**Tanzania: Sector Programme Family Planning I and II**

**Ex-post evaluation**

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| **OECD sector** | 13030 / Family Planning | |
| **BMZ project ID** | (1) Phase I: 1995 66 969<br>(2) Phase II: 1998 66 443 | |
| **Project-executing agency** | Ministry of Health / *Reproductive and Child Health Unit* (RCHU) | |
| **Consultant** | *Crown Agent* (Procurement Consultant) | |
| **Year of ex-post evaluation** | **2004** | |
| | **Programme appraisal (planned)** | **Ex-post evaluation (actual)** |
| **Start of implementation** | (1) Q2 1996<br>(2) Q3 1999 | Q4 1996<br>Q3 2000 |
| **Period of implementation** | (1) 36 months<br>(2) 30 months | 48 months<br>20 months |
| **Investment costs** | (1) EUR 3,48 million<br>(2) EUR 4,7 million | EUR 3.48 million<br>EUR 2.1 million |
| **Counterpart contribution** | (1) EUR 0.15 million<br>(2) EUR 0.6 million | EUR 0.46 million<br>EUR 0.3 million |
| **Financing, of which Financial Cooperation (FC) funds** | (1) EUR 3.07 million<br>(2) EUR 2.05 million | EUR 3.07 million<br>EUR 1.8 million |
| **Other institutions/donors involved** | (1) ODA (UK) (co-financing)<br>(2) USAID, UNFPA (interim financing) | No direct support, indirect basket funding |
| **Performance rating** | 2 | |
| **• Significance / relevance** | 2 | |
| **• Effectiveness** | 2 | |
| **• Efficiency** | 3 | |

## Brief Description, Overall Objective and Programme Objectives with Indicators

The double-phase Sector Programme Family Planning (1996 to 1998 and 2000 to 2001) served the purpose of supplying Tanzanian health stations with contraceptives (three-month injectables). This way the programme was designed to cover the rising need for contraceptives (programme objective). The overall objective was to reduce the population growth and unwanted pregnancies (Phases I and II) as well as maternal and infant mortality (only Phase II).
The following indicators were used to measure the achievement of the programme objective:

- Phase I: Increase of the contraceptive prevalence rate to at least 20% until after the end of the programme period (originally 1998; at final inspection: until after depletion of the remaining supplies at the end of 2000)

- Phase II: The programme objective was considered achieved if at least 80% of the three-month injectables supplied under the FC programme were properly delivered to the target group by mid-2002.

Given the complex cause-and-effect relationships no (quantitative) indicators at the level of the overall objectives were formulated at the time of programme appraisal.

The first phase was conducted in cooperation with the British *Department for International Development* (DfID). The measures of the second phase of the programme were integrated into a programme consisting in the supply and distribution of other contraceptives and financed mostly by USAID and UNFPA. The total cost of the programme amounted to EUR 3.48 million in the first phase and EUR 2.1 million in the second phase, of which EUR 3.02 million and EUR 1.8 million, respectively, was financed from FC funds.

**Project Design / Major Deviations from the original Project Planning and their main Causes**

As was planned at the time of programme appraisal, around 3 million three-month injectables of the *Depo-Provera* brand were procured under Phase I and 1.525 million under Phase II. The transport of contraceptives, their storage, distribution, sale and monitoring/consultancy services were also financed from programme funds. The financed contraceptives were sufficient to meet the demand of around 20 months (Phase I, as planned at programme appraisal) and 10 months (Phase II, cut in half because of unavailability of DfID funds). During implementation, three major changes were made to the design against the original planning:

- As condoms were still in stock and demand was sufficiently met by funds of the UNFPA and USAID, and given the significantly rising demand, the originally planned procurement of oral contraceptives was substituted by the procurement of three-month injectables in Phase I.
- A co-financing with the *Overseas Development Administration* (ODA), today *Department for International Development* (DfID), which was not planned at programme appraisal, was carried out as well. The co-financing with DfID, which was planned for the second programme phase, did not materialise, however, because DfID reprogrammed the funds earmarked (about 50% of the total funds) in favour of the basket fund in the health sector.
- The low-priced British procurement agency *Crown Agent* was contracted owing to experience gathered by the ODA. This made the German procurement consultant considered at the time of project appraisal superfluous.

The responsibility for the programme implementation lay with the *Reproductive and Child Health Unit* (RCHU) of the Ministry of Health (MOH). This department is conducting the national family planning programme, including the FC programme, in an extremely competent and efficient manner. As the RCHU is conceived as a planning and distribution unit, it could be efficiently complemented by the technical support rendered by *Crown Agent* in the handling and logistics of the procurement measures. The services of the consultant were rendered in very good quality in both programme phases.
The Ministry of Health rejected the proposal to substitute brand name products in the second phase with generic drugs that might have achieved lower prices on the basis of international competitive bidding. It was feared that a change in the product name could cause uncertainty among the women using them and lead to a decline in demand. In this connection a study was proposed to the Ministry but not conducted.

Considering the changes made particularly in the first phase, the implementing concept has generally proven to be suitable for ensuring the procurement and smooth distribution of the

contraceptives in both programme phases. As confirmed by the Audit Report of 2001[1] and the reviews of the use of funds performed under the programme, the contraceptives were mostly stored and distributed properly and correctly throughout the entire programme term by existing structures of the Tanzanian health system. The costs of storing contraceptives at the district level and in the health stations and distributing contraceptives were financed by other donors (particularly USAID). The quantities and delivery times were based on consumption analyses and forecasts performed annually in accordance with the planning for all contraceptives by the Ministry of Health (under the USAID programme) with the support of *John Snow International* (JSI). Supplies to the health stations are performed by the district health teams on the basis of orders ("pull" system). The short-term supply bottlenecks that occurred in the years 2000 and 2001 were the result of inaccurate estimates of consumption made at the central level that were based on inadequate data resulting from the division of responsibilities for the distribution by the Medical Stores Department (MSD) and the collection of data by the district. The bottlenecks could be overcome locally without any serious consequences.

With support from the consultant the internal monitoring was adequate. The external monitoring (two studies on contraceptive distribution and quality of counselling in Phase I and a study on the use of funds in Phase II) revealed no relevant deviations. The routine reports from the districts and the reports of the MSD were not always qualitatively impeccable but were further improved in the course of the sector reform. The annual external audit of the MSD ensures that flaws are revealed and solutions sought. The consultant performed the control of the quality of the three-month injectables as planned. Three-month injectables were delivered in adequate quantities, so there were no supply bottlenecks between the first and second phase. There are no indications of improper utilisation of FC funds.

The FC financing was handled by the Ministry of Finance. No deviations were detected in internal and external audits. There are no indications on any misappropriation of funds (commodity audit). The balance from the first phase was utilised in the second programme phase. Residual funds from the second phase in the sum of EUR 253,900 were reprogrammed to the project "Maintenance and Rehabilitation of Diesel Locomotives" - Phase 4 (investment – 1998 66 765, complementary measure – 1998 70 460) within the framework of the German-Tanzanian inter-governmental negotiations of February 2003. The remaining balance of EUR 84,680.20 still available from a repayment under the consulting contract is to be utilised in the ongoing programme "CSSC - Social Services of the Churches 3" (2002 65 181), for which we will inform the BMZ under a pending progress review. The necessary consent has yet to be obtained from the Tanzanian Ministry of Health.

**Key Results of the Impact Analysis and Performance Rating**

In Tanzania, one of the poorest countries in the world (HDI: 140 of 162 countries, 2000), around 40% of the population lives under the poverty line. The basic public health facilities, which offer nearly all family planning services (FP), are accessible to around 90% of the population in a perimeter of around 10 kilometres. Facilities of the churches sometimes offer modern FP methods (Protestant facilities) while some of them restrict their FP to purely traditional contraception methods (Catholic facilities). We assume that the entire target group, particularly the poorer rural population, was able to generally benefit from the programme because of the generally free state FP services offered. The programmes mainly reduce the health risks caused by unwanted and excessively frequent pregnancies, thus benefiting women most of all. The programmes caused only limited environmental strain as syringes and needles are buried after use in most health facilities.

[1] Commodity Audit of Contraceptives Procured under German Financial Cooperation 1997-2001, Dar Es Salaam, November 2001

In the past 10 years the main impact of the Tanzanian family planning programme was a significant increase in the contraceptive prevalence rate (CPR) for modern FP methods for women aged 15-49 from 5.9% in 1991 to approximately 16% in 1999. The CPR for all contraception methods has more than doubled between 1991 and 2002 (from 10% to 25%)[2]. Thus the indicator for Phase I has been more than fulfilled. There is also an unmet need for contraception for unmarried women (1992: 28%, 1999: 22%), and Tanzania has a rather low CPR against comparable countries. In the past 10 years the fertility rate fell from 6.2 to 5.2[3]. Within the contraceptive mix there was a clear CPR increase for the three-month injectable of 3.7% to 5.3% between 1995 and 1999. By comparison, the CPR for condoms rose from 1.3% to 3.4% in the same period. The CPR for oral contraceptives (4.8% and 4.6%) and the CPR for IUDs (1.9% and 1.8%), in turn, remained nearly unchanged.

By May 2002 all supplies financed from FC funds had been used up and distributed properly to the target group. The regular supervision conducted by the district health teams and confirmed by the auditor (2001) generally ascertained the proper utilisation of the three-month injectables at the level of the health stations. The review of the utilisation also did not reveal any signs of any major losses during the storage and distribution of contraceptives. The target indicator for the second phase of the programme has thus been achieved. Given that the target indicators were achieved, we rate the effectiveness of the programme as satisfactory (rating 2).

In both programme evaluations the risk to the achievement of the programme objective was rated medium and its influenceability medium as well. Generally, the measures that were applied to reduce the programme risks, such as the deployment of a qualified procurement consultant and periodic inspections of the use of the funds, have contributed to reducing these risks as well as to the successful completion of the programmes and the achievement of their objectives. Nevertheless, even after the conclusion of the programme in Tanzania, the risks to the supply of contraceptives remain, with the biggest deficits in the logistics area, the analysis of consumption and ascertainment of needs. The quality of counselling has generally improved over time as a result of the training measures supported throughout the country (primarily by USAID and UNFPA). However, the increasing shortage of personnel in the health sector increases the risk that access to family planning services as well and, in particular, the counselling services will be impaired.

The indicators specified at the level of the overall objective, such as population growth, unwanted pregnancy and maternal and infant mortality, cannot be applied because of the complex interrelationships. Besides, there are opposing trends in this regard: While population growth has declined according to the World Bank (from approximately 2.8% per annum in the 1990s to 2.1% per annum in 2002), maternal and infant mortality has risen slightly. The overall objective is considered achieved, as assumed at programme appraisal, if the programme objectives have been achieved. However, there is a very close, negative correlation between the fertility rate and the contraceptive prevalence rate (CPR): it was possible to demonstrate empirically that the substantial increase in the CPR as mentioned above almost fully explains (by 92%) the also considerable decline in the fertility rates. Together with the impacts on the target group mentioned above we rate the contribution of the FC programme to Tanzania's family planning programme as having a satisfactory developmental relevance and significance (rating 2).

The consumer price per couple year of protection (CYP) amounted to the equivalent of EUR 5 for the three-month injectables. By comparison, the CYP consumer prices for oral contraceptives average USD 8.87 and for IUDs USD 2.16. Including transport, service

[2] Human Development Report (HDR) 2003
[3] United Nations Population Division 2004

personnel and administrative costs, the cost per CYP for three-month injectables is still clearly below the average cost of USD 12 per CYP established by the World Bank in comparable low-income developing countries. Generally, women practising family planning incur no costs besides transport and opportunity costs because the FP services, including the dispensing of contraceptives, are free of charge. We consider the programme approach to be suitable for contributing to substantial budget savings for private households at large by reducing the high health risks women are exposed to from frequent pregnancy and abortion which, however, cannot be quantified with accuracy at a reasonable effort. Families also have financial advantages as healthier women are more productive.

With a view to economic impacts, family planning measures are also of great significance if hard to quantify. The rising CPR, generally improved FP services and the provision of contraceptive methods in line with demand suggest that the number of unwanted pregnancies is declining. This reduces the above complications and risks that contribute to the high risk of disease for women and high maternal mortality (600-1000 per 100,000 live births, DHS 1999). Studies in Kazakhstan, Kyrgyzstan, Uzbekistan, Bulgaria, Turkey, Tunisia and Switzerland[4] show a clear connection between the decline in abortions and the rise in the use of modern contraceptive methods. As the cost of disease is mainly borne by the Tanzanian state, the decline in morbidity among women has a great impact on public health expenditure. On the basis of surveys conducted in other countries it is normally assumed that fewer pregnancies mean better care for infants/children which, in turn, can positively influence infant and child mortality. However, the development of infant and child mortality has tended to deteriorate in Tanzania over the past years. With good impacts at the project level and the overall economic level, and given the low cost of logistics and the use of existing structures, we rate the efficiency as adequate (rating 3) because of the lack of involvement of the population and the medium CYP costs, which are also the result of the refusal to procure generic drugs.

The apprehension held at programme appraisal that the Ministry of Health and the MSD would not be able to ensure the procurement of sufficient contraceptives over the medium term has so far not proven to be justified. On the basis of its many years of experience the MSD is capable of carrying out the procurement and distribution process satisfactorily. In accordance with the "*Final Report Situational Assessment of Logistic Systems*" and the study "*Commodity availability for selected health products"* no significant supply bottlenecks were found after completion of the programme: With regard to the sustainability of the programme the supply of three-month injectables was ensured after completion of the deliveries up to the financing from the basket fund by providing supplies of contraceptives from USAID and UNFPA (a total of 2.1 million doses, enough for more than two years). Subsequently, sufficient funds were also applied for the procurement of contraceptives including the three-month injectable under the basket funding. The other contraceptives are being financed by USAID and UNFPA. Recently, however, the allocations to the basket fund dropped as DfID switched to general budget financing. Consequently, the Ministry of Health applied for renewed parallel financing for the expensive three-month injectables.

After weighing the above mentioned key criteria we classify the programme as having generally satisfactory effectiveness (rating 2).

The risks to operation mentioned in the final inspections persist. The quality of the estimate of needs at the national level is still being impaired by unreliable surveys of consumption performed at the local level. The data from the districts are made available to the RCHS at the national level only with a considerable delay of six to 12 months. If the supplies are

[4] Scott Radloff, USAID. Does Family Planning Reduce Abortion. The Latest Evidence, May 10, 2004; International Family Planning Perspective 2003 March, 29

procured regularly as scheduled in the medium-term spending plan, however, these flaws should not have any medium-term impact on the supplies for the users. Further operational risks, such as remaining shortcomings in the supervision or quality of counselling, are rated low given the measures already introduced (training programmes for district health teams and FP counsellors). Nevertheless, the risk of personnel shortages remains, particularly in rural regions. So far, family planning services are free of charge in Tanzania. There are no plans to have the target group in this sub-sector contribute to the costs in the short to medium term. As a result, the Ministry will continue to be dependent on support from the development partners. Consequently, financial sustainability cannot be expected for a measurable period of time.

**Lessons learnt**

Despite the great demand for three-month injectables, Tanzania should maintain the balanced mix of contraceptives that was intended. Given the cost of the three-month injectable and the lack of sustainability resulting from its dependency on donors, the country should ponder how the costs could be financed from funds of its own in the long term. Higher costs are also caused by the use of brand products. Tanzania should therefore step up its efforts to organise the procurement of generic drugs in contraceptives as well.

Effective measures should be taken within the framework of the health sector reform to counteract the growing personnel shortage which is jeopardising the access and quality not only of family planning services but generally of basic health services, particularly in rural regions. As health workers at the district level do not always appear sufficiently competent to ensure proper distribution of contraceptives and necessary FP counselling under the national family planning programme, support for training measures should continue. The remaining problems with the quality of the supervision performed by the district health teams should continue to be treated with priority under the health sector reform.

**Legend**

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| Developmentally successful: Ratings 1 to 3 | |
| Rating 1 | Very high or high degree of developmental effectiveness |
| Rating 2 | Satisfactory developmental effectiveness |
| Rating 3 | Overall sufficient degree of developmental effectiveness |
| Developmental failures: Ratings 4 to 6 | |
| Rating 4 | Overall slightly insufficient degree of developmental effectiveness |
| Rating 5 | Clearly insufficient degree of developmental effectiveness |
| Rating 6 | The project is a total failure |

**Criteria for the Evaluation of Project Success**

The evaluation of the "developmental effectiveness" of a project and its classification during the ex-post evaluation into one of the various levels of success mentioned above concentrate on the following fundamental questions:

- Are the **project objectives** reached to a sufficient degree (aspect of project **effectiveness**)?
- Does the project generate sufficient **significant developmental effects** (project **relevance** and **significance** measured by the achievement of the overall development-policy objective defined beforehand and its effects in political, institutional, socio-economic and socio-cultural as well as ecological terms)?
- Are the **funds/expenses** that were and are being employed/incurred to reach the objectives **appropriate** and how can the project's microeconomic and macroeconomic impact be measured (aspect of **efficiency** of the project conception)?

- To the extent that undesired **(side) effects** occur, are these tolerable?

We do not treat **sustainability**, a key aspect to consider for project evaluation, as a separate category of evaluation but instead as a cross-cutting element of all four fundamental questions on project success. A project is sustainable if the project-executing agency and/or the target group are able to continue to use the project facilities that have been built for a period of time that is, overall, adequate in economic terms, or to carry on with the project activities on their own and generate positive results after the financial, organisational and/or technical support has come to an end.