

**Tanzania Case Study:
A Successful Program Loses
Momentum**

**A Repositioning Family
Planning Case Study**

December 2006



USAID
FROM THE AMERICAN PEOPLE

the **ACQUIRE** project

ACQUIRE Report

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By John M. Pile and Calista Simbakalia



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Contents

Acknowledgments	v
Executive Summary	vii
Introduction	1
Methodology	3
Findings	5
Timeline	5
What Was Achieved?	7
Contraceptive prevalence rate	7
Total fertility rate	7
Variations in contraceptive prevalence	8
Method mix	10
Awareness and knowledge	11
Demand and unmet need	11
What Was Done?	13
Context	13
Program	17
Lessons Learned	23
References	25

Appendixes

Appendix 1: List of Persons Contacted	27
Appendix 2: Documents Reviewed	31

Tables

Table 1. Prevalence of use of any contraceptive method, by geographic zone, 1991–1992 and 2004–2005	9
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Figures

Figure 1. Total fertility rate (TFR), use of any contraceptive method, and use of modern contraceptive methods among married women of reproductive age, Tanzania, 1991–1992 and 2004–2005	7
Figure 2. Total fertility rate for urban and rural areas, Tanzania, 1991–1992 and 2004–2005	8
Figure 3. Prevalence of modern contraceptive use, by wealth quintile, 1996 and 2004–2005	8
Figure 4. Contraceptive prevalence, any method, by region, 1992	10
Figure 5. Contraceptive prevalence, any method, by region, 1996	10

Figure 6. Contraceptive prevalence, any method, by region, 1999	10
Figure 7. Contraceptive prevalence, any method, by region, 2004	10
Figure 8. Percentage of currently married women using a contraceptive, by method used, 1991–1992 and 2004–2005	11
Figure 9. Percentage of demand for family planning that was satisfied, by region, 1992	12
Figure 10. Percentage of demand for family planning that was satisfied, by region, 1996	12
Figure 11. Percentage of demand for family planning that was satisfied, by region, 1999	12
Figure 12. Percentage of demand for family planning that was satisfied, by region, 2004	12
Figure 13. Total fertility rate (TFR) and mean ideal family size among women and men, by survey year	13
Figure 14. Percentage distribution of contraceptive provision, by sector, 1991–1992 and 2004–2005	15
Figure 15. Funding of family planning commodities, by source, 1996–2006	21

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Executive Summary

Family planning saves lives and has long been considered a key aspect to socioeconomic development. Although this is widely acknowledged and well-documented, the attention and resources directed toward improving family planning programs in developing countries have been decreasing, even though need remains high. This is particularly true for Sub-Saharan Africa; for the region as a whole, only 14% of women are using modern methods of contraception (PRB, 2004). To address this need, the U.S. Agency for International Development (USAID) has identified Repositioning Family Planning as a priority for its work in Africa. To guide future investments, USAID supported five country-specific case studies to identify strategies and lessons learned that have contributed to or detracted from family planning programs in the region. Together, the case studies are being used by USAID to guide the strategy development for Repositioning Family Planning and to inform efforts to identify key investments in the region.

Family planning services in Tanzania began in 1959, when the Family Planning Association of Tanzania (UMATI) introduced services at urban clinics. However, it was not until 1974 that the Government of Tanzania became actively involved in service provision, when family planning services were integrated into the maternal and child health program. Through the 1970s and 1980s, levels of contraceptive use remained unchanged, as there were few trained providers, limited contraceptive supplies, and a weak logistics system.

A 1988 speech by former President Julius Nyerere was pivotal to placing family planning on the national agenda. In 1989, the Government of Tanzania designed a national population policy and launched the National Family Planning Programme (NFPP). Government and mission/faith-based organizations joined together to comprise the national program, with UMATI mandated to provide supervision and quality assurance in the public sector. USAID and other donors provided significant support to family planning, and the 1990s were the “golden age” of family planning in Tanzania. In the 1990s, along with Malawi, Tanzania posted the largest annual increase in contraceptive prevalence rate in the East Africa region—two percentage points per annum. Modern method prevalence increased from 6.6% in 1992 to 13.3% in 1999. Over the same period, use of any method increased from 10.2% to 25.4%.

Momentum has slowed considerably since 1999, however. The annual increase in prevalence dropped to 0.2 percentage points per year, with prevalence reaching only 26.4% in 2004–2005. The annual percentage increase in modern method use dropped by half, from 1.5 percentage points per year (from 1991–1992 to 1999) to 0.6 points (from 1999 to 2004–2005). Currently, more married women have an unmet need for contraception (1.1 million) than are currently using a modern contraceptive method (880,000).

Key Findings

A number of factors appear to account for Tanzania’s loss of momentum in contraceptive use. These include:

Impact of Decentralization, Health-Sector Reform, and Other Policies

A confluence of developments combined to interfere with the progress of Tanzania’s family planning program in the late 1990s. These include: decentralizing responsibility for delivery of

basic health services (including family planning) to the district council level; integrating the family planning program into the Reproductive and Child Health Services (RCHS) and subsequently integrating the RCHS into a broader health-sector program; shifting donor funding from targeted geographic programs or commodities to “the basket”; and launching the Poverty Reduction Strategy Program, in which there is only one indicator for family planning. All of these developments reduced the visibility of the family planning program and, consequently, the resources devoted to it. Funding, contraceptive commodities, and personnel were adversely affected.

Reduced Advocacy by Champions

In the “golden age” of family planning, the program had strong advocates within the Tanzanian government, especially in the Family Planning Unit (which was charged with overseeing the NFPP) and among key donors. As the program’s visibility waned, supporters both within and outside of the program were less able to advocate for it. For example, District Council Health Management Teams responsible for supervision do not by statute include the reproductive and child health coordinators. The absence of these coordinators from these teams reduces their influence on the program at the local level. Also, there was little continuing effort in communications activities to mobilize champions for overall policy support.

Failure to Sustain Training and Other Program Supports

Since 1997, there has been no funding for in-service training except through donor “off-budget” programs, due to inconsistencies between local government regulations and Ministry of Health (MOH) requirements. The shift to “basket funding” and to district budget authority for the RCHS resulted in significant stockouts of contraceptives, and it was not until 2005 that the Tanzanian government allocated a budget line item for contraceptives. The Green Star program and related media initiatives were effective communications strategies, but there has been little follow-up since the late 1990s. Continuing the momentum required a continued investment in basic supports, and these investments either diminished or disappeared altogether.

Weakening of Community-Based Programs

The “golden age” of family planning programming in Tanzania was built on the long history of community involvement there. With assistance from nongovernmental organizations, mission/faith-based organizations, and donors, the National Community-Based Distribution Program was launched by the MOH in four regions in 1993 and was scaled up almost nationally by 1999. However, service integration and decentralization have disrupted this initiative, and many community-based resources have been diverted to the national home-based care program for persons living with HIV and AIDS.

Transition from Key Partnerships

Marie Stopes Tanzania (MST) was an important provider of long-acting and permanent family planning methods (LAPMs) in the private sector. In addition to coordinating the provision of LAPM services on behalf of the MOH, UMATI supervised and provided program support for capacity-building, quality of care, training, and expendable supplies for 98 public- and private-sector sites. U.S. government policy ended USAID support to MST in 2001 and to UMATI in 2003, which led to a reduction in the number of partners available to support the national program, particularly LAPM service delivery. The transition time to shift oversight of LAPM services and training was insufficient and led to some disruption of services. The full transition is now complete.

Introduction

Family planning saves lives and has long been considered a key aspect to socioeconomic development. Although this is widely acknowledged and well-documented, in recent years decreasing attention and resources have been directed toward improving family planning programs in developing countries, even though need remains high. By one estimate, satisfying the unmet need for contraceptive services in developing countries would avert 52 million unintended pregnancies a year, thereby saving 1.5 million lives and preventing 505,000 children from losing their mothers (Singh et al., 2003).

To address this need, in 2003 the U.S. Agency for International Development (USAID) and other stakeholders identified Repositioning Family Planning as a priority for its work in Africa. In the face of scarce resources, weak infrastructure, and a growing focus on HIV/AIDS, many African countries had found it extremely difficult to strengthen their family planning programs and raise contraceptive prevalence. To guide future investments, USAID supported five country-specific case studies to identify strategies and lessons learned that have contributed to or detracted from successful family planning programs in the region.

USAID undertook the first case studies in three countries that had made significant progress over the past 10–20 years: Ghana, Malawi, and Zambia. Each of these countries had experienced considerable growth in contraceptive prevalence and fertility decline, despite a challenging environment and limited resources. Their success can provide guidance for other Sub-Saharan African countries. Subsequently, USAID undertook case studies in two countries that had shown relatively stable contraceptive prevalence and/or fertility rates or a significant decline in growth: Tanzania and Senegal. These latter case studies reinforced lessons learned from the “success stories” by documenting significant gaps in program composition and highlighting pitfalls to be avoided. Together, the case studies are being used by USAID to guide the strategy development for Repositioning Family Planning and to inform efforts to identify key investments for the region.

Methodology

The Tanzania and Senegal case studies are intended to identify conditions that have impeded more substantial improvement in family planning programs in low-resource settings in Sub-Saharan Africa. The two countries were selected based on composite criteria balanced with USAID's intention to have representation from both West Africa and East Africa. The analysis covers the particularly dynamic socioeconomic, political, and epidemiological contexts of the past 10–20 years in the region.

The methodology for this report consisted of a combination of group discussions and individual interviews with key informants (Appendix 1) and a review of secondary documents (Appendix 2). This study followed the research protocol established during the Ghana, Malawi, and Zambia case studies and addressed the following key questions in both interviews and secondary research:

1. What do you feel have been the main achievements and successes of the family planning program in Tanzania in the past 10 years?
2. What were the main reasons for these achievements and successes (including program factors, policies, and societal/cultural factors)?
3. What were the main challenges or constraints encountered in implementing the family planning program?
4. How were these challenges addressed?
5. Have any regions of the country or segments of the population been more challenging to effectively provide services to? If so, what has been done to meet their needs?
6. What are the current priorities for the family planning program in Tanzania?
7. What do you see as the main lessons learned from the work on family planning in Tanzania?
8. What do you see as the challenges currently confronting the program and threatening past achievements to date? What should be done about them?

The information presented in this report gives a picture of the family planning program in Tanzania and identifies general lessons learned. The report benefits from an extensive body of data and documentation on family planning in Tanzania, including project and program progress reports; technical analyses; operations research; and statistical surveys. Appendix 2 provides a listing both of these documents and of the Internet web sites where documents are available for readers wishing additional information.

Findings

Timeline

Year	Key Policy and Program Activities	FP Impact	Context
1959	♦ Family Planning Association of Dar es Salaam (FPAD) is formed, opens three clinics—Dar es Salaam, Liwale (Lindi), Moshi (Kilimanjaro).		Preindependence
1961			Independence
1964			United Republic of Tanzania is formed by Tanganyika and Zanzibar—Julius Nyerere becomes first president.
1967	♦ FPAD is renamed—eventually becoming UMATI (Uzazi na Malezi Bora Tanzania) to reflect a national focus—and becomes an International Planned Parenthood Federation (IPPF) affiliate.		Arusha Declaration heralds almost 20 years of socialism.
1970s	♦ Ministry of Health (MOH) Family Planning Unit is established. ♦ National health policy provides for free health care. ♦ Germany begins assistance to Tanga; U.S. Agency for International Development (USAID) begins assistance to Arusha.		
1974	♦ Government becomes actively involved in service provision with launch of integrated family planning—maternal and child health program.		
1977	♦ Private for-profit health services are banned under the Private Hospitals (Regulation) Act.		
1984–1985	♦ Government starts National Child Spacing Program, with support from the United Nations Population Fund. ♦ Family planning training and information, education, and communications are provided by MOH and UMATI.		President Nyerere steps down; President Ali Hassan Mwinyi is elected. Socialist era is over.
1988	♦ Former President Nyerere speaks out publicly in support of family planning. ♦ MOH provides first orientation on family planning to Parliament. ♦ Minilaparotomy under local anesthesia is introduced in public sector via UMATI.		National economy moves toward free market; privatization is underway.
1989	♦ National Population Policy is drafted. ♦ Five-year National Family Planning Programme is launched. ♦ USAID begins direct support to MOH for family planning. ♦ Marie Stopes Tanzania opens and begins providing low-cost family planning services.		
1990	♦ National Health Policy is launched; Family planning is not included.		President Mwinyi is re-elected for a second term.
1991	♦ 1977 Private Hospitals Act is amended to permit qualified medical practitioners to manage private hospitals, with the approval of MOH. ♦ No-scalpel vasectomy is introduced in public and nongovernmental sectors (with UMATI the primary provider).		

Timeline (cont.)

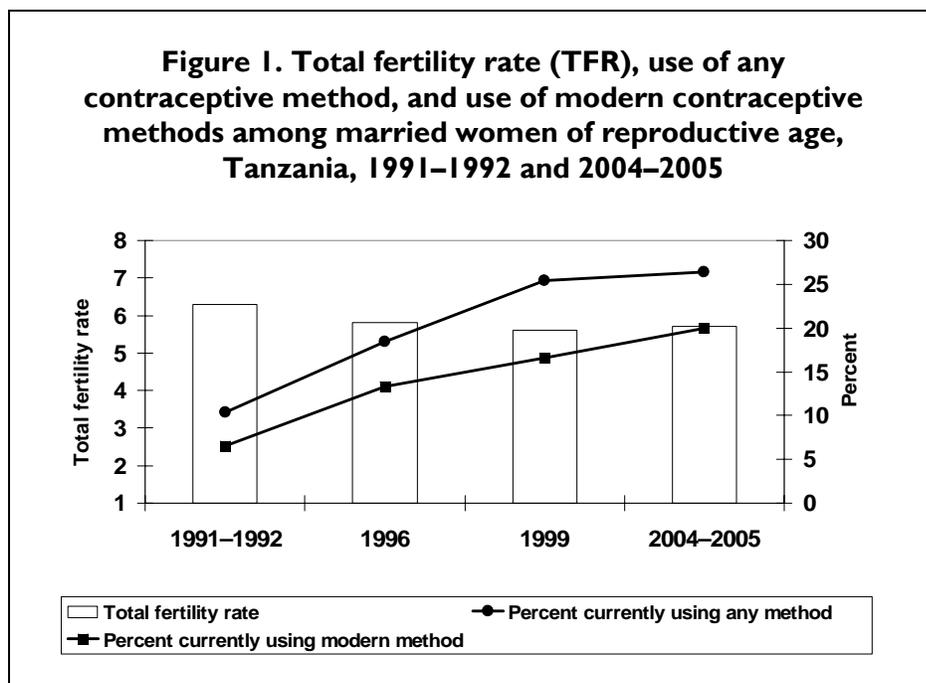
Year	Key Policy and Program Activities	FP Impact	Context
1991 (cont.)	<ul style="list-style-type: none"> ◆ Tanzania Family Planning Communications Project is launched (1991–1994). 		
1992	<ul style="list-style-type: none"> ◆ First Tanzania Demographic and Health Survey (DHS) is conducted. ◆ MOH issues National Family Planning Guidelines and Safe Motherhood Strategy. ◆ MOH establishes a family planning community-based distribution (CBD) unit. ◆ Planning Commission issues National Population Policy. 	Contraceptive prevalence rate (CPR): 6.6% modern Total fertility rate (TFR): 6.3	
1993	<ul style="list-style-type: none"> ◆ Family planning Logo (Green Star) is inaugurated and used by public, nongovernmental, and private sectors. ◆ MOH's National CBD Program is launched in four regions (Dodoma, Tabora, Iringa, and Coast). ◆ MOH's first Health Sector Strategy is issued. ◆ Social marketing of Salama brand condom is launched. 		Health-sector reform commences.
1994	<ul style="list-style-type: none"> ◆ National Family Planning Strategy is developed and launched. ◆ First national contraceptive logistic training is held. 		International Conference on Population and Development (ICPD) takes place in Cairo.
1995	<ul style="list-style-type: none"> ◆ Norplant is introduced via UMATI in public (MOH) and nongovernmental sectors 		In first multiparty elections. Benjamin Mkapa is elected president.
1996	<ul style="list-style-type: none"> ◆ Second DHS is conducted. ◆ Private sector begins providing long-acting and permanent methods. ◆ Integrated reproductive and child health (RCH) training is initiated. 	CPR: 13.3% modern TFR: 5.8	
1997	<ul style="list-style-type: none"> ◆ First RCH strategic plan is developed (1997–2001). 		Government starts decentralization in 37 districts; responsibility for health personnel is shifted to local councils.
1997	<ul style="list-style-type: none"> ◆ MOH issues National CBD Guidelines. 		
1998	<ul style="list-style-type: none"> ◆ MOH establishes RCHS program to integrate six vertical programs, including family planning. ◆ Review and revision of National Population Policy includes reproductive health and gender. 		
1999	<ul style="list-style-type: none"> ◆ Tanzania RCH Survey is conducted. ◆ Tanzania RCH Facility Survey is performed. ◆ Integration of family planning logistics into semi-autonomous Medical Store Department (MSD) to District level 	CPR: 16.9% modern TFR: 5.55	Disbursements under “basket funding” commence.
2000	<ul style="list-style-type: none"> ◆ Second RCH strategy is started (2000–2005) ◆ Sector-Wide Assistance program (SWAp) is launched. 		President Mkapa is reelected.
2002	<ul style="list-style-type: none"> ◆ USAID funding/provision of family planning commodities to UMATI ends. ◆ MOH Department of Hospital Services initiates provision of long-acting and permanent methods at all hospitals; all family planning methods are now mainstreamed by MOH. 		
2003	<ul style="list-style-type: none"> ◆ USAID direct funding to MOH RCHS is stopped. 		
2004–2005	<ul style="list-style-type: none"> ◆ DHS III is conducted. 	CPR: 20% modern TFR: 5.7	
2005	<ul style="list-style-type: none"> ◆ RCH strategy 2005–2010 is launched. 		New President elected.

What Was Achieved?

Contraceptive Prevalence Rate

Modern method use has more than tripled in the past decade. In the 1990s, Tanzania (along with Malawi) posted the largest annual increase in contraceptive prevalence in the East Africa Region—two percentage points per year. In Tanzania, the percentage of married women currently using any method of family planning increased from 10.2% in 1992 to 25.4% in 1999. Modern method use increased from 6.6% to 16.9% over the same time period. In 1999, Tanzania seemed well positioned to meet the contraceptive needs of its growing population.

However, since 1999, program momentum in Tanzania has slowed considerably (Figure 1). The annual increase in contraceptive prevalence dropped to 0.2 percentage points per year—only rising from 25.4% in 1999 to 26.4% in 2004–2005. The annual increase in modern method use dropped by half—from 1.4 percentage points between 1991–1992 and 1999 to 0.6 points from 1999 to 2004–2005. Now, one out of five (20%) currently married women are using a modern method of family planning.

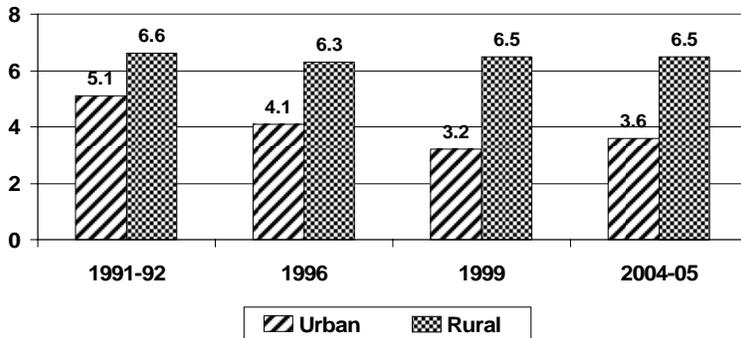


The percentage of sexually active unmarried women using a method of contraception has tripled since 1991–1992—from 12% to 36% in 2004–2005—and sexually active unmarried women are now more likely than currently married women to use a method of contraception.

Total Fertility Rate

While the total fertility rate (TFR) declined by nearly one birth from 1988 (6.5 lifetime births per woman) to 1996 (5.8 births), there is no evidence of fertility decline in Tanzania over the past eight years. The TFR estimated for 2004–2005 (5.7 lifetime births per woman) is statistically indistinguishable from the rates estimated for 1996 (5.8) and 1999 (5.6). Though the TFR for urban areas has dropped in the last 12 years by two births—from 5.6 births per woman in 1991–1992 to 3.6

Figure 2. Total fertility rate for urban and rural areas, Tanzania, 1991–1992 and 2004–2005



in 2004–2005—the TFR for rural areas has remained constant (6.5). Moreover, rural women have on average three more lifetime births than their urban counterparts (Figure 2).¹

In Tanzania, fertility is inversely related to education and wealth. Women with no education have more than twice as many births as women with at least a secondary education (6.9 vs. 3.3). Fertility differentials are even greater according to household wealth, ranging from a high of 7.3 lifetime births

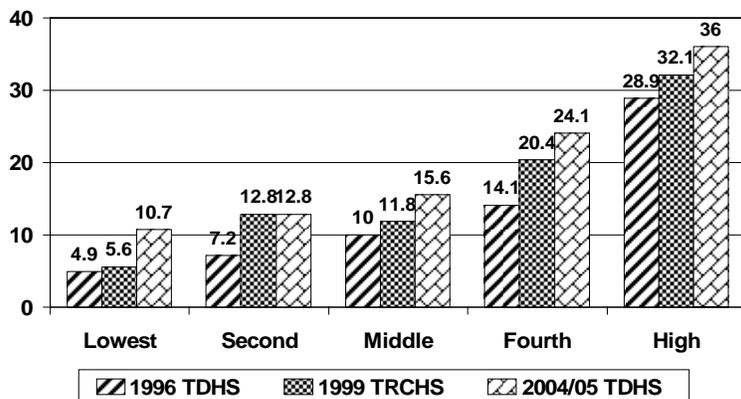
among women in the lowest quintile to a low of 3.3 lifetime births among women in the highest quintile.

Variations in Contraceptive Prevalence

Current use of any contraceptive method and of a modern method varies with urban-rural and regional residence, as well as with level of education and wealth. Women in urban areas are twice as likely to use contraception as are women in rural areas—41.8% vs. 21.6% for any method, and 34.3% vs. 15.5% for a modern method. Use of any method among women with a secondary education is nearly four times

that of women with no education (50.6% vs. 13.4%).

Figure 3. Prevalence of modern contraceptive use, by wealth quintile, 1996 and 2004–2005



Education plays a significant role in approval of family planning as well. Eighty-four percent of women with at least some secondary education reported that both they and their husband approve of family planning. This is twice the proportion of women with no education who say so (41%). Approval of family planning is also higher among those living in wealthier households.

Use of any modern method is three times as high among women in the highest wealth quintile as in the lowest quintile (36.0% vs. 10.7%) (Figure 3).

¹ The population of Tanzania is predominantly rural, though the proportion of urban residents has increased over time—from 18% in 1988 to 32% in 2005.

Prevalence in the lowest quintile nearly doubled (from 5.6% to 10.7%) between 1999 and 2004–2005, while increases in other quintiles were less modest.

Contraceptive use varies significantly by geographical zone, from a high of 41.5% in the Northern Highlands (Arusha, Kilimanjaro, and Manyara regions) to 12.8% in the Lake Zone (Kagera, Kigoma, Mara, Mwanza, Tabora, and Shinyanga regions) (Table 1 and Figures 4–7, page 10). At the regional level, Kilimanjaro has the highest level of contraceptive use (50%) and Pemba North the lowest (7%). The Southern Highlands (Iringa, Mbeya, and Rukwa) had the largest increase in contraceptive use during the 1990s, rising from 10.5% in 1991–1992 to 36.5% in 1999—an increase of 3.7 percentage points per year.

Two zones experienced declines of two percentage points in prevalence over the past five years—the Lake Zone and the Central Zone (Dodoma and Singida regions). In 1999, contraceptive prevalence in the Lake, Central, and Southern Zones was less than the national average. However, whereas the Lake and Central Zones seemed to have suffered most from the disruptions in services coinciding with decentralization and health-sector reform, the Southern Zone benefited from the continued presence and investment in family planning services of donors or nongovernmental organizations (NGOs) such as Marie Stopes Tanzania (MST) and UMATI.

Table 1. Prevalence of use of any contraceptive method, by geographic zone, 1991–1992 and 2004–2005

Zone	Contraceptive prevalence (any method)				Annual % change in prevalence			Absolute change, 1992–2004
	1992	1996	1999	2004	1992–1999	1999–2004	1992–2004	
Coastal	13.1	26.3	29.8	37.7	2.4	1.58	2.1	24.6
N. Highlands	24.0	31.0	37.4	41.5	1.9	0.82	1.5	17.5
Lake	5.9	9.9	15.1	12.8	1.3	–0.46	0.6	6.9
Central	11.0	14.6	23.0	21.6	1.7	–0.28	0.9	10.6
S. Highlands	10.5	17.8	36.5	36.4	3.7	–0.02	2.2	25.9
South	6.5	18.3	20.0	33.5	1.9	2.70	2.3	27.0
Total	10.4	18.4	25.4	26.4	2.1	0.20	1.3	16.0

At the regional level, eight of 21 regions had an annual percentage-point change in prevalence of greater than 1.5 points; seven of these eight were either focal regions for a particular donor (the UK Department for International Development [DFID], or GTZ) or an NGO partner (MST, UMATI).² Three regions—Coast, Kilimanjaro, and Tabora—experienced a decline in overall contraceptive prevalence between 1996 and 2004.

² Arusha, Iringa, Lindi, Mbeya, Morogoro, Mtwara, Ruvuma, and Tanga.

Figure 4. Contraceptive prevalence, any method, by region, 1992

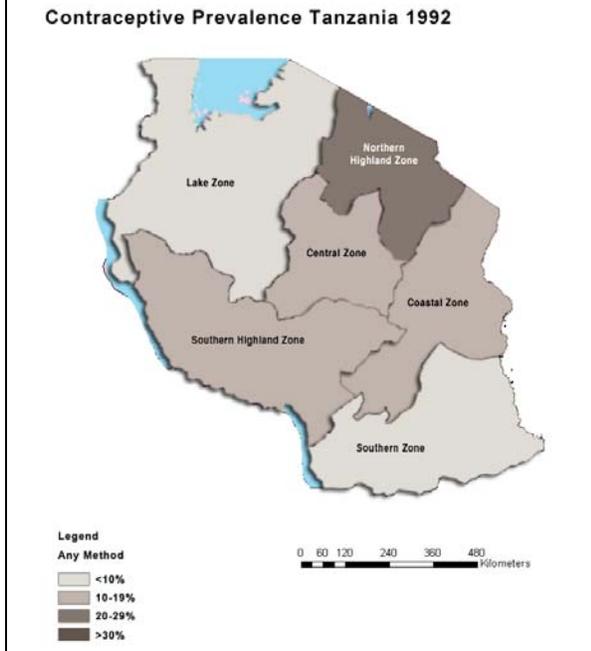


Figure 5. Contraceptive prevalence, any method, by region, 1996

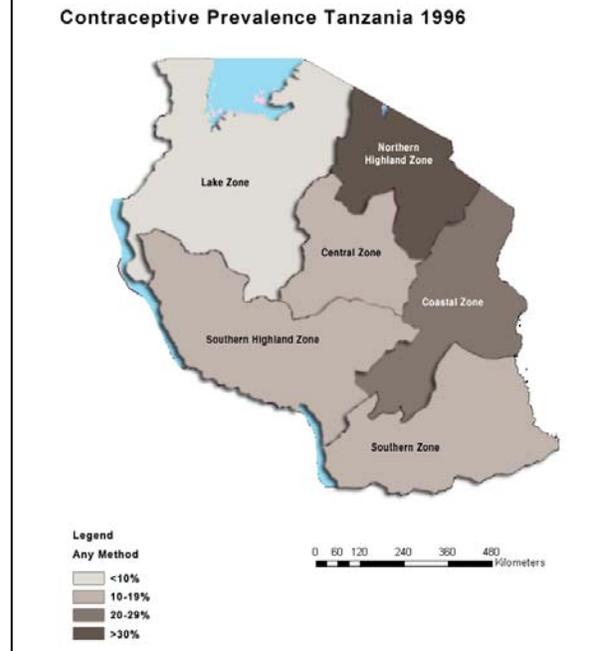


Figure 6. Contraceptive prevalence, any method, by region, 1999

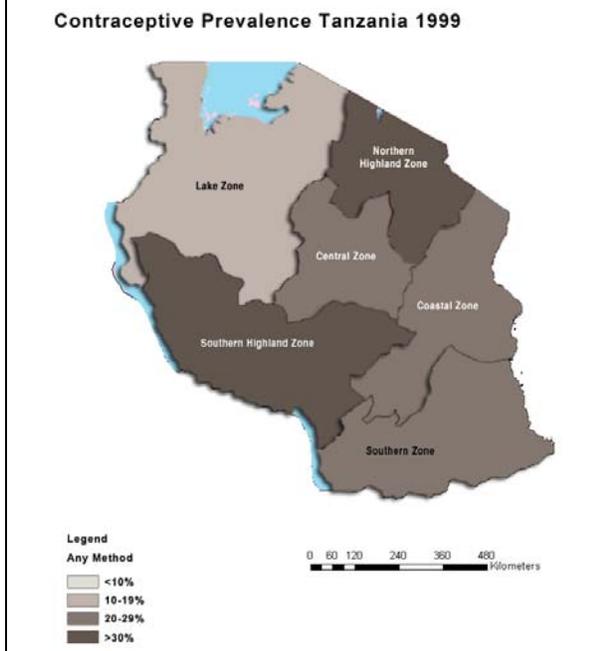
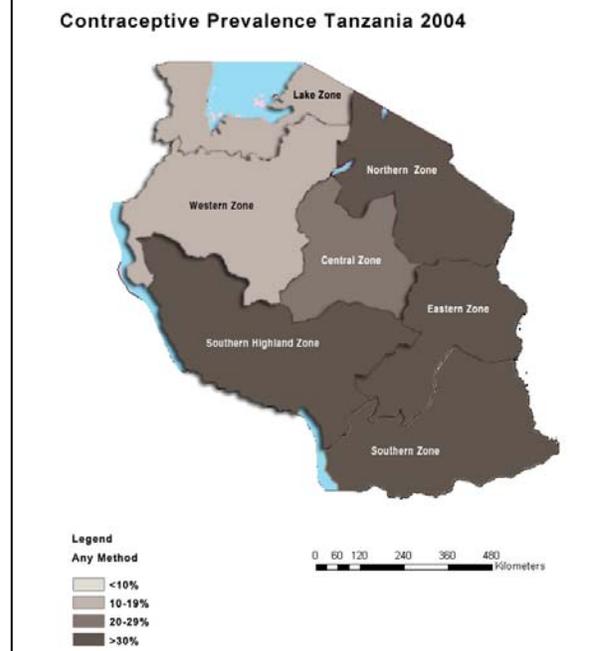


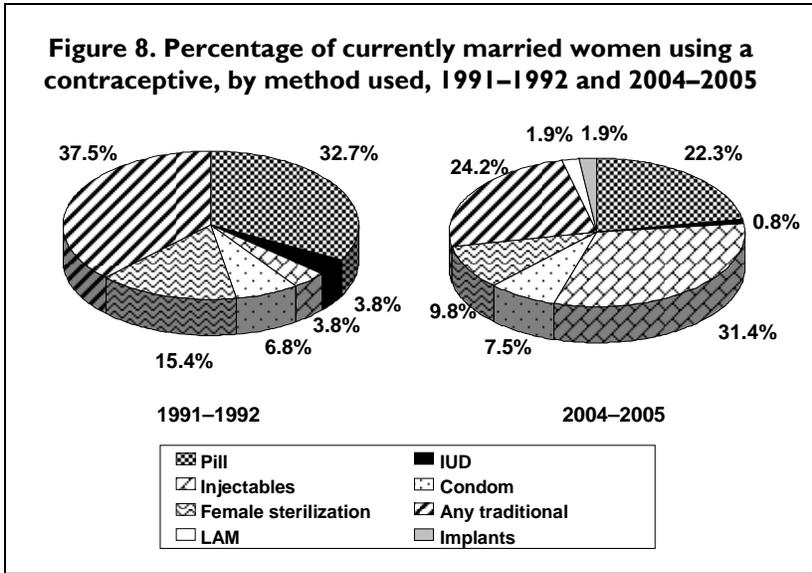
Figure 7. Contraceptive prevalence, any method, by region, 2004



Method Mix

Among currently married women, injectables (8.3%), traditional methods (6.4%), and the pill (5.9%) are the most widely used methods. The percentage of women using injectables rose from less than

1% in 1991–1992 to 8% in 2004–2005. Over the same period, the prevalence of female sterilization rose only slightly, from 1.6% to 2.6%, whereas use of the IUD declined by half—from 0.4% to 0.2%. Use of male condoms more than doubled, most likely due to the threat of HIV/AIDS. In terms of modern method mix, short-acting hormonal methods (the pill and injectables) currently



account for 71% of all modern method use (Figure 8). Use of any traditional method is significantly higher in the Northern Highlands (11.5%) and Southern Highlands (14.6%) than elsewhere in the country. In Mbeya region (Southern Highlands), traditional methods are used by 21.6% of currently married women—nearly half the overall contraceptive prevalence rate of 45.1% there.

Female sterilization rebounded slightly in 2004 after declines in the mid- to late 1990s. Gains in selected regions appear to be historically associated with the

presence and efforts of UMATI and/or MST: Rates are still relatively high in Kilimanjaro, where UMATI community-based agents were the “champions” for sensitizing women to sterilization. Rates over 3% within the total contraceptive prevalence rate in other regions—Dar es Salaam, Lindi, Iringa, and Kagera—are also associated with the long presence of UMATI and/or MST. Of note is Ruvuma region, where out of a total modern method prevalence of 34.8%, 6.1% of women use female sterilization (Bureau of Statistics and Macro International, 2005). Knowledgeable informants believe that this is due to outreach (mobile) services, conducted first by UMATI from its Iringa office and more recently by MST from its Makambako branch. The prevalence rate of 4.5% for female sterilization in Morogoro region is believed to be due to similar efforts

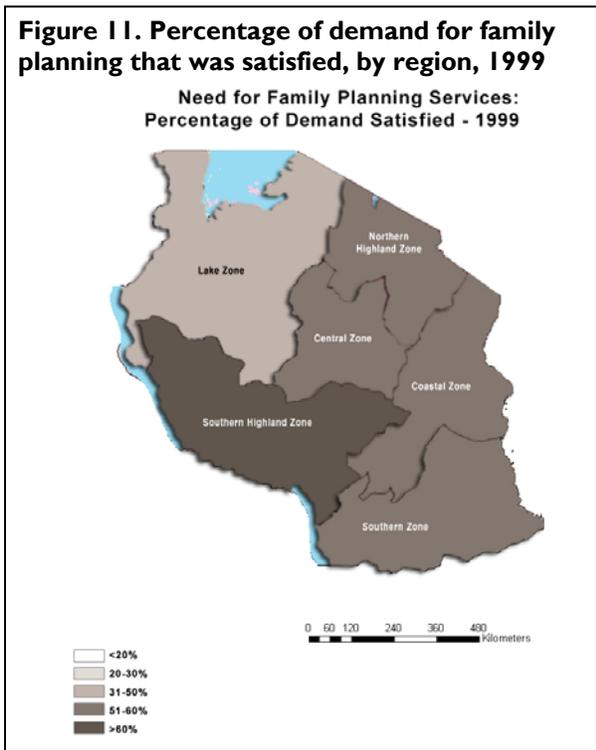
Awareness and Knowledge

While awareness of any family planning methods is high (96% among all female and 97% among male respondents in the 2004 DHS), it is significantly lower for long-acting and permanent methods (LAPMs) than for short-acting methods. Fewer than one in three men or women know about vasectomy, and only two out of three men and women know about female sterilization. Just 57% of women and 40% of men reported knowledge of IUDs, while 54% of women and 34% of men reported knowledge of Norplant implants.

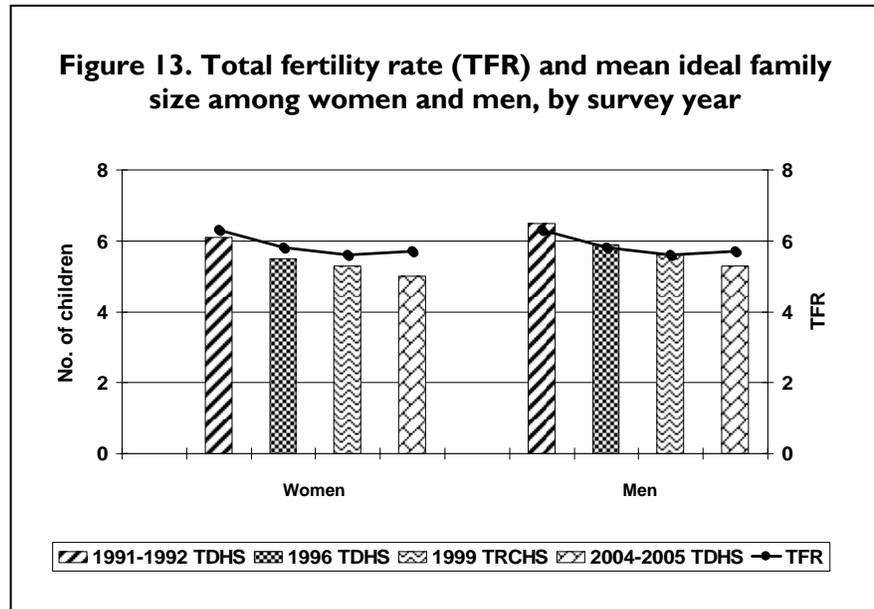
Demand and Unmet Need

Overall, demand either to space for at least two years or to limit future births entirely has remained high: 63% in 1992, 65% in 1996, and almost 69% in 2004. In urban areas, approximately four out of 10 women (36.6%) state that their need for family planning has been met. The comparable level among rural women is only one-fourth (26.5%). The unmet need for family planning remains high—one in five currently married women (21.8%) have an unmet need for family planning. More married women have an unmet need for contraception (1.1 million) than are currently using a modern contraceptive method (880,000).

Though unmet need remains significant, the percentage of family planning demand that is met has risen significantly in the past 15 years (Figures 9–12). Whereas only one-fourth of the demand for family planning was being met in 1991–1992 (25.7%), by 2004–2005, 52% of Tanzania’s population lived in zones where more than 60% of demand was being met.



Family size preferences have gradually declined over time in Tanzania: The mean ideal number of children has fallen by more than one child since the 1991–1992 DHS, from 6.1 children to 5.0 children among women and from 6.5 children to 5.3 children among men (Figure 13).



What Was Done?

Context

Political and socioeconomic environment

Administratively, Tanzania is divided into 26 regions, of which 21 are on the mainland and five are on Zanzibar. Tanzania's estimated 2005 population (36.5 million) is primarily rural (68%). There are 120 ethnic groups but little tension among them.

Since independence in 1961, Tanzania has stood out as one of the few stable countries in Eastern and Southern Africa. Following decades of one-party socialism and economic stagnation, Tanzania embarked on a fundamental political and economic transformation in the early 1990s. The nation's first multiparty elections were held in 1995. Tanzania has made major strides in converting to a market economy, institutionalizing reforms that are controlling inflation and deficit spending, attracting increased investment, privatizing public enterprises, and sustaining annual economic growth rates that are among the best in Sub-Saharan Africa.

These important economic gains have been accompanied by improvements in social indicators. From 2000 to 2005, infant mortality rates dropped from 100 per 1,000 live births to 68 per 1,000, and child mortality decreased from 156 per 1,000 live births to 112 per 1,000 (Bureau of Statistics and Macro International, 2005). Net enrollment rates for primary schooling of boys and girls increased from 58.8% in 2000 to 90.5% in 2004.

Nevertheless, Tanzania remains one of the poorest countries in the world. The World Bank estimates Tanzania's 2005 per capita income at \$340 (World Bank, 2006). Women's income levels are 50% lower than those of men, and 60% of Tanzanian women are estimated to live in poverty. The cost of health treatment was reported as the third most acute household problem, affecting more than 50% of all households.

About 40% of Tanzania's population is Christian and about 40% is Muslim, with the remaining 20% retaining indigenous beliefs. Fundamentalist Muslim groups frequently promote traditional methods of family planning through outreach activities. There is a strong, positive relationship between the government and religious missions and related faith-based organizations (FBOs) in the health field in general. These FBOs own and operate 15–20% of facilities, with varying degrees of government participation. Most FBOs participate in supporting the national family planning effort,

although 20% of all hospitals, about 10% of health centers, and about 6% of dispensaries are operated by the Roman Catholic Church, which supports natural family planning only.

Traditional values and practices remain strong in rural, largely remote, and inaccessible regions of the Lake Zone (northwest near Lake Victoria) and Central Zone,³ in which about 45% of Tanzania's population resides. Only 76% of adults are literate, and a mere fraction of boys and girls (5.3%) enroll in secondary school.

Access to services

Tanzania benefits from a strong network of health facilities owned and managed by religious missions and related FBOs. There are nearly 5,000 registered health care facilities in Tanzania, of which 59% are operated by the government, 18% by voluntary FBOs, 12% by other private entities, and 6% by parastatals. (Parastatal and private facilities are mostly urban-based.) FBOs are believed to provide health care services to more than 40% of all Tanzanians and mostly serve rural areas.

About 80% of the population has access to health services, and about 90% of the population lives within 10 kilometers of a health care facility. Nevertheless, time and distance to the health facility constitute a major problem for one-third of rural households and for up to one-fifth of people in urban settings. Distance, poor roads, and the lack of suitable transport were the second-most-cited obstacle to health care in the 2003 Policy and Service Satisfaction Survey (PSSS).⁴ While the mean distance to primary health facilities has decreased in the last decade, nearly a half million households remain more than 20 km from the nearest health facility.

UMATI and MST have been very active in the provision of family planning services. Up until 2002, UMATI coordinated the provision of LAPM services on behalf of the MOH and supervised and provided program support for capacity building, quality of care, training, and expendable supplies for 98 public- and private-sector sites. U.S. government policy ended USAID support to MST in 2001 and to UMATI in 2003, which led to a reduction in the number of partners available to support the national program, particularly LAPM service delivery. The transition time to shift oversight of LAPM services and training was insufficient and led to some disruption of services. The full transition is now complete. Meanwhile, UMATI has shifted to a broader reproductive health agenda focusing primarily on youth.

Beyond UMATI and MST, however, few other NGOs or CBOs are currently involved in family planning activities; most NGOs work in HIV/AIDS-related activities. There is little or no integration of family planning with other health services at this time, although some work has been done to integrate family planning and services to prevent mother-to-child transmission of HIV in recent years.

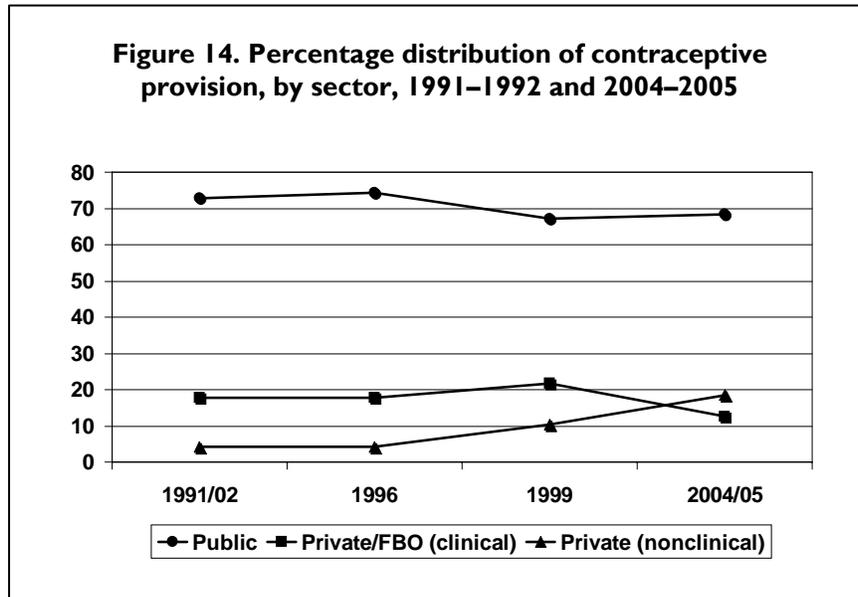
In 1991, the Private Hospitals (Regulatory) Act of 1977 was amended to permit individual qualified medical practitioners to practice on a for-profit basis. Tanzania's private medical sector has grown considerably since that time. Beyond the hospital level, however, private commercial provision of family planning services is believed to be limited and restricted to short-acting methods.

³ Lake Zone: Tabora, Kigoma, Shinyanga, Kagera, Mwanza, and Mara regions. Central Zone: Dodoma and Singida regions.

⁴ The PSSS is a periodic public opinion survey conducted under the auspices of Tanzania's Poverty Reduction Strategy Program (PRSP).

Source of method

The major source of modern family planning methods is the government/parastatal or public sector, accounting for 68% of supply. The dominance of the public sector has changed little since 1992 (Figure 14). In the 2004–2005 DHS, 8% of users of modern contraception obtained their method



from the religious/voluntary sector, 5% from the private medical sector, and 18% from some other private source. A key contributor to the increase in the private sector's contraceptive market share is Tanzania's widespread national pharmacy network, which increased its share from 2% in 1992 to more than 10% in 2004.

The public sector is the source most commonly reported by users of female sterilization (67%), the pill (78%), injectables (84%), and implants (76%). Seventy-seven percent of male con-

dom users reported the private sector as their source—specifically, pharmacies (36%) and shops or kiosks (37%).

The HIV/AIDS epidemic

Tanzania's mainland faces a generalized HIV/AIDS epidemic, with a 7% prevalence rate (6.3% among men and 7.7% among women). Close to 85% of HIV transmission in Tanzania occurs through heterosexual contact, less than 6% through mother-to-child transmission, and less than 1% through blood transfusion. HIV is firmly established in Tanzania's urban and rural areas, particularly in high-transmission trading centers, in border towns, and along transport routes. The National AIDS Control Program surveillance reports significant regional variations in infection rates. Men and women are differentially affected, with the peak number of AIDS cases among women occurring in 25–29-year-olds, while among males it is in 30–34-year-olds. HIV prevalence is very low in Zanzibar.

Given the high rates of infection, Tanzania is receiving more than US \$100 million per year from donors, notably the Global Fund for AIDS, Tuberculosis, and Malaria and the U.S. President's Emergency Plan for AIDS Relief. While this level of funding is necessary and welcomed to address the epidemic, it is diverting human resources and facilities from other health programs, including family planning. For example, the Medical Store Department, so important to contraceptive security, is diverting staff and facilities to meet the demands for HIV test kits and antiretroviral drugs. One stakeholder put it succinctly: "Everything has been sideswiped by HIV/AIDS."

Decentralization, health-sector reform, SWAps, and PRSP

Decentralization

Decentralization of public administration was an integral component of the development policies promoted immediately after independence to achieve self-reliance, meet basic human needs, and distribute the benefits of economic growth equitably. Under the 1996 Civil Service Reform, all

government departments at the district level (earlier under the direct supervision of the line ministries) were to be supervised by local government authorities. In theory, local district councils were held responsible for decentralized planning and management of primary health care in the districts. As a result, parallel hierarchical institutional structures were created over time under the Ministry of Health. Talks about reforming the health sector began in 1991 as part of structural adjustment policies, and were formalized in the Health Sector Action Plan in 1995. The process of all public-sector reforms is mostly donor-funded (by World Bank, by Denmark, the United Kingdom, and Switzerland, and by other bilateral agencies).

Beginning in 1997, the Tanzanian government decentralized responsibility for the delivery of basic health services (including family planning) to the district council level. Seven years later, in June 2004, the World Bank concluded that the MOH had not been successful in its human resource development efforts in line with the needs of decentralization. While the MOH succeeded in opening (funding) vacant posts at the district level to meet staff shortages, these posts frequently remained unfilled by the local government. It is challenging for poorer districts to find applicants for funded positions, while more attractive districts have unemployed health providers. Salary levels in the public sector are low compared with other options; private-sector salaries are twice as high, and salaries in neighboring countries are three to four times more. HIV/AIDS adds to the burden, with the HIV/AIDS challenge threatening to monopolize a large portion of the health sector:

Without a way to break through the human resources for health impasse, the Tanzanian government's laudable recent commitment to the care and treatment of HIV/AIDS will either a) succeed, but overwhelm the provision of basic services essential to reduce mortality and morbidity from other causes, or b) fail, or at least fall well short of the levels of HIV/AIDS care and treatment required to contain the disease, but still drain away more human resources for health than the rest of the system can adjust for.

(McKinsey & Company, 2004)

Health-sector reform

As a part of health-sector reform, the government introduced cost recovery to enhance health system sustainability, improve availability of drugs, reduce inefficiency (e.g., by discouraging unnecessary use and preventing bypassing of lower-level facilities), and improve equity (through its impact on utilization). User fees are fully operational at all levels. A system of exemptions was established for maternal and child health and family planning services, together with waivers for the most indigent patients. While cost-sharing in government facilities has exempted maternal and child health and family planning services, with the introduction of cost sharing, some public-sector health facilities ask clients to pay a token fee. Such payments may be in the form of paying for patient cards or contributing toward the cost of supplies in the maternity wards. The exception is that faith-based facilities that serve as designated district hospitals and facilities owned by NGOs such as MST charge for services. Though the service should be exempt, some FBOs and NGO/private facilities charge 2,500–5,000 shillings for female sterilizations, while postabortion care clients pay up to 15,000 shillings. Catholic hospitals that serve as district hospitals frequently do not provide any modern family planning services.

The Local Government Reforms and the health-sector reforms are not well synchronized. For example, the Local Government Guidelines for Comprehensive District Plans do not permit support for training of more than one week in duration. Yet the shortest MOH training module for family planning is two weeks long. In general, the only family planning training at the district level in the last decade has been “off-budget” under donor and NGO/FBO programs.

Sector-wide approaches (SWAp)

Beginning in 1996, the MOH collaborated with the World Bank and other partners to prepare the framework for a Sector-Wide Approach (SWAp) in the health sector. The Reproductive and Child Health Services (RCHS) program itself was integrated into a broader health-sector program, and stakeholders outlined joint funding mechanisms, called the “basket.” Several donors shifted their family planning funding from targeted geographic programs or contraceptive commodities to the basket. The basket became effective in 2001–2002. As of 2004, all major donors participate in the basket or in general budget support. USAID maintains its place at the table with the health stakeholders, but it does not contribute funding to the basket.

At the district level, family planning must compete with many other priorities for funding within the Comprehensive Council budget. A 1999 survey of District Health Management Teams (DHMTs) found that family planning ranked fourth in terms of priority, behind maternal and child health, sexually transmitted infections (STIs), and “other” health services, but ahead of tuberculosis and malaria. Budget allocations made by the DHMTs closely correlated with these priorities (Hutchinson, 2002). Many districts have returned funds at a time when the program was facing stockouts of commodities and expendable supplies.

Poverty-reduction strategy program (PRSP)

In parallel with the development of the health SWAp, the Tanzanian government developed and launched the Poverty Reduction Strategy Program (PRSP), which includes preparation of successive three-year Medium Term Expenditure Framework (MTEF) budgets tied to achievement of key milestones. There is only one indicator for family planning within the PRSP, related to “number of new family planning acceptors,” which is not reported on. This lack of reporting tends to confirm the family planning program’s overall loss of visibility and identity over the last decade: As one key informant commented, “Family planning just fell off the government’s radar screen.”

The PRSP’s key strategy for decentralization is the Local Government Reform Program (LGRP), which has a significant impact on funding for family planning services. The LGRP transfers funding and budgeting responsibility from the central level to district levels for all development sectors. However, “there is still limited coherence between the LGRP and the Sectoral Reform Programs (such as health). This has already hampered effective district planning and has affected the allocation of funds to districts and nongovernmental development actors (and hence the implementation of essential development interventions)” (World Bank, 2004). Further, local government reforms for training conflict with those of the health sector: The former support training of one week’s duration, whereas the shortest MOH family planning training module is two weeks long. This contributes to the dearth of skilled staff.

Supervision of hospitals, health centers, and dispensaries as part of the health-sector integration and decentralization is undertaken through the use of a matrix in which family planning is often overlooked. The council health management teams responsible for supervision do not by statute include the reproductive and child health coordinator; such participation is ad hoc for some district councils.

Program

Family planning services have been available in Tanzania since the late 1950s. UMATI introduced family planning services in 1959, opening urban clinics in Dar es Salaam, Kilimanjaro, and Lindi. The Tanzanian government became actively involved in providing family planning services in 1974, with the integration of family planning services into the MOH’s maternal and child health program.

However, it was not until the mid-1980s that Tanzania recognized the effects of a high population growth rate on the magnitude of social service needs and on natural resources deterioration. With support from the United Nations Population Fund (UNFPA), the government initiated a national childspacing program in 1984. Other donors in the 1980s included USAID and the International Planned Parenthood Federation (IPPF), which provided support for training, for information, education, and communications (IEC) activities, and for commodities.

By the end of 1988, government and mission/FBO network facilities (with the exception of Roman Catholic facilities) had joined forces as a national public-sector program and provided family planning services for free, with UMATI mandated to provide supervision and quality assurance in the public sector. The majority of these service-delivery points were limited to short-acting methods, and an evaluation of this program noted that a lack of trained providers and poor logistics support hampered expansion of services (UNFPA, 1996). There was no public-sector-supported community-based distribution (CBD) and/or services, social marketing, or private commercial services, and fewer than one-half of all women (42%) lived within one hour of a facility providing family planning services.

The launch of the National Family Planning Programme

Many service providers and stakeholders who have been associated with family planning in Tanzania cited a 1988 speech by former President Nyerere as being pivotal to placing family planning on the national agenda. The MOH understood the value of building on the national visibility and in 1989 undertook its first orientation of the national parliament. The government began two exercises that same year that demonstrated a more proactive role in family planning: It designed a national population policy,⁵ and it drafted a five-year plan of operations. The National Family Planning Programme (NFPP) was launched in 1989. Tanzania established the Family Planning Unit (FPU) to be the overall manager of the NFPP. Tanzanian and international stakeholders interviewed for this study had high and uniform praise for the MOH's strong vision and leadership in the early years of Tanzania's national family planning program. One key informant said during an interview that "the early 1990s were the 'Golden Age' of family planning in Tanzania." A number of other informants expressed similar views.

The 1990s were the "Golden Age" of family planning in Tanzania: Necessary policies and guidelines were in place; committed national leadership provided vision and strategies; and a small group of donors, NGOs, and FBOs assisted and complemented MOH service delivery. Modern method use rose from 6.6% in 1992 to 13.3% in 1999.

To support the NFPP, USAID designed the Family Planning Services Support (FPSS) Project (1990–1999), which focused on the basics—training, supervision, logistics, and IEC—and expanded access through CBD programs and social marketing. In addition, in the south, the British provided support to Mbeya Region throughout the 1990s. Germany began an integrated rural development program in Tanga in the 1970s and expanded it to Lindi and Mtwara regions in the 1990s. This program has since taken over assistance to Mbeya from the British. These donors forged close partnerships with regional and district technical and elected officials, as well as with religious missions in those regions, and are achieving impressive results. Prevalence rates in these regions increased more than 20-fold, and prevalence exceeds the national average. The high contraceptive prevalence rates (34–45% in Mbeya, Lindi, and Tanga) are frequently linked to the important German-assisted CBD program there.

⁵ Drafted in May 1989, the policy was approved in 1992.

UNFPA's first three country program (1981–1996)⁶ made significant contributions to the development of Tanzania's first National Population Policy and to the strengthening of government capacity to deliver maternal and child health and family planning services, including the establishment of the NFPP under the Family Planning Unit of the MOH.

While not all higher performing areas have been associated with the presence of a donor presence (e.g., Dodoma in central Tanzania, with a 147% increase in prevalence between 1992 and 2004), none of the low-performance areas has benefited from an intensive and long-term donor presence for family planning. In any event, collective donor influence has largely been subsumed in the more recent SWAp and MDDBS approaches.

A focus on the basics

Training

Prior to 1990, a great deal of “training” had been going on, but very little was competency-based. Further, providers who were trained in IUD insertion would go back to their sites without insertion equipment, expendable supplies, or even IUDs. Policies restricted the role of primary health care 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 and the MOH to develop a more rational system of clinic-based family planning training.

Regional training teams were developed so as to institutionalize in-country capacity to continue training. Donor flexibility and the availability of additional funds permitted the training to go nationwide. Assistance was flexible and adapted to changing needs. FPSS devoted major resources to the training of providers to increase access to LAPMs, including voluntary sterilization, the Norplant implant, and the IUD (inserted postpartum). UMATI developed a decentralized system of training and supervision of LAPM teams.

At the policy level, USAID assisted the MOH to develop training strategies that clearly spelled out national training objectives—numbers to be trained, types of training, implementers, and donors. For the first time, the NFPP had a plan of who needed to be trained, in what, by whom, and at what cost. A series of national guidelines, curricula, and standards were developed to ensure that medical and legal barriers were minimized.

Communication strategies: “Put the Green Star under your bed!”

Tanzania's National Population Policy called for wider dissemination of family planning information. From 1991 to 1994, the MOH, with USAID support, undertook a Family Planning Communication Project to expand the target audience to all men and women of reproductive age. In May 1992, a new national family planning logo, the Green Star, was officially launched by Tanzania's president, Ali Hassan Mwinyi. Numerous media activities by NGOs (MST and UMATI) and other donors complemented the MOH work, including the airing of Zinduka radio spots. The UNFPA-supported radio serial drama by Radio Tanzania, *Twende na Wakati* (“Let's Go with the Times”), has run continuously since 1992. The social marketing's Modern Methods Family Planning Campaign (*Mama Ushauri*), aimed at periurban populations, communicates the general benefits of birthspacing and addresses common misconceptions about family planning methods.

The Green Star campaign created a logo and recognition that remains strong today, with very little supporting communications. Informants joked that “You need to put that Green Star under your bed!” is a familiar jest for couples with four or five children. A 1999 study concluded that

⁶ UNFPA's Fourth Country Programme (1997–2001) showed a significant reorientation away from the family planning focus of previous country programs.

“...women’s exposure to media sources of family planning messages was associated with increased contraceptive use, especially that of modern methods. ... Furthermore, use of modern methods rose as the number of media sources increased, reaching 45% among women exposed to six media sources” (Jato et al., 1999). Given the limited scope and duration of the media program, only about 5% of women were exposed to television or radio spots, and only about 30% were exposed to print materials, with wide variation by region and by urban or rural location.

Logistics and contraceptive supply

Until 1992, contraceptive ordering was done individually by each donor. Orders were not coordinated by either donors or the government. There were virtually no service delivery or consumption data, and certain items (e.g., oral contraceptives) were overstocked at the central level, with stockouts nationwide at the service-delivery points. The FPSS provided an umbrella for preparation of annual contraceptive procurement tables, and USAID Mission staff ensured that other main donors (UNFPA and the Overseas Development Authority [the predecessor to the Department for International Development]) participated in planning,

Filling the pipeline with the right quantities, warehousing them properly, and transporting them so that they reached service-delivery points on time was a major achievement. New contraceptive methods and services were added to the mix—no-scalpel vasectomy (1992), injectables (1992), and Norplant implants (1995). As one key informant noted, “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.”

Expanding access—Community programs and social marketing

Tanzania has a long history of community involvement in development, both in traditional tribal structures and later from the *Uhuru* movement during the socialist years. German aid, the Seventh Day Adventists, the Evangelical Lutheran Church in Tanzania, UMATI, MST, and many other NGOs and FBOs are recognized as having had community-based health workers involved in family planning in the 1980s and early 1990s. The MOH wisely decided to build on this history and experience, and in 1993 it launched the MOH National CBD Program in four regions (Dodoma, Tabora, Iringa, and Coast). It developed National CBD Guidelines and trained approximately 300 trainers and supervisors. With assistance from NGOs, FBOs, and donors, the government was able to scale up this program almost nationally by the end of the 1990s.

USAID has supported the social marketing of products in Tanzania since 1993. The social marketing program made great strides in increasing the awareness and utilization of reproductive health and HIV/AIDS prevention products, particularly the condom. The name of the socially marketed brand, *Salama* (Safe), has become the generic word for condom in Tanzania, and since 2000, revenue from *Salama* sales has underwritten the cost of condom procurement. The female condom, *Care*, was launched in 1998, and the oral contraceptive, *SafePlan*, was introduced in 2001. Brand promotion has been primarily through mass media (television and radio spots), with rural outreach consisting of road shows and mobile video units.

Loss of focus and momentum—Program shifts from vertical to integrated

Despite early vision and leadership for the family planning program, its prominence on the national agenda diminished significantly by the end of the 1990s. In 1994, the same year as the International Conference on Population and Development in Cairo, the MOH began a series of reforms that eventually included integrating vertical health programs into the general health services and redefining the role of the central MOH as facilitator of health services, providing policy leadership and serving in a normative and standard-setting role. In 1998, the family planning program was integrated into the broader RCHS, where it remains in collaboration with the Hospital Directorate.

Systemic integration and other reforms diluted family planning’s prominence and contributed to a significant loss of momentum. As one long-time service provider explained: “Under integration, now we all do everything ...and we all do nothing.”

From 1999 to 2004, disruptions in the availability of funding at both the national and district levels caused by integration and reforms in the health sector, coupled with decentralization, local government reforms, and the PRSP/MTEF processes, resulted in uneven progress across regions. While some regions maintained good progress, the national contraceptive prevalence rate increased modestly, from 25.4% in 1999 to 26.4% in 2004–2005, and the TFR did not change.

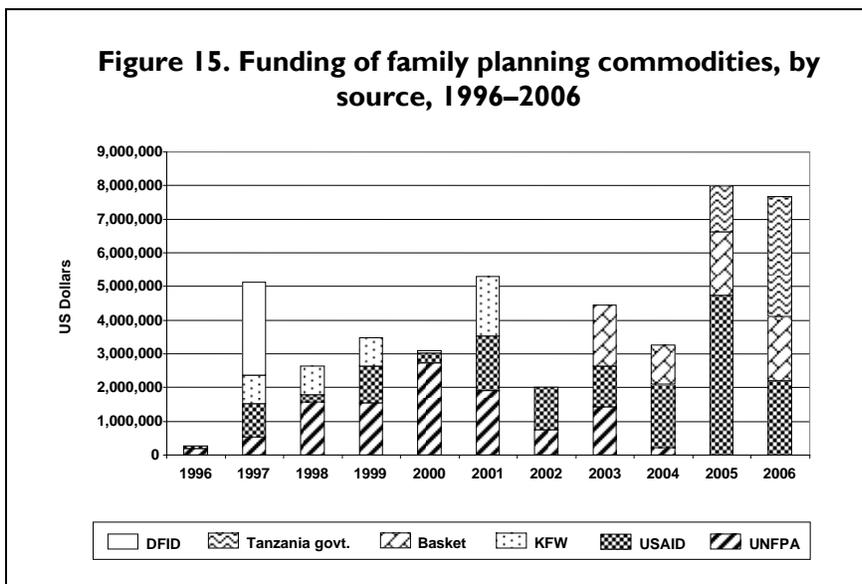
In-service training in family planning for doctors, clinical officers, midwives, nurses, and nursing assistants was well-established in the early to mid-1990s, but subsequently it was seriously affected by decentralization. Even during the period 1994–1999, when training was a focus, it was not very far-reaching. Only 78% of targeted regional trainers, 20% of district trainers, and 24% of preceptors were trained, and these in turn reached only 52% of zonal regional maternal and child health officers and 30% of DHMTs. Except through donor “off-budget” programs, in-service training has not been funded since about 1997, due to inconsistencies between local government regulations and MOH requirements.

Many dedicated and committed providers have only recently benefited from contraceptive technology updates or refresher courses *for the first time since the mid-1990s*. There is no current national training strategy for family planning.

Contraceptive security

The shift to basket funding and—increasingly—budget support had a significant effect on the family planning program, most visibly with regard to procurement of contraceptive commodities. Prior to the basket, the MOH and donor partners got together about once a year to develop contraceptive procurement tables and obtain pledges for “off-budget” provision of contraceptives. Once the basket became operational, the RCHS had to suddenly establish a large line item for contraceptive procurement in the MOH budget where none had previously existed. A line item was developed, and limited funds were made available for logistics to move contraceptives from the central office to the zones/regions. However, it was not till 2004–2005 that the Government of Tanzania purchased contraceptive commodities. On the procurement side, the RCHS now had to collaborate with the semi-autonomous Medical Stores Department to procure contraceptive commodities on the world market in a cost-effective and timely manner. As shown in Figure 15, there was a sharp shift in the source of contra-

ceptive funding from 2001 to 2004, with USAID support being the only constant source of funding.



The German development bank KFW's last year of direct procurement of contraceptives was 2001, but its contribution to the basket is not reflected in contraceptive procurements until 2003. UNFPA decreased its direct procurement more slowly, but it was fully absorbed into the basket as of 2005. In 2005, the MOH and key stakeholders effectively lobbied for, and obtained, a line item for contraceptives within the MTEF budget associated with Tanzania's PRSP. As a result, the Tanzanian government is now contributing significantly to the procurement of its own contraceptives.

The MOH's shift to basket funding and to district budget authority for the RCHS was accompanied by significant stockouts of contraceptives. Data from a sample survey taken as part of a July 2005 Situation Analysis illustrate the problem:

- ◆ On average, 53% of facilities had been stocked out of at least one family planning product for more than 30 days in the last year.
- ◆ The pill had the highest stockout rate, with one brand at 94% and another at 70%.
- ◆ Injectables were the next highest, at about 60%, followed by condoms at 35% and the IUD at 12%.
- ◆ Government facilities were more likely to be stocked out than were the mission/FBO facilities.

Simply stated, there was not enough money in 2002–2003 to order adequate supplies for 2004.

There is no coordinated logistics and supply system in the health sector. As of 2004, three logistics systems (Kit, INDENT, and LMIS) provided basic commodities (essential drugs, basic medicines/supplies, and contraceptives) to Tanzania's 4,000 public, mission/FBO, and parastatal health facilities. Each system is a little different and has either a top-down or bottom-up management style. As of 2004, the Kit system⁷ used a "push" approach and was still functional in about 40% of Tanzania's 121 districts, while the INDENT "pull" system for essential drugs was in the other 60%. The family planning commodity system (LMIS) was established around the mid-1990s and was a "pull" system. There are also separate systems for drugs for tuberculosis and leprosy; for the Expanded Program of Immunization; and for HIV/AIDS test kits and antiretroviral drugs.

The confusion was widespread, and emergency shifting of stock from one facility to another to compensate for imbalances was common. The result was wide swings in various commodity levels throughout the system and a weakened national program. The MOH is now pilot testing an Integrated Logistics System that combines essential medicines and contraceptives into one system.

That the Tanzanian government now finances and manages procurement of half of its own contraceptives is an important achievement in and of itself. There were growing pains during the transition, since MOH officials needed to develop procurement skills and relationships with vendors. Problems in the flow of funds for procurement and for district-level training, together with inadequate attention to the need to absorb multiple and uncoordinated logistics management systems, contributed to supply-side disruptions. In November 2005, significant stockouts throughout the country still were affecting the program's credibility. One nurse explained: "They come and yell at me, what can I do? I have nothing to give them."

⁷ A kit of basic medicines and supplies delivered to the district bimonthly, based on estimated requirements of one kit per facility per month and without facility or district report-back on drug use.

Lessons Learned

Lessons learned from Tanzania’s experience include the following:

Even successful programs are fragile. Success cannot be taken for granted.

In the 1990s, Tanzania posted one of the largest annual increases in contraceptive prevalence in the East Africa Region—two percentage points per annum. Five years later, the annual increase in contraceptive prevalence had dropped to 0.2 percentage points per annum.⁸ Family planning does not exist in a vacuum, and programs and services are easily lost in the jumble of health-sector reform and competing health priorities. Donor funding and interests shift, as demonstrated by the influx in funding for HIV/AIDS, malaria, and avian flu.

“The job is not done yet—stay the course, as change takes time.”

Consistent and meaningful commitment of national and local government (and donor) attention and resources over time is essential if a country is to avoid a loss of momentum like that seen in Tanzania. Particularly in the context of complex reforms, the visibility of the family planning program and adequate resources for its viability must be maintained. This in turn demands a proactive stance by family planning supporters and managers. At the operational level, ongoing efforts to develop human resources and systems to implement reforms effectively are equally important.

Invest in the basics—no access, no program. The adage “No product, no program” needs to be expanded—no product, no trained provider, no equipped/supplied site, and no attention to information and behavior change equals no program. It is important that family planning services be available routinely and regularly, with trained staff and a reliable supply of commodities for a broad method mix. Limited method mix, particularly in more remote areas, contributes to unmet need and decreased contraceptive use. Training of all types and at all levels (didactic and clinical, technical and managerial, preservice and in-service) will continue to be a necessary and important intervention. A diminished focus on family planning as a result of sectoral and local government reforms, and inconsistencies between the MOH technical program and local government requirements, have resulted in insufficient family planning training, adversely affecting the quality of services and therefore their use. Attention to advocacy, IEC, behavior change communications, and demand creation is a necessary part of holistic programming; neglecting it will diminish program impact. These are important tools in support of informed choice and demand creation. Supply must keep pace with demand, and vice versa. Demand for services will increase when clients know that services are available and that others have found the quality of those services acceptable.

Nurture champions. Continued, strategic, multilevel advocacy is needed to maintain government, donor, and private-sector commitment to and leadership for family planning. Such advocacy is especially indicated during periods of government reorganization and reform, and/or when more urgent priorities such as HIV/AIDS threaten family planning resources. Without at least one accomplished champion, the chances of successfully sustaining, nurturing, and transforming a program are virtually nil. Dedicated individuals maintain focus and motivation to sustain programs

⁸ Similarly, Malawi’s annual increase in contraceptive prevalence has dropped to 0.4 percentage points per annum over the past five years.

over time. In Tanzania, a small, highly motivated family planning unit ensured the early success of the program. The Program Manager of the NFPP went on to head the Preventive Services Department of the MOH, where she was able to continue to advocate for and support attention to the family planning program. Donors, including UNFPA and USAID, also lobbied to ensure that the program received attention and funding.

With decentralization under health-sector reform, however, the Tanzania program lost many of its local champions. The Council Health Management Teams responsible for supervision do not by statute include the district reproductive and child health coordinators, thus eliminating the potential for these champions to influence the program at the local level.

Money, timing, and flexibility are critical to program success. The timing of USAID’s FPSS project in 1991 coincided with the establishment of the NFPP. FPSS became a nine-year, \$30 million project. In addition, large amounts of central funds were made available, and other donor support increased. Concurrent with the money, technical assistance was available in sufficient quality and quantity to support initial NFPP activities. Complementary activities with UNFPA and ODA (clinical and logistical training, and contraceptives) provided some synergy to USAID support.

“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 the Family Planning Unit) were provided almost simultaneously—nothing lagged behind.”
[D. Vogel]

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Appendix I: List of Persons Contacted

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Paul Mwakipesile, Service Delivery Officer (Arusha)
Lillian Shoo, Project Assistant (Arusha)

USAID/Tanzania

Pamela White, Director
James Allman, Ph.D., Health Public Sector Team Leader
Charles Llewellyn, Chief, Health Strategic Objective Team
Michael V.C. Mushi, Project Management Specialist
Dr. Sithara Batcha, International Development Intern, Health Strategic Objective Team
John Dunlop, former Chief, SO10/USAID/Tanzania
Dana Vogel, former Chief, Health/Population/Nutrition Office/USAID/Tanzania 1991–1995

USAID/Washington

Joan Robertson, Global Health Bureau
Shawn Malarcher, Global Health Bureau
Alexandra Todd-Lippock, Global Health Bureau
Elizabeth Warnick, Global Health Bureau
Ishrat Husain, Africa Bureau
Tanvi Pandit, Global Health Bureau
Dana Vogel, Global Health Bureau

Ministry of Health

Dr. Zacharia A. Berege, Director of Hospital Services, Ministry of Health
Dr. Catherine Sanga, Head, Reproductive Health Section, Ministry of Health

Other Donors

Nicola Jones, Representative, UNFPA
Dorothy Temu-Usiri, National Program Officer, UNFPA
Cordula Schuemer, Policy Advisor, Reproductive Health, GTZ
Akwilina Mlay, GTZ

Kilimanjaro Region

Dr. K. Saganda, Medical Officer i/c, Mawenzi Hospital
Ms. M. Kaale, Regional RCH Coordinator
Dr. A. Mtamakae, Medical Officer, Moshi Municipality
Mr. E. Makunde, Health Officer, Moshi Municipality
Ms. M. Mosha, Nurse/Midwife, Majengo Health Center
Five satisfied clients from Majengo Health Center
Ms. E. Shayo, Municipality RCH Coordinator
Ms. B. Mushi, Matron, Machame Hospital

Mr. J. Mwanga, Hospital Secretary, Machame Hospital
Dr. M. Mvungi, Medical Officer-in-Charge, Machame Hospital
Dr. B. Lema, Ob/Gyn, Machame Hospital, and focal person for ACQUIRE Project

Arusha Region

Dr. H. Mariki, Acting Regional Medical Officer (Surgeon)
Dr. J. Lekundai, Ob/Gyn, Mount Meru Hospital
Ms. M. Mallya, A/Arusha City Nursing Officer
Ms. R. Mushi, Arusha City RCH Coordinator
Dr. E. Shayo, In-Charge, Ngarenaro Health Center
Five satisfied clients from Ngarenaro Health Center
Reuben K. Makala, Max Medics Pharmacy

Manyara Region

Ms. M. Mwanba, Nurse/Midwife Magugu Health Center (Hanang District Council)
Ms. E. Msuya, Clinical Officer, Magugu Health Center
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Current/Former Cooperating Agency Participants at Arusha Repositioning FP Discussion

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Leah B Manongi, ACQUIRE/EngenderHealth
Moshi Ntabaye, ACQUIRE/EngenderHealth
Veronica Nkurunziza, Marie Stopes Tanzania

Appendix 2: Documents Reviewed

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