA (UK), FPSS will provide a variety of support to the FPU for the implementation and coordination of FP services. This continued assistance is expected to enable FPU to oversee the implementation of the NFPP Strategic Plan (1994 - 1999); ensure quality of services by monitoring and revising national policy guidelines and standards for FP service delivery; and coordinate the national training strategy and decentralization of paramedical training. FPU will also continue to actively participate in evaluations and assessments of FPSS and other donor-assisted activities.

2. Sustainability action plan

FPSS addresses both technical and financial sustainability issues associated with the NFPP. On the technical level, FPSS is working to build technical and managerial capacity of the FPU and NGOs through the provision of training, TA and commodity support to improve efficiency in management. The objective is to elevate host country personnel to the point where they can run programs with minimal expatriate TA in the future. On the financial side, FPSS seeks to develop greater use of NGO and private sector clinics for voluntary surgical contraception services, with almost half of the VSC sites to be developed in the NGO or for-profit sectors.

D. Output #3: NFPP Monitoring and Evaluation System Established.

The original FPSS output #3 -- "information base established" -- has been modified to be more explicit. Since 1990, activities have shifted from obtaining baseline information to development of the monitoring and evaluation system. In 1991, service statistics were poor or unavailable. A TDHS was conducted in 1991/2 and a Situational Analysis (TSAS) was carried out in 1992 to provide important baseline information. In 1994, a TKAPS was done to measure the progress of the project. Operations research (OR) tested FP service delivery within factories and studied ways to improve quality of services.

V. Budget

The FPSS Grant Agreement has eight project elements and financing for each will continue, based on a new LOP total of \$30 million. Table 1, which is reproduced here, shows the revised LOP budget from 8/90 - 12/99. The items include four additional person years of technical assistance; training for different cadres of health staff; equipment and vehicles; institutional support for FPU to oversee and manage the program; research, monitoring, including funds for a 1996 TDHS; continuation of the SPPS to manage the project until the PACD; funds for annual audits, and an end of project evaluation. Funds will be OYB transferred for contraceptive commodities and assistance for training.

Table 1
FAMILY PLANNING SERVICES SUPPORT PROJECT REVISED
PROJECT BUDGET 8/1990-12/1999
(in \$000's)

Project Element	Original Grant (as amended)		This Supplement Budget		Total LOP Funding	
	USAID	GOT	USAID	GOT	USAID	GOT
Technical Assistance	4130	0	400	0	4530	0
Training	3706	100	800	150	4506	250
Equipment/Commodities	550	100	300	100	850	200
Institutional Support	2775	1400	3000	1750	5775	3150
Research/Monitoring	1310	50	600	50	1910	100
AID Management	1500	0	600	0	2100	0
Audit/Evaluation	400	0	200	0	600	0
Contingency	300	100	754	100	1054	200
Total Obligation	14671	1750	6654	2150	21325	3900
OYB TRANSFERS						
Contraceptives	2829	0	3146	0	5975	0
PAC Training	2500	0	200	0	2700	0
LOP FUNDING	20000	1750	10000	2150	30000	3900

VI. Implementation Plan

Implementation arrangements for the extension period will continue as planned in the original PP. A direct grant to the FPU will be developed based on a yearly workplan. Cooperating agencies (CAs) will be utilized as necessary to provide the wide variety of technical assistance required by the project. OYB transfers will be made on an as-needed basis to the central commodities project of G/PHN/POP to ensure that contraceptive commodities are delivered in a timely manner.

VII. Mission Review

A Mission review of the PPS was held on February 7, 1995 and recommended approval of the amendment. It was agreed that the Conditions Precedent to the Project have been met, and the covenants remain valid. A copy of the memorandum which discusses other issues (addressed in the revised PPS) is appended as Attachment 6.

VIII. Congressional Notification

A Congressional Notification for the amendment adding \$10,000,000 and extending the PACD to 12/31/99 expired on April 22, 1995 without objection.

IX. Authority

Pursuant to Sections 4(A)(2) and (3) of Delegation of Authority (DOA) 551, as amended, you have the authority to amend a Project Authorization executed by a USAID official unless the amendment: increases the Life of Project (LOP) funding to an amount greater than \$30 million; presents significant policy issues or deviates from the original Project Purpose; requires the issuance of waivers which may only be approved by the Assistant Administrator or the Administrator; or results in a new LOP of more than ten years. The FPSS Amendment does not change the original Project Purpose or goal. The Amendment presents no significant policy issues nor does it require the issuance of waivers. This amendment brings the total LOP funding to \$30 million and the LOP to nine years and four months.

X. Recommendation

That you sign: (1) the attached Project Data Sheet; (2) Project Authorization Amendment for the Tanzania Family Planning Services Support Project (number 621-0173); Project Paper Supplement; and (4) Project Grant Agreement Amendment thereby approving a life of project amount of \$30,000,000 and a new PACD of 12/31/99.

Approved: Mark Wentling

Disapproved: _____

Date: APRIL 25, 1995

Mark G. Wentling
Mission Director

Attachments:

1. FPSS/PPS Project Data Sheet
2. FPSS/PPS Project Authorization
3. FPSS/PPS
4. FPSS PIL 18 (signifying concurrence in the Project Paper amendment)
5. FPSS Project Paper Annex G (waiver of host country contribution)
6. Memorandum of Meeting, dated 2/9/95

Drafter: FM Mburu, SPPS: 16 February 1995 *fm buru*

Clearance for the Action Memorandum of the Family Planning Services Support Project number 621-0173 Project Paper Supplement.

DVogel	HPO	<u><i>RJowl</i></u>	date <u><i>2/17/95</i></u>
PMorris	PO	in Draft	date: 02/07/95
PFleuret	PDO	<u><i>PF</i></u>	date <u><i>2/17/95</i></u>
DLarson	CONT	<u><i>DL</i></u>	date <u><i>2/21/95</i></u>
WAnderson	DDIR	<u><i>Hwa</i></u>	date <u><i>2/24/95</i></u>
SPage	RLA	in draft	date: 02/07/95; 02/28/95
ATBlecky	EXO	<u><i>AB</i></u>	date: <u><i>2/22/95</i></u>

Tanzania Family Planning Services Support PP Supplement

Project Authorization Amendment Number One

**Tanzania
Family Planning Services Support Project
Project Number 621-0173**

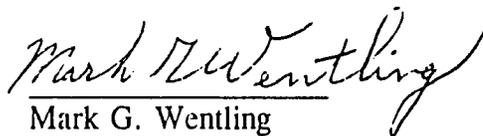
1. Pursuant to Section 496 (Development Fund for Africa) of the Foreign Assistance Act of 1961, as amended, I hereby authorize the First Amendment to the Authorization for the Family Services Support Project for Tanzania, involving planned obligations not to exceed Thirty Million United States Dollars (\$ 30,000,000) in grant funds, subject to the availability of funds in accordance with the USAID operating year budget (OYB)/allotment process, to help in financing foreign exchange and local currency costs for the Project. The planned life of project (LOP) is until December 31, 1999.

2. The original goal and purpose of the Family Planning Services Support Project (FPSS) remain unchanged. The goal is to improve the health and well being of women and children by enhancing the opportunity to choose freely the number and spacing of children. The purpose is to increase contraceptive acceptance and use. A mid-term evaluation by outside experts (October 1994) recommended that FPSS activities should be sustained and expanded, additional monies provided (including child survival funds) and the life of project extended. The Project Paper Supplement (PPS) describes an extension of the project which will consolidate gains made to date, and expand and accelerate the implementation of the activities described in the original project paper (PP). In addition, child survival activities which contribute to the overall Project goal will be enhanced.

The Congressional Notification for this amendment expired without objection on April 22, 1995.

Except as amended herein, all other terms and conditions of the original Project Authorization, as amended, remain in full force and effect.

Signed:



Mark G. Wentling
Mission Director
USAID/Tanzania



USAID MISSION TO TANZANIA

U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

February 13, 1995

The Principal Secretary
Ministry of Finance
P.O. Box 9111
Dar es Salaam

Subject: USAID/T Project No. 621-0173
Family Planning Services Support (FPSS)
Project Implementation Letter No.18

Refs: (1) Draft Report of FPSS Mid-Term Review:
Sept. 19 - October - 6, 1994

(2) FPSS Project Paper Supplement,
February 1995 (Draft)

The purpose of this Project Implementation Letter (PIL) is to inform you of the results of a recent mid-term review (MTR) of the FPSS; propose changes to the life of the project (LOP) budget; and propose extension of the project activity completion date (PACD).

In October, 1994 the MTR of the FPSS Project concluded that it had made "exceptional progress in reaching the goal and purpose originally laid out in the Project Paper." However, the MTR team felt that the momentum that had been built up should be sustained and expanded with a few adjustments, but that the basic nature and outputs of the FPSS should not change. Further, the MTR team recommended that USAID/T should instead consider extending the current project for 2-3 years in order "...to better institutionalize capacity in the public and private sectors..." and consolidate progress to date.

Among the major findings of the MTR are that: since the FPSS was signed, modern contraceptive prevalence (CPR) among all women has increased rapidly from 5.9% in 1991/92 to 11.5% in 1994; new acceptors increased 40-50% between 1991 - 1994; by mid-1994, 79% of women and 90% of men knew at least one modern method of contraception; the proportion of facilities offering injectables, IUDs and foam has more than doubled and almost 100% of facilities offer oral contraceptives and condoms (improvement in the quality of care as wider choice is available); a wide variety of training has been supported, but requirements for additional training present a great challenge.

The Mission agrees (based on the MTR team's findings) that the goal, purpose and outputs are still fully relevant and are making a positive contribution to Tanzania's National Family Planning Programme (NFPP). Therefore, pending the availability of funds, we plan to make

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additional resources available to increase the life of project funding from \$20 million to \$30 million (an increase of \$10 million) and extend the Project Assistance Completion Date to December 31, 1999.

The new LOP funding level and PACD will enable the NFPP to accelerate the development of comprehensive and universally available FP services.

The Covenants to the FPSS Grant Agreement (attached) remain valid and the Government of Tanzania is still expected to fulfill them during the life of project. In particular, section 5:2 of the Grant agreement (a and b) stipulate that the Government will increase annually the funding for family planning over the LOP and report yearly to USAID/T on these amounts; and will finance a variety of salary, warehouse, office space and commodity costs over the LOP. In addition, Covenant (e) also refers to development of cost information and issues of cost sharing for family planning. The annual report of the FPU should indicate progress made in fulfilling the covenants. For example, the report should show GOT financial allocations for family planning, and specify the FPU staff (and HED staff for that matter) supported by the Government, USAID and other donors. In order to obtain an overall picture of the GOT contribution to the NFPP as a whole, the recent Report on the Study to Quantify the Government Contribution to Family Planning (Kessy and Neukom) should be updated annually. USAID Population and Health Office staff would be pleased to work with Ministry of Health staff to determine exactly what type of information is needed and how it can be collected and regularly reported.

Copies of all relevant documents, including the draft MTR report and draft supplement to the FPSS Project Paper have been shared with the relevant departments of the Ministry of Health.

Your signature, or that of an authorized representative, is requested in the space provided to signify your agreement to the action described. Please return the original of this letter to USAID/T.

Sincerely,



Mark G. Wentling
Director

ACCEPTED BY:

Title: Ass. Chief Med. Officer

Signature: Dr. Fatma Mrisho

Name: DR. FATMA MRISHO

Date: 22-02-95

ASSISTANT CHIEF MEDICAL OFFICER
PREVENTIVE SERVICES
P.O. Box 9083
DAR ES SALAAM

cc: Dr. C. Simbakalia, FP Manager

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PIL: 18

CLEARANCES:

Drafted:	FMMburu	<u>[Signature]</u>	Date	<u>2/13/95</u>
PHO:	DVogel	<u>[Signature]</u>	Date	<u>2/13/95</u>
A/PO:	PFleuret	<u>[Signature]</u>	Date	<u>2/14</u>
CONT:	DLarson	<u>[Signature]</u>	Date	<u>2/14</u>
D/DIR:	GWAnderson	<u>[Signature]</u>	Date	<u>2/15/95</u>

Article 5: Special Covenants

SECTION 5.1. Project Evaluation. The Parties agree to establish an evaluation program as part of the Project. Except as the Parties otherwise agree in writing, the program will include, during the implementation of the Project and at one or more points thereafter:

- a) evaluation of progress towards attainment of the objectives of the Project;
- b) identification and evaluation of problem areas or constraints which may inhibit such attainment;
- c) assessment of how such information may be used to help overcome such problems; and,
- d) evaluation, to the degree feasible, of the overall development impact of the Project.

SECTION 5.2. Additional Covenants

- a) The grantee covenants to increase annually funding for family planning over the life of the project and to report yearly to A.I.D. on the amount budgeted to family planning.
- b) The Grantee covenants to begin to finance at the end of year three the salary costs of MOH personnel initially funded by the AID project and by the end of year four begin to finance warehouse and office costs. From year four the GOT will begin to contribute to the purchase of commodities available locally. By year seven the GOT will fully finance these costs.
- c) The grantee covenants that none of the funds made available under this grant may be used to finance any costs relating to:
 - i. performance of abortion as a method of family planning;
 - ii. motivation or coercion of any person to undergo abortion;
 - iii. biomedical research which relates, in whole or in part, to methods of, or performance of, abortion as a method of family planning;
 - iv. active promotion of abortion as a method of family planning;
 - v. involuntary sterilization.
- d) The Grantee covenants to convene a meeting of all key implementing agencies, including CAs, once a year to develop and approve work plans for the coming year and to review progress over the previous year.

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e) The Grantee covenants to develop cost information for the delivery of family planning services and to develop approaches for introducing methods of cost recovery and project sustainability.

f) The Grantee covenants to recruit and assign, in a manner consistent with the project implementation plan, all GOT personnel necessary to implement the Project.

g) The Grantee covenants that special accounts will be established at the Cooperative and Rural Development Bank, or other financial institution mutually agreed to, when necessary to carry out project activities.

Article 6: Procurement Source

SECTION 6.1. Foreign Exchange Costs. Except as A.I.D. may otherwise agree in writing, disbursements pursuant to Section 7.1 will be used exclusively as follows:

a) With the exception of contraceptives, commodities financed by A.I.D. under the project shall have their source and origin in countries included in A.I.D. geographic code 935.

b) Contraceptives supplied under the project shall have their source and origin in the United States. Suppliers of contraceptives shall have the United States as their place of nationality.

c) Except for ocean shipping, air transportation, and contraceptives, the suppliers of commodities or services financed by A.I.D. under the Project shall have countries included in A.I.D. Geographic Code 935 as their place of nationality. All reasonable efforts will be used to maximize U.S. procurement wherever practicable. Air travel and transportation to and from the U.S. shall be upon certified U.S. flag carriers.

d) Ocean shipping financed by A.I.D. under the project shall be financed only on flag vessels of countries included in A.I.D. Geographic Code 935, subject to the 50/50 shipping requirements under the Cargo Preference Act and the regulations promulgated thereunder.

SECTION 6.2. Local Currency Costs. Disbursements pursuant to Section 7.2 will be used exclusively to finance the costs of goods and services required for the Project having their source and, except as A.I.D. may otherwise agree in writing, their origin in Tanzania ("Local Currency Costs"). To the extent provided for under this Agreement, "Local Currency Costs" may also include the provision of local currency resources required for the Project.

Waiver of 25 percent Host Country Contribution

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523ACTION MEMORANDUM FOR THE ACTING ASSISTANT ADMINISTRATOR FOR
AFRICAFROM: AFR/PD, Timothy J. Boer 

SUBJECT: Family Planning Services Support PP (621-0173)

Problem: Your approval is requested to waive the requirement of Section 110 of the FAA for a host country contribution of at least 25 percent of project costs.

Background: Tanzania is a relatively least developed country as defined by the United Nations General Assembly. It is currently under an IMF program which severely restricts the amount of government expenditures. While that economic growth rate is 4-5 percent a year, it is not likely that the government budgets will increase markedly. Social sectors such as health are under added pressure as the government's first priority is the transport sector. The recently announced budget for next fiscal year provided no funds for new investment in the health infrastructure.

The Tanzanian contribution to this project is mainly in the form of personnel who provide family planning services, and the buildings, supplies and equipment they utilize. At the national level, family planning is carried out within the Maternal Child Health (MCH) section within the Department of Preventative Services. It is also carried out at the zonal, regional, district and finally at the clinic and dispensary level. Zonal MCH offices are located in consultant or regional hospitals. Regional and district MCH offices would be located in hospitals or health centers.

There are over 2800 MCH facilities of which approximately 2000 provide family planning services. Total employment at these facilities is about 6,000. The UNFPA estimates that the personnel costs of these facilities total about 325 million Tanzanian shillings. Another 700 million Tshs is expended to meet recurrent buildings, supplies and equipment costs. This brings the total to just over 1 billion shillings. This amounts to about \$5,300,000 at the current exchange rate of 192 Tshs per dollar. Admittedly, these are existing costs which would occur whether our project existed or not. The project if successful will increase the number of clinics offering family planning services; it will increase the number of persons visiting the clinics seeking the service; and will increase the amount of time present personnel devote to family planning.

In the early years of the project, GOT support will mainly be in the form of management personnel at MOH in Dar Es Salaam and regional technical staff who will take part in the training, logistics, MIS and IEC activities. There are also GOT warehouses for the storage of contraceptives and vehicles for the distribution of contraceptives.

Our estimate is that the GOT contribution will slowly rise during the life-of-project and total about 10 percent of the recurrent budget by year seven. Therefore the GOT contribution on an annual basis will average about 5 percent or about \$250,000 per year. Over the life-of-project this is about \$1,750,000. Since this is less than 25 percent of total project costs USAID/Tanzania is seeking a waiver from section 110 of the FAA. The Mission believes the GOT is otherwise committed to the project. This project is a key element in the 1989-93 GOT draft population program, which was prepared by the GOT, based on lessons learned from its prior population programs. The GOT has already removed all legal constraints that it could identify to service delivery, a major element of this project. There is an existing clinic infrastructure and a large staff of health personnel. We realize that the lack of GOT resources raises sustainability questions. These will be addressed throughout the life-of-project.

Authority: You have authority to waive the cost sharing requirement under Delegation of Authority 403. Such authority may not be redelegated.

Recommendation: That you waive the FAA Section 110 requirement that Tanzania contribute 25 percent or more of the project costs for the Family Planning Service Support Project (621-0173).

Approved: Walter G. Rudy

Disapproved: _____

Date: 7/31/90

Clearances:

AFR/PD/EAP:DMackell	(draft)	date	7/13/90
AFR/PD:BBurnett	<u>12/13</u>	date	7/20/90
AFR/EA:JRose	(draft)	date	7/11/90
GC/AFR:MAKleinjan	(draft)	date	7/17/90
AFR/EA:DLundberg	(draft)	date	7/11/90
DAA/AFR:ELSaiers	<u>AS</u>	date	7/30/90

Drafted: AFR/PD/EAP: CPerry: Doc. 0214J CP



U.S. Agency For International Development
memorandum

DATE: February 9, 1995

REPORT TO:
FROM: PHO, Dana Vogel *D. Vogel*

SUBJECT: Mission review meeting - FPSS PP Supplement, 2/7/95

TO: DIR, Mark Wentling

On February 7, 1995, the Mission reviewed the draft of the project paper supplement (PPS) for the Family Planning Services Support Project (FPSS). The following are the comments and suggestions made by the representatives from various Mission offices. They will be incorporated into the final PPS draft.

1. **Delegation of Authority.** The Mission Director has been delegated the authority under DOA SS1 to authorize project amendments up to \$30 million and 10 years for the life of project, as long as the amendment does not present significant policy issues, deviate from the original Project purpose or require the issuance of waivers that may be approved only by the Administrator or the AA. FPSS will be amended to be a \$30 million/10 year project. There are no significant policy issues and the goal/purpose remain unchanged. The RLA advised that the DOA will be changed soon to reflect \$50 million for project approvals, \$100 million for amendments. LOP will remain at 10 years.

2. **Project procurement.** While perhaps 90% of commodity procurement has been completed, there will be occasional vehicle replacements (10 pick-ups and two 10 ton trucks) that will require EXO assistance. They will also assist with clearing about two more shipments of INTRAH-provided equipment, as these are subject to theft at the port. INTRAH will receive, inventory, and otherwise manage equipment distribution. PHO has no other procurement-related actions scheduled for FY 95, (though ad hoc procurements may arise).

3. **The CN is being drafted by AFR/DP.** PROG and PHO have provided extensive comments and information. AFR/GC will clear, and we will be advised if and when the CN has expired without objection.

4. **A glossary has been drafted with abbreviations and acronyms.**

5. **Child survival.** It was suggested that a short description of what child survival actually is be inserted into the justification and that the second paragraph which talks about issues other than child spacing be moved up. PHO will also incorporate

child survival language into other sections (description of the project components).

6. Regarding the percentage of the \$10 million allocated to G/PHN cooperating agencies, we estimate that about one-third will be utilized for community-based distribution, information/education/communication, and support for long-term/permanent contraceptive methods, as well as the Michigan Fellows. CAs will implement these programs. Another one-third is for programming through the Family Planning Unit; and one-third to support project management costs, audits, equipment purchases (things managed directly from the Mission).
7. Sustainability. It was suggested that the GOT contribution be mentioned in the action plan, as well as some discussion of the first two covenants to the PP (which mention GOT contributions in kind).
8. The macro economic and political context in which FPSS has to operate will be discussed in the background section (Anne to draft).
9. Written concurrence from the GOT will be in the form of an FPSS PIL. This is in line with keeping the PPS as a modification of the FPSS, instead of a "new project."
10. The "AID Management" line item will be modified to read "Project Management." More information will be provided in the budget section on the Michigan Fellows and the audits and evaluations planned. Better explanation on different management responsibilities will be provided.
11. Gray Amendment issues will be added to the end of the PPS, stating progress to date (e.g. use of BHM for the mid-term evaluation, and the INTRAH equipment which is procured by a Gray Amendment firm).
12. The original waiver for the 25% contribution from the GOT will be attached to the action memorandum, and discussed briefly at the end of the PPS.
13. The Authorization will be drafted by the RLA. Assionally, she will provide some language on the DOA for the Action Memorandum and draft the Project Agreement Amendment.