Perspectives and Recommendations for USAID/Tanzania on Community-based Distribution (CBD) Programs

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SO1 - Increased use of family planning/maternal and child health and HIV/AIDS preventive measures

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EXECUTIVE SUMMARY

USAID/Tanzania has a unique opportunity to help set new directions for Tanzania's CBD program. CBD fits well into the overall USAID/Tanzania strategy, and can contribute to a solid family planning program. Tanzania is large, heavily rural and still in the early stages of demographic transition. CBD is particularly appropriate as an access strategy for isolated rural areas, and in conjunction with promotion of LTPMs and other public health interventions.

Tanzania has a rich history of public and private sector CBD programs, beginning in the late 1980's. A consensus of the technical professionals working in Tanzania--drawing on this rich experience-- is that with programmatic improvements and donor investment, CBD can expand to scale. These include better monitoring and evaluation, a new look at program design and in-service training, strengthened IEC and community mobilization, and linkages to other programs, such as LTPMs, care and support for AIDs patients and child survival efforts.

USAID should take advantage of existing networks, such as ongoing partner programs (GTZ, TACare), FBO/NGO networks and district programs, plus the technical expertise in regional training centers. Some program elements require simplification or streamlining if expansion to scale is to be achieved. Two crucial elements will be support by districts through the "Basket" mechanism and community involvement. Thus it is strongly recommended that investments in CBD be part of the USAID program in Tanzania.

I. INTRODUCTION, SCOPE OF WORK and METHODOLOGY

USAID/Tanzania is in the process of developing its strategic plan for 2005-2014 to establish the strategic direction of USAID assistance to Tanzania for the next decade. USAID has been a major donor and provider of state-of-the-art technical assistance in reproductive health since the early 1990's and will continue to play this role into the future. Although there is an increasing focus on programs to fight the HIV/AIDS epidemic, significant resources also will be allocated to reproductive health and child survival.

USAID programs will operate within the overall framework of the Government of Tanzania's decentralization strategy, but will continue to allocate funding outside of common donor "basket" funding. USAID also intends to continue to support private sector health initiatives, through social marketing, NGOs (non-governmental organizations), FBOs (faith-based organizations) and some community-based organizations (CBOs).

To support its strategy development, USAID/Tanzania developed an "analytic agenda" and undertook a series of assessments. One of those was a strategic assessment of reproductive health and child survival, undertaken by a four-person team in July 2003 (Harris was a member of this team.). As part of this assessment, Harris and colleagues from the Ministry of Health and EngenderHealth traced the evolution of the Tanzanian Long Term and Permanent Methods (LTPMs) program and provided perspectives for the future. This analysis highlighted the importance of LTPMs to achieving successful demographic transition. The conclusion was that USAID should remain a key player in improving access, quality and utilization of LTPMs in Tanzania. A clear rationale was provided for investments in this area.

The rationale for investments in CBD is also very strong. The RH and CS assessment noted that CBD agents and other types of community volunteers continue to provide a highly valued service to communities in various parts of the country. Anecdotal evidence suggests the value of CBD programs in referral for LTPMs, improving contraceptive prevalence rates (CPR) in target communities, and providing access to family planning in isolated rural communities. It was also noted that, increasingly, there is a perceived need to link CBD programs with village health workers (VHW) and community-based programs for HIV/AIDS, especially home-based care and support. CBD is a particularly good mechanism to increase access in isolated rural communities throughout this rural country. On the other hand, currently programs are not systematic, and it is difficult to tease out impact in terms of geographic coverage, sustainability and results. Issues of cost, cost-effectiveness, district-level support, community implication and programmatic direction would need to be sorted out prior to major investments by USAID.

This two-week TDY is a continuation of the reproductive health (RH) and commodity security (CS) assessment, focusing on CBD programs. The purpose of the assignment is to provide USAID/Tanzania with a summary of the main program and technical issues related to expansion of family planning service delivery using CBD and linking CBD programs to improved long-term method sites and possibly other health activities. It is intended to provide USAID/Tanzania with information to assist in decisions on resource allocation and program direction.

The methodology included field visits to the successful GTZ CBD program, individual interviews and a "brainstorming" session with key informants, and a literature review. A visiting graduate student from the Harvard School of Public Health was sponsored to conduct several in-depth interviews with current and past CBDs.

II. EVOLUTION AND CHARACTERISTICS OF CBD PROGRAMS IN TANZANIA

The public sector Tanzania National Family Planning Program has been active since the early 1990s. Tanzania began a national program of community-based distribution of contraceptives in 1993 in four pilot districts. Currently the program covers all or part of 26 districts with UNFPA funds, six with GTZ funds, and possibly others. Initially, UNFPA, DfID and GTZ provided program funding. Funding from UNFPA and GTZ continue, whereas DfID has put its funding in the general pool. Under the leadership of the former dynamic Reproductive and Child Health Service (RCHS) of the Ministry of Health, a comprehensive technical framework was laid down. National policy guidelines and standards were developed, and a pool of some 300 well-trained CBD trainers and CBD supervisors was put into place. A three-week curriculum for CBD training was designed, tested and is used by most programs, and a system to use existing health infrastructure down to the community level was mobilized to support CBDs.

An evaluation of the national public sector CBD program that was conducted in December 2000 (more or less at the height of the program) noted these program strengths, and others. At that time, the program seemed poised to expand to a truly national scale. The focus of Health Sector Reform programs on district and community-level planning and implementation was seen as an important opportunity to expand and sustain CBD programs. To date, this support, along with "Basket" funding from the donors, has not materialized. The result has been a gradual decrease

in interest in, and effectiveness of, CBD programs. Lack of dynamism at the RCHS also appears to be a factor in the lackluster public sector CBD program.

In addition to the national program's many strengths, the December 2000 evaluation pointed out significant weaknesses. The most important was lack of effective community participation during the initiation, implementation and management of the program. Lack of "community ownership" was seen as a key barrier to success. Another somewhat surprising weakness identified was that the CBD program was not well integrated into the normal health system implementation. This could explain lack of funds for supervision, and the poor competitiveness of CBD programs in the race for district budget allocations. Finally, the evaluation found competition from private sector CBD programs and lack of clarity on donor commitment to be major risk factors in the program's future.

Full scale and routine "basket" funding budgets from districts are not yet a reality, but donors are striving to address this, through policy dialogue and possibly matching funding to districts. Should such funding become routinely available, great potential exists to revive both public and private sector efforts and expand to a national scale.

The second type of CBD programs that evolved in Tanzania are private sector programs. Prior to 1993, when the national program began, a number of NGOS and FBOs were already active in CBD and community health worker programs. Many of these programs persisted, and grew along with the national program. These included a large program with the IPPF affiliate, UMATI, Marie Stopes International (where CBDs are directly linked to clinical RH facilities), the Seventh-day Adventist Church (SDA), the Lutheran Church, and Pathfinder International, which ran a large USAID-funded program. Funding sources included USAID, IPPF, JOICEF and other minor donors. USAID discontinued its funding to Pathfinder in the end of 1999, effectively ending this program. The UMATI Program is struggling to survive discontinuation of USAID funding, and looks to other donors for support. Marie Stopes Tanzania appears to have found alternative sources of funding (besides USAID) for its CBD program, which is closely linked to its LTPM and post abortion care (PAC) programs. This is one of the few programs where CBDs are directly linked to referral sites.

USAID began supporting CBD through its cooperating agencies (such as FPIA, Pathfinder International, Population Council, etc.) several years before there was a national program. Under the USAID bilateral program, Pathfinder International was the main vehicle for USAID funding for CBD prior to 2000, when another firm won the private sector contract. This firm's contract was terminated, and CARE was given a contract to run an integrated Voluntary Sector Health Program (VSHP). The original VSHP budget allocated 20% of funds and LOE to family planning. The project thus far has been disappointing in terms of CBD. Most of the grantees focus on education and do not provide substantial services. Of the several hundred CBDs the VSHP program supports, it is not clear how many are double counted as part of other PVO programs. Also, very little state-of- the-art technical assistance appears to be being provided.

The Jane Goodall Institute, with funding from the Packard Foundation, started a small population-health-environment program in Kigoma. This project has produced impressive results, albeit in a small area. In fact, nearly every program reviewed has shown dramatic increases in CPR in catchment areas, with increases ranging from 4% to 26%. At the CBD

Program's height (around 1997), the percentage of a district's couple years protection (CPY) attributed to CBD varied from 33% to 86% in Shinyanga and Kibaha, respectively.

FBOs continue to run programs with a variety of program designs and outreach modalities. Currently, most FBOs focus on more comprehensive village health workers who perform a variety of tasks in community health outreach program. An undetermined number of former CBDs have migrated to programs working in other areas, such as community malaria programs and home-based care programs for AIDS patients.

Thus CBD programs, in various forms, persist throughout Tanzania. They vary in effectiveness and approach. Donor funding has not kept pace with the need to expand, nor has the hoped for "Basket" funding dividend been realized. Because of both data collection and M&E weaknesses and the diversity of programs, it is difficult to estimate the current reach and impact of the program.

III. THE RELATIONSHIP OF CBD TO THE USAID STRATEGY.

There are strong arguments for placing CBD in the USAID/Tanzania strategy. They are summarized by part of the strategy. CBD is a good fit with the three USAID "critical transitions" (1. Health sector reform and public-private partnerships; 2. Changing donor modalities; and 3. Evolution of a new institutional framework for HIV/AIDS.)

In **health sector reform and public-private partnerships**, CBD programs use both Government of Tanzania (GOT) and NGOs/FBOs. They rely mainly on existing communities and structures, so represent a "bottom up" contribution to health sector reform. CBD is part of the picture of changing **donor modalities**, especially given that ultimately, public sector programs are dependent on the SWAP funding for sustainability. Collaboration among donors (especially UNFPA, GTZ and USAID) can help influence regions and districts to include specific line items to fund CBD. CBD and similar community programs play a critical role in the evolution of the **new institutional framework for HIV/AIDS.** CBD infrastructures are well positioned to provide a truly grass roots response to HIV/AIDS. A well-run CBD program can foster durable community care and support mechanisms. Youth programs that distribute condoms and the newly established bicycle social marketing ventures have much to learn from 15 years of USAID investment and experience in Tanzania.

The relationship to the USAID strategy in terms of the USAID Comparative Advantage is clear. In **information technology** CBD programs would be assisted through regional training centers. CBD programs that emphasize good monitoring and evaluation and use of routine health information systems can improve data for decision making at all levels. CBD programs foster **public-private alliances** because by definition they link government, NGOs and communities. It is in the area of **capacity building** that the value of CBD programs can be most clearly seen. CBD programs "grow" capacity at all levels, from individuals (empowerment of CBDs is well documented), to villages (participation), wards (supervision), districts (planning, financing, technical support) and regions (leadership).

Another USAID comparative advantage is its vast corporate experience in CBD program design, management, and evaluation. Given the historical USAID experience in CBD, it can help the

Tanzania program evolve into something that is both efficient and effective. USAID also is "a leader in a coordinated response to complex health transitions." Thus involvement in CBD is both a policy challenge (i.e. basket funding) and a technical challenge (i.e. improving efficiency, effectiveness and targeting).

The USAID strategy identifies four cross cutting themes (1. HIV/AIDS; 2. Gender balance; 3. Civil society participation; and 4. Education.) The relationship between CBD and **HIV/AIDS** programs is close. Condom distribution programs for youth, for example, are a form of CBD. Many current and former CBDs are essential part of counseling, care and support mechanisms in communities. CBDs are trusted by the communities they serve, and so they have an important role to play in stigma reduction. **Gender** balance is promoted because over 50% of all CBDs are women. Most of the beneficiaries of these programs are women, too. Community mobilization enhances democracy, reinforcing **civil society participation.** Most CBDs start out as community activists. It is well documented that children from small families are more likely to go to school. Well-spaced, well-cared for children automatically improve **education.**

The "bottom line" for USAID/Tanzania is **results**. CBD programs must compete with other reproductive health activities (social marketing, clinical LTPMs, investments in logistics systems, etc.) in achieving the ambitious USAID long-term goal to reduce fertility, maternal morbidity and mortality, improve spacing and expand CYP. A criticism frequently leveled at CBD programs is that they are an "expensive" way to recruit new clients. This is undeniably true on the surface, but only if one looks at programs narrowly.

All CBD programs in Tanzania have shown dramatic increases in contraceptive use within the first two years. Still, the impact of this is marginal because activities have been implemented on a relatively small scale. In addition, it is difficult (and perhaps unnecessary) for CBD programs to compete with urban phenomena such as social marketing and private sector expansion. Contraceptive prevalence is much higher in cities than in rural areas, and a variety of contraceptive delivery mechanisms assures access. Thus the argument for labor intensive programs such as CBD is less strong in urban areas.

In rural areas, on the other hand, the potential for CBD to increase access and improve utilization rates is good. CBD has its greatest potential in addressing rural communities, where access is very poor and utilization painfully low. CBD programs have proven "people level" development impact. They may be more sustainable if SWAP funding is routinely allocated. Given that Tanzania is still a largely rural society, and given the problems of physical access to services in this huge and expansive country, there is clearly a role for appropriate adapted CBD programs. In addition, the impact of these labor-intensive efforts can be magnified if linked or combined with long-term method programs and/or other health activities. This is key.

IV. SELECTED LESSONS LEARNED OVER THE LAST 15 YEARS

Lessons learned described below come from a variety of sources. A major source was an informal information exchange with most of the Tanzanian partners who are now--or have in the past--undertaken CBD. Another rich source of information is several thorough and thoughtful

program evaluations that took place in the late 1990s. Changing donor funding and careful review of lessons learned forced many NGOs to alter their way of providing services. The principal lessons learned included the following:

1.) **Local partnership** (between communities and district governments, churches and communities, etc.) is seen as crucial to success. Every evaluation highlighted this, and attributed program strength or weakness in the proportion that communities were actively involved. The Ministry of Health's (MOH) published guidance on developing and managing CBD programs wisely counsels planners not to "rush" communities and to listen and take their needs into account. It is clear that the most effective programs are ones where communities are active participants. The most important manifestation of this is participation by communities in selection of CBDs. However, managers of CBD programs were divided on how much communities should actually "supervise" CBDs. Still, all agreed that keeping community leaders in the loop is important to ensure optimal performance and retention of CBDs.

2.) **Cost sharing should begin at the start.** This was one of the major findings of the evaluation (including many stakeholders) of the USAID-funded Pathfinder program. The evaluation concluded that once a program begins with one model or funding scenario, it was difficult to change to another. Cost sharing by the community can take the form of non-monetary incentives for CBDs (such as being excused from communal clean-ups or other duties, in-kind gifts and recognition) to actually supporting the CBD. Currently, only the social marketing program has cost sharing by users through purchased contraceptives. The most important cost sharing mechanism will be through the SWAP mechanism, with District Management Teams (DMT) allocating resources for CBD programs. Convincing DMTs to plan for and allocate funds for community-based distribution will take time, technical assistance and policy efforts. However, even modest or "token" contributions at the start could be enough to justify co-funding by USAID and other donors. To help achieve this, the brainstorming group strongly suggested that it is time the name "CBD" be retired and that something like **Community-based Service Providers (CBSP)** be adopted. This more accurately represents their actual (and potential) roles and is likely to be more acceptable to district management teams, given that they are under pressure to adopt a lot of community-based initiatives, such as malaria, condoms for HIV/AIDS, PMTCT, etc.

3.) **CBDs perform best in the first 2-3 years of work.** A variety of studies in both Tanzania and Kenya present some similarities in the "profile" of CBD workers, despite apparent program design and management differences. CBD output, for example, is not closely related to paid or unpaid status. In fact, two reports noted that paid CBDs "complain a lot more" than volunteers! Private sector CBDs perform slightly better than their public sector counterparts, but even this data is not uniform. Finally, CBDS seem to perform best in the early years of the program. Programs are often conceptualized as monolithic, when, in fact, they evolve naturally and organically. In actual practice, most CBDs evolve into "depot holders" .after a certain length of time. A depot holder is a person who distributes contraceptives to individuals who come to his/her home, versus home visits by the CBD worker. Program planners need to take this information into consideration when designing programs.

4.) **Training, supervision and non-financial incentives are seen to be very important,** but this raises cost questions. Virtually all CBDs in Tanzania are now volunteers. The SDA church, which formerly compensated CBDs, has suspended giving stipends. Training and status in the community appear to outrank material rewards, including salaries, in terms of incentives. Some physicians worry that additional training will give CBDs too much knowledge, and they will attempt to play "doctor" in their communities. While this is a legitimate concern, it also is true that most CBDs already play an important role in community health care. Often, they are the only even remotely trained person in an emergency. CBDs can be trained to undertake simple tasks. Arming them with good information and knowledge about **when, where and how to refer clients** can only improve the positive results of practices that are already entrenched in isolated communities. Regular supportive supervision also appears linked to performance. However, the data are far from clear on just exactly what motivates CBDs, since some continue to work despite relatively long absences from technical supervision or refresher training. More study of this issue is necessary prior to coming up with an optimal "package" of incentives and supervision for CBDs.

5.) **CBD drop-out rates are predictable and should be planned for**. Program after program castigates themselves about drop-out rates. In recent programs, CBD drop outs range from 4 to 26%. However, worldwide experience shows similar drop out rates across programs. A certain number are for "good" reasons (e.g. death, serious illness, cannot physically do the job), and rates are predictable. Thus drop-outs should no longer be viewed as a "negative," but rather as a routine phenomenon that must be expected and planned for. CBDs should be viewed programmatically as a "renewable" resource. Regular new and refresher training needs to be organized. First and foremost, program planners must not lose sight of the fact that CBDs are **volunteers.**

6.) **Once established and functioning, most CBDs can accomplish (and usually desire to) additional health activities.** A classical worry about CBD programs that was expressed by a few stakeholders is the fear of "overloading" CBDs with so many activities that they cannot perform. This is particularly a worry with community-based family planning, since the goal is to improve coverage, and other activities are sometimes viewed as a distraction. While this concern has merit, it also is true that in most rural areas CBDs already play an important and expanded role in health service provision and as community leaders and decision-makers. In addition, once convinced of the advantages of family planning for their clients' health, they are unlikely to abandon this important community service. CBDs are busy people and proven "activists" in their communities. Once CBDs have "mastered" the basic role of counseling and provision of contraceptives and have recruited the first uptake of clients, other kinds of activities can be incorporated into their roles and responsibilities. Types of activities that work well include counseling and referral for LTPMs, sale of impregnated mosquito nets, and community action to prevent HIV/AIDS.

7.) **CBDs can play an important role in referral for LTPMs.** The historical experience of Marie Stopes provides compelling evidence of the potential role of CBDs in recruiting clients for LTPMs. Approximately 80% of Marie Stopes' referrals for sterilization come from their volunteer CBDs, who get "credit" in the record-keeping for both referrals and contraceptive distribution. Apart from Marie Stopes, CBD program data reveal only modest

recruitment of clients for LTPMs. Still, when interviewed, CBDs working with GTZ were positive about the method, and barriers in access seem to be an important factor in low recruitment. Currently, CBD training is light on LTPMs, CBDs have few IEC (Information, Education, and Communication) or referral materials, and almost none have actually seen a procedure. In Tanga, the MOH (district hospital staff), Marie Stopes, GTZ and CBDs themselves have expressed willingness to experiment with allowing CBDs to observe tubal ligations (TLs). This change, combined with a recently inaugurated mobile TL effort and planned upgrades (by the MOH and EngenderHealth), could dramatically improve uptake in LTPMs. A CBD program closely linked to improvements in clinical services and regular dates/times for TLs could dramatically increase the CYP generated by these programs, and possibly even begin to impact on fertility in rural areas where programs operate. At some point, USAID probably also could invest in operations research to see whether CBDs can provide injectable contraceptives, although this is controversial.

8.) **Monitoring, Evaluation and record keeping is weak in almost all programs.** It is unusually difficult to piece together information on ongoing or past CBD efforts in Tanzania. This is in part because every CBD program evaluation, and most interviews, cited weaknesses in monitoring, evaluation and record keeping. Some of this is a result of the overcomplicated MOH health information system, which collects too much data on many things, while failing to collect data essential for monitoring a large contraceptive distribution effort (i.e. commodities dispensed to user data). Incremental improvements in routine health data collection and use could improve the situation. Most informants felt that as a rule CBDs spend too much time keeping records and preparing reports and fail to use the records they keep to inform their own efforts. Although CBD training includes a community mapping exercise, the exact catchment area of each CBD is poorly defined and often self-defined. Under these circumstances, measuring and interpreting results is not easy. Programs such as the Madagascar Champion Communities Program have demonstrated that communities can collect simple information on health indicators, interpret what the information means in terms of health improvement, and use this information to encourage district leaders to improve volume and quality of services. If USAID/Tanzania invests in CBD, it will need to make specific, targeted investments in improving monitoring and evaluation, using existing routine HMIS, and in data for decision-making at the local level.

V. TECHNICAL AGENDA: SEVEN PROGRAM DECISION POINTS

As USAID conceptualizes and begins to support CBD (or CBSD), there are seven technical areas where there are "decision points" that will affect how the program evolves. They are:

1.) **What activities should CBDs (or CBSPs) undertake and in what sequencing?** A series of decisions will need to be made about the role of CBSP's. Will they continue to focus only on family planning (contraceptive distribution and referral), or add activities on HIV/AIDS, plus other health inputs? There also is much discussion on "income generation" activities as a way to compensate CBDs. Worldwide experience (including UMATI in Tanzania) suggests that this can be a "trap" that embroils programs in expensive and labor intensive efforts that fail to improve core performance. On the other hand, efforts such as sale of impregnated mosquito nets have a direct health impact, while providing small incomes to motivated CBDs.

2.) **What model of training and refresher training should be adopted?** The existing MOH CBD curricula for training and for training-of-trainers are impressive. The fact that they were produced by the public sector is equally impressive. However, given that time has passed since the curricula and guidelines were developed, a review of content and methodology is probably merited. The most important topic for revision is HIV/AIDS. The training curricula are comprehensive, but somewhat more knowledge-oriented than skill-based. For example, CBD trainees have at least five hours of reproductive anatomy and physiology. Most of this time could probably be more productively spent building skills.There is little consensus in the Tanzanian CBD community on whether the length of initial training (three weeks) is adequate, too long or too short. There is little guidance on refresher training. Nevertheless, there is agreement that technical emphasis should be on short, timely, and flexible in-service training, rather than on a complete overhaul of the curricula. If a program evolves sequentially in terms of output and types of services, a more systematic approach to refresher training could be developed. In almost all programs, CBDs gather at least once a month at some central place (usually a clinic) to turn in their reports and help with immunization days or prenatal visits. This is an ideal time for short (2-4 hours), skill-based in-service training on a variety of topics.

3) What model of supervision will work best for the lowest cost? Most evaluations and CBD managers cite supervision as important for CBD performance. However, data are confusing on this, since some of the value of supervision is self-reported or anecdotal, and some reasonably successful programs suffer from inconsistent and inadequate supervision. Supervision is almost always understood in the Tanzanian context as **supervisory visits**, which depend on time, transportation and allowances being available for supervisors. In many programs, this intensive on-site supervision does not routinely happen. On the other hand, the supervisory model that has actually evolved (in both public and private sectors) involves CBDs visiting a central facility—a clinic or hospital—to volunteer and to turn in reports. Arguably, this system is better than a complex one that cannot be sustained and costs a great deal. One compromise might be annual site visits and periodic visits in the first six months of the CBDs' tenure. Site visits by medical personnel increase the prestige of CBDs in the community and can affect their output. In addition to the "model" of supervision to be adopted, other questions to be answered are what costs and allowances should be paid to supervisors?

4) How should community participation be assured? What kinds of community mobilization activities should be envisioned? How much investment in IEC is called for? This is the area that will vary the most in public and private sector programs and with the design and management of each program. For example, FBOs often define "community" as the church community, and church members/volunteers become CBDs. Clearly, community participation needs to be assured. Emphasis on community mobilization and community decision-making needs to be emphasized at the outset of the program. Often programs focus more on individual decision-making rather than acknowledging the role of changing "community norms". Apart from a flipchart for CBDs, there are few IEC materials and no systematic approach that could be determined to IEC.

5) **What kinds, quantities and sequencing of compensation and incentives should be given?** It is unlikely (and would be undesirable) that Tanzania will retreat from its policy of volunteer CBDs. Beyond that, there needs to be some uniformity in the kinds of non-financial incentives given, particularly material incentives, such as bicycles, T-shirts, bags, etc. Currently, a wide variety of practices exist. Even isolated CBDs seem to be aware of the types of incentives given by other programs. Incentives are seen as important to improvement, but this is mostly self-reported and anecdotal. A "package" needs to be determined, along with sequencing of these incentives (prizes, a bicycle after a specified time and performance, etc.). The package should be cost-effective and tied to results.

6) **Cost and financing.** Ways to insure ongoing funding through the "basket" mechanism is the key issue in public sector programs. A coordinated multi-donor policy and planning effort is needed here. USAID should consider bargaining with districts to cost share with those that invest in CBD. NGOs and FBOs will continue to need outside donor assistance. Financing and sustainability will focus on obtaining multiple donor support, picking cost effective inputs and evaluating success. Across the board, programs need to put much more emphasis on **cost containment—**doing more with less—with a view towards **scaling up** programs. All current models are expensive and difficult to scale up. One way to garner efficiency may be to work more closely with the Regional Training Centers (RTCs) that USAID is already supporting.

7) **How can targeting, monitoring and evaluation be improved?** A reasonable investment in technical assistance needs to be provided by USAID in CYP targeting, stock management and logistics, LTM referral mechanisms and reporting, data gathering and analysis and data for decision making (DDM). Some programs, notably the FBOs, use a participator rural appraisal mechanism for baselines and community involvement. This should be studied with a view toward streamlining these approaches for larger programs.

V. RECOMMENDATIONS

USAID has an unusual opportunity to set new directions for Tanzania's CBD programs, making them evidence-based, targeted, and in harmony with other important health sector priorities. Based on the analysis, the following recommendations are made:

1.) **Link all CBD programs directly to LTPM referral**. This should be done as soon as possible and be linked with USAID/EngenderHealth/MOH expansion of LTPMs. More pro-active IEC and refresher training of CBD need to be part of this transition.

2.) **Fund selected NGO/FBOs to start (e.g. SDA, Lutherans, TACARE).** As a target of opportunity, USAID should provide technical and material support to selected NGO/FBOs, especially those already receiving funding to improve quality and/or increase LTPM services. The Jane Goodall Institute's TACARE project is small but effective and in a potential priority district. It links population and environment, and operates in an area where USAID is making significant investments in the Environment sector. It would be relatively easy to continue the modestly funded program, at least for a time, once Packard foundation funding terminates.

3.) **Pick three to four districts to roll out** (e.g. Kigoma rural, Moshi rural, Iringa, rural, and a district in an environment community in Manyara Region) USAID should start with a few districts that are well known to them, have cooperative leadership and are willing to undertake this kind of commitment. Activities should ideally be rolled out in an entire district, using cost effective approaches.

4.) **Make public sector funding contingent on Basket contribution, however modest**. This is undoubtedly a controversial recommendation, since it commits USAID to act quickly (given that Basket Funding planning begins in March-April) and involves the possibility that no district will meet the criteria. Nevertheless, it is crucial in the long term. With rapid action, USAID and other donor partners may well be able to secure modest co-funding in selected districts. UMATI, Marie Stopes and GTZ are all negotiating with districts on co-funding through the Basket.

5.) Reinforce in-service training through RTCs. Include more up-to-date HIV/AIDS information, make training more skill-based (rather than knowledge-based). These areas have been described in other parts of the report. Focus on flexible, short and behavior-based in-service training.

6.) Collaborate with partners. Establish a CBD technical working group (GTZ, UNFPA, MOH, CBD parnters, VSHP, Engenderhealth, others). Consider a programmatic partnership with GTZ. The CBD Brainstorming exercise provided a useful opportunity to share experiences, plus a platform for continued collaboration. GTZ, USAID and UNFPA already collaborate through the Family Planning Donors Forum. This working group would be more technical, would include existing expert CBD managers and cooperating agencies, and would focus on design, performance and other technical issues.

7.) Co-fund CBD (renamed as CBSP) with the HIV/AIDS Strategic Objective, if possible. The case to jointly fund community family planning and HIV/AIDS activities is very strong. USAID should consider attracting a modest percentage of its programs from the HIV/AIDS funds, and enhancing all aspects of the program, from CBSP training through activities such as care and support and counseling.

8.) Put technical assistance and funding into M&E and IEC/community mobilization as well as the usual funding categories. This also has been discussed in various sections. The Tanzanian CBD program, as it has evolved, focuses on "straight" service delivery (individual counseling, CBD of contraceptives).and training (of CBDs and Trainer-Supervisors). Community mobilization and IEC have lagged behind, as has attention to monitoring, evaluation and advocacy. A broader program management perspective is required.

CONCLUSION

USAID has a unique opportunity to redefine "CBD" as a programmatic mechanism that can, indeed, be valuable and contribute to a solid national family planning program as well as demographic transition. Improved CBD programs need to be correctly targeted (to rural, isolated

areas, integrating LTPMs and HIV/AIDS), managed (community participation, M&E, IEC, logistics), financed (basket funding, cost containment for scaling up) and supported by donors (collaborative efforts). While it is true that CBD (…now CBSP) may be only marginally useful in high access urban areas with growing contraceptive prevalence, they could literally be a life saving intervention in rural, isolated communities that currently have little or no access to family planning services. This describes much of Tanzania. And, once again, USAID/Tanzania will be on the forefront of adapting "best practices" to new circumstances, as it has many times in the course of its 15 years of assistance to Tanzania.

ANNEX 1 - REFERENCES

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ANNEX 2 - CONTACT LIST

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Note: The consultant made a comprehensive round of visits to the USAID-funded Cooperating Agencies working in health and HIV/AIDS in Tanzania, plus a range of MOH and Government representatives and the major multi-lateral and bilateral partners in July 2003 as part of a strategic assessment of the sector. This short TDY specifically focused on groups relevant to expansion and reanimation of CBD programs.