THE STATUS OF FAMILY PLANNING SERVICES IN KISARAWE DISTRICT

A Rapid Assessment Report

April 2012

The Advocacy Network on HIV and AIDS in Tanzania (ANAT) and Advance Family Planning (AFP)

INTRODUCTION

The Advocacy Network on HIV and AIDS in Tanzania (ANAT) is one of 11 Tanzania Non-Governmental Organizations (NGO's) implementing the Advance Family Planning (AFP) project within a coalition known as the Reproductive Health Supplies Coalition. AFP is a three-year advocacy initiative that aims to increase funding and improve the policy environment for family planning services in Tanzania.

The coalition values family planning as a preventive measure in reducing unintended pregnancies, unsafe abortions and maternal and child deaths. According to the National Road Map Strategic Plan for Accelerating Reduction of Maternal and Child Deaths, family planning can prevent 20 to 35 percent of all maternal deaths. Also the analysis done by United Nations Population Fund (UNFPA) in 2007 (*Family Planning and Poverty Reduction – Sheet 4 English. P65)* revealed that every 1,585 shillings spent by government for family planning can save 49,135 shillings spent in health, water, education and other social services.

Working closely with the Ministry of Health and Social Welfare (MoHSW) and the established Parliamentary Family Planning Club (PFPC) and other stakeholder organizations, the AFP contributed to a successful effort to increase the government budget for family planning from 0.5 billion shillings (2010/2011) to 1.83 billion shillings for the fiscal year 2011/2012. Other key milestones are the inclusion of family planning as an item in the Ministry of Health and Social Welfare' Mid-Term Expenditure Framework (MTEF) and the space dedicated by major media houses to support family planning advocacy agenda.

While AFP continues to work with the central government and other national stakeholders, the project is expanding to work within two local government authorities, Kinondoni (urban) and Kisarawe (rural). The aim is to accelerate the implementation of the nationally set targets and indicators for family planning at the district level. These national targets, among other things, include the attainment of the 60% national contraceptive prevalence rate by 2015 as a preventive approach towards reduction of maternal deaths from 454 (2010) to 175 for every 100,000 live births and child deaths from 112 to 45 for every 1,000 live births by 2015 as per the National Strategy for Growth and Reduction of Poverty (MKUKUTA II) and National Family Planning Costed Implementation Program (NFPCIP).

In focusing on district-level advocacy, the following points were considered:

- Advocacy to improve the policy environment for family planning has yielded strong national policy commitments as witnessed in the health policies and poverty reduction strategies and guidelines prepared by government under the Ministry of Health and Social Welfare. However, while Central Government remains a policy maker and coordinator, the majority of local government authorities (the implementers) have not comprehensively localized the implementation of these policies in their development plans (District Strategic Plans, Comprehensive Council Health Plans and Annual Action Plan).

- Since Tanzania District Authorities have a mandate to collect revenues from their own sources and allocate them according to their respective identified areas of priority, district-level advocacy has great potential in complementing national efforts and contributing to a reduction of the family planning funding gap nationally.

- Encouraging in-roads have taken place at the national level with respect to increased family planning funding from the government's own resources (the increase of family planning budget from 0.5 billion to 1.83 billion). The positive trend needs to be complemented by action at the local government authority (LGA) level, where most do not include family planning in their district plans and budgets, as part of national budget process.

- Eighty percent of family planning services are provided by decentralized public-sector health facilities through 133 LGAs. Yet, the order of the day is poor service provision and inaccurate forecasting and quantification of the demand for family planning, which contribute to stockouts and increasing unmet need for family planning among women who want to prevent pregnancy but are not using contraception.

From these premises ANAT, within the AFP project, conducted a field rapid assessment from 2-3 April 2012 to document the family planning situation in the Kisarawe district. The assessment was designed to highlight:

- Trends in maternal and child deaths and efforts taken by the Kisarawe District Authority in reducing them.

- The situation of reproductive health and family planning services in the district.

- The extent to which the district has prioritized family planning in their development plans and budgeting processes.

- Action points that AFP advocacy partners can take in helping the district authority accelerate reduction of maternal and child mortality through reproductive health and family planning approaches.

METHODOLOGY OF THE ASSESSMENT

The ANAT team led by Mr. Zacharia Ssebuyoya in collaboration with AFP office staff conducted a literature review of national policy and guidelines to extract the roles assigned to district-level governments on reproductive health, family planning and reduction of maternal and child deaths. The reviewed documents include:

- The National Strategy for Growth and Poverty Reduction II—MKUKUTA II,
- Tanzania Reproductive and Child Health Policy Guidelines (2003);
- National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008 -2005 (One Plan);
- National Family Planning Costed Implementation Plan (NFPCIP) 2010-2015.
- Tanzania Demographic and Health Survey, 2010; and
- Comprehensive Reproductive Health Community Assessment, November 2011 (UNFPA report).

The team next developed a tool for collecting updated and relevant information from a variety of district leaders (District Development Director as entry point person, District Council Chairperson, District Health Committee Chairperson, District Budget Committee Chairperson, District Planning Officer, District Medical Officer, District Nursing Officer, District Reproductive and Child Health Coordinator, District Social Welfare Officer, and Acting Program Officer of Plan International as one of the strong NGOs operating in the district). The tool is attached as **Appendix 1** of this report.

Then on March 26 2012, ANAT fixed an appointment through a letter sent to the Kisarawe District Development Director (DED) with the timetable requesting that he and his executives meet the project officers on the first week of April 2012. As a result of the letter, ANAT got a chance to conduct an interview with district executives from 2-3 April 2012.

Mr. Zacharia Ssebuyoya (ANAT), accompanied by Renna Mtenga (ANAT), Neema Duma (Tanzania Gender Networking Program- TGNP), Peter Bujari (Human Development Trust) and Edward Kinabo (AFP-Tanzania office), led the interviews. The

interviewers, guided by the list of questions, employed an interactive and conversational style to get the required information. In addition to the interviews the team accessed and reviewed relevant district development plans including the Comprehensive Council Health Plans, Annual Development Plans and the District Strategic Plan 2007/2010.

RESULTS OF THE RAPID ASSESSMENT

1. Kisarawe district is one of the seven districts of Coast Region with a population of 113, 780 people, 25,779 being women of the reproductive age, as per the 2002 National Census.

2. The number of maternal deaths has fluctuated from 2008 up to the time of the assessment (April 2012) and follows closely with the availability of reproductive health and family services, which depends mainly on the projects implemented by service provision organizations. In Kisarawe nine women's deaths were recorded as resulting from pregnancy-related causes in 2008.In subsequent years, maternal deaths were 4 (2009), 2 (2010), 5 (2011) and 2 by April 2012 (CCHP 2011/2012). According to statistics provided by the district coordinator for reproductive and child health section, Ms Felista Kiyemi, neonatal deaths increased from 39 in 2010 to 49 in 2011 (statistics from prior years were not found).

3. Organizations mentioned to have helped the district in the provision of family planning services (e.g.building capacities of health providers or supporting community-based distribution of family planning) are Engender Health, Plan International, Marie Stopes Tanzania and UNICEF.

4. Contraceptive use in Kisarawe has decreased from 26% in 2010 to 4.51% in 2011[1]. Low contraceptive use is mainly attributed to limited access to family planning services and partly due to misconceptions that family planning methods can cause cancer or impede women's fertility.

5. With respect to availability and accessibility of contraceptives, Kisarawe district is grappling with data collection on quantification and forecasting of these commodities. A number of bottlenecks have been identified, which include the timing of data gathering (February/March), which is not in line with the Ministry of Health and Social Welfare's budgeting exercise through the Mid-Term Expenditure Framework [2].

[1] District Reproductive Health Service Statistics, 2011, Kisarawe
[2] A Comprehensive Reproductive Health Commodity Security (RHCS) Assessment in Tanzania mainland)

6. The most preferable modern family planning method in Kisarawe is the contraceptive injectable and the least preferred is the oral contraceptive pill. Frequent stock-outs of all types of contraceptives in Kisarawe are due to inadequate supply within health facilities, which access commodities through the Medical Stores Department (MSD) with financing from the Central Government and Donor Community. The district has never financed their own contraceptives at any time, leaving it as the specific duty and procedure of the central government through the MSD.

7. The district has about 24 health facilities, which include one district hospital, three health centers and 20 dispensaries. Of these facilities, 19 provide family planning services while five cannot do so due to lack of necessary infrastructure and skilled personnel.

8. Family planning has not been prioritized in the district annual budgets though listed in the Council Comprehensive Health Plan (CCHP), as evidenced in the 2011/2012 CCHP. The financing of family planning service provision has been mainly left to the central government and the donor community working in Kisarawe. This situation affects implementation of planned activities because in most ocassions the funds are either not released on time or not released at all.

9. Some of the key reasons given by the office of District Medical Officer (DMO) for "de-prioritizing" family planning in the annual district budgets is inadequate district revenues and in particular, the negative attitude of some politicians on family planning. There is also seemingly minimum effort to prioritize family planning due to competing health priorities such as tuberculosis, malaria, HIV/AIDS and frequent outbreaks of communicable diseases like cholera, as advanced by district authorities.

10. Though nearly all councilors are concerned with the problem of maternal and child deaths, when it comes to tackle it, the interest has been in opting the short-term interventions (for building fast political profiles) instead of investing in the preventive solutions like family planning whose results are perceived to not be immediate or as urgent.

11. Apart from the councilors, district officials also set priorities. The District Council Management Team, District Council Finance Committee, District Council Health Services Board and District Council Health Management Team tend to focus more on taking care of the burden of chronic and infectious disease, which contributes to family planning being a lower budget priority.

12. Kisarawe district faces a number challenges in providing family planning services. These include inadequate health providers to render the services, inadequate supply of reproductive health commodities including contraceptives, as well as challenge of maintaining trained technical staff including those tasked with community-based distribution of services and supplies. The District RH Coordinator says the district needs 50 family planning service providers but they only 25, 18 of who need urgent training in family planning.

13. Though family planning is listed in the CCHPs, the ANAT review of the Kisarawe Strategic Plan (2007-2010), revealed that there is neither an indicator(s) nor strategic activity included in the document.

RECOMMENDATIONS FOR KISARAWE DISTRICT AUTHORITY

1. Recognize that district commitments are critical to reducing maternal and child deaths.

To achieve the national target (MKUKUTA II) of reducing maternal deaths from 454 to 175 by 2015, on average there should be no more than 1 maternal death occurring in each of Tanzania's 133 districts. This implies that trends in maternal and child deaths (neonatal) in Kisarawe are already falling short of contributing to attainment of MKUKUTA target and therefore sustained commitment to reverse the situation is critical.

1. **Prioritize family planning in annual district budgets.**

Since the Kisarawe district authority, like all districts, is obligated to complement central government efforts in attaining the 60 percent national contraceptive prevalence rate by 2015 as a preventive approach towards reduction of maternal and child deaths, the prioritization of family planning at both planning and budgetary levels is highly recommended in order to ensure effective implementation and follow ups. Because the district has not been allocating funds for family planning for past five years based on this review[3], a 5% allocation from the District Health Budget would be a good starting point.

2. **Add family planning to district strategic plans and annual action plans.**

During the rapid assessment it was shared that the district is about to start a review process of their strategic plan in preparation for a new Strategic Plan. This process is an opportunity for the Kisarawe district to include strategic objective and indicators that will ensure availability of the family planning supplies and quality service provision to all

[3] District Comprehensive Council Health Plans (CCHPS 2009-2012); District RH Coordinator records from 2007

targeted persons, including family planning interventions in the District Strategic Plan as well as in annual action plans and budgets.

3. **Form a district contraceptive security committee.**
A district-level committee is needed to focus on overcoming contraceptive stock outs, delays in supply of contraceptives, poor provision of family planning services and ensuring broader knowledge of family planning services among key audiences. A District Contraceptive Security Committee can work closely with the National Level Contraceptive Security Committee in facilitating timely solutions for all problems related to family planning services in the district.

4. **Strengthen family planning service provision.**
Periodic capacity building programs focused on provision of quality family planning services is also recommended to equip Kisarawe health providers with required knowledge especially in addressing myths and misconceptions about family planning.

Address the shortage of family planning providers through task shifting.
Work with the national Ministry of Health to assess how to increase the number of individuals who can overcome inequities and provide priority health services, such as family planning, in communities.

AFP/ANAT COMMITMENTS TO INCREASING FAMILY PLANNING ACCESS IN KISARAWE DISTRICT.

- **Technical Assistance**.
  - *Evidence* related to high-impact practices in family planning, capacity building for reproductive health providers and costs to enable district leaders to include these activities and costs in the 2012/2013 annual action plans and budgets.
  - *Objectives and indicators* on family planning for the District Strategic Plan based on evidence-based information/data and submitted to the review team. AFP/ANAT has been invited to be part of the review process.
- **Facilitation.**
  - *Advice and assistance* to speed up the formation of a District Contraceptive Security Committee for continuous tracking of family planning commodities, and to avert stock outs for long periods of time.
  - *Strengthening partnerships with NGOs active in the district* to bring key actors in service provision (Marie Stopes Tanzania, Plan International, Vijana Vision, Engender Health, Pathfinder International, UNICEF, UMATI) together with

district leaders and foster greater sustainability of FP services and availability of contraceptives.

LIST OF REFERENCES

The Second National Strategy for Growth and Reduction of Poverty 2010-2015 (MKUKUTA II)

National Road Map Strategic Plan for Accelerating Reduction of Maternal and Child Deaths (2008-2015)

National Family Planning Costed Implementation Plan (NFPCIP) -2010-2015

Five Year Development Plan (FYDP) -2011-2016

Comprehensive Reproductive Health Commodity Security (RHCS), Assessment in Tanzania mainland – UNFPA and Mzumbe University Draft Report 2011.

Family Planning and Poverty Reduction – *Sheet 4 English. P65,* UNFPA 2007

Tanzania Reproductive and Child Health Policy Guidelines (2003);

Tanzania Demographic and Health Survey, 2010

Comprehensive Council Health Plan (CCHP)-Kisarawe 2011/2012

Draft Comprehensive Council Health Plan (CCHP) –Kisarawe 2012/2013

District Strategic Plan – Kisarawe 2007-2010.

Appendix 1.

Data Collection Tool

1. **Policy makers:**

- Are you involved in the district planning process?
- How are you involved?
- How is family planning generally perceived in your district?
- Do the District's plans include family planning as a development priority?
- If we are to advocate for improved family planning access, what do you see to be key bottlenecks?

2. **Health staff**:

- How has the contraceptive commodity flow/situation been in the district for the past three years (periodic supplies flow, stock outs situation)?
- What methods are usually available?
- Do your clients mostly prefer these methods?
- How many facilities provide family planning services in the district? Public/ Private?
- Which ones do not offer family planning services and why?
- How many staffs are providing family planning services? What qualifications do they have?
- Are they adequate?
- In the facilities, how are youth friendly services addressed?
- Do you have current information about MMR and IMR in the district?
- Does the district use CBDs for outreach services?
- Are there NGOs conducting family planning outreach services?

3. **NGOs operating in the district:**

- How is family planning generally perceived in your district?

- What methods do your clients usually prefer?
- Are these methods usually available?
- How is youth friendly family planning services addressed?
- If we are to advocate for improved family planning access, what do you see to be key bottlenecks?