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Tanzania's National Family Planning Program:

Factors for Success

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Foreword

This paper discusses some of the factors behind the remarkable and rapid progress of Tanzania's National Family Planning Program (NFPP) since 1990. It is based on the experience and observations of the USAID/Tanzania Population and Health Office staff over the past five years and does not reflect the official views of the Agency for International Development.

The following persons made comments and suggestions on the various drafts: Dr. F. Mburu, USAID/Tanzania Senior Population Program Specialist; Dr. Anne Fleuret, USAID/T Evaluation Officer; Miss Pauline Muhuhu, Director, INTRAH Regional Office for East and Southern Africa. In addition, the participants at the regional conference for Africa Health/Population/Nutrition Officers (Nanyuki, Kenya, May 17 - 21, 1995) made helpful suggestions and comments during the initial presentation. This paper will be presented at the USAID/W State of the Art Course in Health, Population and Nutrition, Washington, DC, June 1995.

Tanzania's National Family Planning Program: Factors for Success

Introduction

Previous literature and case studies have identified the many of the factors that contribute to successful family planning programs. Over the years, our knowledge of the "ingredients" of a successful family planning (FP) program has been exhaustively researched and discussed. The Population Information Program¹ has summarized these factors as: demand for FP; improved contraceptive access and choice of methods; client centered quality; well-trained providers; good communications; strong program leadership and political commitment; a good research and evaluation program; and adequate financial resources. These sum up the major factors that make for a successful program.²

However, each country is different, and these factors may assume greater or lesser importance. Further, there may be other factors that have an impact on a program. These may include the sudden removal of a particular contraceptive from the method mix (legal barriers) or the positive influence that removal of medical barriers may have. And, the various factors don't exist in a vacuum; rather, they interact closely with each other. For example, a strong national program can provide the impetus for increased access through removal of medical barriers as well as good oversight of all its aspects, including logistics and training. Designing a commodities program with good transportation and adequate supplies is useless without trained personnel to administer the various methods. Often IEC programs are launched without paying enough attention to what will happen after demand is stimulated (are providers adequately trained? are supplies there?).

This paper discusses the following contributory factors to the NFPP's success:

- **Higher than expected demand for FP-services**
- **Improvements in the service delivery system: the impact of an improved commodities/logistics system and an intensive, high quality training program**
- **Availability of adequate resources and strong NFPP management**
- **Government commitment**
- **USAID's special role**

¹Population Reports, "Making Programs Work." Series J, Number 40, August 1994.

²Also cf. "Helping Services Meet Demand: An Assessment of A.I.D. Assistance to Family Planning in Kenya." J. Dumm, R. Cornelius, R. Jacobstein, B. Pillsbury, Johns Hopkins University Center for Communication Programs, 1992. The factors for success in Kenya included: high demand; policy support; trained workers; VSC services; strong partnership with the private sector; CBD; contraceptive logistics and management; and building up the institutional capacity of the NCPD.

Background

General. Tanzania has a population of 27 million. 1991/92 DHS statistics reflected a total fertility rate (TFR) of 6.3 and high infant mortality (IMR) and child mortality rates (CMR) of 91.6 and 141.2 (under fives) respectively, despite high rates for breastfeeding and immunization.³ Significantly, very few women practiced modern contraception, resulting in the typical pattern of many, closely spaced births and unacceptably high maternal mortality rates of 300 or more deaths/100,000 births.

The early years. Family planning services have been available in Tanzania since the 1950s. First promoted by UMATI (the local family planning association and IPPF affiliate), FP was eventually integrated into Government MCH services. Donors -- including USAID -- provided funds within an integrated MCH context as Tanzania struggled to cope with a series of economic shocks and problems throughout the 1980s. Three donors -- USAID, UNFPA and IPPF -- provided support in the FP area, mostly in training and IEC and some commodities. USAID assisted UMATI in the training of Government MCH Aides, provided contraceptives, and sponsored development of a RAPID model. CAs, such as JHPIEGO and FPIA, carried out small programs of assistance, struggling to continue activities despite the USAID phase-out in the mid-1980s. Most support was channeled either through UMATI (which actually had no clinics of its own) or the medical school.

The launch of the National Family Planning Program (NFPP). In the late 1980s, several changes occurred: USAID returned, with a renewed interest in family planning (as well as AIDS); a national population policy⁴ was developed; and the NFPP was inaugurated, with its own implementation plan.⁵ To support the NFPP, USAID designed a seven year bilateral project, the Family Planning Services Support Project (FPSS, signed in August 1990) which contained the usual panoply of support: training, IEC, FP services, research, monitoring and evaluation. UNFPA too was implementing a new five year program. However, the NFPP had a staff of only two persons assigned to oversee donor, Government and NGO efforts. Expectations of demand were somewhat contradictory. On one hand, the preparatory analysis for the FPSS and the creation of the NFPP indicated that FP services should be offered to meet the as yet un-determined level of unmet demand. On the other hand, it was also expected that acceptance of modern methods would be slow. The mind-set among Government and donors alike was of a profoundly conservative, mostly rural population.

³DHS results showed 99.2% of children 10-11 months of age were being breastfed; 95.4 received BCG, 80% three doses of DPT, three doses of polio 77% and measles 81%.

⁴drafted May 1989, approved 1992.

⁵Plan of Operations, 1989 - 1993, Ministry of Health, Dar es Salaam.

which had much more important things (like basic economic survival) on its mind than the fertility control. The FPSS anticipated a yearly increase in CPR of 1% over baseline (which was unknown until 1991 when the DHS was conducted). Progress would be modest at best.

Achievements of the first four years

Dramatic and rapid rise in CPR. With the benefit of hindsight, we now see that these assumptions were much too conservative. The 1994 Tanzanian Knowledge, Attitudes and Practices Survey (TKAPS) showed that use of modern contraception increased from less than 6% to 11.3% for all women, and from 6.6% to 13.1% (currently married women); use of all methods rose from 9.5% to 17.9% (all women) and from 10.4% to 20.4% among currently married women. It has doubled in both rural and urban areas.

Demand for contraception increased. Significantly, even in 1991/92, the DHS showed that demand for spacing/limiting was much higher than originally thought (41%) and has increased further to 48%. The question now is how the NFPP and its bilateral donors can move fast enough to keep up with this increasing demand for FP services.

New acceptors increased between 40% - 50%; monthly resupply visits rose 23%.

Client choice improved markedly. Facilities offering injectables, IUDs and foam have more than doubled and almost 100% of facilities offer oral contraceptives and condoms. VSC sites increased from two to over 40. Accordingly, the method mix "improved:" users of injectables increased from 6% of the method mix in 1991/2 to 24%; users of IUDs increased from 6% to 10%; users of oral contraceptives decreased from 52% to 37%.

Factors That Account for Success

Although many factors contributed to the NFPP's ability to meet growing demand, we believe that the following should be examined more closely.

1. Family planning demand was much higher than anticipated.

In the case of Tanzania, the desire of women to limit and space births was underestimated. The TDHS (and subsequent TKAPS) were important *national sources of data* which helped statistically prove the existence of demand for FP. The TDHS found that the *total demand for FP (unmet need plus current use) was 41% but only 6.6% of currently married women were practicing a modern FP method.* In 1994, total demand increased further, to 48% (the unmet proportion decreased). Field visits and other surveys showed that once FP services were offered, women turned up in droves, especially for injectables and female sterilization. Program decisions were therefore made to increase planned VSC sites from 30 to 116;

accelerate the national clinic-based FP training program; and to expand support for innovative CBD projects.

2. Improvements in the service delivery system.

Logistics. Until 1992, contraceptive ordering was done individually (by each donor) and haphazardly. Orders were not coordinated by either donors or Government. There was virtually no service delivery or consumption data and there was overstock of certain methods (mainly oral contraceptives) at the central level, with stock outs nationwide at SDPs.

FPSS provided the umbrella for preparation of annual CPTs, and Mission staff ensured that the other main donors (UNFPA and eventually ODA) became full fledged members of the planning team. For the last two years, these donors have used the FPLM estimates for their own ordering.

Filling the pipeline with the right quantities, warehousing them properly, and transporting them so that they reached SDPs on time was a major achievement. New methods were added to the mix, such as injectables and Norplant. *Flexibility in responding to emergency needs* was critical as demand for certain methods increased rapidly, as was *provision of transport, staff and other inputs* to the NFPP, enabling them to monitor and deliver contraceptives. A unique sharing arrangement with EPI is used to transport contraceptives to districts and outlying areas.

An intensive, high quality training program. Training expands the availability of methods and improves the quality of services. In 1990, although a great deal of "training" had gone on, very little of it was competency based; providers (mostly MCH Aides) who were trained in IUD insertion went back to SDPs without insertion equipment, expendable supplies or even IUDs; policies restricted the role of primary providers in supplying clinical methods. There was no national strategy nor were there guidelines or standards for service provision.

From 1991, USAID worked closely with UNFPA to develop a more rational system of **clinic-based FP training**. INTRAH was contracted by both organizations to train service providers and prepare regional training teams so as to institutionalize in-country capacity to continue training. Donor flexibility (and more funds) permitted the original scope of the training to go nationwide. Equipment, not originally envisioned, was supplied to the first 30 (of about 100) practicum sites. Assistance was flexible and adapted to changing needs.

FPSS devotes major resources to the training of surgeons, counsellors and providers in order to expand **permanent and long-term methods (P/LT) of contraception**, including voluntary sterilization, Norplant and post-partum IUD insertion. High demand for VSC and Norplant has led to an increase in the planned number of sites from the original 40 to 116. UMATI

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(the implementing agency, in conjunction with AVSC) developed a decentralized system of training and supervision of VSC teams.

Accurate and timely reporting from the field is necessary for ensuring national contraceptive needs are accurately forecast. As part of the larger national effort to institute a Health Management Information System, USAID and UNFPA have worked together to develop a **national logistics training course** (with TA from FPLM) that trains regional and district FP/MCH and AIDS control staff in contraceptive information management.

At the **policy level**, USAID (through INTRAH) assisted the MOH to develop two training strategies⁶ which clearly spelled out national training objectives (including numbers, types of training, implementors and donors). For the first time, the NFPP actually had a plan of who needed to be trained, in what and by whom, and the cost. A series of national guidelines and standards⁷ were developed. The Guidelines were developed incountry by Government, NGO and other Tanzanian agencies. "All males and females of reproductive age including adolescents regardless of their marital and health status" *now had access to FP services*. All modern methods were to be offered (assuming the facility had the ability to do so), and any cadre of service provider who received a standardized course of clinical training could offer services, including injectables and IUDs.

3. Availability of adequate resources and strong NFPP management.

The timing of the signing of the FPSS Grant Agreement coincided with the establishment of the NFPP. Originally funded at \$20 million over a seven year period, FPSS became a nine year/\$30 million project in 1995. It was originally conceived as a 20 year commitment to the NFPP, and provided funds for all aspects of NFPP implementation, including management, training, commodities/logistics, research and evaluation (two DHSs and a TKAPS, as well as operations research) and equipment/vehicles, as well as funds for USAID management. In addition, large amounts of central resources were made available, and other donor support has increased over time. *Crucial factors were: the financial resources were available more or less at the same time, providing a large budget from which to operate; the inputs (e.g., contraceptives, training, equipment, management support for FPU were*

⁶A three year training strategy was developed by INTRAH and the MOH in August 1991, to coincide with the first Plan of Operations. A second, Five Year Strategy for Family Planning Training 1994 - 1999, was published in September 1994. The second Strategy was a more comprehensive attempt to institutionalize the NFPP's capability and capacity to organize, manage, conduct and evaluate training. It was expanded to all types of service providers, include CBD agents and those involved in voluntary surgical contraception, as well as pre-service training institutions. Estimates were that over 13,000 people would have to be trained over the five year period.

⁷National Family Planning Policy Guidelines and Standards for Family Planning Service Delivery and Training, Ministry of Health, (August 1992, updated 1994). UNFPA funded.

provided almost simultaneously -- nothing lagged behind. Also important was the fact that beginning in 1991, technical assistance (including two years of long-term TA) was available in enough quality and quantity to support initial NFPP activities. Complementary activities with UNFPA and ODA (clinical and logistics training, contraceptives) provided a synergistic element to USAID support.

But who was to manage these resources and coordinate them?

In 1990, the head of the Muhimbili Department of Community Medicine, Dr. Fatma Mrisho was designated as the NFPP Manager and assigned to head the newly created Family Planning Unit (FPU). This individual was an FP/MCH expert profoundly dedicated to women's reproductive health issues in general and family planning services in particular. Her deputy, a physician who came from one of the major training institutions, was a technically competent and equally committed individual, with a particular interest in training. Other staff were deployed from the Ministry of Health and provided technical expertise, but more importantly, dedication and commitment to the job.

To support actual NFPP program management, supervision and implementation, a modest percentage of the FPSS budget (15%) was allocated to the Family Planning Unit (FPU) in the form of a direct grant to the Government. USAID committed itself to share costs for staff, rent, transport and other administrative costs, but it was anticipated in 1991/92 that the FPU's ability to actually implement activities would be limited, and their ability to manage the funds was somewhat in doubt. However, as the FPU developed, there was a surprising increase in the number of activities it implemented directly, and their ability to absorb funds increased. From their first workplan, funded at about \$400,000, FPU now spends about \$1 million annually (of this only about 10% is for salary/administrative costs), mostly for field supervision, commodity distribution and a large-scale training effort (both clinic-based and CBD). Finances are managed well, with annual audits turning up few deficiencies.

By getting the tools it needed -- vehicles, computers, office space -- FPU transcended the usual morass of the MOH bureaucracy and quickly (in two - three years) fashioned itself into a truly professional group. Sharing costs with Government and UNFPA has lessened the financial burden, and USAID is working on a "sustainability action plan" with FPU to ensure greater GOT contributions over time.

4. Government commitment.

Policy. In 1989, the GOT began two exercises that demonstrated a more proactive role in FP and population control: it designed a national population policy; and a five year plan of operations. The National Population Policy aimed to increase the legal age for women at marriage to 20 (still pending); increase CPR to 30% by the year 2000; and reduce the TFR by 2. Other aims were to reduce infant and maternal mortality, moderate the rate of

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rural/urban migration and improve the status of women.

Programs of action. The Five Year Plan of Operations, 1989 - 1993, aimed to raise CPR from an estimated 5% (very close, considering the DHS was still two years off!) to 10% by 1993. A follow-on five year Strategic Plan, 1994 - 1999 estimates that CPR will increase by 2% per year. If we use the TKAPS baseline of 11%, this would achieve a CPR of about 20% by 1999.⁸ So, there is official Government commitment to a fairly rapid increase in CPR by the year 2000, to between 20% and 30% (although modern vs. all methods is not specified).

The NFPP. The creation of the NFPP was another step forward in demonstrating GOT support for FP. It made NGOs and Government full partners in the effort to expand FP services, with a special role for UMATI. Continued support for the development of progressive Standards and Guidelines for service provision ensured that medical/legal barriers were minimized. The GOT established the FPU to be the overall manager. However, the GOT provided neither sufficient staff nor office space and equipment, which was left to USAID and UNFPA (for the most part) to supply. The FPU's organizational status within the Preventive Services Department remains modest (despite its many donor resources). Government newspapers and public fora (the Parliament) openly support the NFPP, but the President has been silent on the subject.

Is the NFPP (or FPU) considered some sort of vertical program outside the MOH? Does the heavy donor support make it something the GOT can take or leave? In fact, the Program Manager of the NFPP went on to head the entire Preventive Services Department. Her capable deputy assumed responsibility for the NFPP and Government continued to treat the FPU and the NFPP with respect and interest, compared to other government departments also concerned with population. As a tangible symbol of the FPU's leadership, it will move into a new three story building of its own later this year. Finally, increasing demand for FP will ensure that FP are fully integrated into MCH services.

5. USAID's special role

Leadership in population/family planning. In Tanzania, USAID is the preeminent donor, both financially and technically. Financially, obligations (bilateral and OYB transfers only) are about \$3 million per year. Approximately \$5 million in additional headquarters funding (Global Bureau) is provided in different types of support. Technical assistance from the various CAs is recognized by other donors as unique in relation to institutional backup, long-term follow up and variety.

⁸The FPSS PP Supplement estimates that by 1999, 18% of all women will be using a modern contraceptive method.

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Donor coordination. USAID has taken a lead role in ensuring that there is stronger, more concerted efforts in support of the NFPP. Areas include contraceptive ordering, logistics training, clinic-based training, and administrative support to the FPU. New donors, such as German KFW and the European Union have expressed an interest in working with USAID to fund new activities.

USAID staff. As in many countries, USAID staff have played a key role in negotiating GOT acceptance of outside technical assistance (as the "honest broker"). We can help redirect CAs or encourage them to do more. The Mission basically maintains an on-site team of technical experts who guide and manage outside TA, and provide direct assistance and advice to the Government and NGOs and ensure that the FPSS is managed in a professional manner.

Conclusions and Cautions for the Future

We often remind ourselves that the FPSS and the NFPP are still in their relatively early stages, and a solid program takes many years to build up. The desire to serve desperately underserved areas which are often very remote causes constant tension with the desire to focus and concentrate resources. The NFPP has made great strides, but its success is fragile and can easily be destroyed. What is heartening is the fact that knowledge and demand for child spacing choices won't go away and that this demand will ultimately have to be met. There are many pitfalls as the program continues to develop. Some of these include:

Family planning doesn't exist in a vacuum. It is part of the larger health sector and the socio-economic life of the country as a whole. As cost-sharing is implemented and Government begins to reduce the numbers of health workers and even charge for preventive services, it is unknown what may happen to FP as part of MCH services. Political changes and continuing economic problems may cause severe instability within the system.

Donor funding may be unreliable. USAID and other donors are reviewing their programs of assistance for a variety of reasons. Some are phasing out of health altogether. Others -- such as ourselves -- will be either moving out of the current development mode altogether or focusing much more on impact. Further, Tanzania is now on the "watch list." Progress in economic reform and good governance will be carefully monitored and resources released accordingly.

Sustainability is still an issue. The NFPP is basically sustained by the GOT at the regional and district level and institutionalized within the overall MCH structure. However, there is no question that large amounts of money are required to keep the commodities moving, the training system going and central management operations. Can the Government do more? Can it show more interest in its own program? Can the private sector and NGOs -- notably UMATI -- do more (or will they require just as much TA and financial support)?

Decentralization. This complex issue affects many countries. The management burden of overseeing a decentralized system is enormously complex -- no one yet has a good answer as to how this will work.

Family planning is a long-term effort. Care, patience, and resources are required to ensure that safe, effective FP methods can be easily accessed by those who choose to use them. The NFPP is still fragile -- much remains to be done. But if Tanzanian and donor commitment can continue, at least for the next five years, this country will have an exemplary FP program that helps meet the goals and aspirations of its people.

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FACTORS FOR SUCCESS

- Higher than expected demand for FP services
- Improvements in the service delivery system: the impact of an improved commodities/logistics system and an intensive, high quality training program
- Strong NFPP management and availability of adequate resources
- Government commitment
- USAID's special role

BACKGROUND STATISTICS FOR TANZANIA

Population:	27 million in 1995
TFR:	6.3 births per woman
CPR:	6.6 modern/3.5% traditional (CMW)
IMR:	91.6
Under 5's:	141.2
% children 10-11 mos breastfeeding:	99.2
% children 12-23 mos who received:	
BCG:	95.4
DPT (3 doses):	79.8
Polio (3 doses):	77.1
Measles:	81.2
All vaccs:	71.1

(Source: 1991/92 DHS)

In Tanzania
many births are high risk

From 1987 to 1992:

59% of teenagers had begun child bearing

18% if births occurred with 2 years of a previous sibling birth

22% of births were to mother with 7 or more children

BENCHMARKS IN FP

- FP services ostensibly available since the 1950s (UMATI)
- 1990: national population policy drafted; National Family Planning Program (NFPP) inaugurated. Both had ambitious goals of achieving 25% - 30% CPR by Year 2000
- 1989 UNFPA new five year program; 1990 USAID new seven year bilateral (FPSS)

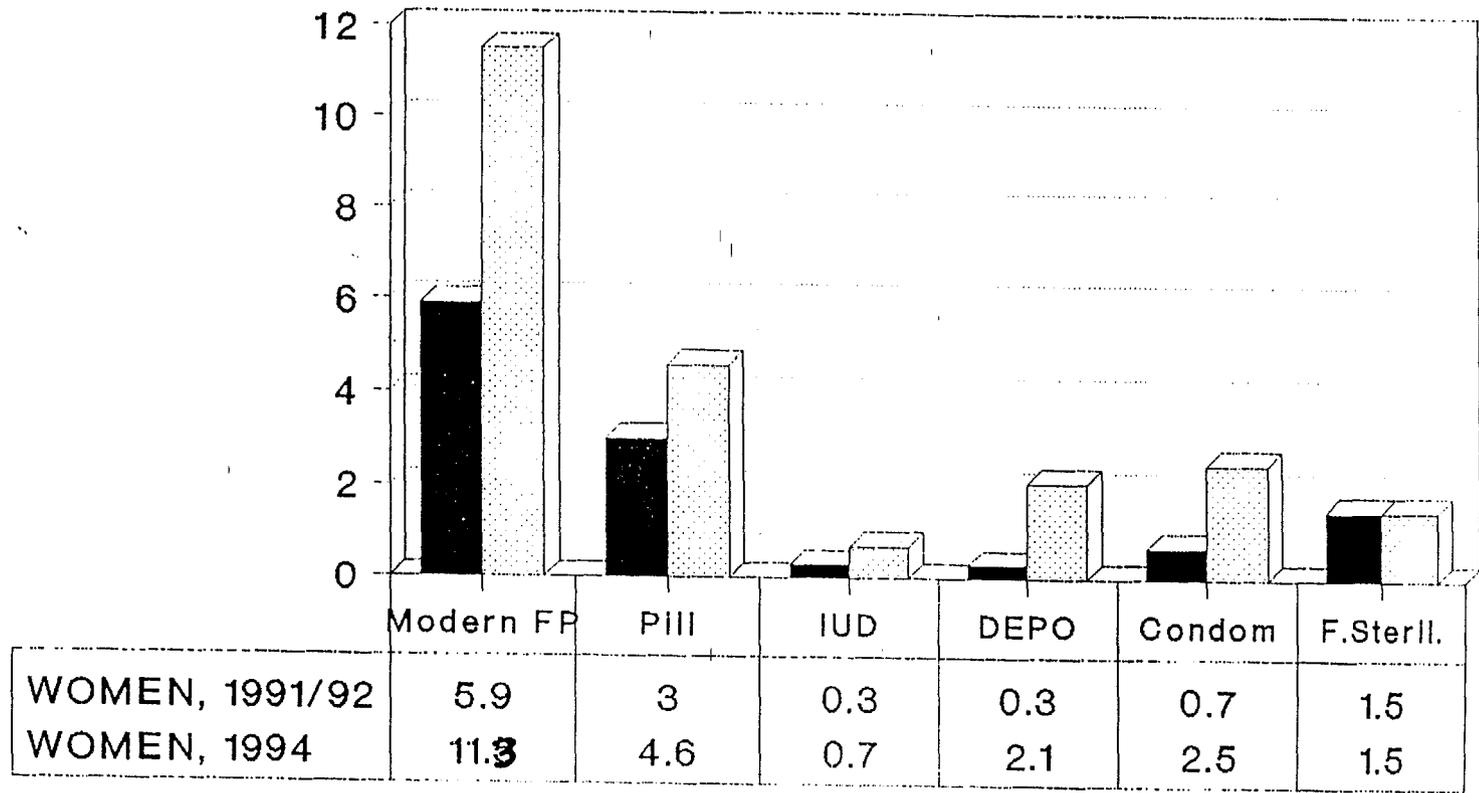
NFPP ACHIEVEMENTS FROM 1991/92 TO 1994

- Dramatic and rapid rise in CPR from less than 6% to 11.3% (all women/modern methods)
- Demand for contraception increased from 41% to 48% for spacing/limiting
- New acceptors increased between 40% - 50%
- Client choice improved markedly (method mix)

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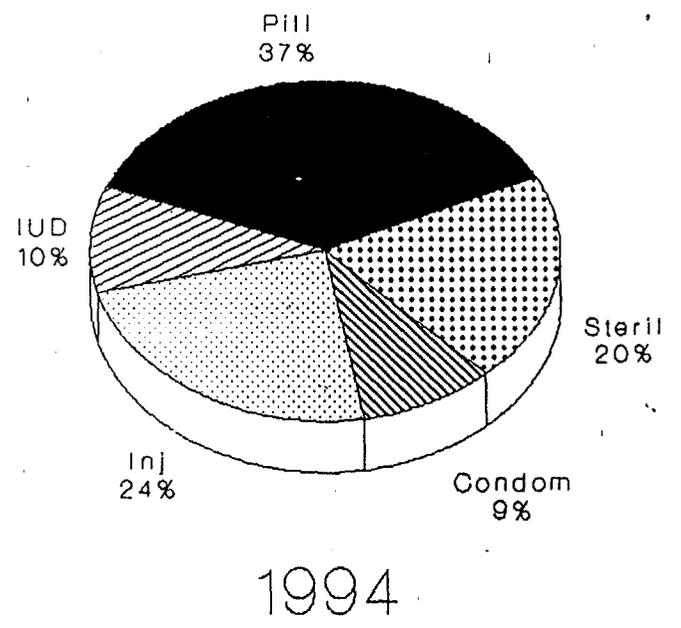
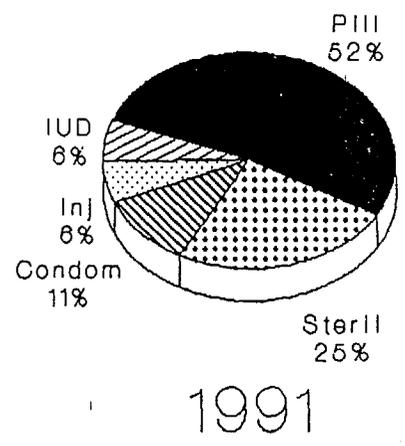
Percentage of all women using Contraceptive methods, 1991/2 and 1994



WOMEN, 1991/92
 WOMEN, 1994

Table 1

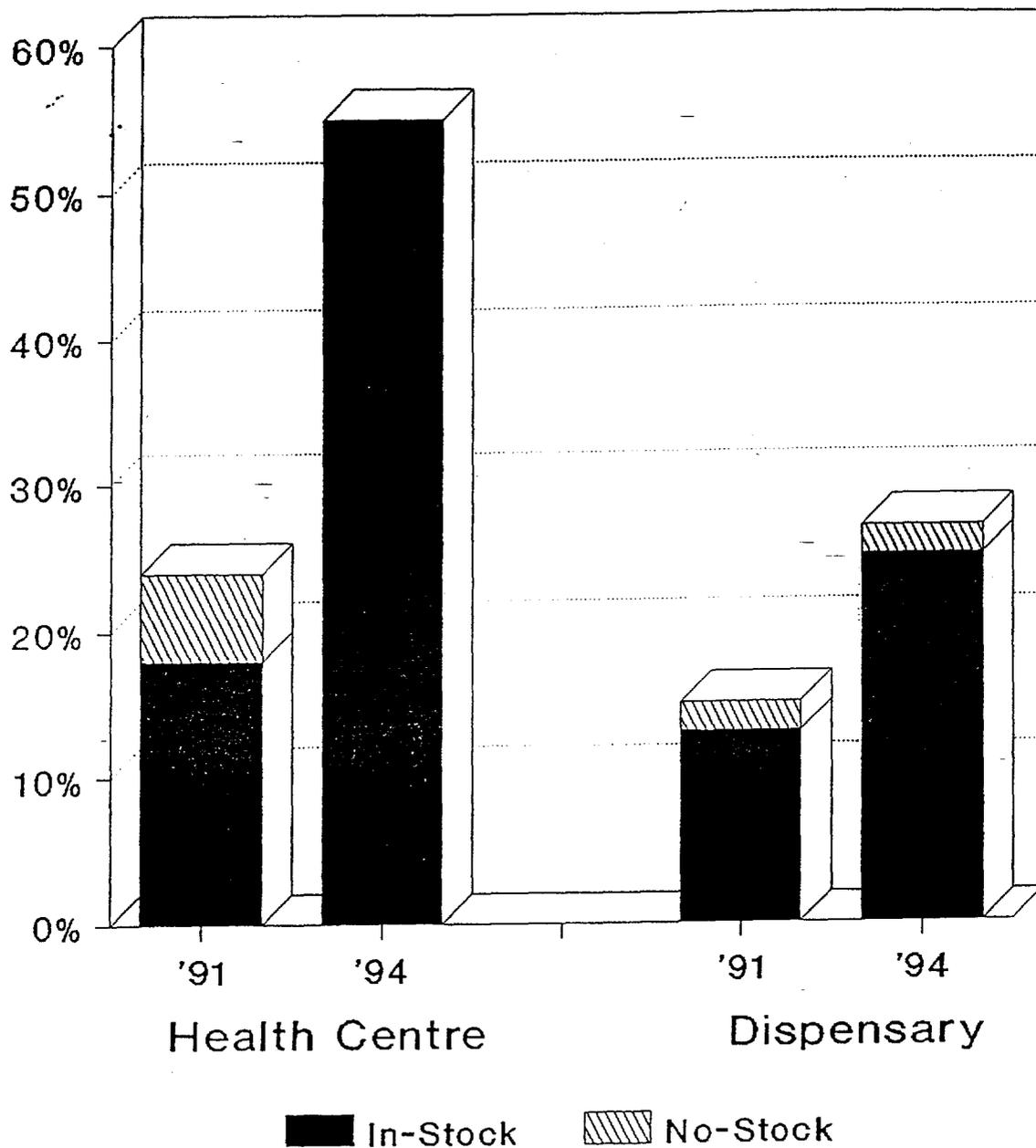
Method Mix Tanzania, 1991 and 1994



Source: TDHS & TKAP

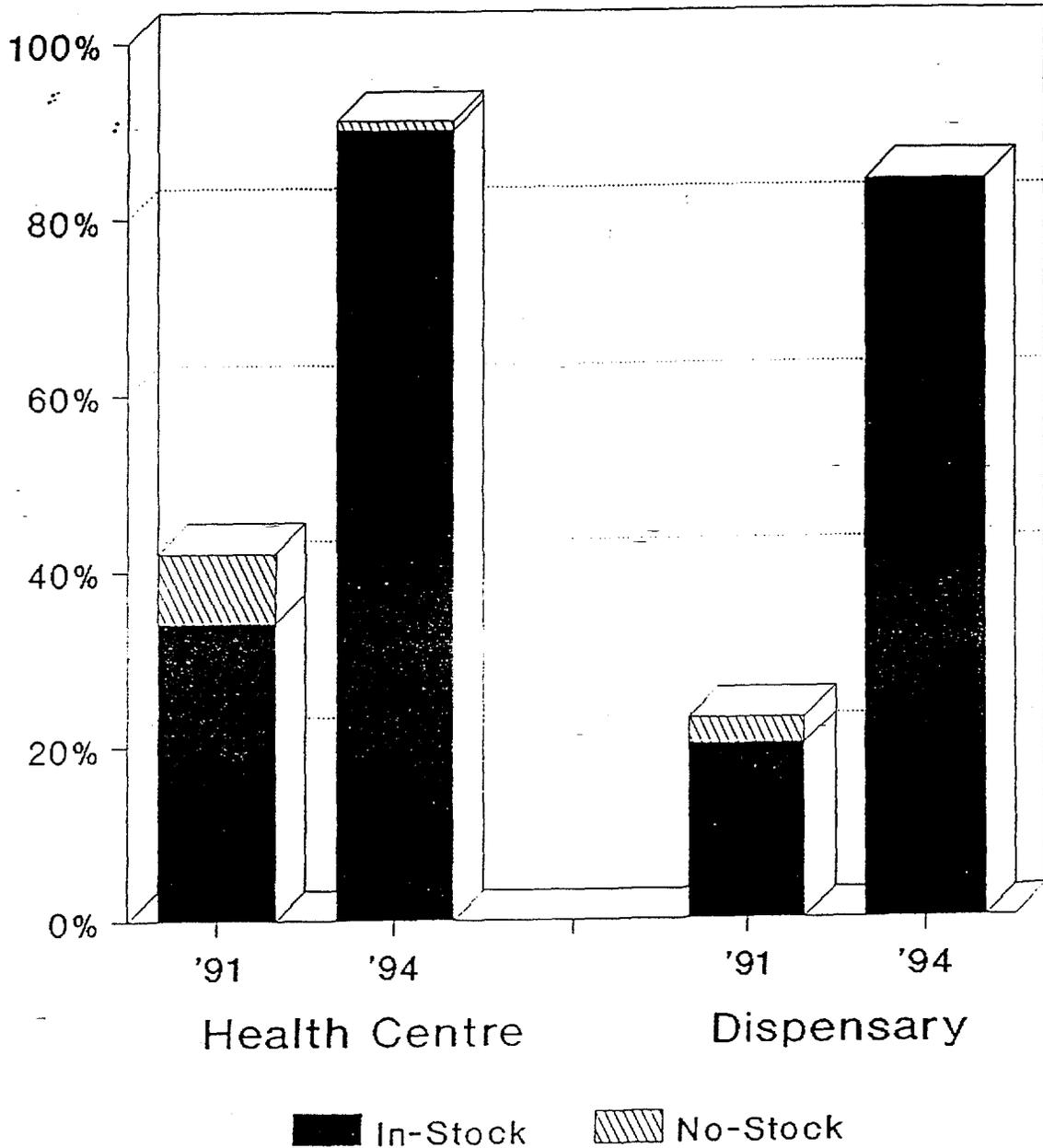
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Service and Method Availability IUDs, '91 and '94



Source: DHS Service Availability Modules

Service and Method Availability Injection, '91 and '94



Source: DHS Service Availability Mod's

FACTORS FOR SUCCESS OF THE NFPP

- 1) **Family Planning demand was much higher than anticipated.**
 - Total demand for FP in 1991/92 was 41% but only 6.6% of currently married women were users
 - High demand for injectables and sterilization once they were offered
 - National data sources (TDHS, TKAPS, TSAS) essential in establishing baseline data and measuring progress

**Demand for Family Planning Services
Tanzania, 1991 and 1994
(Currently Married Women)**

	Total Demand	Unmet	Modern	Traditional	Total
1991	41	30.1	6.6	3.9	10.4
1994	48	27.3	13.1	7.4	20.4

FACTORS FOR SUCCESS OF THE NFPP

2) Improvements in the service delivery system

Logistics

- Donor coordination improved
- Pipeline filled
- Provision of transport, TA and money for staff and running costs of the logistics system
- LMIS developed

Training

- Strategic planning, standardization and national guidelines
- Provision of short/long TA
- Development of training management function in the FPU and in local NGOs and development of clinic-based training teams
- Direct training of service providers and provision of equipment
- Preparation of greater numbers of P/LT teams/sites
- National logistics training program
- Donor collaboration in TA/local costs

Results

- increased client choice of methods
- increased TZ ability to manage and conduct training (both Govt and NGOs)

3) Strong NFPP management and availability of adequate resources

- Adequate financial and human resources were made available all simultaneously
- FPSS: \$20m/7 yrs extended to \$30m/9 yrs
- Increased donors support and coordination (logistics, training) among USAID, ODA, UNFPA and GTZ
- Strong leadership of the NFPP (individuals)
- FPSS/UNFPA gave FPU the tools they needed to manage, supervise and implement the NFPP (computers, vehicles, staff), with an increase in absorptive capacity and satisfactory audit reports
- FPU able to transcend the MOH bureaucracy

4) **Government commitment**

- NFPP established in 1990
- National Population Policy approved in 1992
- Programs of action: 5 yr Plan of Operations 1989-1993, Strategic Plan 1994-1999

5) USAID's special role

- Technical/financial leadership in FP
- Lead role in donor coordination and promoting FPU's role as the major coordinating force
- TA as unique through the CAs
- Field staff presence (honest broker, technical experts, trust)

CONCLUSIONS

- NFPP is relatively new and fragile
- Sustainability is an issue
- FP is part of the overall social/health sector
- Decentralization
- FP-if along-term effort -- both Tanzanian and donor efforts must continue to ensure that the NFPP is firmly established