



Family Planning in **Tanzania:**

A Review of National and District Policies and Budgets



DSW

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Acronyms

CCHP	Council Comprehensive Health Plans	NSGRP	National Strategy for Growth and Reduction of Poverty
CDHP	Council Development Health Plan		
CHMT	Council Health Management Team	PMO-RALG	Prime Minister's Office Regional Administration and Local Government
CPAC	Comprehensive Post Abortion Care	RCH	Reproductive and Child Health
CPR	Contraceptive prevalence rate	TFR	Total Fertility Rate
DED	District Executive Director	USAID	United States Agency for International Development
DHMT	District Health Management Team	UNFPA	United Nations Population Fund
DHS	Demographic and Health Survey	ZHMT	Zonal Health Management Team
DMO	District Medical Officer		
DRCHO	District Reproductive and Child Health Coordinator		
FBO	Faith Based Organization		
FP	Family Planning		
GoT	Government of Tanzania		
HMIS	Health Management Information system		
HSSPIII	Health Sector Strategic Plan III		
IMCI	Integrated Mother and Child Interventions		
LAPMs	Long acting and permanent methods		
LGA	Local Government Authority		
MCH	Mother and Child Health		
MDG	Millennium Development Goals		
MKUKUTA	Mkakati wa KukuzaUchuminaKu punguzaUmaskini Tanzania		
MMR	Maternal Mortality Rate		
MoFEA	Ministry of Finance and Economic Affairs		
MoHSW	Ministry of Health and Social Welfare		
MTEF	Medium Term Expenditures Framework		
NHP	National Health Policy		
NFPCIP	National Family Planning Costed Implementation Program		
NPEFPI	National Package of Essential Family Planning Interventions		

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¹ Leveraging German and European Union Funds for Global Health and Global Development



Executive Summary

DSW Tanzania as part of the Euroleverage² project conducted a study to establish the level of policy engagement and budget commitment at national and district/sub national level that address unmet needs of family planning. The specific objectives of the study was to: assess how different policies related to RH prioritize Family Planning, assess the level of implementation of RH/FP policies at district level, establish the level of government and donor commitment in funding FP interventions at national and sub-national level and also as a case study obtain community perspectives and district level information on access and budgets.

Findings indicate that majority of community members understands the concept of Family Planning and its importance, however not all member of the community support use of family planning. Most men think family planning is for women, the youth view FP as a practice for adults who already have children. With regards to FP commodity security, community members stated that pills and injectables are always available at the health facilities although women prefer injection and implant. Implant, IUD and other permanent methods are only available during mobile clinics or at the Regional hospital for those based in Shinyanga and at District hospital in Handeni. In summary two issues appeared to influence utilization of FP which includes: Widespread community misconceptions and false beliefs associated with the use of modern contraceptives and the community members do not sufficiently trust the competence of RH/FP service providers.

To some extent the political and policy environment is supportive of RH/FP. The policies and strategies found to be in line with the ICPD, MDG and Maputo Plan of Action were: the national health policy, the population policy, national youth development policy, MKUKUTA II, Family Planning Cost Implementation Plan (NFPCIP) 2010-2015, The national road map strategic plan to accelerate reduction of maternal, newborn and child deaths in Tanzania 2008 – 2015, Human resource for health strategic plan and the Health Sector Strategic Plan 2009 – 2015 (HSSP III). A number of these national policies and strategies are also committed to the international SRH principles although a number do not explicitly reaffirm commitment and universal access to: safe abortion, adolescent SRH information and services, contraception and sexual rights. Findings also indicated that Family planning is a priority as stated in the National Family Planning Costed Implementation Plan that there is need to increase One Plan Operational Target for Family Planning by 2015, Increase Modern Contraceptive Prevalence to 60%. Also according to MKUKUTA II priority areas, the government will focus on improving survival, health and wellbeing of all children, women and of marginalized vulnerable groups.³ Although FP is not elaborately included in the vision 2025 of Tanzania, the emphasis is on providing equitable and affordable health care at the highest affordable standards to the citizens of Tanzania. Most policies emphasized that Tanzania must consider and address the implications of its rapid population growth rate on its social and economic development. In a nutshell most of the reviewed policies indicated the main priorities for the country's family planning programs should include: Awareness and demand creation for contraceptives, IEC for Family Planning, Improving accessibility to contraceptives to all, Affordability of family planning services

The overall picture is that the budget allocation for RH/FP has been inconsistent over the years. At national level, budget allocations for health increased between FY 2010/11 to 2011/12 then dropped in FY 2012/13 and was significantly increased in FY 2013/14. There was a significant decrease in national budget allocations for SRH between FY 2010/11 to 2012/13. The national FP budget only increased between the FY 2010/11 to FY 2011/12 since then the

¹ Leveraging German and European Union Funds for Global Health and Global Development

³ GoT (2007)Mkukuta II Key Priority Result Areas

national budget allocation for FP has been on the downward trend. Both the national and district FP budget trends still simulate the overall SRH budget trends. Planned budget for family planning and expenditure was at the same level during the FY 2010/11 and FY 2011/12. There was a significant drop in FP expenditure during the FY 2012/13. Nationally from FY 2010/11 to FY 2013/14 proportion of health budget allocated to SRH and FP has constantly remained at an average of 1% of the total health budget. Relative to the FP budget, it is apparent that budget allocation for HIV and AIDS for the FY 2010/11 to 2012/13 was taking 16% of the health budget and this has doubled in FY 2013/13 to 38%.

Based on the study findings the following recommendations are proposed:

- The Tanzania government should design and implement a multi-sectoral approach to FP intervention with the aim of: improving knowledge about FP and encourage a responsible and healthy attitude towards Family Planning; ensuring the government including districts councils allocate adequate financial resources for family planning interventions and the funds are utilized efficiently and encouraging active involvement and participation of the district level institutions to meaningfully contribute towards FP.
- The Tanzania government should ensure recruitment and distribution of adequate and competent health service providers in rural health facilities to reduce unmet need for FP.
- The religious leaders and community leaders should be engaged positively to help address myth and misconception about FP methods at the community level. It is necessary to continue and even expand public education about modern FP methods so that people get factual and accurate information on FP.
- Inform policy dialogue, planning and budgeting at all levels is necessary to strengthen the case for FP in the development agenda.
- The Tanzania government should mobilize and sustain both government and external resources that are essential for achieving cost-effective and scaled up FP services as well as develop benchmarks for GoT and Development Partners to monitor and support the FP program.



1.0 Introduction

1.1. Tanzania country context

The United Republic of Tanzania is the largest country in East Africa, occupying an area of about 945,087 sq. km. It lies between 6.82 degrees south of the Equator and shares borders with 8 neighboring countries. For administrative purposes, Mainland Tanzania is divided into 25 regions, which are subdivided into 133 councils. Local Government Authorities (LGAs) manage government activities within districts. According to the 2012 census, the population of Tanzania is 46.9 million people, with an annual growth rate of 2.9%. Nearly half of the population (47%) is below 15 years, 49% are aged of 15-64 years and only 4% are over 65 years. Tanzania Mainland accounts for 97% of the total population, of which 73% live in rural areas. The female to male sex ratio stands at 1.04:1 with a life expectancy at birth of 56 years for females and 53 years for males. The fertility rate is 5.6 children per woman; Socio-economic factors such as poverty, increasing cost of living and education levels is assumed to have contributed to the decline in population rates. Population distribution is extremely uneven, with density varying from 1 person per square kilometer in arid regions to 51 per square kilometer in the mainland's well-watered highlands, to 134 persons per square kilometer in Zanzibar. More than 80 percent of the population is rural.

1.1. Family planning in Tanzania

It is noted that family planning is critical for preventing unintended pregnancies and unsafe abortions ultimately contributing to reducing maternal and child mortality. Family planning also helps to reduce poverty and empowers women and men to choose freely and responsibly the number and spacing of children. Globally, the demand for family planning (FP) is expanding and unmet needs continue to increase, especially in Africa. Although contraception offers a variety of benefits for the mother, her family and the community at large (Singh, Darroch, Vlassoff, and Nadeau, 2003), unmet need for family planning (FP) averages 19.4% in sub-Saharan Africa. Tanzania is no exception, as evidenced by high unmet needs for family planning which is estimated to be 22% among married women aged 15-49 years and 23.5% among young women aged 20-24 (TDHS 2010). In absolute numbers, this equates to one in five married women having an unmet need for family planning and married women with an unmet need for contraception are 1.1 million more than are currently using a modern method of contraception (880,000) (TDHS 2010).

1.2. Fertility and contraceptive use in Tanzania

The total fertility rate (TFR) in Tanzania is 5.4 births per woman, the TFR among rural women on the mainland is 6.1 higher than among urban women which is 3.7 (TDHS 2010). The Tanzania demographic health survey (TDHS 2010) indicates that there has been a decrease in TFR from 6.3 in 1992 to 5.4 in 2010 due in part to an increase in use of contraceptives over the past two decades. About 29% of women (married and unmarried) in Tanzania are currently using some method of contraception; 24% use modern methods which include injectables (9%), pills (5%), and condoms (4%). A higher percentage of urban women 46% use contraceptives than rural women 31%. Use of any method of contraception among married women increased from 10% in 1992 to 34% in 2010.

1.3. Family planning as reflected in national policies

Recognizing the importance of meeting its people's reproductive health needs including unmet need for FP, Tanzania has worked to establish policies and reforms aimed at improving maternal and child health services. For instance the National Health Policy has made specific attempts to address maternal, newborn and child health as part of the Health Sector Reforms and included into the Health Sector Strategic Plan III (HSSPIII, 2009-2015). Whereby the government recognizes the need to improve provision of family planning services and ensure that the services are fully integrated

into reproductive and child health services. Recently, the government's recognition and commitment to improving maternal and child health services has been captured in the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn, and Child Deaths in Tanzania (2008-2015); and the National Family Planning Costed Implementation Program (NFPCIP-2009) and the draft National Package of Essential Family Planning Interventions (NPEFPI). In particular, the NFPCIP is a plan to help identify the actions and resources needed to achieve the 60 percent contraceptive prevalence rate goal by 2015 making family planning services more accessible to all Tanzanians. The NPEFPI was developed from the NFPCIP and presents priority family planning activities and their unit costs that can be used to allocate resources for family planning in the district plans.

1.4. Euroleverage project

"Euroleverage" is part of "Leveraging German and European Union Funds for Global Health and Global Development" programme funded by Bill and Melinda Gates Foundation. The charitable purpose of this project is to increase and improve funding from Germany and the EU for global health and development. The project sub goal three is being implemented in Africa (Tanzania, Kenya, Uganda, Rwanda, Mozambique, Burkina Faso, Niger and Mali) and South Asia (India). The project duration is three years beginning November 2012 to October 2015. During the project life DSW will build on its proven successes in developing countries to measurably increase overall Official Development Assistance (ODA), funding for Global Health and/including investments in Global Health Research and Development (GH R&D). In a nutshell this study is part of a broader program that seeks to enhance understanding of unmet need for FP and identify factors that inhibit effective implementation of family planning policies and advocate for responses to address the bottlenecks at district level.

1.5. Objective of this study

In order to leverage national efforts to reduce unmet need for FP, a study was conducted by DSW to establish the level of policy engagement and budget commitment at national and sub national levels that address unmet needs for FP and draw recommendations for advocacy to improve ongoing efforts. The specific objectives were:

- To assess how different policies related to RH prioritize Family Planning
- To establish the level of government and donor commitment in funding FP interventions at national and sub-national level
- To assess the level of implementation of RH/FP policies at district level
- To describe unmet need for FP according to community perspective at District level.



2.0. Methodology

The methodology detailed in here was adopted from the Euroleverage methodology. A mix of quantitative and qualitative methods was used to collect and analyze data at national and district level. The rationale behind a mixed methods approach was to generate deeper and broader insights and full understanding of key relevant RH/FP policies and outline the policy commitment and strategies toward Reproductive Health narrowing to the Family Planning. The methodology was based on the concepts of 'triangulation', which involves determination of the situation through several sources of information along with various methodological tools; 'complementarity' to explain and understand the findings obtained by one method by applying a second; 'interrogation' where diverging findings emerge from the application of different methods. In a nutshell the data/information was generated through: Document Review, RH/FP Budget tracking, Key Informant Interviews, Focused group discussions and Facility assessment.

At the national level the study team had to; identify the key RH/FP policies, analyze the agreed policies to reveal policy commitments and strategies toward RH and FP, undertake a National budget review from 2010/2011, 2011/2012, 2012/2013 and 2013/2014 to state the overall national budget for each year, track the money allocated for ministry of health, track the money allocated for RH overall and money allocated for FP visa v expenditure and conduct key informant interview with government official, donors and NGOs. At the district level, the study team held a series of focus groups discussion (FGD) in Handeni (from 21st to 24th June 2013) and Shinyanga rural (from 4th to 6th July 2013). The Focus group discussion involved representatives from the community among group of women, men and youth residing near health facilities and those who lives far from health facilities.

2.1. Data collection

2.1.1. Document Review

A systematic review of key policies and strategies was conducted with the primary objectives to:

- Assess the extent to which family planning and other reproductive health issues are prioritized in broad development and health policies and strategies;
- Understand key policy and programme priorities and policy implementation challenges and responses that are considered critical for the achievement of the objectives of the policies;
- Assesses the extent to which key family planning issues identified by communities members are reflected in the policies.

Strategies and policies reviewed included: National health policy, National population policy, National youth development policy, MKUKUTA, National Policy Guidelines for Reproductive and Child Health Services 2003, The National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008 – 2015, National Family Planning Cost Implementation Plan (NFPCIP) 2010-2015, The 2009 Primary Health Services Development Programme (PHSDP), Health Sector Strategic Plan III and Human resources for health strategic plan 2008-2013. The policy analysis tool was used to analyze policies and strategies on a number of issues including: Responsiveness to International and national Commitments, Prioritization of FP, Policy Implementation challenges and responses, Sustainability of FP Programmes and Policy Responses to Unmet need issues Identified by Communities.

2.1.2. RH/FP Budget tracking

Budget documents at national and district level were reviewed and analyzed using a budget tracking tool developed to gather financial data on funding distribution for RH/FP and through what mechanisms this funding was distributed. The tool facilitated collection of data on the proportion of the funds allocated, or committed, to RH/FP compared to the amounts actually spent on RH/FP and also on the decision making power related to funding allocations. Themes addressed include but were not limited to:

- Commitments vs. expenditures: documenting allocations or commitments as well as expenditure. Where there was no expenditure data, this was supplemented by the rate of implementation (i.e. proportion of planned activities that has been implemented).
- Disaggregation: financial data was disaggregated by: overall health budget, SRH budget, Family planning budget and HIV and AIDS budget.

2.1.3. Key Informant Interviews

The key informant's interviews (KIIs) targeted the national level were Ministry of Health Officials (Reproductive Health Official and Director of Planning) and at the sub national level (Council Health Management Team). Key informant interview guides were provided including the interview protocol to guide the key informant interview process. The key informant interviews were important in providing the context and detail on decision-making and priority setting processes. They also provided an important access point for additional financial data not publically available.

2.1.4. Focused group discussions

DSW held 18 focus group discussions (FGD) with 276 men (67), women (117) and youth (99) between 21st to 24th June 2013 in Handeni and 4th to 6th July 2013 in Shinyanga. FGDs were equally distributed between the two districts and ranged from 10 to 12 people per group. FGD guide was used to gather the information from the community in regard to the following outcomes;

- To understand the attitudes to Family Planning: What are the general attitudes and views about family planning in this community?
- To understand the choice of method Mix: Which methods of family planning do women in this community prefer to use most?
- To understand the sources of Family Planning: Where do most women in this community get the family planning methods they use?
- To understand the causes of Unmet Need for Family Planning: There are some women who do not want to get pregnant now or they want to stop childbearing altogether, but they are not using family planning.
- To understand the challenges face community and rank them and suggested solutions for the mentioned challenges

2.1.5. Facility assessment

A total of five health facilities from Handeni and Shinyanga rural district were also assessed. In Handeni the three facilities where the assessment was conducted were: Mkata, Mazingara and Suwa, while in Shinyanga rural the facilities were: Mwamala and Itwangi. Mkata in Handeni was the only health center assessed; the rest were dispensaries. A health facility assessment tool alongside national guidelines on RH/FP service provision were used to collect data on a number of thematic areas as follows:



- Availability of family planning methods in Health facilities
- Health facilities staffing
- Availability of Youth Friendly services
- FP stock and stock out
- Supervisory visits
- IEC material for FP awareness

2.2. Data Analysis

A thematic analysis and synthesis of the information collected from the document review was done using the policy analysis tool. RH/FP Budget tracking data was analyzed using MS Excel computer program. Qualitative data from FGDs and KIIs were entered into qualitative data matrices which allow for discourse analysis. Discourse analysis enables common themes and trends in responses from stakeholders identified. These were then used to draw conclusions and validate and triangulate the findings from the policy and budget analysis.

3.0. Study findings

3.1. District sampled for gathering community perspectives

3.1.1. Handeni district

Handeni District is among the 8 districts in Tanga Region. The district covers an area of 7,080 km² and occupies the southwestern part of Tanga Region. The District is administratively divided into 7 divisions, 19 wards and 112 registered villages with 983 hamlets. Handeni is the major township and headquarter respectively. The district has one of the most rapidly growing populations in the country. According to the National Population Census of 2012 the total population count was 276,646 people (137,218 male and 139,428 female), with an annual growth rate of 3.3% per year. The population density per kilometer square is estimated to be 50 people. The population is mainly concentrated along the main roads where road market for food crops and fruits are practiced. About 15% of the population lives in the townships of Handeni. The district has 2 hospitals, of which one is government owned and the other one faith based (owned by Anglican Church). Other health facilities include 3 health centers owned by the government, and 32 dispensaries i.e. 29 governments owned and 3 by private sector.

Vital health statistics

Characteristics	Data by 2010
Total Population	276,646
Population growth rate (%)	3.3
Total Fertility Rate (%)	5.6
Children < 1 year	14,200
Children < 5 years	74,500
Women 15 – 49 years	13,942
Infant Mortality Rate	18/1,000
Under 5 Mortality Rate (U5MR)	40/1,000
Maternal Mortality Ratio	183/100,000

3.1.2. Shinyanga district

Shinyanga district is one of the 5 districts forming Shinyanga Region. The district is located south of Lake Victoria. Shinyanga district covers an area of 4212 square kilometers. Shinyanga has a total population of 334,417, 162,956 male and 171,461 female (National Population Census report 2012). Inhabitants of this district get their medical services from the Shinyanga Regional Government Hospital, Health Centers and Dispensaries located in rural areas since the district have no district hospital. There are: 4 Health Centers, 30 government Dispensaries and 7 private Dispensaries



Vital health statistics

Characteristics	Data by 2010
Total Population	334,417
Population growth rate (%)	3.3
Total Fertility Rate (%)	6.5
Children < 1 year	18,528
Children < 5 years	87,538
Women 15 – 49 years	171,461
Infant Mortality Rate	81/1,000
Under 5 Mortality Rate (U5MR)	168/1,000
Maternal Mortality Ratio	181/100,000

3.2. Community perspectives

FGDs conducted in Handeni and Shinyanga elicited the following views on: their attitudes to Family Planning, their choice of Family planning method, sources of FP methods, and the key factors resulting in unmet need for FP and suggested solutions for reducing unmet need for FP.

3.2.1. FP awareness and attitude

Majority of community members understand the benefits of FP. Majority of respondents are aware that family planning helps couples plan the size of their family and space their children. The following two quotations summarize the views held by majority of the participants:

“...Family planning is about deciding the size of your family how many children do you want to have and when to get them...” (FGD, Kwedigulu sub-village in Handeni)

“...Family planning is about the size of the family you want to have how many children and ability to decide an average space from one child to another...” (FGD Usule village Shinyanga)

However, not all members of the community support use of family planning even though they understand its benefits. The participants who support FP pointed to the broader benefits of FP as their reason for support, specifically it helps couples better manage their resources towards ensuring that the essential needs of their families including education, food and health are well catered for as noted by two participants:

“...We wants to plan for our families so that our women have time to rest and spend their time in economic activities...” FGD Usule village Shinyanga)

“...Family planning help our wives remain health and beautiful...” (FGD Kwedigulu, Handeni)

Emergent reasons for not supporting FP were not similar in both Handeni and Shinyanga. Community members who do not support the use of family planning mentioned the following reasons for not supporting:-

- **Religious beliefs. One of the participant was quoted saying**

“...God has given you the ability to reproduce children and this is a gift from him, we cannot in any way prevent pregnancy. There are people who work day and night to get pregnant, now since God has given us ability to have children let us have kids until the eggs are finished...” (FGD Handeni)

- **Myths and misconception about FP.** Respondent in the various discussions mentioned that the use of family planning has health effects including not having kids in future, over bleeding to women, losing weight or adding too much weight, vomiting and resulting to have abnormal children in future.
- **Service providers are not professional.** Respondent in Handeni said they are not using FP commodities because the nurses are not skilled enough. There was one example given of a client who the implant was not inserted properly resulting in a health problem and the family incurred cost for treatment.
- **FP is perceived by men as a woman's business.** Of note, most men from Shinyanga rural perceive family planning is women's business. Men agreed on the importance of family planning for planning the family size and spacing of children. They, however, noted that women are more concerned about FP as they are educated on FP and given FP methods when they go for clinics as indicated in the following quote from an FGD participant:

"...FP is women business they are told to use them when they go for clinics, they come home and start using them but when it backfire it is men who suffer treatment cost..." (FGD Shinyanga rural)

- **Youth view FP as a practice for people who already have children.** On the other hand, youth view FP as beneficial for people who already have children rather than for youth are who have no families and are not yet thinking of having a family. A youth from Mwamala was quoted saying:

"... Those commodities are good for people who already have children for us if we use condom is for protecting us from STIs only but those other methods is not for young people like me..." (FGD Shinyanga rural)

3.2.2. FP method Availability

In both Handeni and Shinyanga, short acting FP methods are more readily available than long acting and permanent methods. FGD participants noted that pills and injectables are always available at the health facilities but this is not the case with implants and IUDs. One participant is quoted saying:

"...if you want to plan your family, pills and injectable are all over when you approach the health facilities. Only when you want implant and IUD you may need to wait for those people who come from the district hospital during mobile clinics..." FGD Handeni

In Shinyanga, women's preferred FP methods are injectables and implants. However, Implants, IUDs and other permanent methods are available during mobile clinics or in the Regional hospital since Shinyanga rural district does not have district hospital.

3.2.3. Challenges of accessing FP

Participants cited a number of barriers to accessing FP including.

- Distance to health facilities.
- Cost to travel to regional hospital when they need other methods apart from pills and injection
- Sporadic Mobile clinics
- Men are not supporting their women to use family planning
- Clients are not confident with the health service provider's expertise.



3.2.4. Causes of unmet need

In Handeni, during FGD it was revealed that in some areas unmet need for family planning is high. According to FGD participants, there are number of reasons why some women in Handeni and Shinyanga do not use family planning methods even though they would like to postpone or stop childbearing. The two main reasons cited are:

- **Widespread myths and misconceptions on FP commodities.** Community members' men and women are wrongly informed or they misunderstand facts about FP commodities. They believe the use of FP may cause one not to have children in future, cause RH cancer and to cause having abnormal children future.
- **Mistrust of quality of service.** Lack of confidence with the health service provider's capacity to deliver.

Other important reasons cited included:

- **Fear of side effects** e.g. Over bleeding
- **Socio-cultural beliefs and practices.** Majority of men do not allow their women to use FP methods.
- **Accessibility.** Health facilities are away from where people live; it is hard to reach especially during rain seasons.

In order to reduce unmet need for FP community members suggested the following recommendations:

- Education on FP to the wider community so that FP does not remain women business.
- Recruiting and posting enough and competent service
- Health facility should be constructed in every village so that the service is provided at their locality

3.2.5. Views of policy makers on addressing unmet need for FP

Key informant interviews with sub-national and national policy makers elicited the following views on causes of unmet need

District key informants

According to the representative of the offices of the district medical officers (DMO) in Handeni and Shinyanga, myths and misconceptions and lack of male involvement is largely contributed by traditional and religious beliefs, which favor bearing many children. MoHSW through the office of DMO is currently implementing a policy promoting male involvement where men are encouraged to accompany their wives to clinics. The representatives from the offices of the DMOs suggested that there is need for more educative programs and demand creation at the community but belittle is being done due to budget limitations.

In addition, representatives from the offices of the DMOs confirmed that Human resource for Health inadequacies related to shortage of staff and lack of competence to provide RH/FP services remains a challenge. They noted that the problem is a National crisis resulting from a number of factors. The science-learning environment is not motivating due to lack of teachers and library and laboratory facilities and equipment, in school youth therefore do not opt for science subject and the doctors are not also motivating.

National key informants (MOHSW) comments***Issue 1: Widespread community misconceptions and false beliefs associated with the use of modern contraceptives:***

Certainly, the MoHSW knows this issue. The ministry gets feedback related to these false beliefs from its staff providing FP services, including counselors. Also various survey reports, including the countrywide Demographic and Health Surveys report about this challenge. Sometimes people who oppose FP based on their own personal beliefs, mostly religious and / or cultural beliefs, deliberately propagate the misinformation. Male opposition to FP is also contributing to the spreading of misleading information. Generally, this is not a new phenomenon although the scale of occurrence changes from time to time. It is necessary to continue and even expand public education about modern FP methods so that people get factual and accurate information on FP, otherwise they can be easily misled by misconceptions. From time to time, the MoHSW in collaboration with its partners, particularly those specializing on behavior change communication, designs and runs programs to address this problem.

Issue 2: Community members do not sufficiently trust the competence of RH/FP service providers

This has not been a major challenge to the MoHSW operations for now. The sporadic complaints about service providers' competence could be associated with misinformation to the service clients rather than actual technical incompetence. On the other hand, the insufficiency of HRH sometimes lead to service providers being overwhelmed by the burden of work and this can make them to be seen as insufficiently competent. However, the MoHSW collaborates with its partners to conduct capacity building trainings to FP service providers as well as updating and disseminating various service manuals to try and ensure that the provided services are up to date. Also the MoHSW has been taking stern measures to increase the numbers and quality of HRH, including increasing enrollments and setting up new HRH training facilities.

3.3. Findings from facility assessment**Availability of family planning methods in Health facilities**

In all the facilities assessed, pills and injectables are available at any time a client want them. It was also noted that women prefer injection and implant, but Implant, IUD and other permanent methods are only available during mobile clinics or at the district hospital and the Regional hospital for Shinyanga rural residence since the district does not have a district hospital.

Health facilities staffing

It was only in Mkata health centre where the in charge of the facility was Assistant Medical officer, and majority of the staff were nurses. By comparing the staff available and the number of people they serve it was evident that the health centre has a shortage of staff. In all the dispensaries, which are always the first call for majority of the community members, there were only two staff available; one assistant medical officer and one nurse. The staff attests that they are rarely invited for seminars or workshop aimed at capacity building.

Availability of Youth Friendly services

In all facility assessed there is no special treatment for youth as they receive services like any other clients.

FP stock and stock out

It was found that all lower cadre facilities only provide injection, pills and condoms and there has not been any stock out experienced in the last six months. However community members prefer implant and other permanent methods, which are not provided at these facilities unless the there is a mobile clinic, or a client travelled to the District hospitals.



Supervisory visits

This one is done though not in regular basis; there are challenges on human and financial resources. Most of the staff interviewed particularly those based at the rural dispensaries concurred that they are rarely visited by their supervisor from the district. But even if there is a supervisory visit, the supervisors do not have enough time to discuss their challenges, as their time is always limited since they have to visit many centers.

IEC material for FP awareness

In all facilities IEC materials for FP awareness were posted on the walls, only IEC to take home were not available.

4.0. Findings from policy Review

In this section various relevant key policies which responds to reproductive health and family planning are reviewed and analyzed to see to what extent those policies responds to RH/FP issues. We also assess the extent to which key family planning issues identified by community members are reflected in the policies. Therefore the primary objectives of the policy review component of this project were to;

- Assess the extent to which family planning and other reproductive health issues are prioritized in broad development and health policies and strategies;
- Understand key policy and programme priorities and policy implementation challenges and responses that are considered critical for the achievement of the objectives of the policies;
- Assesses the extent to which key family planning issues identified by community members are reflected in the policies.

4.1. The national health policy

Responsiveness of national health policy to International Commitments

The national health policy of Tanzania is in line with the ICPD, MDG and Maputo Plan of Action. It highlights among other things access to quality reproductive health services for all individuals of appropriate ages similar to the ICPD, MDG and Maputo Plan of Action. MGDs goals also have three objectives, Goal 4, 5 and 6, which are related to health.

In Tanzania, the struggle to meet these goals before 2015 is also evident through the prioritizing reproductive health, under the essential health package.⁵ Maputo Plan of action has influenced behavior of most African governments, including Tanzania. The ultimate goal of this Maputo Plan of Action is for African Governments, civil society, the private sector and all development partners to join forces and redouble efforts, so that together the effective implementation of the continental policy including universal access to sexual and reproductive health by 2015. It also touches on the gender equality and empowerment of women in all health parameters.

National Health Policy commitment to the international SRH principles

The national health policy reaffirms advancing gender equality and equity and the empowerment of women, including education for girls though not very explicit. The goal highlights Gender equality and empowerment of women in all health parameters, which in a broader sense encompasses the principle. Policy Mission highlights facilitation of the provision of equitable, quality and affordable basic health services, which are gender sensitive and sustainable, delivered for the achievement of improved health status. It is also not clear if the national health policy articulated population issues as integral parts of economic and social development. At the same time the review revealed that though there is a chapter for reproductive health and family planning, the policy is not clear whether couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information and means to do so.

On budget allocation, the national health policy does not indicate allocation of at least 15% of national annual budgets to improve the health sector as expected by the international principle. The facts on the ground also indicates that the Government of Tanzania has not yet achieved its commitment to reach the Abuja declaration target of allocating 15% of total national budget to health by 2015. Tanzania is currently allocating 12.1% (FY 2010/11) of its budget to the health sector, with family planning currently receiving less than 0.1 percent of this. However, this is a significant improvement compared to the last ten years

⁵ National health policy final draft 2004



The national health policy was also reviewed to ascertain whether it explicitly reaffirm commitment and universal access to:

a) Safe abortion

Findings indicate that safe abortion is not discussed in the national health policy. The policy highlights Maternal and child health and family planning under the primary health care but does not come out clearly on safe abortion.

b) Adolescent SRH information and services

Adolescent SRH health is not described explicitly by the national health policy (NHP). It states that the Ministry will promote Youth – friendly services to improve access to reproductive health information and services. At some point it also recommends Equity and accessibility to health care by ensuring that every individual has the right to health care and equitable distribution of health resources in the country; so critically it is not explicit on Adolescents

c) Contraception

This is part of the primary health care, which is included in the maternal child health and family planning

d) Sexual rights

This is not included in the national health policy. It is conspicuously missing though education is mentioned as part of IEC.

4.2. The population policy

Responsiveness of the population policy to International Commitments

One of the principles for implementation of Population policies is that it will be done in adherence to the objectives and goals of the National Development Vision 2025 and targets set in the Millennium Development Goals, which, among other things, emphasize the role of the market in determining resource allocation and use.

Population Policy commitment to the international SRH principles

The population policy captures the issues of gender equality and equity. It calls for equal rights, responsibilities and duties as shown in the policy objectives:

- To promote gender equity, equality, and women empowerment at all levels
- To transform socio-economic and cultural values and attitudes that hinder gender equality and equity

The population policy direction also reiterate through the following points:

- Increasing awareness of the society about the importance of education for all children
- Promoting the participation of women in decision-making, including in political affairs at all levels
- Promoting women’s employment opportunities and job security
- Eliminating all forms of discrimination and gender-based violence
- Creating an environment conducive to the reduction in women’s workload
- Ensuring mainstreaming of gender concerns in development plans and policies
- Creating an environment conducive for various stakeholders to carry out advocacy activities on gender and population issues

In the population policy, it is indicated that population issues are integral parts of economic and social development. There is a close relationship between population growth and development. In the short run, the effects of population growth may appear marginal, but it sets into motion accumulative process whose adverse impact on various facets of development might turn out to be very significant in the medium and long terms. This is because population variables influence the development and the welfare of individuals, families and communities at the micro level, and the district, region and nation as a whole at the macro level. It explicitly indicated that the effects and responses to population pressure interact at all these levels.

On if interrelationships and balance between population, resources and development are fully recognized as an integral part of sustainable development in the population policy. Findings indicate that this is partially included in the population policy where it is stated that the majority of the poor and specifically the rural poor suffer from the above and other preventable conditions. The Ministry will increase resource allocation to address these cost effective interventions, while at the same time join hands with other stakeholders, the communities and development partners to reorient the services to be more responsive to the needs of the population, and specifically targeting the indigent and the vulnerable groups.

Population and development influence one another. The influence may be positive or negative depending on other factors and conditions. In the case of Tanzania, the fore-mentioned demographic factors interact and create the following problems, at least, in the short run.

- The rapidly growing young population demands an increase in expenditure directed at social services such as education, health, water and housing.
- The rapidly growing labor force demands heavy investments in human resource development as well as development strategies, which ensure future job creation opportunities.
- Rapid population growth in the context of poverty eradication reduces the possibility of attaining sustainable economic growth.

On whether all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information and means to do so. This is partially highlighted in the population policy objectives, which stipulate:

- Promotion of public awareness of sexual and reproductive health and rights for adolescents, men and women
- Expanding quality reproductive health services and counseling for adolescents, men and women

The population policy was also reviewed to ascertain whether it explicitly reaffirm commitment and universal access to:

a) Safe abortion

One of the issues noted in population policy under reproductive health is that the number of health facilities offering Emergency Obstetric Care (EOC) and Post Abortion Care (PAC) is quite inadequate. Furthermore, there are also inadequate and irregular supplies of essential drugs and equipment for EOC and POC. The policy recommends offering comprehensive reproductive health services to take care of poorly addressed problems, including infertility among men and women, cancers of the reproductive system, post-natal care, post abortion complications and fistulae.



b) Adolescent SRH information and services

This is noted in the population policy whereby it is indicated that there are inadequate programmes that address reproductive health needs for specific population groups especially adolescents and elderly people. As a result, they lack access to correct information and services. Therefore the policy objectives advocates for promotion of public awareness of sexual and reproductive health and rights for adolescents, men and women

c) Contraception

This is part of the primary health care which is included in the in the maternal child health and family planning

d) Sexual rights

The population police note that the use of modern methods of family planning (FP) is still relatively low. There are also few community-based programmes for family planning and the un-met need for FP is as high.

4.3. National Youth development Policy (Ministry of Labour and Youth Development)

Responsiveness of the National Youth development Policy to International Commitments

While National Youth development Policy is the first ever policy on youth in Tanzania, it gives direction to development planners in various sectors of development in Tanzania.⁶ It is, thus, a useful instrument which enables other sector to develop relevant strategies and programmes for youth.⁷ For example, objective one, is to promote the lives of the youth, female and male, by developing them in areas of economy, culture, politics, responsible parenthood, education and, more importantly, health.⁸ As a plan, one of the goals is to protect the youth rights, which include right to health.⁹ The nexus between this policy and other vital international protocols is rooted on its approach to health as youth right.

In a 1979 ICPD conference, for example, defined reproductive rights and sexual, and sexual and reproductive health in an elaborate sense.¹⁰ The latter is defined as (a) All couples and individuals have the right to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so; and (b) Decisions concerning reproduction should be made free from discrimination, coercion and violence.¹¹ MGD goals, on the other hand, addresses health issues in three areas: that is goals 4, 5 and 6. While, in the context of Maputo plan of action, focus has been on reproductive rights and reproductive health. In sum, the health aspect and the youth right, as outlined in the national youth development policy, are intrinsically linked to these three protocols mentioned above.

⁶ See Preface to Ministry of Labor and Youth Development, p. iii.

⁷ Ibid.

⁸ Ibid. p iii. See Objective 3.1

⁹ Ibid., p.12 See Goal 4.1.2

¹⁰ UNPF. 2008. Reproductive Rights and Sexual and Reproductive Health Framework. p.12

¹¹ Ibid.

National Youth development Policy commitment to the international SRH principles

On Advancing gender equality and equity and the empowerment of women, including education for girls, the policy among other things, focuses on making sure that youth grow in good health and provided for their education without gender discrimination. The ministry of education and culture is required, as part of this policy to continuously review the school curricular to accommodate youth needs which will change with time. In addition, this ministry will continuously review and solve problems, which discourage girls from pursuing science subjects and from training in science and technology with intention of devising strategies to increase the number of girls in those subjects. Within the ministry of Community development, there shall be a close collaboration with the ministry responsible for youth development and together plan strategies to empower the girls.

Again in light of the goals, highlighted in the youth development policy, there were plans to involve youth, both boys and girls in economic, social and cultural activities as a way of preparing them to assume leadership roles. Two, policy on village governments, will ensure that youths receive the essential social services and assistance in establishing their self-employment projects. In addition, good plans are made in the locality to provide youth with employment.

On the Interrelationships and balance between population, resources and development and if fully recognized as an integral part of sustainable development. The youth development policy points out that the ministry of finance recognizes the importance of youth in social and economic development of a nation and hence allocates adequate funds for youth programmes. Incorporate the programme of implementation for the youth development plans and to make sure that it is implemented. The ministry of information and broadcasting will prepare programmes, which will educate communities and sensitize them on implementation of the youth programmes. There is no special mention that all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information and means to do so, albeit the ministry of education and culture will strengthen and provide family life education to youths at all levels of education. In addition, the ministry will prepare programmes through which youths will be taught acceptable morals according to culture of Tanzania.

National Youth development Policy commitment to the international SRH principles

On Advancing gender equality and equity and the empowerment of women, including education for girls, the policy among other things, focuses on making sure that youth grow in good health and provided for their education without gender discrimination.¹² The ministry of education and culture is required, as part of this policy to continuously review the school curricular to accommodate youth needs which will change with time.¹³ In addition, this ministry will continuously review and solve problems, which discourage girls from pursuing science subjects and from training in science and technology with intention of devising strategies to increase the number of girls in those subjects.¹⁴ Within the ministry of Community development, there shall be a close collaboration with the ministry responsible for youth development and together plan strategies to empower the girls.¹⁵

Again in light of the goals, highlighted in the youth development policy, there were plans to involve youth, both boys and girls in economic, social and cultural activities as a way of preparing them to assume leadership roles.¹⁶ Two, policy on village governments, will ensure that youths receive the essential social services and assistance in establishing their self-employment projects.¹⁷ In addition, good plans are made in the locality to provide youth with employment.¹⁸

¹² Ibid., footnote 1, p.16

¹³ Ibid., footnote 1, p. 19

¹⁴ Ibid., footnote 1, p. 19

¹⁵ Ibid., p 20 – 21. See section 5.90 Ministry of Community Development

¹⁶ Ibid., footnote 1, p.14

¹⁷ Ibid., footnote 7

¹⁸ Ibid., footnote 1, p.17



On the Interrelationships and balance between population, resources and development and if fully recognized as an integral part of sustainable development. The youth development policy points out that the ministry of finance recognizes the importance of youth in social and economic development of a nation and hence allocates adequate funds for youth programmes.¹⁹ Incorporate the programme of implementation for the youth development plans and to make sure that it is implemented.²⁰ The ministry of information and broadcasting will prepare programmes, which will educate communities and sensitize them on implementation of the youth programmes.²¹ There is no special mention that all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information and means to do so, albeit the ministry of education and culture will strengthen and provide family life education to youths at all levels of education.²² In addition, the ministry will prepare programmes through which youths will be taught acceptable morals according to culture of Tanzania.²³

The youth development policy was also reviewed to ascertain whether it explicitly reaffirm commitment and universal access to: safe abortion, Adolescent SRH information and services, Contraception, Sexual rights. Findings indicate not necessarily so, but it in an implied sense. The ministry will, according to sectoral role 5.4.2, ensure the availability of health services, which will be accessible to youth without fear, intimidation, or discrimination of any kind.²⁴ In addition, in 5.4.3 this ministry was to animate youth and community in general to identify health problems that affect them especially STDs, AIDS and drug abuse.²⁵

Looking at specific interventions findings is as indicated below:

a) Safe abortion

It is not explicit, although this may be implied from ministry strengthening of sexual health education to youth, both boys and girls.²⁶

b) Adolescent SRH information and services

The ministry of health will, among other things, involve youths in preparing, planning and implementing health programmes geared to promote youth health²⁷. In addition, the ministry was to prepare a curriculum on youth health which will be used to train professionals and health workers at various levels.²⁸

c) Contraception

No special mention on contraceptives, but the ministry of health will strengthen sexual health education to youth, both boys and girls, as well as prepare a curriculum on youth health which will be used to train professionals and health workers at various levels.²⁹

d) Sexual rights

The ministry would endeavor to strengthen sexual health education to youth, both boys and girls.³⁰ In addition, the ministry will prepare programmes through which youths will be taught acceptable morals according to culture of Tanzania.³¹

¹⁹ Ibid., p.19 Section 5.7 Ministry of Finance.

²⁰ Ibid., p. 22 see section 5.14.1 under the Planning Commission,

²¹ Ibid., p 21. See Section 5.12 Ministry of Information and broadcasting

²² Ibid., see Section 5.6 Ministry of Education and Culture

²³ Ibid., see Section 5.6 Ministry of Education and Culture

²⁴ Ibid., footnote 1, p. 19

²⁵ Ibid.

²⁶ Ibid., footnote 1, p. 18

²⁷ Ibid., footnote 1, p. 19

²⁸ See Ministry of Health in Section 5.4

²⁹ See Ministry of Health in Section 5.4

³⁰ Ibid., footnote 1., p. 18

³¹ Ibid., see Section 5.6 Ministry of Education and Culture

4.4. MKUKUTA II (National Strategy for Growth and Reduction of Poverty (NSGRP))

Responsiveness of the MKUKUTA II to International Commitments

MDG 1 and 2 emphasize on the eradication of extreme poverty and hunger and achievement of universal primary education respectively. The ICPD also advocates for raising the quality of life through population and development policies and programmes aimed at achieving poverty eradication, sustained economic growth in context of sustainable development. MKUKUTA II is a medium term mechanism to achieve the aspiration of Tanzania's Development Vision 2025 (TDV 2025) and the Millennium Development Goals (MDGs) of transforming Tanzania into a middle income country characterized by, high quality livelihood, peace, stability and unity, good governance, a well-educated and learning society, and a strong and competitive economy. This clearly indicates the close relationship between MKUKUTA II and the ICPD and MDG

MKUKUTA II commitment to the international SRH principles

The implementation of MKUKUTA I interventions in Cluster II focused on achieving two broad outcomes, namely:

- Improved quality of life and social well-being, particularly of the poorest and most vulnerable groups in the population
- Reduced inequities e.g., in education, survival, and health across geographic areas, income, age, gender and other attributes. To that effect, the interventions made recorded considerable improvements in the delivery of social services—notably in education, health, water, sanitation and social protection.

On whether Population issues articulated are integral parts of economic and social development, Cluster II focuses on improving the quality of social services (education, survival, health and nutrition, clean and safe water, sanitation, decent shelter and a safe and sustainable environment) and reach the majority of the poor and vulnerable groups. Apart from wellbeing, the essential target of this cluster is to create human capital out of learning and healthy population. Gaps in the low-to-medium level technical cadre in all sectors are identified as the primary focus for improvement.

Two broad outcomes under Cluster II are as follows:

- Quality of life and social wellbeing for enhancing capabilities, with particular focus on the poorest, people with disabilities, and other vulnerable groups improved.
- Inequities in accessing social and economic opportunities, along geographical areas, income, age and gender reduced.

MKUKUTA has included Family Planning as an effective strategy to achieving Goal 3: Improving survival, Health, Nutrition and Well Being, Especially for Children, Women and Vulnerable Groups. In a nutshell Family planning has been elaborated in the document. By definition of family planning, it can be seen that the decision to have the number of children and at the desired spacing is well captured

a) **Safe abortion**

Safe abortion is not discussed MKUKUTA II. The policy highlights Maternal and child health and family planning under the primary health care but does not come out clearly on safe abortion.

b) **Adolescent SRH information and services**

This is discussed as one of the strategies for intervention on fertility, maternal and neonatal health. MKUKUTA recommends promoting adequate child spacing by enhancing access to modern contraceptive use for all sexually active persons, particularly targeting women and their spouses, adolescent girls and boys.



The MKUKUTA was also reviewed to ascertain whether it explicitly reaffirm commitment and universal access to:

c) Contraception

It is indicated in the MKUKUTA that as a way of Improving Survival, Health, Nutrition and Well Being, Especially for Children, Women and Vulnerable Groups, the operational target is slowing down Total Fertility rate from 5.4 (2010) to 5.0 by 2015. This can be achieved by increasing the contraceptive rate among all women of reproductive age from 28 per cent in 2010 to 60 per cent by 2015 and also by providing information, services and education on family planning methods and options.

d) Sexual rights

Good Governance and Accountability democracy, good governance, human rights and the rule of law deepened has been ensured. Generally MKUKUTA talks about human rights but is not particular on sexual rights

4.5. Health Sector Strategic Plan III (HSSP III)

Responsiveness of the HSSP III to International Commitments

Focus of the third Health Sector Strategic Plan 2009 – 2015 (HSSP III), will be on “Partnership for delivering the Millennium Development Goals”. Year 2015 is the target year for the achievement of the Millennium Development Goals (MDGs) and the end year for the HSSP III. This strategic plan therefore, contributes to Tanzania’s efforts to reduce child and maternal mortality and to control important infectious diseases, as well as, in its efforts to improve the environment and access to clean water. It also touches on the gender equality and empowerment of women in all health parameters

HSSP III commitment to the international SRH principles

The HSSP III document indicates that Tanzania Vision 2025 provides direction and a philosophy for long-term development. Tanzania wants to achieve by 2025 a high quality of livelihood for its citizens, peace, stability and unity, good governance, a well-educated and learning society and a competitive economy capable of producing sustainable growth and shared benefits. The document identifies health as one of the priority sectors contributing to a higher quality livelihood for all Tanzanians. This is expected to be attained through Gender equality and empowerment of women in all health parameters

The population issues highlighted in this strategic plan touches on economic and social development. The plan emphasizes on improving health of the population as a way of improving the general well-being of the population. In the cross cutting issues, geographic equity for underserved populations and equity for vulnerable groups who cannot fend for themselves has been emphasized. Gender in health needs attention due to the specific health needs of women and men. Health services should be increasingly alert to respond to such needs, especially of women who are more vulnerable to health problems. The involvement of men in family programmes will be stimulated.³²

The interrelationships and balance between population, resources and development are fully recognized as an integral part of sustainable development in HSSP III. The plan highlights improvement of human resources as well as financial resources. Resources will be mobilized for immediate response, and when necessary funds will be made available bypassing bureaucratic procedures. These are geared towards improvement of health services to ensure sustainable development

³² Ibid., see Section 5.6 Ministry of Education and Culture

Pertaining to whether all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information and means to do so. The HSSP III focuses on reproductive health rights. It is not very explicit on decision making by the couples on the number of children they should have but it further talks about family planning, which encompasses all issues related to child spacing.

On allocation of at least 15% of national annual budgets to improve the health sector, it is indicated that Health Care Financing is fundamental for realizing the ambitions of the MOHSW. The Ministry aims at increasing the health budget to 15% of the Government budget. Increasing the funding through the Health Basket Fund is an advantageous way of resource mobilization. The Ministry will develop strategies to increase complementary financing through the Community Health Fund and National Health Insurance Fund.

The HSSP III was also reviewed to ascertain whether it explicitly reaffirms commitment and universal access to:

a) Safe abortion

Abortion in particular is not singled out in the plan. Although it says that more than 50% of women aged 19 years are pregnant or already mothers, increasing their vulnerability to sexual and reproductive health (RH) problems.

b) Adolescent SRH information and services

The document is not clear on adolescent sexual reproductive health information

c) Contraception

The document only mentions that the contraceptive prevalence rate has gradually increased to 20% the total fertility rate remains high at 5.7 with an unmet need for family planning at 22% (DHS 2004).

d) Sexual rights

The Plan is not particular about sexual rights but instead generalizes the whole idea by saying that one of the outputs expected during the HSSP III period is coherence between policies, legislation and plans. A gender sensitive and human rights-based governance system that ensures accountability, transparency and adherence to leadership ethics

4.6. Human resource for health strategic plan

Responsiveness of the human resources for health strategic plan to International Commitments

National Strategy for Growth and Reduction of Poverty (NSGRP) advocates for improvement in the quality of life and wellbeing of all Tanzanians. Human Resource Strategic Plan in a greater proportion it has identified effective interventions that will facilitate the implementation of tasks with direct impact on quality of life and wellbeing such as immunization for children and control of diseases by ensuring availability of skilled workforce to provide quality services. The Millennium Development Goals aim at reducing child mortality by two-thirds, Maternal Mortality rate by three-quarters, combat HIV/AIDS Malaria and other diseases by controlling them by 2015. Human Resource strategic Plan has been developed to ensure availability of the necessary resources such as adequate health workforce to provide health services. Abuja Declaration advocates the increased share of total government expenditure allocation to health to a minimum of 15%. Human resource strategic plan provides justification for increased allocation to the human resource given the fact that it is the most important resource worth extensive investment.



Human resource for health strategic plan commitment to the international SRH principles

In the human resource for health strategic plan, not so much has been discussed about advancing gender equality and equity and the empowerment of women, including education for girls. There is no particular aspect of empowering women and education of girls. The document points out that population issues articulated are integral parts of economic and social development. It is indicated that increase in social problems is due to uncontrolled population growth, socio-cultural changes, HIV and AIDS pandemic and poor socio-economic trends. There is therefore the call of family planning by improving the funding in reproductive health to curb the problems associate with high population growth. It is noted in the document that the uncontrolled population has been one of the causes of high levels of poverty in Tanzania. If the population growth is not checked the implication will be depleted resources leading to high poverty levels.

The dictum that all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information and means to do so is not included in the document. This leaves a gap and makes it difficult to control population growth

On budget allocation, The Abuja declaration recommends allocation of 15% of national budget to health sector, whereas the health sector has been receiving less than 15% of national budget. The strategy indicates that these fluctuations affect allocations to human resources in particular the recruitment, incentives, retention and capacity building.

The human resource for health strategic plan was also reviewed to ascertain whether it explicitly reaffirm commitment and universal access to:

a) Safe abortion

Human Resource for health strategic Plan has been developed to ensure availability of the necessary resources such as adequate health workforce to provide health services, indicating generalization of health issues. Safe abortion has not been singled out. The document has also talked of high MMR though abortion has not been mentioned as one of the causes.

b) Adolescent SRH information and services

Adolescent issues are not discussed in this document. There is no much information on sexual and reproductive health opposing the main objectives of meeting the millennium development goals by 2015

c) Contraception

This is part of the primary health care which is included in the in the maternal child health and family planning

d) Sexual right

Not singled out

4.7. The national road map strategic plan to accelerate reduction of maternal, new-born and child deaths in Tanzania 2008 – 2015

Responsiveness of the national road map strategic plan to accelerate reduction of maternal, newborn and child deaths in Tanzania to International Commitments

The National Road Map Strategic Plan to accelerate reduction of maternal, newborn and child deaths in Tanzania stipulates various strategies to guide all stakeholders for Maternal, Newborn and Child Health (MNCH), including the Government, development partners, non-governmental organizations, civil society organizations, private health sector, faith-based organizations and communities, in working together towards attainment of the Millennium Development Goals (MDGs) as well as other regional and national commitments and targets related to maternal, newborn and child health interventions

National road map strategic plan to accelerate reduction of maternal, newborn and child deaths in Tanzania commitment to the international SRH principles

The strategy seeks to employ a multi-sector and partnership approach to address the underlying causes of maternal, newborn and child death such as, Education, gender equality and women empowerment to ensure sustainability.³³ The population issues are considered in this document as an important social development item. It is used as a family planning indicator for every 500,000 people.³⁴ Although the interrelationships and balance between population, resources and development are not fully recognized as an integral part of sustainable development, the general theme indicated is that family planning is reducing population growth thus stabilizing economy.

On whether all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information and means to do so. In this respect the strategy focuses, among other things, addressing birth preparedness; with an emphasis on birth planning for individual couples and promotion of key MNCH practices at the household and community levels.³⁵

On budget allocation the strategy indicates that although there has been advocacy and commitment at different levels in addressing maternal, newborn and child health issues, the meager budget allocation to the health sector has been a hindrance to effective implementation of the Essential RCH Package. Due to other competing health priorities such as malaria, HIV/AIDS and tuberculosis, the budget allocation for reproductive and child health is still limited.³⁶ In advocating for improved MNCH, Increased budget allocation for MNCH interventions including FP and nutrition will be emphasized. The target is to mobilize resources from internal and external sources in order to complement the Government's efforts towards reducing maternal, newborn and childhood deaths.³⁷

³³ The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008 – 2015, p.31.

³⁴ Ibid, p.65

³⁵ Ibid, p.40e

³⁶ Ibid, p.27

³⁷ Ibid, p.38



The National Road Map Strategic Plan to accelerate reduction of maternal, newborn and child deaths in Tanzania was also reviewed to ascertain whether it explicitly reaffirm commitment and universal access to:

a) Safe abortion

The strategy indicates that abortion complications contribute to about 20% of maternal deaths worldwide. It further shows that in Tanzania, induced abortion is illegal hence the actual magnitude of the problem is not known. However, several attempts have been made to document the severity of the issue.³⁸ Post abortion care (PAC) services can significantly reduce maternal mortality due to unsafe abortions; however, only 5% of health facilities in Tanzania currently provide this service.³⁹ The strategy thus recommends provision of IEC to women, men, adolescents and communities about the dangers of unsafe abortion.⁴⁰

b) Adolescent SRH information and services

The strategy stipulates that adolescent health is an area that must be given high priority in the country's development plans as healthy adolescents are more likely to safeguard the health of their own children in future and, as the future workforce, contribute more effectively to the development of the economy.⁴¹

c) Contraception

This is discussed explicitly. The strategy notes that despite knowledge of contraceptives, which is at (90%), and only 26 % of married women use any method of contraception, with only 20% using a modern method. Factors contributing to low contraceptive prevalence include: low acceptance of modern FP methods, Erratic supplies of contraceptives with limited range of choices, Limited knowledge/skills of providers and provider's bias affecting informed choice, Limited spousal communication and inadequate male involvement and lack of adolescent-friendly health services and misconceptions about modern family planning methods.

In an attempt to improve access to family planning services, community-based programmes are being implemented in 46 mainland districts; however, this represents less than half of all districts in the country.⁴²

d) Sexual rights

This is not very explicit in the document. The overall picture portrayed is human rights and gender and health.⁴³

4.8. National Family Planning Costed Implementation Program (NFPCIP) 2010-2015.

Responsiveness of the NFPCIP to International Commitments

NFPCIP 2010-2015 is in line with the millennium development goals (MDGs). Family planning saves the lives of women, newborns, and adolescents as well as contributes to the nation's socioeconomic development. Family planning prevents maternal mortality, one of the major concerns addressed by various global and national commitments and reflected in the targets of the Millennium Development Goals, Tanzania Vision 2025, the National Strategy for Growth and Reduction of Poverty, and the Primary Health Services Development Program, among others.

Family planning also reduces infant deaths from AIDS by preventing unintended pregnancies and hence mother-to-child transmission of HIV. Family planning also helps governments achieve national and international development goals because it can contribute to the achievement of all of the United Nations' Millennium Development Goals, including reducing poverty and hunger, promoting gender equity and empowering women, reducing child mortality, improving maternal health, combating HIV/AIDS, and ensuring environmental sustainability.

³⁸ In Hai District, for example, it was reported that nearly a third of maternal deaths are related to unsafe abortion.

³⁹ Ibid, p.175

⁴⁰ See the table on post abortion care. The National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008 – 2015

⁴¹ Ibid, p.245

⁴² Ibid, p. 16

⁴³ Ibid, p. 32

NFPCIP commitment to the international SRH principles

The Ministry of Health and Social Welfare developed and uses the National Family Planning Cost Implementation Plan (NFPCIP) 2010-2015 as a guide to implement activities to reinvigorate access to and use of Family Planning in Tanzania. Five strategic action areas have been identified as needed to reposition the FP implementation, including: Contraceptive Security, Capacity Building, Service Delivery, Health System Management, Advocacy and Social and Behavior Change Communication.

Pertaining to advancing gender equality and equity and the empowerment of women, including education for girls, the document states that Family planning also helps governments achieve national and international development goals because it can contribute to the achievement of all of the United Nations' Millennium Development Goals, including reducing poverty and hunger, promoting gender equity and empowering women, reducing child mortality, improving maternal health, combating HIV/AIDS, and ensuring environmental sustainability. It further states that early childbearing usually curtails educational attainment for girls and constrains women's participation in economic productivity⁴⁴

Population issues are well articulated as integral parts of economic and social development. The program encourages access to safe, effective, acceptable, and affordable FP methods and services as a key, highly cost effective intervention to save lives and reduce the adverse social and economic consequences of rapid population growth. The policy states that family planning is able to regulate population growth.⁴⁵ With low population, the available resources would be able to meet the demand of the people thus maintaining sustainable development

On whether all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information and means to do so, the basic right to decide freely does not come out clearly. Though the policy proposes providing a choice of methods to meet the changing needs of clients throughout their reproductive lives increases overall levels of contraceptive use and enables individuals and couples to meet their reproductive goals

On allocation of least 15% of national annual budgets to improve the health sector, it is stated that funding allocations through the MTEF are not adequate to meet contraceptive commodity requirements because of competing priorities in the health sector. However, the government is progressing well towards meeting the Abuja declaration target of 15 percent of the total national budget to cover improvement in the health sector.

The National Family Planning Cost Implementation Plan (NFPCIP) 2010-2015 was also reviewed to ascertain whether it explicitly reaffirm commitment and universal access to:

a) Safe abortion

The document highlights that maternal mortality rates in Tanzania are among the highest in the world. Abortion is illegal in Tanzania, and abortion complications are estimated to contribute to about 16 percent of maternal deaths. Family planning services can significantly reduce unintended pregnancies and maternal mortality from unsafe abortions. Maternal mortality rates in Tanzania could be reduced by as much as 35 percent if the One Plan FP goal is achieved.

b) Adolescent SRH information and services

The MoHSW/Reproductive and Child Health Section (RCHS) has developed a national strategy on adolescent RH that outlines key strategic objectives to enable adolescents to cope with their growing up in this transition period. Despite

⁴⁴ National Family Planning Costed Implementation Program 2010-2015

⁴⁵ Ibid, p.5



having the strategy, many gaps still remain in terms of fostering implementation of existing supportive policies and laws for young people to exercise their sexual and reproductive rights; access friendly RH information, education, and services; human resource capacity for providing services; and parent and community support towards young people.

c) Contraception

An estimated 2.9 million unintended pregnancies could be averted over the next decade if the unmet need for contraception were met. Although achieving the One Plan target will require increased demand for FP, meeting the currently high level of unmet need alone would make a substantial contribution toward achieving the goal.

d) Sexual rights

In this document positions that many gaps still remain in terms of fostering implementation of existing supportive policies and laws for young people to exercise their sexual and reproductive rights; access friendly RH information, education, and services; human resource capacity for providing services; and parent and community support towards young people. It does not talk of the sexual and reproductive rights of adults

4.9. Key policy and programme priorities and policy implementation challenges and responses

Prioritization of FP

Family planning is a priority as stated in the National Family Planning Costed Implementation Plan that there is need to increase One Plan Operational Target for Family Planning by 2015, Increase Modern Contraceptive Prevalence to 60%. Also according to MKUKUTA II priority areas, the government will focus on improving survival, health and wellbeing of all children, women and of marginalized vulnerable groups.⁴⁶ Although FP is not elaborately included in the vision 2025 of Tanzania, the emphasis is on providing equitable and affordable health care at the highest affordable standards to the citizens of Tanzania. It also talks of revitalizing and integrating community health centers to improve preventive healthcare. Lowering fertility by making family planning services available to those couples that want them creates potential for a more rapid rate of economic growth for the country. A lower fertility rate can also help many families escape poverty. Most policies emphasize that Tanzania must consider and address the implications of its rapid population growth rate on its social and economic development. It is indicated that;

- Tanzania's fertility rate has a profound impact on the future size of the population. Rapid growth of the population in such a short period of time has serious implications for the national vision to achieve a high quality of life and eliminate severe poverty.
- Tanzania's population growth and therefore, the future population size can be influenced by public policy, and measures must be taken now.

Since the 1990s Tanzania has been doing so much on health issues. In one of the policy objectives the government undertook to create awareness through family health promotion that the responsibility for one's health rests squarely with the individuals as an integral part of the family, community and the nation.⁴⁷ The keys to effective and sustainable family-planning programmes are well established: high-level political commitment; a broad coalition of support from elite groups; adequate funding; legitimization of the idea of smaller families and modern contraceptives through mass media; and making a range of methods available through medical facilities, social marketing, and outreach services.

⁴⁶ GoT (2007) Mkukuta II Key Priority Result Areas

⁴⁷ National Policy Health Objectives

In the Essential Health Care Package (EHCP), Reproductive and Child Health which include family planning is ranked first, followed by Control of Communicable and Non Communicable Diseases, Treatment of Common Conditions of local prevalence within the District, Community Health Promotion and Disease Prevention, through environment sanitation and management and Occupational health services.⁴⁸ In a nutshell most of the reviewed policies indicate the main priorities for the country's family planning programme to include but not limited: Awareness and demand creation for contraceptives, provision of IEC for Family Planning, Improving accessibility to contraceptives to all and affordability of family planning services

Challenges for implementing the FP policy in Tanzania

The main challenge is insufficiency of the needed financial investment in the FP program. The NFPCIP program outlines the level of needed resources in order to effectively implement the national FP program. Year after year, the amount of available resources has been short of the needed levels. As pointed out before, the GoT budget outlay is faced by many competing priorities, even within the health sector alone, making it difficult to scale up the program as planned. Overdependence on development partners' support is threatening the program because of uncertainty with regard to availability of resources both in terms of amounts and timing. There are also other challenges like community false beliefs, insufficiency of service providers, technological development requiring regular training of service providers; all of which are embedded in insufficiency financial resource investment. In summary the following are the main challenges for implementing the FP policy in Tanzania include

- Declining Funding Support: Shifting Donor Funding Mechanisms and Shrinking Government Budget
- Waning Program Visibility: Confluence of development policies
- Competing Priorities: Diverted Resources – Human, Infrastructure etc.
- Cultural and religious practices and beliefs: Polygamy, Early marriage, Value of children as a source of domestic and agricultural labor and old-age economic and social security for parents, Male child preference, Low social and educational status of women in society, which prevents them from taking decisions on their fertility and use of family planning services, Large age differentials between spouses which constrain communication on issues related to reproductive health, Socio-economic and gender roles

Strategies for addressing the FP policy implementation challenges

First within the MoHSW, FP is managed under the Family Planning sub-section under the Reproductive and Child Health Section. The Family Planning sub-section has particular staff members managing each of the priority areas, that is, Contraceptive Security, Service Delivery, Capacity Building, Information and Education for Behavior Change as well as for Advocacy. These specialized staff members coordinate activities of many implementing partners who collaborate with the Ministry. The operational areas are elaborated in the National Family Planning Costed Implementation Program. Therefore the strategies highlighted by stakeholders in addressing the FP policy implementation challenges include:

- Inform policy dialogue, planning and budgeting at all levels to strengthen the case for FP in the development agenda.
- Enable Government of Tanzania to project budgetary needs for different FP program target scenarios;
- Mobilize and sustain resources that are essential for achieving cost-effective and scaled up FP services.
- Develop benchmarks for GoT and Development Partners to monitor and support the FP program.

⁴⁸ National health policy final draft 2004, p 10



Main causes of Unmet Need for FP

The policy review noted the main causes of Unmet Need for FP are: Inadequate resources (Financial, human, equipment), Conflict between modern practices and the traditional ones and religious belief and practices.

Main strategies that the policies have defined for addressing unmet need for FP

Several factors were identified during the policy review which can contribute to a successful strategy to satisfy the unmet need for family planning services. These include:⁴⁹

- Sustained commitment and support from leaders at national and district levels
- Improved access to high-quality, affordable services
- Increased private sector participation in service provision
- Guaranteed availability of contraceptive commodities and services
- Sustained donor support
- Increased participation of civil society and faith-based organizations
- Consistent messages and support from opinion leaders about the need to make family planning services readily available for those who want them
- Behavioral change communications so couples know the available family planning options

Sustainability of FP Programmes

The policies reviewed so far did not indicate the issue of sustainability. But it is apparent that most governments in poor countries have appropriate population and family-planning policies but are receiving little encouragement and insufficient funds from international and bilateral donors to implement them with conviction.⁵⁰ During Key informant interviews, the MoHSW believes that there is a political willingness to prioritize FP in the country as implied by several national policies that specifically highlight FP as an important intervention area. Also occasionally, national political leaders, including the Prime Minister and some Members of Parliament have publically advocated for FP through their speeches. At the district level, findings show that RH/FP is not given enough space by political leaders, hence not seen as a priority by the community leaders. In council meeting RH/FP is not often discussed. It is only the non-state actors who play a big role in popularizing RH/FP through media campaign and trying to engage district based political leaders.

⁴⁹ Population, Reproductive Health and Development in Tanzania: A Policy Brief

⁵⁰ Family planning: the unfinished agenda*

5.0. Findings from Budget Analysis

5.1. National Budgeting process

The MOHSW Head of Healthcare Financing in the Department of Policy and Planning, and the National Family Planning Coordinator, under the Reproductive and Child Health Section (RCHS) were interviewed on the budgeting process.

Specific budget line for RH/FP

The MoHSW budget framework has a several targets for RH activities and services under the main RCHS Objective. These targets do not necessarily include FP. In some years where resources are specifically allocated for FP (for procurement of contraceptives, for example), such allocations are also specifically indicated under the main RCHS Objective. The RCHS Objective does not also include HIV and AIDS activities / resources as this has got its own main Objective. Between the 2010/11 and 2012/13 FYs, for example, the RCHS Objective has covered such activities like conducting monitoring of distribution and use of contraceptives and other reproductive and child health commodities, procurement of specialized medical supplies, providing administrative services and logistics support to RCHS, procurement and distribution of contraceptives, procurement and distribution of vaccines, outsourcing the development of Strategy for Prevention, Control and Management of Reproductive health cancers and Policy guidelines for Screening Breast and Prostate cancers screening, strengthening of disease management and health service delivery for under five children.

The Personnel involved in developing the RH/FP budget in the MoHSW

The RH/FP budget is part of the overall RCHS, which constitutes to the Department of Preventive Services of the MoHSW. The RCHS has several sub-sections, such as Safe Motherhood Initiative, Neonatal and Child Health, Adolescent Reproductive Health, Gender and Reproductive Health, Reproductive Health Cancers, Expanded Program on Immunization, and Prevention of Mother to Child Transmission.

All these sub-sections are eligible for annual RCHS budget allocations and therefore the staff and coordinators of these sub-sections are involved in budget development by initiating planning activities for the year. After that the process follows the usual budget development hierarchy of the MoHSW management where budget proposals have to be approved by the Head of RCHS, then the Director of Preventive Services, the Chief Medical Officer, and finally the Permanent Secretary / MoHSW management team before they form the overall MoHSW annual budget proposal to be presented to the parliament for final approval.

Professional backgrounds of personnel involved in the RH/FP budget development

Budget development is a process involving many people from different backgrounds such as medical, public health, economics and development planning, social welfare, accounting, from within the MoHSW. However, the annual budget development is a cycle that also involves many other people outside the MoHSW. This is further described in response to the following question below.



Reviewing and approving the budget

The budget process essentially involves the determination of resources and their uses for attainment of government objectives. In Tanzania it involves four main stages:

Stage 1: Budget Formulation: Largely depends on the Ministry of Finance (MoF) directives and guidance. The budget estimates are formulated in line with detailed macroeconomic forecasts on future growth, inflation and external sector (import) trends. Donor/Government consultations assist the budget process by confirming donor financial commitment in the budget. These discussions take place between the MoF and development partners. To some special cases, some discussions can be done within the sectors depending on the framework. For example, health sector has a Sector wide Approach (SWAP) framework supported by the Health Basket Fund; the discussions take place within the sector with some invited members from Ministry of Finance, Prime Minister's Office - Regional Administration and Local Governments (PMO-RALG) and others where necessary. The MoHSW then using bottom up approach compiles actual requirements for each program (the MoHSW internal process of budget review and approval described above). Priority areas are outlined from policies, like the Health Sector Strategic Plan III and other government directives, especially the Budget Guidelines.

The GoT has a collaborative process of formulating the Budget Guidelines, which are prepared by a committee comprising representatives from the Ministry of Finance, the President's Office Planning Commission (POPC), Prime Minister's Office, Civil Service Department, and Prime Minister's Office - Regional Administration and Local Government. The Budget Guidelines contain the following key information:

- An overview of macroeconomic performance and projections
- Priority sector MTEFs (prepared by Sector Working Groups in the Public Expenditure Review process which are consistent with the Poverty Reduction Strategy Paper (MKUKUTA) targets and have been updated and costed
- Vote expenditure ceilings based on resource availability; and
- Procedures for preparation and submission of the draft budget to the Ministry of Finance

The Inter Ministerial Technical Committee (IMTC), which is a meeting of all Permanent Secretaries together, the Cabinet and then the Parliament approve these Budget Guidelines. After the approval, all ministries, departments and agencies (MDAs) receive copies of the guidelines that indicate among other things the budget ceiling for that year. Then the ministries review their submitted proposals of their actual requirements to fit in the provided ceiling according to the prioritization process. Once the sectoral performance review and resource projections are completed, the MoHSW then shares these actual requirements with development partners and other stakeholders. Then these actual requirements are submitted to the MOF using special software called Strategic Budget Allocation Software (SBAS). The budget frame is also formulated for a longer three-year time period in a document called the Medium Term Expenditure Framework (MTEF). Since the GoT has decided to focus on poverty reduction, the Poverty Reduction Strategy Paper (PRSP), the MKUKUTA document, and program implementation progress reports become the basis of allocating resources. Thereafter, the budget is submitted to the Ministry of Finance where it is compiled with other MDAs for national process as follows:

Stage 2: Scrutiny of Budget Proposals and Dialogue in the IMTC: The IMTC is a committee of all Permanent Secretaries with a role to scrutinize budget proposals before they are finally approved by the cabinet. To facilitate the discussions, the MoF prepares a draft cabinet budget paper that covers the budget framework, the financial demands after dialogue with MDAs, the government priorities and financial implications. After a thorough review, IMTC may require the MoF to make further technical improvements on the paper or put up recommendations for consideration by the Cabinet.

Cabinet Approval of the Estimates:

The Cabinet (all ministers together with the President of the United Republic of Tanzania) budget paper is discussed by the cabinet after preliminary review by IMTC. The role of the cabinet is to deliberate on the budget paper and then finally approve government budget proposals for fiscal year in question before they are submitted to the legislature.

Parliamentary Social Services Committee

The process of obtaining Parliamentary authorization starts with discussions by the Parliamentary Standing Committee for Social Services, where preliminary briefs are provided by the Minister of Health and Social Welfare. Then the MoHSW budget and previous year's performance is submitted to this Parliamentary Social Services Standing Committee for scrutiny and recommendations. After the Social Services Committee has passed the Budget, then sectoral (e.g. for health or education) preliminary briefs are prepared by the Minister of Finance for integration in the final annual budget.

Public Debate and Authorization

After the Estimates have been reviewed by the sector committees (Social Services Committee) of the Parliament, then are tabled to the Parliament for debate and authorization. The major events during Parliamentary debate and authorization of the government budget include the following steps:

- Presentation of a Public Speech on macroeconomic performance and projections by the Minister for Finance
- Presentation of the government budget proposals to Parliament by the Minister for Finance through a budget speech
- Parliamentary debates/discussions on sector estimates submitted by each minister responsible
- Parliamentary approval of estimates by passing the Appropriation Bill.
- Parliamentary approval and passing the Finance Bill that empowers the Minister for Finance to raise the money and finance the budget.

Stage 3: Budget Execution: Budget execution is an important stage of the budget process as it is at this stage that actual revenue collections and service delivery take place. Execution of the budget, therefore, is about the collection and accounting for revenue, provision of services through the recurrent budget and implementation of development projects. The key documents used during implementation of the budget are Revenue and Expenditure estimates books, action and cash flow plans and budget memorandum. Main activities are:-

- Release of funds by the MoF
- Delivery of services and project implementation by MDAs. This involves both government institutions and Development Partners. Donors are required in some cases to release funds and award of contracts they have committed to.
- Maintenance of proper Accounts for control and accountability
- Reporting on budget performance (both financial and physical) and quarterly evaluations
- Project inspection and expenditure monitoring

The Ministry of Health and Social Welfare prepares quarterly Budget Performance and submits them to the MoF. MOFEA also publishes reports to maintain transparency on actual use of public funds in line with the budget estimates approved by Parliament.



Stage 4: Budget Monitoring and Control: Budget monitoring, control and evaluation are necessary for closer supervision of programs and projects. This involves a continuous monitoring of the plans and budget in order to identify achievements and bottlenecks. Basically, monitoring, control and evaluation focus on the following:

- Accountability – to ascertain appropriateness of expenditure and revenue and their conformity to the authorities through financial reports.
- Management assistance – for providing management with information on performance.

The overall control and monitoring of public expenditure is now affected largely through an Integrated Financial Management System (IFMS). This is a computerized system which links up most of the GoT paying stations. For that reason, most payments are centralized and controlled. Hardly can an expenditure or commitment be incurred without financial provision from IFMS. Major outputs from IFMS include:

- Monthly flash reports on revenue collections and expenditure
- Quarterly and annually performance reports
- Control of excess spending beyond approved budgets
- Specific reports based on user requirements

In addition to IFMS sub-treasuries have been established in all the regions for processing payments from decentralized government ministries and regions. In the nutshell, this shows that GoT budget development, review and approval are a long and complex process, involving a large number of people and authorities beyond the MoHSW staff and administration.

The monitoring and evaluation mechanisms or tools used for tracking allocated resources to the MoHSW

The resources provided by various development partners to the MoHSW for RH and FP interventions, either through the pooled funding mechanisms like the GBS and HBF, or through bilateral agreements are subjected to the same monitoring and evaluation mechanisms used by the MoHSW to manage locally collected revenue applied to various health services. The MoHSW has a section under the Department of Policy and Planning responsible monitoring and evaluation, which tracks activities against budgeted activities, disbursed resources and submitted financial reports from specific departments, sections and sub-sections.

Guiding documents (policies, strategies, sector plans) used by the MoHSW in preparing budgets

In preparing its annual budgets, the MoHSW is guided by several national policy and sectoral documents as explained before. These include the appropriate Budget Guidelines, which in turn are guided by policy documents like the Tanzania Development Vision 2025, the National Strategy for Growth and Reduction of Poverty (MKUKUTA) and Tanzania Five Year Development Plan. The health sector documents include the National Health Policy and the Health Sector Strategic Plan. Together, these documents set priority areas where resources should be allocated. On the other hand, budget allocations are influenced by service and quantification data from the field feedbacks. For example, if a particular service of FP method is reported to be in increasing demand also more resources would be allocated to that particular service or FP methods.

Needed initiatives in order to increase budget allocation for Reproductive Health and Family Planning

Increasing resources for RH/FP requires expansion of the health budget because at current level it is already over-stretched with many competing health - related priorities. Other initiatives could include strengthening advocacy efforts to decision makers regarding the importance of RH/FP services for our national development plans. This could make more resources available. The advocacy efforts also should be expanded to reach our development partners because a very significant proportion of the Tanzania health sector is financed from outside GoT own budget.

Opinions on the principal issues affecting resource flows from central level to the regions and districts

The main factor is insufficiency of the available resources for disbursement. Formulation of the budget is one thing but realizing the budgeted resources is a different thing. It happens that both the GoT and some committed development partners sometimes release funds not according to the agreed time schedule. Other factors include districts not submitting reports timely and insufficiency accountability in the resources already disbursed to them in the past.

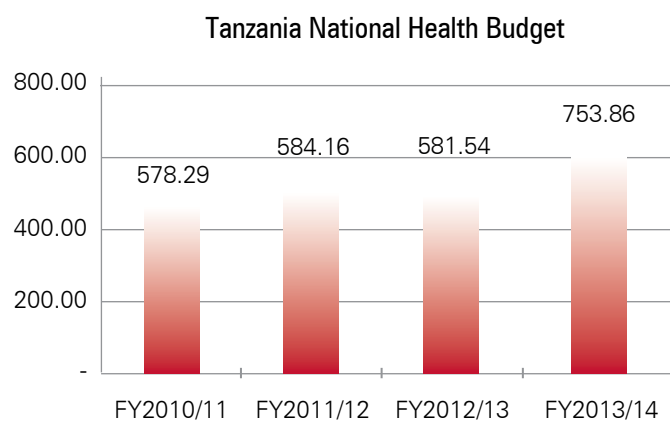
5.2. Financial data findings

In this section we analyzed financial data which tells us what funding has been allocated and expended to support RH/FP. In summary the set of questions which the financial data had to answer include but not limited to: national and districts budget Commitments vs. expenditures whereby we are documenting allocations or commitments as well as expenditure. In this section the financial data is analyzed by: Health budget trends, SRH budget trends, Family planning budget trends, Health, SRH and Family planning budget Vs Expenditure, Sources of funds for health budgets

5.2.1. Health budget trends

In order to facilitate tracking of resources provided for FP/RH, a request was made to the MoHSW (Healthcare Section in the Department of Policy and Planning) and the two districts (Handeni and Shinyanga DC) to share financial information for RH/FP. The findings as indicated in figure 1 below, shows that national budget allocations for health increased between FY 2010/11 to 2011/12 then dropped in FY 2012/13 and was significantly increased in FY 2013/14.

Figure 1: Overall national health budget trends from the year 2010/11-2013/1 (Tshs)

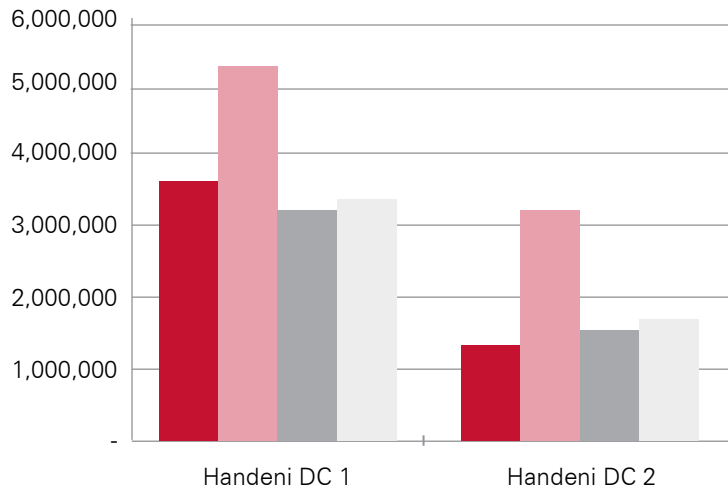


Data source: MOHSW



On the other hand, data obtained from the CCHP for both Handeni and Shinyanga district as presented in figure 2 below indicate inconsistent budget allocations from FY 2010/11 to 2013/14. In both district budget allocation for health was low during the FY 2010/11 and highest in FY 2011/12, this trend as dropped significantly during the FY 2012/13 and 2013/14

Figure 2: Overall District Health budget trends (Figures in 000 Tshs)

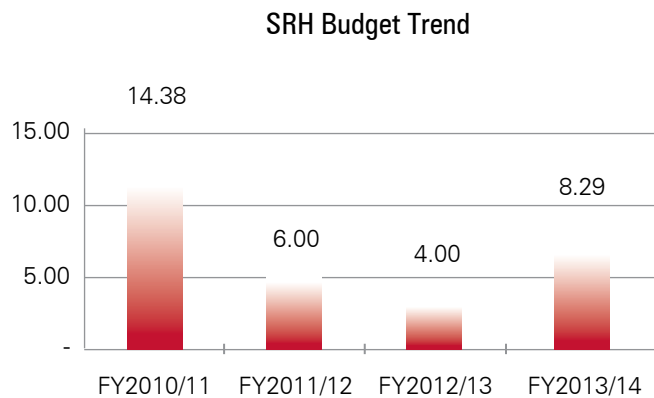


Source: Handeni and Shinyanga DC CCHP

5.2.2. Sexual Reproductive Health budget trends

Data obtained from the MOHSW as presented in figure 3 below shows a fluctuation in national budget allocations for SRH between FY 2010/11 to 2012/13. The SRH budget shows the lowest decrease in FY 2012/13, from Tshs 14.38 billion in FY 2010/11 to Tshs 4 billion in FY 2012/13, but this figure has since increased during the FY 2013/14 to Tshs 8.29 billion.

Figure 3: Overall national SRH budget trends



Data source: MOHSW

By comparison the SRH budget for the two districts has also been erratic as depicted in table 1 below. Handeni district recorded the highest overall budget allocation for SRH during the FY 2011/12 the same with Shinyanga district which also recorded the highest budget allocation during the same period as indicated in table 1 below

Table1: Overall District SRH budget trends (figures are in '000' Tsh)

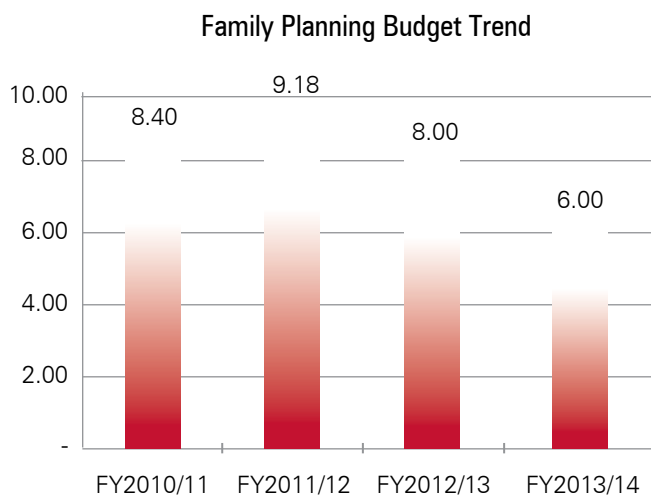
DC	Handeni DC				Shinyanga DC				
	FY	2010/11	2011/12	2012/13	2013/14	2010/11	2011/12	2012/13	2013/14
FP		6450	6220	5030	7268	21196	16199	17800	1500
ARH		3218	4020	4530	4630	11868	0	0	0
MNCH		72160	40,437	10722	38573	688075	581832	239500	141259
RH Cancer		0	0	0	0	0	310,112	0	0
Other RH issues		0	52000	0	0	4489	29125	113364	0
Total		81828	102677	20282	50471	725628	937268	370664	142759

Source: Handeni and Shinyanga DC CCHP

5.2.3. Family planning budget trends

Both the national and district family planning budget trends still simulate the overall SRH budget trends. The national family planning budget only increased between the FY 2010/11 to FY 2011/12 since then the national budget allocation for FP has been on the downward trend (see figure 4). The district budget allocation for FP also indicate an irregular trend as shown in figure 5 below whereby the budget allocation for FP is either increasing or decreasing at will

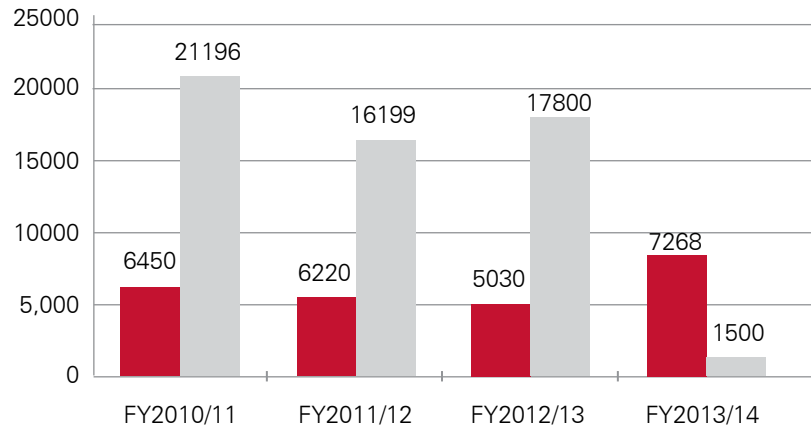
Figure 4: Overall national Family planning budget trends



Data source: MOHSW



Figure 5: Overall District Family planning budget trends (figures in '000' Tsh)

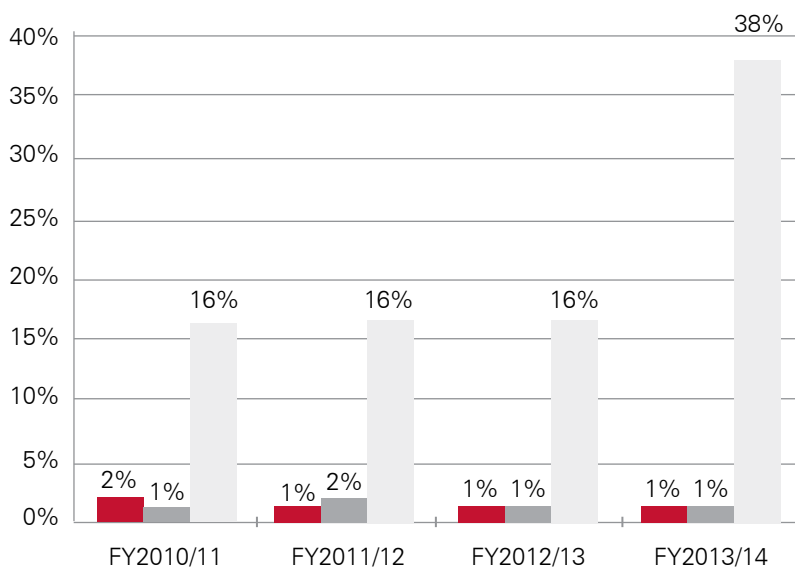


Source: Handeni and Shinyanga DC CCHP

5.2.4. Proportion of budget allocation for Reproductive health and Family planning

We also assessed the percentage of health budget that is allocated for reproductive health and ultimately family planning. Nationally from FY 2010/11 to FY 2013/14 proportion of health budget allocated to SRH and FP has constantly remained at an average of 1% of the total health budget except during FY 2010/11 where proportion allocated for SRH was 2% the same with FP during the FY 2011/12 (see figure 6 below). It is also apparent that budget allocation for HIV and AIDS for the FY 2010/11 to 2012/13 was taking 16% of the health budget and this has doubled in FY 2013/14 to 38%

Figure 6: Proportion of SRH, Family Planning and HIV/AIDS Budget in the Total National Health Budget



Data Source: MOHSW

For the case of districts as shown in figure 7 and 8 below, the SRH percentage share of Handeni district health budget over the years has been between 0.52% and 2.23% although Shinyanga district is performing well. ShinyangaDC Health budget allocation for SRH has been decreasing significantly from 36.10% during the FY 2010/11 to 6.15% during the FY2013/14

Figure 7: Proportion of Handeni DC Health budget allocation for SRH and FP

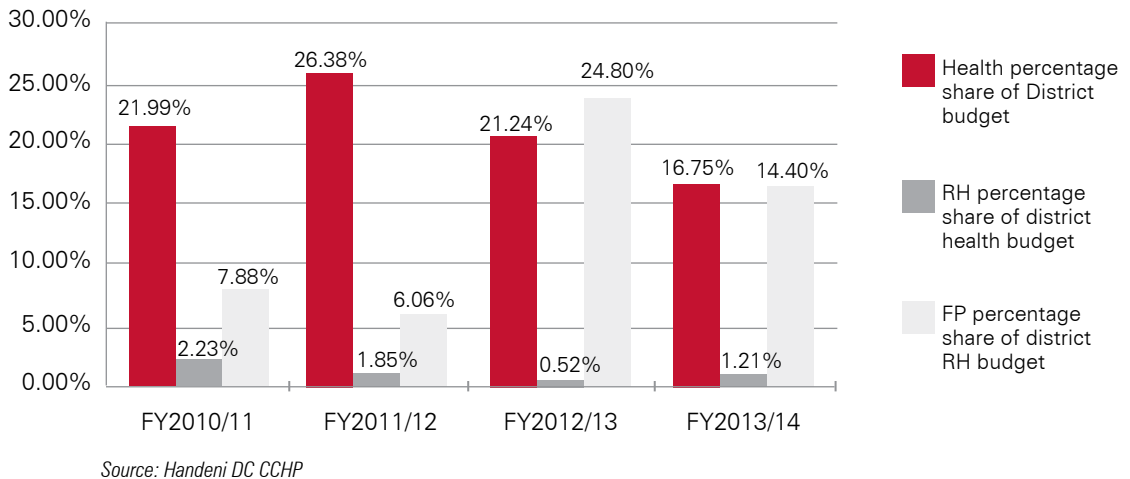
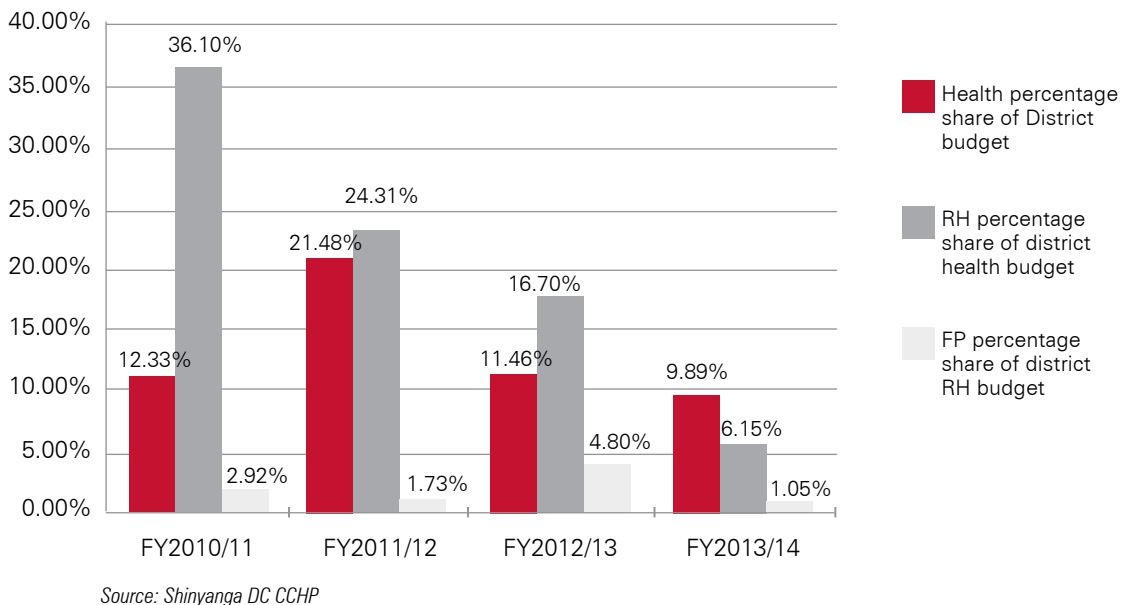


Figure 8: Proportion of Shinyanga DC Health budget allocation for SRH and FP





5.2.5. Health budget Vs Expenditure

An analysis of the National health budget from FY 2010/11 to FY 2012/13 in shows a discrepancy between the planned budget and expenditure (see figure 9 and 10). During this period the expenditure was 80% of the planned budget in FY 2010/11, 52% in FY 2011/12 and 85% in FY 2012/13.

Figure 9: National Health Budget vs Expenditure

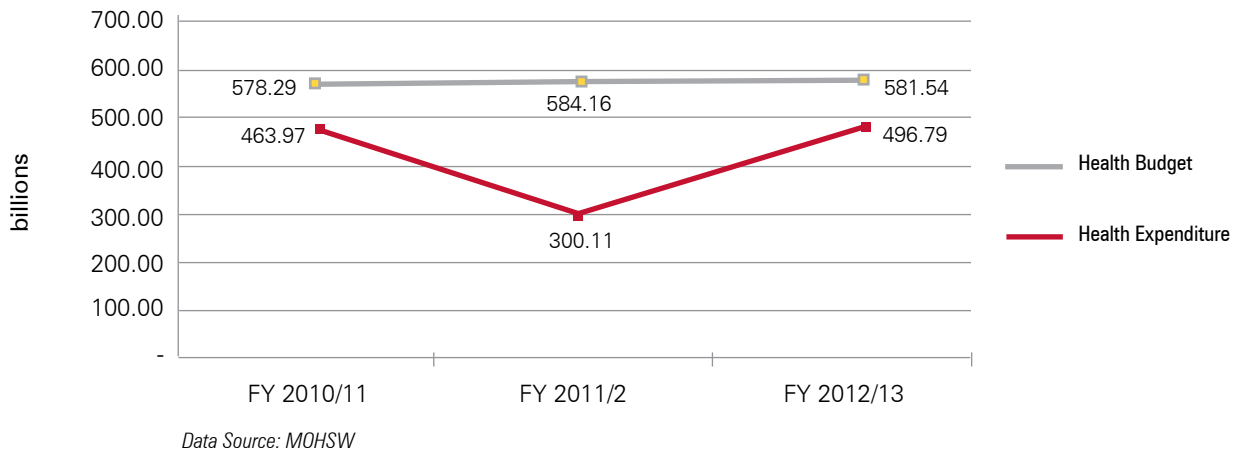
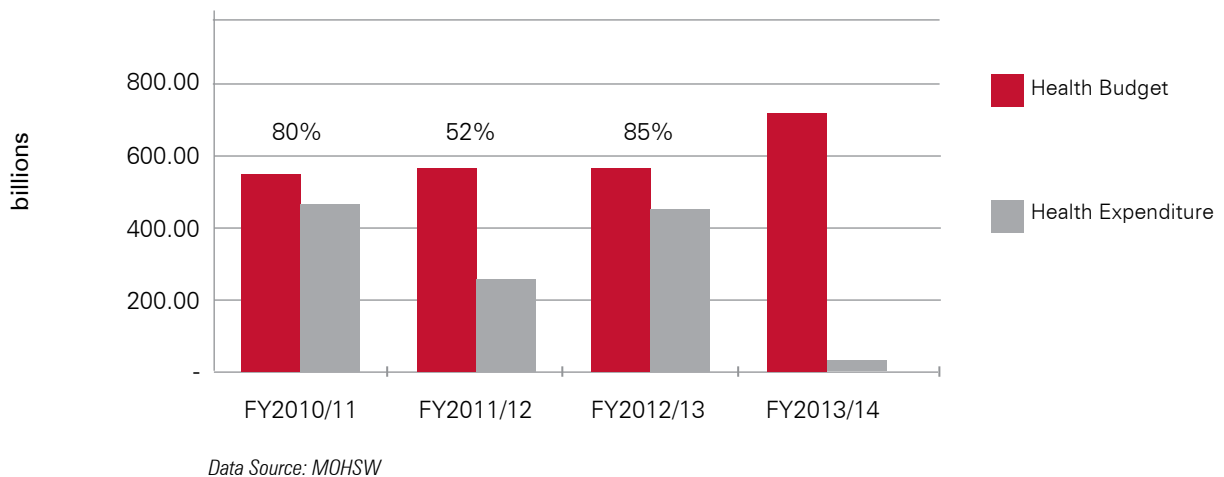
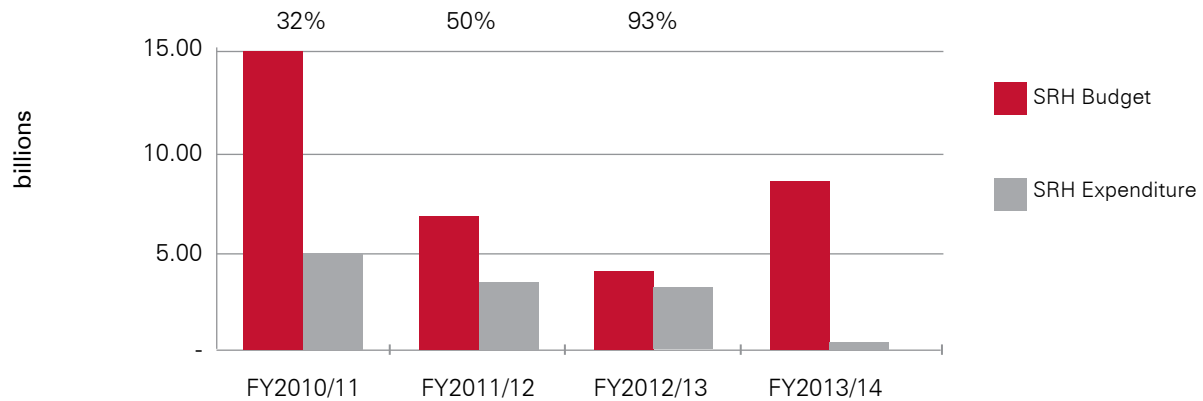


Figure 10: % of Expenditure over Health Budget



However, as presented in figure 11 below, it can be seen that the SRH expenditure has been increasing significantly over the years. This could be attributed to the fact that the planned budget for SRH has also been decreasing over the three years.

Figure 11: SRH Budget vs Expenditure



Data Source: MOHSW

The analysis of the district health budget from FY 2010/11 to FY 2012/13 as presented in table 2 and 3 below shows that SRH expenditure has been decreasing significantly over the years although budget allocations still remain erratic.

Table 2: Handeni DC Reproductive health budget vs expenditure (figures in '000' Tsh)

FY	FY2010/11		FY2011/12		FY2012/13	
	Allocation	Exp	Allocation	Exp	Allocation	Exp
Total allocation Vs expenditure	81828	75980	102677	91437	20282	10521
% of expenditure over allocation	92.9		89.1		51.8	

Source: Handeni DC CCHP

Table 3: Shinyanga DC Reproductive health budget Vs expenditure (figures in '000' Tsh)

FY	FY2010/11		FY2011/12		FY2012/13	
	Allocation	Exp	Allocation	Exp	Allocation	Exp
Total allocation Vs expenditure	725628	101624	937268	923554	370,664	251807
% of expenditure over allocation	-		98.5		68	

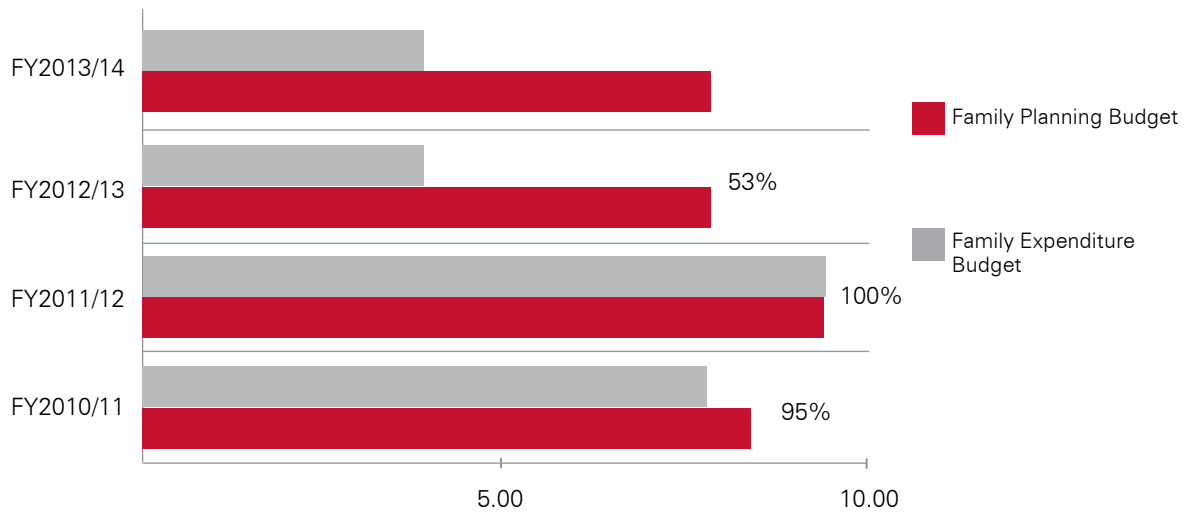
Source: Shinyanga DC CCHP



5.2.6. Family Planning Budget Vs Expenditure

National financial data obtained from the MOHSW after analysis indicates that planned budget for family planning and expenditure was at par during the FY 2010/11 and FY 2011/12. There was a significant drop in FP expenditure during the FY 2012/13 (see figure 12). It can also be observed the budget allocated for FP have been decreasing over the years. At the district level as reflected in table 4 below, the only FP expenditure data available for Handeni DC was for FY 2010/11. Shinyanga DC has been expending most of the budget allocated for FP.

Figure 12: Family Planning Budget vs Expenditure



Data Source: MOHSW

Table 4: District family planning budget vs Expenditure (figures in '000' Tsh)

District	FY2010/11		FY2011/12		FY2012/13	
	Allocation	Exp	Allocation	Exp	Allocation	Exp
Handeni	6450	3820	6220	-	5030	-
Shinyanga	21196	21796	16199	14100	17800	-

Source: Handeni and Shinyanga DC CCHP

5.2.7. Sources of funds for SRH and FP Budgets

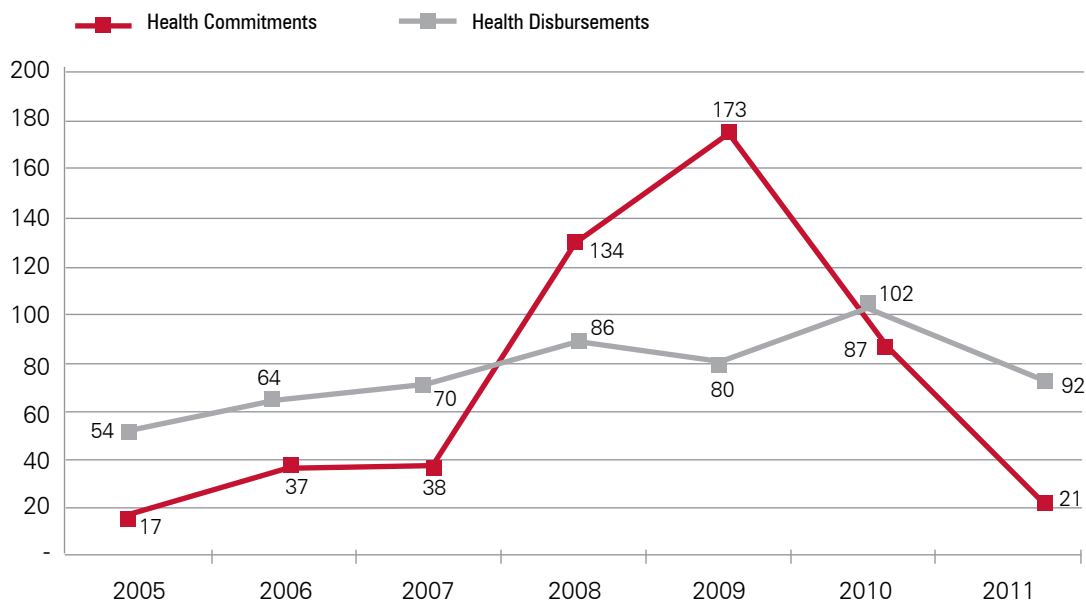
Sources of funds for SRH and FP at National levels

Nationally the main partners supporting the MoHSW on RH and FP budget lines include the Department for International Development (DFID) of the United Kingdom, the United Nations Population Fund (UNFPA), the United States Agency for International Development (USAID), the Health Basket Fund, the Norwegian Agency for International Development (NORAD), the Canadian International Development Agency (CIDA), German Agency for International Development (GIZ), etc. The main health sector partners who fund RH/FP programs outside of the government budget are largely the non contributors to the HBF like the USAID and international NGOs or Foundations from different developed countries. They include Marie Stopes Tanzania, Population Services International, Engender health Tanzania, KfW of Germany, Pathfinder International, John Snow Incorporated, Tanzania Marketing and Communication Agency (T-Marc, etc. Most of these agencies are branches of global business companies, which receive financial support directly from their home country governments or other private sector agencies

European countries health funds commitments Vs disbursement for the Tanzanian government

Euroleverage project provided a mapping funding for reproductive health in Tanzania. An analysis of the data provided as shown in figure 13 indicate European countries health commitments Vs disbursement for the Tanzanian government

Figure 13: European countries health commitment vs disbursements for the government of Tanzania (figures in Millions USD)



Data Source: Euroleverage project

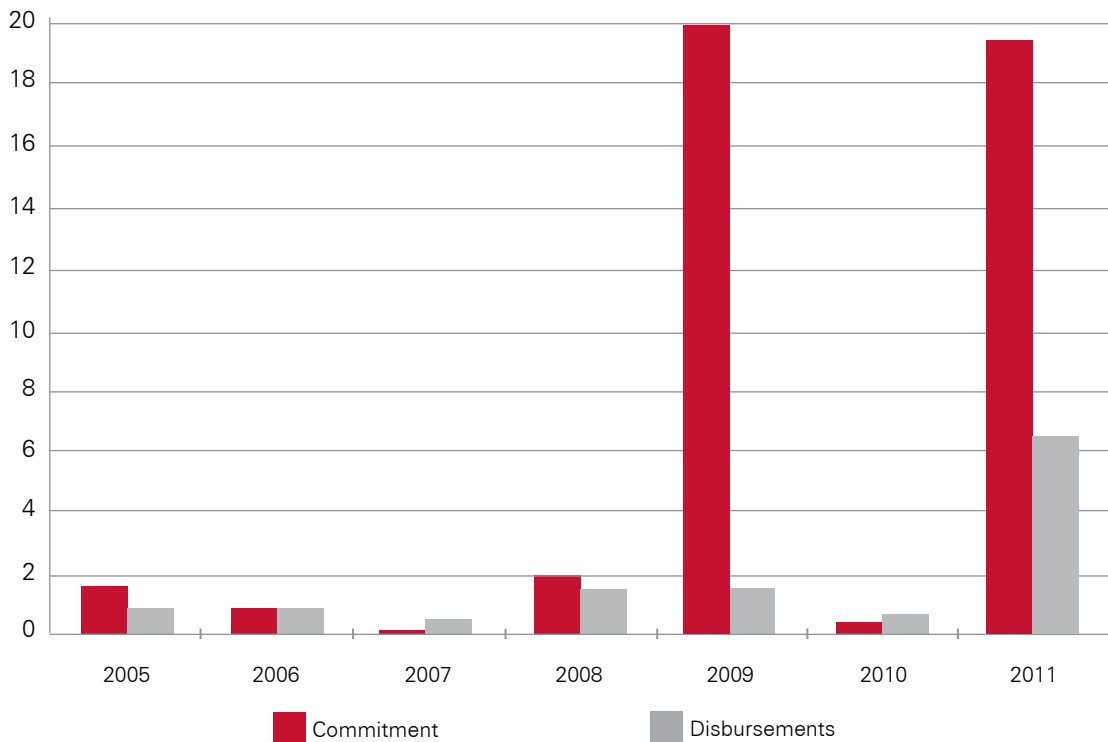
The figure 13 above shows that health funds committed by European countries do not always lead to disbursements. Looking at the trends for committed funds and disbursements, the amount of health funds committed was highest between 2008 and 2009 yet the disbursement was almost half the funds committed. The amount of funds disbursed was also higher than the funds committed between the year 2005 to 2007 and 2010 to 2011. These trends show that not all the funds committed are not disbursed nor were the funds disbursed committed. What can be noticed is that the funds that are disbursed by European Countries for health have been rising steadily except in 2009 and 2011.



European countries Reproductive health care funds commitments Vs disbursements

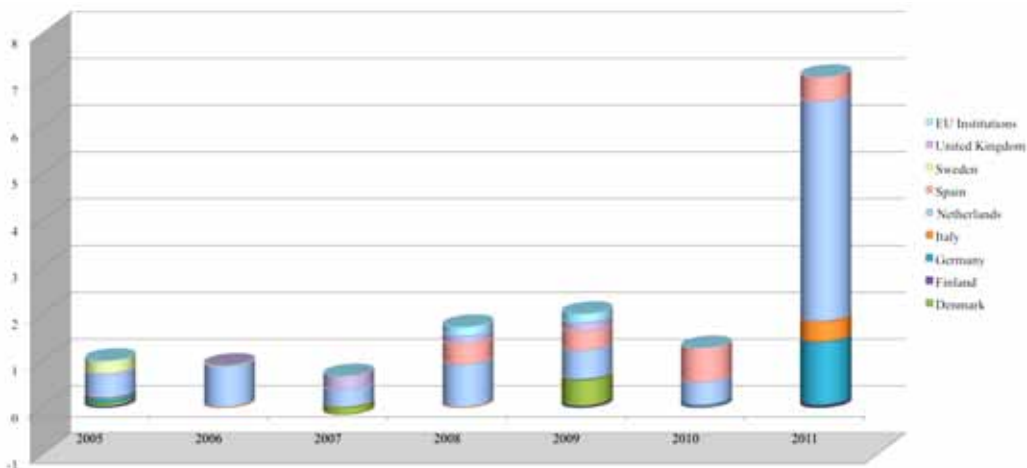
The figure 14 below also indicates that reproductive health care funds committed by European countries do not always lead to disbursements and vice versa. Large amount of funds were committed for reproductive health yet only a quarter was disbursed. Figure 15 below also gives information on countries which usually disbursed money for reproductive health; the leading are European institutions, Netherlands and Germany.

Figure 14: Reproductive Health Care Funds Commitments vs Disbursements (figures in Millions USD)



Data Source: Euroleverage project

Figure 15: Reproductive health care funds disbursements from European countries (figures in Millions USD)

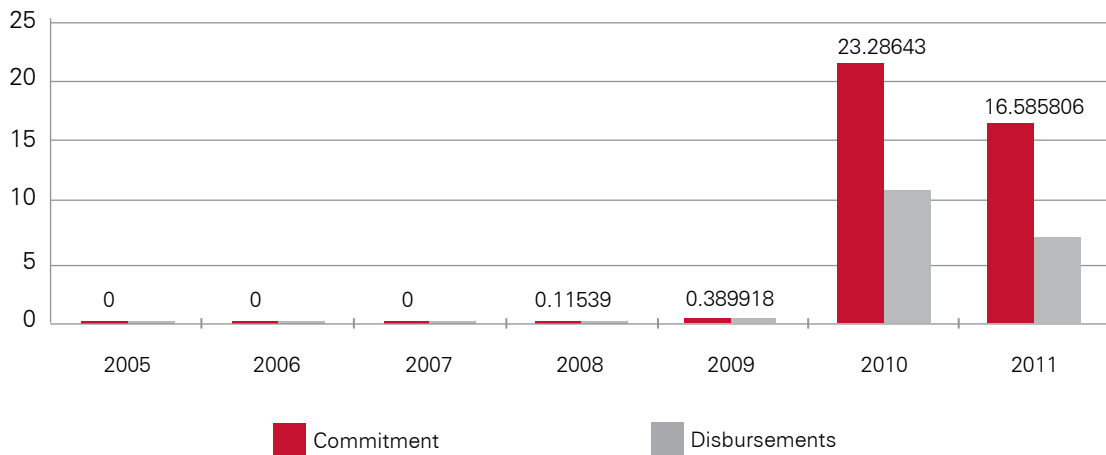


Data Source: Euroleverage project

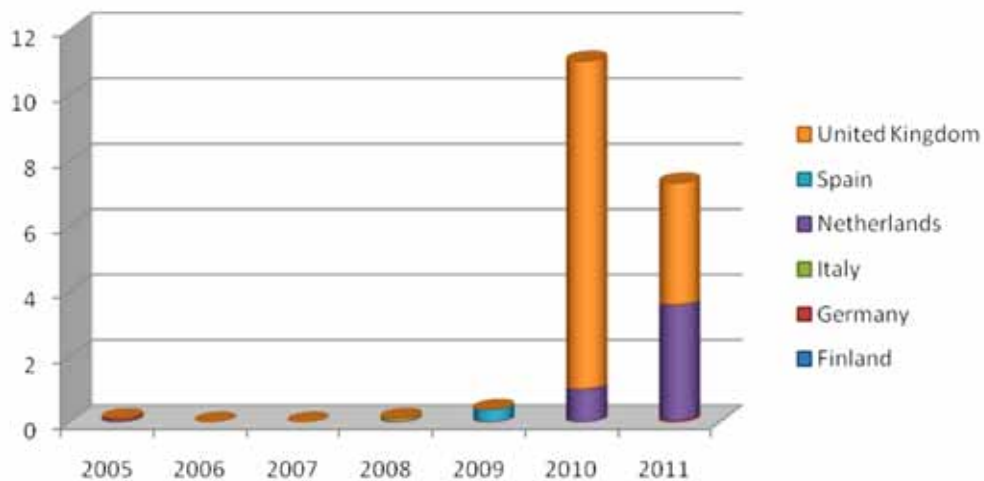
European countries Family planning funds commitments Vs disbursement

The figure 16 below shows that no funds were committed nor disbursed for FP between 2005 and 2007 by European countries. Funds committed and disbursed for FP started trickling in 2008 and rose significantly in 2010. There are only two European countries (United Kingdom and Netherlands) who committed and disbursed funds for Family planning (see figure 17)

Figure 16: Family Planning funds Commitments vs Disbursements (figures in Millions USD)



Data Source: Euroleverage project



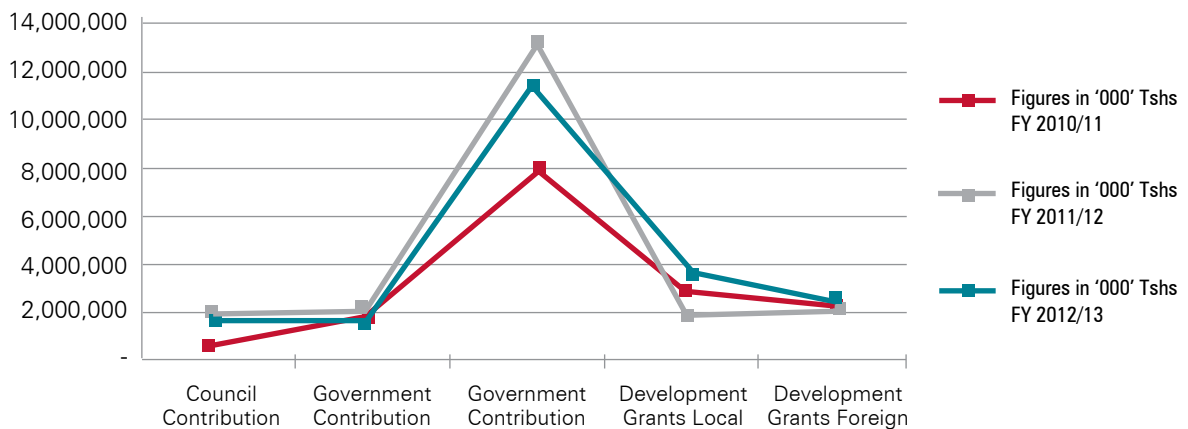
Data Source: Euroleverage project



Sources of funds for SRH and FP at District levels

At the district level data obtained from the districts indicated that government was the main sources of funds for family planning interventions. It was also noted that donors also contribute in the basket funds which can be utilized for family planning. There are also council own funds as well as other sources. The source of funds for the two districts are depicted in figure 13 and 14 below

Figure 13: Handeni DC Sources of Funds for SRH and FP budgets



Source: Handeni and Shinyanga DC CCHP

Figure 14: Shinyanga DC Sources of Funds for SRH and FP budgets



Source: Handeni and Shinyanga DC CCHP

6.0. Conclusion and recommendations

6.1. Conclusion

The findings from this study indicate that majority of community members understands the concept of Family Planning and its importance. However, not all member of the community support the concept of family planning. Most men think family planning is for women, the youth also think FP is for adults who already have children. It was observed from the community members that pills and injectables are always available at the health facilities although women prefer injection and implant. Implant, IUD and other permanent methods are only available during mobile clinics or in the Regional hospital for those based in Shinyanga and Handini Districts. The Causes of unmet need for family planning in the community were mentioned to include: Side effects FP methods, Myth and misconceptions on FP commodities, accessibility, male dominance and lack of qualified service providers. In summary two issues appeared to influence utilization of FP which includes: Widespread community misconceptions and false beliefs associated with the use of modern contraceptives and the community members do not sufficiently trust the competence of RH/FP service providers.

The national policies and strategies have been found to be in line with the ICPD, MDG and Maputo Plan of Action are: the national health policy, the population policy, national youth development policy, MKUKUTA II, National Family Planning Cost Implementation Plan (NFPCIP) 2010-2015, The national road map strategic plan to accelerate reduction of maternal, newborn and child deaths in Tanzania 2008 – 2015, Human resource for health strategic plan and the Health Sector Strategic Plan 2009 – 2015 (HSSP III). A number of these national policies and strategies are also committed to the international SRH principles although a number do not explicitly reaffirm commitment and universal access to: safe abortion, adolescent SRH information and services, contraception and sexual rights. Most policies emphasized that Tanzania must consider and address the implications of its rapid population growth rate on its social and economic development. In a nutshell most of the reviewed policies indicated the main priorities for the country's family planning programme should include: Awareness and demand creation for contraceptives, IEC for Family Planning, Improving accessibility to contraceptives to all, Affordability of family planning services

The study findings also show that national budget allocations for health increased between FY 2010/11 to 2011/12 then dropped in FY 2012/13 and was significantly increased in FY 2013/14. On the other hand there were inconsistencies in budget allocations at the district level. There was a significant decrease in national budget allocations for SRH between FY 2010/11 to 2012/13 but in comparison the SRH budget for the two districts has also been unpredictable. Both the national and district family planning budget trends still simulate the overall SRH budget trends. The national family planning budget only increased between the FY 2010/11 to FY 2011/12 since then the national budget allocation for FP has been on the downward trend. Looking at the percentage of health budget that is allocated SRH and ultimately family planning, nationally from FY 2010/11 to FY 2013/14 proportion of health budget allocated to SRH and FP has constantly remained at an average of 1% of the total health budget except during FY 2010/11 where proportion allocated for SRH was 2% the same with FP during the FY 2011/12. It is also apparent that budget allocation for HIV and AIDS for the FY 2010/11 to 2012/13 was taking 16% of the health budget and this has doubled in FY 2013/13 to 38%. Planned budget for family planning and expenditure was at the same level during the FY 2010/11 and FY 2011/12. There was a significant drop in FP expenditure during the FY 2012/13. It can also be observed the budget allocated for FP have been decreasing over the years.



6.2. Recommendations

Based on the findings the following recommendations are provided.

- There is need to design and implement a multi-sectoral approach to FP intervention with the aim of: improving knowledge about FP and encourage a responsible and healthy attitude towards Family Planning; ensuring the government including districts councils allocate adequate financial resources for family planning interventions and the funds are utilized efficiently and encouraging active involvement and participation of the district level institutions to meaningfully contribute towards FP.
- Education on FP should be aimed at the wider community so that FP does not remain women business as currently perceived.
- To ensure unmet needs are addressed the government through the MOHSW should ensure recruiting and posting enough and competent health service providers in rural health facilities.
- Religious leaders and community leaders should be engaged positively to help address myth and misconception about FP methods at the community level
- MoHSW through the office of DMO should support the implementing of the policy that encourages men to accompany their wives to clinics.
- It is necessary to continue and even expand public education about modern FP methods so that people get factual and accurate information on FP
- The MoHSW to collaborates with its partners to conduct capacity building trainings to FP service providers as well as updating and disseminating various service manuals to try and ensure that the provided services are up to date.
- Inform policy dialogue, planning and budgeting at all levels to strengthen the case for FP in the development agenda.
- Mobilize and sustain resources that are essential for achieving cost-effective and scaled up FP services.
- Develop benchmarks for GoT and Development Partners to monitor and support the FP program.
- Ensure consistent messages and support from opinion leaders about the need to make family planning services readily available for those who want them
- Scale up behavioral change communications so couples know the available family planning options

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2. *Comprehensive Council Health Plan, from Handeni and Shinyanga Districts (20010/11; 20011/12; 20012/2013; 2013/14).*
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4. Ministry of Health and Social Welfare (2008). *Human Resource for Health Strategic Plan 2008 – 2013*
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6. MoHSW (2011, 2012, 2013): Final Medium Term Expenditure Frameworks for the Ministry of Health and Social Welfare for the 2010/11, 2011/12 and 2012/13 years
7. MoF (2010): The National Strategy for Growth and Poverty Reduction (2010 – 2015)
8. MoHSW (2007): The Health Policy (2007)
9. The National Population Policy (2006)
10. MoHSW (2009): The Health Sector Strategic Plan III (2009 – 2015)
11. MoHSW (2008): The National Roadmap Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008 – 2015
12. MoHSW: Division for Reproductive Health: work plans and budgets 2009/10 to 2013/14
13. MoHSW: health performance reports 2009/10 to 2013/14
14. The National Policy Guidelines and Standards for Family Planning Services (1994)



Appendix

Appendix 1: Data collection tools

A) POLICY REVIEW GUIDE FOR DSW PROJECT

The primary objectives of the policy review component of this project are to assess the extent to which family planning and other reproductive health issues are prioritized in broad development and health policies and strategies; to understand key policy and programme priorities and policy implementation challenges and responses that are considered critical for the achievement of the objectives of the policies; and to assesses the extent to which key family planning issues identified by communities members are reflected in the policies.

While reviewing the family planning responsive policies and talking with key stakeholders in each of your countries, you should synthesize responses to the questions and issues outlined below.

Responsiveness to International Commitments

1. How do the key family planning policies position themselves with respect to international policy protocols such as the ICPD, MDGS, and Maputo Plan of Action?
2. Do the family planning responsive policies explicitly reaffirm commitment to the following international SRH principles?

Principle	Summary/key points
Advancing gender equality and equity and the empowerment of women, including education for girls	
Population issues articulated are integral parts of economic and social development	
Interrelationships and balance between population, resources and development are fully recognized as an integral part of sustainable development	
All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information and means to do so.	
Allocation of least 15% of national annual budgets to improve the health sector.	
Do the policies explicitly reaffirm commitment and universal access to:	
Safe abortion	
Adolescent SRH information and services	
Contraception	
Sexual rights	

NOTE: Addition to reviewing the FP and related policies, you should also review the ICPD, MDG, and Maputo PoA assessments that have been done for the country to assess the extent to which the country’s policy framework is taking these protocols into account.

Policy Issue/	Comments From Review (cite which policies you refer to wherever possible and note opportunities for improving the status quo)
<p>3. Prioritization of FP</p> <p>a. To what extent is FP a development priority in the country?</p> <p>b. Is FP highlighted in broad long-term development strategies (such as Vision 2030 in Kenya) and of five-year development plans such as the Uganda Development Plan for 2010-2015?</p> <p>c. What are the main arguments for promoting family planning in policies? (i.e. to what extent are health issues, environmental issues, human rights issues, and general development issues or arguments used?)</p> <p>d. Are there specific interventions promoted and targeted for FP in these development programmes?</p> <p>e. What is the level of political commitment and will in support of family planning at national and sub-national levels? How does this political will manifest itself? How does this political will manifest itself? (most of the insights on this would come from personal knowledge of the local context, review of previous assessments, and interviews with stakeholders during the course of the project). Do national political leaders or champions advocate for FP? In what way?</p> <ul style="list-style-type: none"> • Are there opportunities for strengthening political will and commitment? <p>f. To what extent is FP a priority within the Ministry of Health?</p> <ul style="list-style-type: none"> • How much of the MoH budget is allocated to reproductive health and to family planning? (Review National Health Accounts data or ministry budgeting information) • Where is FP placed in the MoH hierarchy? Is there room to improve this in the light of the hierarchy in other countries? 	
<p>4. Policy Implementation challenges and responses</p> <p>a. What do the policies define as the main priorities for the country's family planning programme?</p> <p>b. What do the FP and related policies define as the main challenges for implementing the FP policy in the country?</p> <p>c. What strategies are highlighted for addressing the FP policy implementation challenges?</p> <p>d. What do the policies note as the main causes of Unmet Need for FP?</p> <p>e. What are the main strategies that the policies have defined for addressing unmet need for FP?</p> <ul style="list-style-type: none"> • Are specific groups of people targeted in addressing unmet need for FP? 	
<p>5. Sustainability of FP Programmes</p> <p>a. Is sustainability of the FP programmes seen as a challenge?</p> <ul style="list-style-type: none"> • What aspects of sustainability are highlighted in policies? • What plans are in place for addressing programme sustainability? 	
<p>6. Policy Responses to Unmet need issues Identified by Communities</p> <p>6.1 For the first issue identified by the community in your district</p> <p>a. What is the history of the issue – is it an emerging issues or it has always been there? Is it getting worse?</p> <p>b. What is the magnitude and evidence of the issue in existing data at national level (i.e. is it a local issues or a national issues as well)?</p> <p>c. What responses are suggested for the issue in national policy and strategy documents</p> <p>d. What responses to the issue are suggested in operational policies or guidelines?</p> <p>6.2 For the second issue identified by the community in your district</p> <p>a. What is the history of the issue – is it an emerging issues or it has always been there? Is it getting worse?</p> <p>b. What is the magnitude and evidence of the issue in existing data at national level (i.e. is it a local issues or a national issues as well)?</p> <p>c. What responses are suggested for the issue in national policy and strategy documents</p> <p>d. What responses to the issue are suggested in operational policies or guidelines?</p>	
<p>7. Other pertinent policy issues</p> <p>Note other key policy gaps you have noted while reviewing the policies that present advocacy opportunities</p>	



B) DOCUMENTARY REVIEW

Introduction

My name is _____ from DSW. We are conducting a Reproductive Health and Family Planning budget analysis through the Euroleverage Project. The Project works closely with the Ministry of Health and other development partners. The purpose of our present is to assess how government policies prioritize FP and how it allocates Reproductive Health and Family Planning Funding at national and district level. We are interested in fully understanding of how the ministry/districts/ council or province have been prioritizing reproductive health and family planning in their plans and budget. To explore this issue we are reviewing key policy and budget documents and carrying out interviews with selected staff. We would like to review budget books for 2010/2011, 2011/2012, 2012/2013 and 2013/2014. The information collected in this review will help DSW and the MOH to ensure reproductive health and family planning is fully integrated in the development plans.

Documents provided Yes No
Documents reviewed Yes No

If you have any doubts or questions please contact the DSW Country Director (Insert number).

Thank you.

NB: Use excel sheet of FP Budget analysis data collection tool 1

C) KEY INFORMANT INTERVIEW ON FP BUDGET ALLOCATION

RESPONDENTS: Budget officers: at Ministry of Finance, Ministry of Health, District/Province and District Health Management team

Introduction and Informed consent

My name is _____ from DSW, we are conducting a Reproductive Health and Family Planning budget analysis through the Euroleverage project. The Project works closely with the Ministry of Health and other development partners. The purpose of our present is to assess how government policies prioritize FP and how it allocates Reproductive Health and Family Planning Funding at national and district level. We are interested in fully understanding of how the ministry/districts/ council/province have been prioritizing reproductive health and family planning in their plans and budget. To explore this issue we are carrying out interviews with selected staff. We would like to ask you some questions about your experience in policy implementation, health budgeting and planning process. The interview will last for approximately 30 minutes. The information collected in this review will help DSW and the MOH to ensure family planning is fully integrated in the development plans through advocacy.

We would like you to speak freely and openly. All information that you give is strictly confidential. Your name will not appear in any reports or notes.

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in the interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate?	Yes	No
Is it okay for me to use a tape recorder?	Yes	No

If you have any doubts or questions please contact the DSW Country Director (Insert number).

Thank you.

Name of interviewee
(Option).....

Position of interviewee

Ministry/Province/ District:

Name(s) of interviewer/data
collector.....

Date:

1: Who is involved in developing the RH/FP budget in your department here at theMinistry/district/council/province?

.....
.....
.....
.....



2. Who reviews and approves your budget? (List all and what they do)

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.....
.....
.....

3. What guiding documents (policies, strategies,sector plans) do you use in preparing your budget? (List all and ask for a copy to review)

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.....
.....

4. Have you organized budget consultations with population and CSOs as per government guidelines before submitting the budget? (For districts only. Not applicable at national level)

Yes/ No

If not why?

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.....
.....
.....

5. Please, describe your district budget to us?

a) Can you give us the figures for your general district budget and your health budget for the financial years 2010/11 to 2013/2014

Ask for district operational plan

Please, use the budget tracking tool to capture those data.

b) Please, list the sources of funds for the general budget and the health budget, for the same years?

Please, use the budget tracking tool to capture those data.

c) Please, point us to the activities carried out to improve RH/FP in your operational plan and the corresponding budget, for the years 2010/11 to 2013/14. What are the sources of funds for these activities?

Please, use the budget tracking tool to capture those data.

d) What determines how much money is allocated in each sector and for different RH/FP components?

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6. Please, describe the expenditures for RH/FP activities.

a)What are the expenditures for RH/FP activities in 2010/11 and 2011/12?
Please, use the budget tracking tool to capture those data.

b) If above data are not available: How many RH/FP activities have been implemented last year? If there is no expenditure report, ask what percentage of the planned RH/FP activities wereimplemented?
Please, use the budget tracking tool to capture those data.

7. What do you think should be done to increase budget allocation for Reproductive Health and family planning?

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Questions emerged from FGD

8. We recently talked with women, men and youth in the district. During these discussions, they identified the following issues of concern:

Issue 1:
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Issue 2:
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Are these issues known by you?

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What is your opinion regarding these issues? Is it an emerging issue or it has always been there and what is the cause?

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Are their activities in your work plan to improve these issues? Please, point us to relevant activities and budgets.

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What could be done by the district to help address those concerns?

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Policy analysis questions

9. What are the key policies that have been developed to address FP in the country? List them.

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10. What are the main priorities for the country's family planning program?

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11. What are the main challenges in implementing the FP policy in the country?

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12. What strategies are highlighted for addressing the FP policy implementation challenges?

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13. What should be done to improve implementation of FP policies?

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14. Is there strong political will and commitment to prioritize FP?

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15. Do national political leaders or champion's advocates for FP? In what way?

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.....
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