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**Capacity Building for Training and
Human Resource Development:
The Case of RH Services in Tanzania**

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PRIME II



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Author

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This case study analyses information over a 10-year period in which the Ministry of Health (MOH) in Tanzania and Intrah developed a national human resource system that resulted in improved and expanded RH services. The information documented in the report was drawn from over 30 reports and from a series of interviews and meetings with key personalities in the MOH, USAID/Tanzania and Intrah, who lived through the experience.

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Acronyms

CH	Child Health
CTT	Central Training Team
DAPP	Diagnostic Assessment of Performance and Potential
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DTT	District Training Team
FP	Family Planning
FPLM	Family Planning Logistic Management
FPU	Family Planning Unit
GOT	Government of Tanzania
GTZ	German Association for Technical Cooperation
HA	Health Attendants
HRD	Human Resource Development
IEC	Information, Education and Communication
IST	In-Service Training
IUD	Intra-uterine Device
MCH	Maternal and Child Health
MOH	Ministry of Health
NFPP	National Family Planning Program
NGO	Non-governmental Organization
PRIME	Project for Training Primary Providers of Reproductive Health Services
PST	Pre-Service Training
RHMT	Regional Health Management Team
RH	Reproductive Health
RTT	Regional Training Team
STI	Sexually Transmitted Infection
UMATI	Family Planning Association of Tanzania
UNFPA	United Nations Fund for Population Activities

Executive Summary

While Tanzania was one of the first East African countries to offer family planning (FP) services, early program efforts in the country did not result in significant increases in users. With the creation of the National Family Planning Program (NFPP) in 1989, though, quality FP and other reproductive health (RH) services became much more widely available throughout the country, as evidenced by the increase of contraceptive use rates, which were under 7% in 1989 and are estimated to be 17% in 1998.

This case study documents the key processes over a 10 year period in which MOH and Intrah developed a national human resources development and training system that supported the improvement and expansion of RH services nation-wide. The study also shows how the development of a **flexible** HRD (human resource development) and training system played an important role in the success of the National Family Planning Program (NFPP). Since Tanzania was decentralizing the management functions of the MOH and also undergoing health sector reforms during the case study period, it was essential to develop systems and human resources that had the **capacity** to respond to the changing policy, health services, and training environments. It should be noted that other agencies worked with the MOH to improve RH services and training, yet Intrah was the only agency that worked with the MOH throughout the case study period that took a national-level perspective to systems and human resources development.

Several critical decisions related to training and HRD were made during the NFPP first plan of operations from 1989-1993 that helped to establish a base for RH services development and expansion and for establishing a national training system. The approaches and activities summarized below were supported by Intrah technically in terms of strategic thinking and capacity building efforts.

- The NFPP addressed decentralization of training by creating the **Central Training Team (CTT)** within the FP Unit or FPU (the program administrative and technical assistance unit of the NFPP), that could then train other trainers at lower levels in the system.
- The FPU developed **national FP policies and guidelines** to guide service delivery and training.
- Coordination and effectiveness of training efforts were improved with the development of a **national training strategy and master training plan**.
- Training of service providers was accelerated by conducting **some training directly** (by the CTT and Intrah) while identifying and then **training regional and district trainers** in several districts (on a pilot basis).
- Standardization of provider training was addressed by developing several **standardized in-service training curricula** of key cadres.
- Other areas of **training system development** were addressed to improve capacity.
- The FPU began **post-training follow-up of trainees** to strengthen the monitoring and evaluation/supervision system while ensuring good application of skills at the

work site. Technical training and FP skills of **CTT members** were improved through joint **on-the-job training and supervision** efforts with Intrah consultants and the Intrah **resident FP clinical training advisor** (who was based in the FPU).

Building on the successes of the first plan, the second NFPP plan was developed for the 1994-1999 period and expanded services further by working with other FP service delivery and training entities such as NGOs, and decentralizing further services, management, and training functions. The NFPP made the following decisions related to training to achieve key objectives established in the NFPP plan of operations from 1994-1999. **PRIME/Intrah** supported the approaches and activities summarized below, in terms of strategic design, technical assistance, and training.

1. Access was improved by increasing the number of service delivery points (accomplished by adding new categories of service providers at peripheral levels and expanding CBD and NGO service delivery/training coordination).
2. Efforts to decentralize training and training management were supported by improved :
 - management and coordination capabilities at FPU
 - capacity of NGOs for training
 - training and training program management/supervision skills of trainers at regional and district levels.
3. Training system efficiencies were improved by creating links between pre-service training (PST) and in-service training (IST) institutions *via* joint revision of strategic pre-service curricula, e.g., PHN B PST curriculum, and sharing of hospital practicum sites for PST and IST trainees, to have new graduates ready to provide FP/RH services once assigned to their work site.
4. Public/private training efforts were addressed by establishing formal partnerships with non-governmental actors such as NGOs that included holding joint planning of training and evaluation activities.
5. Service delivery re-orientations were addressed by: developing and field-testing **curricula that reflected integrated service delivery**.
6. Health sector reforms resulted in combining regional and district level functions and reductions and restructuring of remaining PST schools. This structural change was addressed by **placing main training functions within existing and/or restructured government training institutions**; and initiating and maintaining **contact with DHMTs** (District Health Management Teams) **and local government structures** to ensure coordination of available training resources and minimize duplication of effort.

Several lessons have been learned that can be shared with Ministries of Health and agencies interested in improving training and human resources capacity on a national level:

- Establishing and maintaining substantive relationships with stakeholders is key to moving a national agenda forward.
- A national training strategy is critical to guide training activities at different levels, and is particularly effective when roles and responsibilities of all FP/RH entities – both public and private – are clearly defined in the strategy.
- Placing a **PRIME/Intrah** resident advisor within the FPU worked very well. The placement made technical support immediately available when needed, as the CTT took on new training roles.
- Developing a substantive relationship between the NFPP and NGOs created new and low-cost channels to expand standardized training and RH services.
- In retrospect, training district-level trainers should have been more of a priority in the training strategy than regional trainers, since district service delivery points were more critical to expanding access to RH services than regional points, and at the time, more stable.
- Pre-service and in-service training linkages can be forged successfully along programmatic lines, particularly if the leadership supports the process.
- Training approaches must be realistic when trying to reach large numbers of providers working in isolated areas at the periphery of the health care system. Different training approaches should be used to best fit the training needs of trainers and trainees, e.g., using distance-based training for distant workers. The application of research and evaluation methodologies to study such situations can help determine which approaches have the best chance of succeeding.

At the end of 10 years, the MOH and PRIME/Intrah have much to be proud of. The 1998/1999 evaluation of the national training strategy has documented that training and human resources development systems exist that are responsive to a changing environment.

The main training systems elements are in place, including training policies, standards, and norms; standardized training materials; linkages between PST and IST institutions; systematic follow-up and support of trainees after training; training program management capacity; and evaluation and research capacity.

Human resources capacity has developed to a point where trainers and training managers can take a more flexible approach to training and systems development in order to respond to the changing policy and service delivery environment. With decentralization, the focus of training has shifted to the regional and district levels, while the role of the central level has changed to a technical assistance and coordination role. More people at all levels have skills in developing, conducting, and evaluating training. More people at all levels have additional skills in advocacy and resource mobilization, necessary to access resources in decentralized environments. The inclusion of various stakeholders to move forward and support an RH/FP training agenda has created a sense of ownership outside of the MOH FPU and will help to sustain the training program.

The 1998/1999 evaluation of the national training strategy has also documented that such a training systems and human resource development approach has helped the MOH and NGO partners to expand quality services and increase the use of FP/RH services dramatically over a 7-year period: contraceptive prevalence for currently married women rose from under 7% in 1989 to an estimated 18% in 1996. (Tanzania DHS, 1996) The results reaffirm **PRIME/Intrah's** and the NFPP FPU's approach to building capacity during both the first and second plans of operation of the NFPP. By analyzing internal and external environments and strategically planning actions that need to be achieved, then providing training and technical assistance as well as a variety of applications to learn together and fine tune different skills in training and service delivery and program management, systems can be put into place and capacity developed to support a national RH/FP program. While there is always more that can be done, the main elements of a sustainable training system are well in place.

Introduction

Historical context

The NFPP was launched in 1989 initially with UNFPA support. USAID contributed to the achievement of the NFPP goals through its Family Planning Support Services (FPSS) project. The NFPP program design addressed several constraints to the expansion of services identified in the 1989 evaluation, including a lack of trained service providers and poor logistics support. Since its inception, the NFPP program has proven to be very successful: by 1996, the national contraceptive prevalence rate (currently married women aged 15-49) in 1996 was estimated to be 18% up from under 7% in 1989, for all modern methods (Tanzania DHS, 1996).

At the policy level, the NFPP program efforts were clearly reinforced by strong political leadership to move population activities forward. By the late 1980s, it became apparent to the GOT that poor economic performance and inadequate human resources development were intimately linked with population growth. Expanding and improving the quality of government services was unlikely to happen without first controlling rapid population growth. Against this background, the GOT formulated a National Population Policy in 1992, whose objectives included reinforcing national development by developing available resources in order to improve the quality of life of the people. The policy's main emphasis is on regulating population growth and improving the health and welfare of women and children. With specific reference to family planning, the goals of the policy are to decrease the population growth rate through reductions in the number of births and increases in voluntary fertility regulation.

To achieve this, the government made a commitment to make FP services available to all who wanted them, to encourage every family to space births at least two years apart, and to support family life education programs for youth, and FP for men as well as women.

Purpose of the Tanzania case study

From the perspective of the GOT, Intrah, and many donors who supported FP efforts in the country, Tanzania's National FP Program offers an example of human resources and training systems development that helped to increase access and the quality of FP services throughout the country. Although FP methods were available in over one-half of the country's health facilities in 1989, most service providers in the public and private sector did not have the skills or training to provide quality FP services. There was no overarching training program within which to support a comprehensive set of FP services. In order to reach the objectives established under the NFPP, strategic and coordinated efforts were necessary by all those involved in FP service provision.

The purpose of this case study is to describe how the MOH, in collaboration with Intrah, provided training and technical assistance to help address at a national level the service gaps created by the acceleration of FP services mandated by the NFPP. This case study is thus written for national ministries of health and their training bodies, donors, private sector training institutions, and others interested in training and its potential impact at the national level. Although the case study covers a 10-year period,

the focus is on the last five years, the period when Intrah under the PRIME project (hereafter referred to as **PRIME/Intrah**), provided technical support to the FPU (the program administrative and technical assistance unit of the NFPP).

The reader should note that other international and national agencies have worked with the GOT in the last five years to further national objectives. For example, EngenderHealth has helped to develop hospital-based, voluntary surgical contraception services and Pathfinder International helped launch a prototype CBD program. Marie Stopes International's network of clinics has historically offered a wider range of RH services than most NGOs, including postabortion care. Management Sciences for Health's FP Logistics Management (FPLM) project support of the MOH has resulted in improvements in contraceptive logistics and supply. The IEC section of the MOH's Family Planning Unit expanded its mass media activities and the production and dissemination of FP posters and print materials for clinic use, with technical support from the John Hopkins Centre for Communication Program (JHU/CCP). Intrah, though, is the external agency that has consistently maintained a national training outlook and has approached training to systematically develop national capacity in FP and reproductive health (RH) service delivery and training management.

Elements of the program model that make it worth studying

The case study provides an interesting example of how an international NGO worked with a national government to develop a dynamic, national training program responsive to the changing needs of the government.

1. Intrah became involved in the NFPP at the beginning of a concerted national-level effort to increase access to and the use of FP services. The MOH provided a strong leadership role and developed national FP policies and guidelines that facilitated program development. There were very few main actors in clinic-based FP besides the MOH, UMATI, EngenderHealth, Marie Stopes International, and Intrah throughout the case study period, and only Intrah and the MOH addressed the program at a national level. Therefore, the experience was a 'pure' one in terms of one agency's vision and efforts, combined with the vision and efforts of the MOH, to build training capacity and help create national training support systems.
2. The evolution of the program in Tanzania reflects the changing policy environment currently experienced by many African countries. As such, it can offer a set of lessons learned and a prototype program model for other countries to consider.
3. For example, many external factors influenced FP and other RH service delivery over the 10-year period covered by the case study. Factors such as the decentralization of all government institutions, related health sector reforms, and concurrent efforts (since the mid-90s International Conference on Population and Development) to integrate RH and child health services, have all influenced service delivery and subsequently, training.
4. The case study reinforces the idea that both training and training systems development strategies are needed to build capacity. Integrated human resources development (HRD) strategies, responsive to oftentimes changing policy directions, are required to develop training skills and allow for service and geographic expansion. Training systems are needed to support these HRD activities.

5. The changing FP program environment in Tanzania required systematic reformulation of service policies and guidelines. Subsequently, this required adjustments in training strategies, curricula, and related materials to reflect current MOH policy directions. For example, by expanding the cadres of personnel authorized to become FP service providers, the MOH was required to determine appropriate training approaches for these new providers.

Methodology

Study objectives

This case study has several objectives:

- To demonstrate how a holistic /incremental approach to training was used to develop a critical mass of service providers offering FP/RH services in a relatively short period.
- To identify the main processes used to develop a national training system, noting strategic decisions that were made along the way, and how training systems were developed that could continue to evolve to address new needs and circumstances.
- To document some of the challenges and limitations inherent in training and training systems development, particularly the challenge of maintaining flexibility to address policy-mandated changes in service and training delivery.
- To discuss the impact that a national training program can have on service utilization.

Description of Tanzania's health care system and the effect of NFPP operations on service delivery and training

A. Tanzania's health care system and the availability of RH services in 1989

Tanzania is a large, geographically diverse country. The estimated population based on the 1988 census was just over 23 million. The census confirmed the expected rural/urban pattern of distribution of the population. Only 18% of Tanzanians live in urban areas, the majority of the population live in rural areas. Government of Tanzania health priorities and programs emphasize equity in the distribution of health services, and view access to services as a basic human right. Since the 1970s, FP has been considered an integral part of the mother-and-child health services and is a component of the primary health care (PHC) system. Sixty percent (60%) of health services are provided by the government with the remaining 40% provided by non-governmental organizations (Tanzania Demographic and Health Survey (TDHS) 1991/92).

In 1989, at the beginning of the case study period, there were about 6,700 public and private-sector clinic-based service providers at 3,500 service sites throughout the country. This included four national referral hospitals, 152 hospitals, 273 rural health centers, and 3000 dispensaries. The totals do not include village health posts that were staffed by village health workers (TDHS, 1991/2).

- Community-based FP programs designed to promote FP and distribute or sell methods at the community level did not exist.
- Access to FP services at non-mobile health facilities was reasonable: less than one-half (42%) of women lived within one hour of a dispensary providing FP services (TDHS, 1991/2). The challenges of improving access to FP services were large in terms of the number of service providers to be trained and the geographic distances to be reached in order to train service providers working at the periphery of the health

systems, e.g., in dispensaries.

B. Policy changes influencing use of services, service delivery configurations, and training

Three policy changes during the case study period affected the choice of training strategies and approaches and reinforced the need for a dynamic national training system that could respond to training human resources needs:

- decentralization of public services to the district-level, which began in 1989,
- adoption by the GOT of the Cairo Conference accords in 1994 that called for holistic and integrated approaches to RH services, and
- beginning health sector reforms in 1994/5, which were occurring as a sub-set of larger local government reforms.

The changing policy environment in Tanzania required systematic reformulation of service policies and guidelines. Subsequently, this required adjustments in training strategies, curricula, and related materials to reflect current MOH policy directions. Training systems also required adjustments to coordinate and make linkages as policies evolved. The advent of decentralization of government institutions required linking central level resources with district and regional level management and training resources. The PHC Secretariat, which was involved in health sector reforms, had to establish links with HRD departments and MOH training bodies. The policy decision to provide integrated services in reproductive health (RH) and child health (CH), and expanded access to RH services such as postabortion care meant that coordination mechanisms to connect the different facets of service delivery integration had to be established. Pre-service training and in-service training linkages needed to be made to maximize the impact of training.

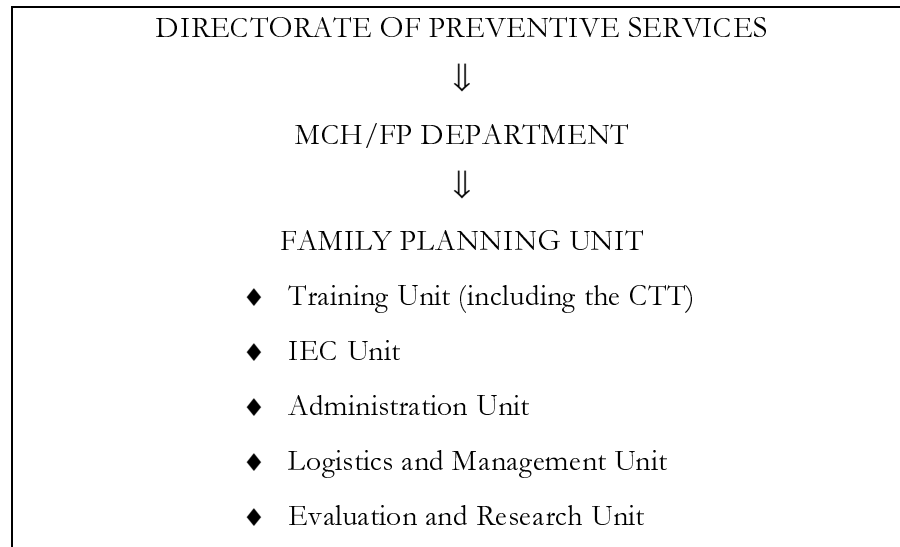
C. Changes observed in FP/RH training systems, service availability, and FP use since the NFPP began: 1989-1998¹

Tanzania's National FP Programme (NFPP) was launched in 1989. Based in the MOH, the NFPP coordinates the inputs and participation of at least 20 related governmental agencies and NGOs. The national coordinating body for the NFPP is the Family Planning Unit (FPU), which operates under the directorate of Preventive Services and is located within the MCH/FP Department. (See Box 1.) The FPU coordinates the planning and processes of the NFPP.

The PHC Secretariat and Steering Committee ensure that NFPP activities reflect the objectives and operational guidelines of the PHC program, of which it is an integral part.

¹ Information found in this section was obtained from a variety of documents and personal interviews, listed in Appendix A.

Box 1: Diagram showing where Family Planning Unit (FPU) is situated within the MOH



At the beginning of the NFPP in 1989, there were essentially no formal guidelines or policies on FP. The guidelines that existed were not centrally located. The number of trainers and service providers with skills in FP was nominal. Since the NFPP began operations, Tanzania has made major inroads in terms of training capacity and capability, and the ability to address changing policy environments and subsequent HRD support in a systematic fashion. Table 1 indicates that by 1993, many elements of a national training system were in place, e.g., a coordinating body (the FPU) was functioning, trainers existed at all levels of the health care system, and many service providers had been formally trained in FP and RH. By 1999, at the end of the second plan of operations, the gains made by 1993 had been furthered, e.g., in terms of service providers trained in FP/RH. Additional system elements were falling into place, e.g., the formal linkage of pre-service and in-service training bodies and the decentralization of training delivery and management was expanding.

Table 1: Changes in national training capacity between 1989 and 1999

SYSTEM ELEMENT	1989	1993	1999
Training system statistics (from PRIME/Intrah documents-1989-1999)			
Existence of national FP policies and standards guiding service delivery	Some FP policies and guidelines available on an ad hoc basis (not centralized)	First draft of FP policies and standards in use throughout the country (they were revised in 1994)	Formal document of national FP policies and standards available and distributed extensively
Existence of national training policies guiding training	Not available	National training strategy existed. Master training plan existed for public sector only	- National training strategy exists - Master training plan exists to guide both public and private sector training
Existence of national training body to guide training	Not available	FPU was created	FPU exists (now known as RCHS*)
Number of FP/RH training teams, by level of health system	- National-level teams - Regional teams or trainers - District teams or trainers	1 Central Training Team was created 0 Regional teams or trainers 0 District teams or trainers	- 1 Central Training Team exists - 18/20 (90%) of regions have regional teams** - 59/300 (20%) of districts have district teams
Availability of national training curricula, by type of curricula	Only one IST curriculum existed on FP for use with all cadres of service providers. Other locally produced training materials did not exist.	Basic FP curriculum existed	PST Curricula for integrated service delivery for different cadres (PHN B, N/M, HAs) exist IST Updated curricula for update and basic courses and materials exist***
PST and IST linkages	No formal linkages	Initial discussions held to begin establishing formal linkages	Formal linkages exist to develop/coordinate curricula, practicum sites and tutor knowledge and skills in training and RH
Organizational training capacity**** - legal/policy support - resources - training plans/curricula - management capacity - community involvement/participation	- Not available - Not available - Not available - Not available	35% 32% 29% 45% 25%	87% 62% 100% 90% 50%

* RCHS Reproductive and Child Health Section ** 20 regions comprise the pilot area for decentralization

*** for classroom/DBL instruction, with related handbooks, manuals, training aids

**** measured as % capacity based on a composite index of FPU and 5 local partner agencies' self-assessment in the five dimensions stated above

Service Availability			
(from the MOH/Evaluation Project Service Availability study of 1996 and the PRIME/Intrah Tanzania final project evaluation studies of 1999)			
	1991/2	1996	1999
Number of facilities (public/private) offering modern FP methods, by type of facility	<ul style="list-style-type: none"> - Hospitals: 85% Total 94% Government 67% NGO - Health Centers 84% Total 87% Government 25% NGO - Dispensaries 67% Total 71% Government 38% NGO 	<ul style="list-style-type: none"> Hospitals: 89% Total 97% Government 75% NGO - Health Centers 98% Total 99% Government 83% NGO - Dispensaries 85% Total 98% Government 38% NGO 	NB Comparable data were not collected in 1999
% of facilities with at least two trained FP/RH providers, by type of facility	Not available	24% TOTAL, with at least 2 trained providers 48% Hospitals 28% Health Centers 9% Dispensaries 70% UMATI 40% Marie Stopes	32% TOTAL, with at least 2 trained providers

These above systems changes are also reflected in improved utilization of RH services. Selected statistics shown in Table 2 demonstrate some of the changes that have occurred in a five-year period between 1991 and 1996 (where comparable statistics are available). More women are using modern contraceptives and obtaining them from a greater variety of sources. Government of Tanzania officials estimate that the modern FP user rate of women of reproductive age in 1996 was 12%, up from 6% in 1991/2 (Tanzania DHS, 1991/2 and 1996).

Table 2: Changes between 1991 and 1996 of FP method use and service availability (NB: Table summaries do not always equal 100% due to rounding.)

	1991/92	1996
User Statistics (from 1991/92 DHS and 1996 DHS)		
% of currently married women users (15-49 years old) of modern FP methods, by method (NB: 1996 data reflect currently married women + sexually active unmarried women)	6.6% Total 3.4% OCs 0.4% IUDs 0.4% Injectables 0.7% Condoms 1.6% VSC	11.7% Total 4.8% OCs 0.5% IUDs 3.7% Injectables 1.3 % Condoms 1.4 % VSC
Source of users' supply of modern contraceptive methods	10% Government health center 11% Government district hospital 2% CBD worker (UMATT) 9% Pharmacies/medical store/shops 3% Private doctor/hospital/clinic 8% Religious facility 32% Dispensary/parastatal health facility 2% Village health post 23% Other (incl 2, 3 hospitals)/DK	22% Government health center 24% Government district hospital 2% CBD workers 9% Pharmacies/shops 4% Private hospital/clinic 6% Religious facility 28% Dispensary/parastatal health facility 1% Village health post 4% Other/DK

Main processes and decisions in the evolution of NFPP

How did the dramatic changes noted in Tables 1 and 2 come about? This section describes the main processes that occurred and decisions that were made over two periods: the period from 1989-1993, which covered the first plan of operations of NFPP, and the period from 1994-1999, which covered the second plan.

A. Accelerating FP service provision during the NFPP first plan of operations: 1989-1993

During the first plan of operations, Tanzania's National Family Planning Program created a strategy and put into place the national management and service delivery system of the program. One of the NFPP priorities was to quickly develop a critical mass of FP service providers that would begin immediately to address the unmet need for FP. (The existence of poorly trained service providers was one of the reasons cited for lack of success in improving contraceptive use rates in the 1987 evaluation of the National Child Spacing Program.) In 1991, Intrah was invited by USAID and the MOH to assist in developing a training strategy to complement the already on-going 1989-93 national FP program plan.

During the first plan of operations, too, Intrah had begun to conceptualize training systems development as a guiding programming construct for its training and technical assistance activities. Although the conceptualization has continued to evolve based on experiences in using this programming construct in other countries, Box 2 shows the main system elements that Intrah thought were necessary to create sustainable national

training programs in 1992.

Box 2: Elements of a training system

- Training policies, standards, and norms ensure that training, which may be conducted at national, regional, and district levels by a variety of trainers, is standardized.
- Standard training materials developed for same reasons, above.
- Certification policies and criteria ensure that services provided by trained service providers are of the same quality.
- Linkages between training (pre-service, in-service, and continuing education), supervision and service delivery ensure that training is relevant to the service delivery site and that trainees have adequate support in using and maintaining new skills upon returning to the work site.
- Trainee follow-up support mechanisms ensure that trainee has adequate support in using new skills upon returning to the service site.
- Training and training program management capability and capacity allow trainers to plan and manage training programs and events, making training as efficient as possible.
- Training program evaluation allows for systematic assessment of training needs, provides feedback on the effectiveness of training, and allows training curricula, materials, and other adjustments to be made to improve training.

Using the systems elements described in Box 2 as a reference of elements that might be in place, it can be seen that by 1991 Tanzania had not yet developed national service guidelines for FP. Training policies, standards, and norms existed at a general level. As Intrah entered into discussions with the MOH, it became apparent that the availability of standard training materials was an issue as well as the need for more proactive coordination of training activities in the country. As noted earlier, during the period covering the first plan of operations a new MOH policy to decentralize health and other government services to the district-level began. To achieve the goal of accelerating the number of FP service providers in the government decentralization framework, the MOH strategy was to decentralize training by adding new trainers at regional and district levels. Important issues included how to ensure that the eventual service delivery was uniform and standardized and how to support trainees once they returned to their work sites. In addition, a number of NGOs were reported to be conducting or planning to conduct in-service FP training. A review of the different agency training program descriptions indicated that while trainees were expected to perform similar functions after training, the duration of training and the minimum levels of achievement for FP technical procedures were different. This would clearly result in different levels of competency and performance in the field.

The FPU needed to ensure that the competency levels of the different cadres of trainees corresponded to and matched the desired post-training FP service delivery performance

of each cadre at the service site. However, they did not yet have the tools (e.g., guidelines and standards) or training strategy to guide multi-agency training efforts. To complicate matters, within the MOH itself there was only one FP curriculum in use for all cadres of service providers. This curriculum was not based on what each cadre of provider could and should provide. Standardized training curricula for different cadres could not even be shared with the various agencies planning to conduct training. Finally, those district level service providers and supervisors who would be involved in later follow up of trainees needed training updates themselves.

Given these realities, several strategic decisions (summarized in Box 3) were made that would help the MOH achieve its goal of creating a critical mass of trained FP service providers within the remaining (1991-1993) years of the NFPP's first plan of operations.

Box 3: Critical decision points that occurred during the NFPP first plan period

- Address decentralization of training by creating the Central Training Team (CTT) within the FPU, who could then train other trainers lower down the system.
- Develop national FP policies and guidelines to guide service delivery and training.
- Improve coordination and effectiveness of training efforts by developing a national training strategy and master training plan.
- Accelerate training of service providers by conducting some training directly (by the CTT and Intrah) while identifying and then training regional and district trainers in several districts (on a pilot basis).
- Address standardization of provider performance by developing several standardized in-service training curricula of key cadres.
- Begin addressing other areas of training system development to improve capacity
- Begin post-training follow-up of trainees to strengthen monitoring and evaluation/supervision system while ensuring good application of skills at the work site.
- Improve technical training and FP skills of CTT members through joint on-the-job training and supervision efforts with Intrah consultants and the Intrah resident FP clinical training advisor (who was based in the FPU).

The MOH was quickly convinced that national guidelines and standards needed to be developed. The guidelines and standards would guide service delivery as well as guide the development of a comprehensive training strategy that responded to the decentralized training model of the MOH and would also guide training conducted by various NGO FP projects. By 1992, an initial set of guidelines was developed by the FPU. These draft guidelines were disseminated by the Policy Project and field-tested by FP trainers, supervisors and managers at central, zonal, regional, district and clinic levels.

A Central Training Team (CTT), located in the Family Planning Unit, was created in 1993 to accelerate standardized training, to follow up those already trained, and to help create links between trainees and their supervisors. The CTT was charged with (among other things) training service providers at the hospital level, establishing model FP

service sites for training new service providers, monitoring and evaluating trainees at their work sites, and ensuring adherence to the standards. Because the comprehensive MOH FP services were just beginning and needed consistent technical support to build technical capacity, a clinical FP resident advisor was seconded by Intrah to the MOH by 1993. With this full time support in place, Intrah worked with the CTT members to improve their training and management capacity in FP knowledge and skills, stand up training skills, trainee and program monitoring skills.

Intrah and the CTT trained essential service providers throughout 1992/93 to develop a critical mass of providers to provide quality services and to help improve access and demand for FP services.

Based on the experience and evaluation of training and its effects in the service sites during this first phase, national FP guidelines and standards were compiled into one document and revised by the MOH, with assistance from Intrah. The National FP service guidelines for Tanzania were revised again in 1994, which greatly facilitated the development of the next five-year national training strategy and training plans. For example, the revised guidelines reduced medical barriers to FP by authorizing FP service provision to new categories of health care workers.

By the end of the first plan of operation, elements of a training system and improved human resources training capacity were evident. The national service guidelines and standards, critical for subsequent training, were completed. The CTT was established and functioning. Twelve (12) central trainers (from UMATI, but attached to the CTT) with improved training capacity existed. Over 1,500 health personnel had been trained to provide FP services, to train service providers, or to provide management and supervision support to service providers (Intrah Resident Trainer and Training Management Advisor Reports). Preliminary activities to begin strengthening practicum sites had also begun.

The final evaluation report of the three- year Intrah project (1991-1994) in Tanzania summarized the outcomes of developing and using national guidelines to guide training and service delivery. The evaluation was conducted with the objectives of determining the changes that occurred as a result of Intrah's assistance; documenting the project strengths and identifying the limitations of the program; and identifying the unmet FP training needs. The study concluded that, by using national policies and guidelines to direct training and technical assistance activities, the MOH and Intrah project had systematized and standardized the FP training in Tanzania. In general, service provision was more uniform and of higher quality in the areas where the project worked, and access to quality FP and other RH services had effectively increased.

At 20 sites with providers trained through Intrah's technical assistance, the number of new clients for IUD increased by 153% (557 to 1411), between 1991 and 1993. The corresponding increase for new clients opting for Depo Provera® within the same time interval was 247% (1155 to 4018) (Intrah/MOH FP project evaluation report, 1994).

B. Changing context requires changing training strategies: NFPP Second Plan of Operations 1994-1999

With the successes of the first plan of operations in hand, key stakeholders, including Intrah, participated in the development of the second National FP Program Strategic Plan (1994-1999). The new plan focused on institutionalizing gains made in the first five years and decentralizing management (and not just training) of the FP program to the regional and district levels. The NFPP plan added new elements, including increasing private sector involvement, expanding services and targeted IEC activities to youth, improving cost-recovery mechanisms, and integrating FP and additional RH service areas (such as postabortion care) into other services. (The new mandate to further integrate existing services was the direct result of the GOT signing the 1994 International Conference on Population and Development accords at Cairo.) The new integrated service configuration, officially redefined in 1995 by the NFPP and further revised in 1997 with the government's Strategy for Reproductive Health and Child Health, would include FP, sexually transmitted infections (STIs), maternal health and child health services.

One other national policy change began to have an effect by 1994 and continues to influence service delivery and training in 1999: the government adoption of structural adjustment activities that focused on local government reforms. Health sector reforms were part of the general government reforms and included rationalizing and streamlining functions within the MOH. Discussions on what decentralization meant in operational terms continued between stakeholders. Institutions and management hierarchies were analyzed regarding their 'added value' and effectiveness. For example, the MOH questioned the need for regional authorities given the focus on the district level. The number and function of pre-service training institutions were also analyzed with recommendations to reduce the number of pre-service training institutions while improving support and resources to institutions that remained. Discussions are currently underway to reformulate and support cost-effective health service packages and to extend cost-sharing activities to include health centers and dispensaries. Decisions of this type would clearly affect service delivery and training in major ways.

The new directions indicated in the National FP Program Strategic Plan created another set of issues. The evolving structural adjustment activities created additional challenges requiring flexibility and a need to respond appropriately and quickly. While certain training strategy directions remained unchanged, e.g., helping to prepare trainers and institutions for the new integrated service package, others needed to be reviewed and revised: Which pre-service institutions and practicum sites should be the focus of training support? How should PST and in-service training (IST) be linked operationally? With the collapse of regional and district level MOH functions into one level, how should training delivery, management, and supervision support be addressed by the FPU? What technical training and planning relationships with new district-level stakeholders needed to be developed with government entities at the district level? What new service provider skills would be required and subsequent responses to new training needs would be developed once health sector reform (e.g., cost-recovery) mechanisms were in place for health centers and dispensaries? Box 4 summarizes the critical

decisions made by the MOH to ensure that the decentralization of FP training and training management would be achieved during the plan's period and that concurrent changes in service delivery mix could be achieved during the second NFPP plan of operations.

Box 4: Critical decision points that occurred during the NFPP second plan period

1. Improve access by:
 - increasing number of service delivery points (accomplished by adding new categories of service providers at peripheral levels and expanding CBD and NGO service delivery/training coordination).
2. Support decentralization of training and training management by improving training and training program management/supervision skills of trainers at regional and district levels.
3. Improve training system efficiencies by creating links between PST with IST institutions via joint revision of strategic pre-service curricula, e.g., PHN B PST curriculum, and sharing of hospital practicum sites for PST and IST trainees, to have new graduates ready to provide FP/RH services once assigned to their work site.
4. Address public/private training efforts to include formal partnerships with non-governmental actors such as NGOs by holding joint planning of training and evaluation activities.
5. Address service delivery re-orientations by: developing and field-testing curricula that reflected integrated service delivery.
6. Address health sector reforms resulting in combining regional and district level functions and reductions and restructuring of remaining PST schools by:
 - placing main training functions within existing and/or restructured government training institutions,
 - initiating and maintaining contact with DHMTs and local government structures to ensure coordination of available training resources and minimize duplication of effort

The 1994-1999 training strategy included four strategic elements: decentralize decision making and planning for training; accelerate service provider training and development of trainers; expand services through training, particularly with NGO partners; and strengthen linkages between pre-service and in-service FP training. The second national training strategy was much more ambitious in order to achieve the goal of expanding and accelerating the national FP training program to improve the coverage and quality of FP services throughout the country. Approximately 13,120 health personnel were to be trained and TA provided in a variety of skills. With the government-mandated shift of direct training program management from central to regional and district levels, those involved in managing training programs or trainees would need to improve skills in

supervision, human resource planning, management, and evaluation.

Intrah and the MOH Family Planning Unit prepared a complementary national training plan that focused on the decentralization of FP training and training management and changes in the existing service configuration. The FPU hosted many meetings over a nine-month period to develop the master training plan. This ensured representation and input of all stakeholders in the process as well as reinforced the FPU's leadership role in implementing the NFPP. Participants at the central-level from various agencies and ministries, regional and district medical officers, and service providers participated as well as the NFPP Strategy Plan Development Working Group. For the first time, the planning involved representatives of many non-governmental and parastatal agencies involved in FP, with participation of agencies such as UMATI, EngenderHealth, GTZ, and the Tanzania Occupational Health Services. The idea behind expanded representation was that all public and not-for-profit partners involved in RH training should play their role in the national training plan. This commitment was exemplified in the eventual national strategic training plan: the various government departments and agency roles and responsibilities in achieving the plan were named.

In this second five year plan, a strategic role shift in the CTT occurred, due mostly to the changing training capacity within the FPU over the first five-year period. The CTT would no longer provide direct clinical training. Instead, they would support regional and district level trainers technically and administratively. Intrah also shifted its technical assistance and training to the CTT away from improving the capacity of the CTT in training delivery to improving CTT skills in management of FP/MH training, in order to support the decentralization of training and management. To this end, an Intrah resident technical advisor who had technical management skills was seconded to the MOH.

With the decentralization of training events and trainee supervision to regional and district levels, the role of the CTT and other departments within the FPU was changing. Skills were needed to manage decentralized training and supervision and the training strategy focused on strengthening central-level program management and coordination and improving monitoring and evaluation skills, particularly research skills (a new area). The latter was needed to improve the FPU capacity to undertake studies to address issues such as selecting which new cadres at peripheral levels should be authorized to become FP service providers.

To help reach the expanded critical mass of service providers in the second plan, another new area of FPU focus would be to maximize the contribution of pre-service training institutions and curricula. This was needed to create efficiencies in training by preparing service providers in RH service delivery skills while they were still in training, thereby eliminating the need to conduct in-service training in RH topics for new graduates of PST institutions. To complement this, a large-scale effort to improve and combine (where appropriate) practicum sites for in-service and pre-service training was planned: NFPP would provide equipment and supplies to 475 practicum sites (Tanzania MOH. The five year strategy for family planning training 1994-1999).

To give the reader a better idea of how the MOH/FPU and PRIME/Intrah² worked to achieve objectives established in the second national training strategy, selected processes and activities that occurred between 1994 and 1998 are highlighted below.

1. Developing a master training plan based on the national FP training strategy

In preparation for the development of a new training plan, the FPU and PRIME/Intrah conducted a project review of achievements and problems that occurred in fulfilling the objectives of the first training plan, and formally solicited opinions of the MOH, donors, and NGOs for the follow-on plan. Given the on-going changes occurring within the MOH, a three-year master training plan was developed. Based on the new plan, PRIME/Intrah agreed to recruit and place a resident training management advisor (having technical management skills and experience and not expertise in clinical skills development). The plan specified that year one activities would include district-focused planning, regional and district level trainer updates/upgrades, expanded collaboration with NGOs and a reworking of existing strategy to strengthen FP components in selected PST schools for MCH Aides and nurses.

The master plan focused on the following elements:

Training delivery

- Accelerate training of service providers, by training 6000 service providers in MOH and NGO clinics.
- Develop regional and district training teams to support the decentralization of training.
- Strengthen the capability of newly trained trainers so that trainers could function more independently of the CTT and could plan and conduct training with minimal technical assistance from the FPU CTT.
- Develop central skills to decentralize planning and expand the pool of trainers.
- Expand service through and with NGO partner agencies by launching an initiative to build teams with NGO partners. The plan activities included holding trainer/supervisor planning and problem solving meetings and developing regional and district training teams. The FPU would provide technical assistance and training to strengthen the training capability of NGOs to conduct in-house training.

Planning, monitoring, and evaluation

- Establish a computerized database and training management monitoring system and begin using the available information for planning-of-training purposes.
- Provide on-site follow-up of sub-group of trainers (in 20 regions).
- Monitor adherence to the master training plan of the MOH and NGOs through

² Intrah's PRIME project, supported by USAID, began in 1994 and will continue through 1999.

training coordination meetings each year and formal annual and mid-term reviews.

Curriculum development

- Integrate safe motherhood interventions into curricula by first conducting training needs analyses and then preparing training curricula, materials and trainers.
- Integrate FP/RH aspects into curative services.
- Expand the range of training materials by translating existing materials into Kiswahili, adding new materials relevant to curricula, and housing all curricula and training materials in a centralized training library.

PST linkages with IST training

- Develop a PST strategy that began by sensitizing officials and conducting RH updates for the national nursing exam committee and nursing council members. After these activities were accomplished, the FPU would work with stakeholders to develop and implement a PST strategy.

With the detailed master training plan, it was possible to provide systematic training and other inputs to help achieve objectives outlined in the national training strategy and the NFPP.

2. Expanding collaboration between the MOH, donors, and NGOs involved in FP/RH training and service delivery activities

A NFPP project launch meeting was held in July 1995 and was attended by all agencies involved in the master training plan activities. Goals of the meeting included how to:

- develop a common base of information about the background scope and purpose of the NFPP;
- achieve a better understanding of roles, responsibilities and authorities in conducting the project;
- identify and explain elements of successful teams; learn about and appreciate the contributions of partners to the overall success of the project; and
- identify and address operational issues, including coordination of work plans (PRIME/Intrah Trip Reports B-370 1 and 2 and Trip Report B-400) .

Each subsequent year, with PRIME/Intrah support, the FPU brought together the main RH/FP training agencies in partnership meetings (held in 1995, 1996, 1997) to reinforce the commitment to the NFPP goal of accelerating the expansion of FH/RH services through increased clinical training activities. The objectives of the partnership meetings were to (re)establish a team effort, plan together the next years' activities, and coordinate and learn from the experiences of each other. The meetings helped to reinforce the leadership role of the FPU and allowed PRIME/Intrah to identify and plan technical assistance needs with partner agencies.

Linked to the partnership meetings were annual training implementation progress

reviews. The review of results of training compared to expected results in the annual training plans allowed the FPU, PRIME/Intrah, and other interested parties to monitor training plan progress and to make adjustments based on the changing internal MOH and external environments.

3. Improving planning capabilities of regional and district health management teams

In 1995, the FPU and PRIME/Intrah began to address the decentralization of planning and training management to the regional and district levels. The first of a series of workshops was held and included representatives from seven regional health management teams (RHMTs), which were comprised of regional medical officers, nursing officers, MCH coordinators, regional training team members and the planning officer from the Prime Minister's office (PRIME/Intrah Trip Report #P- 222). The workshop enabled the RHMTs to assist the District Health Management Teams (DHMTs) to conduct training needs assessment, to mobilize local resources (the regions were chosen because they had district-based donors), and to plan training activities based on district needs and priorities.

The creation of regional/district linkages and the involvement of Regional Medical Officers provided a rich experience and learning opportunity for the FPU and PRIME/Intrah. The workshop clarified what actions would be required in order for the FP program to be incorporated into the regional planning cycle.

For example, it became clear that the FPU/MOH in a decentralized structure would now need to advocate for the inclusion of FP/RH activities and training in regional planning. Through discussions at the district level it was determined that the FPU would also need to improve coordination of FP training since FP training was one of a larger set of training events planned at the district level.

The seven RHMTs trained their respective DHMTs, following a similar curriculum used in the initial workshop. One result of the training was that each year, the DHMTs now began to identify systematically and submit FP/RH training needs/plans to the RHMTs and receive funding from the FPU to conduct training.

Based on the findings of the initial workshop, the FPU hosted other workshops and sensitization activities oriented to administrators to guide the decentralization process throughout the second plan of operations. For example, in 1996, the FPU in collaboration with PRIME/Intrah hosted a workshop for six Regional Health Management Team members and associated District Health Management Team members, planning officials from the MOH, and PST tutor/lecturers. The workshop provided a forum to share ideas on the focus of health sector reforms and their implications on decentralization of FP/RH training to districts and to create a common vision of the NFPP in regard to decentralization of FP/RH training to the district level. By the end of the workshop, the group developed a phased (step-by-step) decentralization plan for FH/RH training activities to all regions (PRIME/Intrah Trip Reports P-2005 and P-289).

4. Developing a variety of curricula and related training materials to support accelerated IST training efforts

From 1996 to 1998, the FPU and PRIME/Intrah established and worked with a variety of working groups to revise curricula to be more performance-oriented and cadre-specific. (Refer to Appendix B for a list of curricula and related materials that were developed.) Work was completed on the PST Public Health Nurse “B” and related tutor clinical and training skills update curriculum and the MCH Aides and Nurse/Midwife in-service training curricula. The work enabled PRIME/Intrah to build MOH capacity in curriculum and training materials development while yielding quality products that would help accelerate the formation of trained RH service providers. Products from the working groups varied. For example, one group worked to develop a distance-based learning curriculum to reach geographically isolated Health Attendants, who had been recently authorized by the MOH to provide RH services. (Refer to “Assessing abilities of peripheral service providers to provide RH services: the case of Health Attendants and improving research skills of the FPU” (below) for details of how this course was developed.)

Because of the changes created by new policy initiatives from the Cairo Conference and USAID that committed the MOH to full integration of RH, CH, and FP services, it was necessary to revise critical curricula to reflect the new subject areas and to formulate training to reflect the integrated nature of eventual service delivery at the work site.

PRIME/Intrah provided technical assistance and supported the FPU as it organized working groups to revise curricula. The FPU also advised the PHC Secretariat of necessary changes in the national service policies and guidelines and the FP Procedures Manual, to ensure that training was coherent with formal service delivery approaches.

5. Developing a training project evaluation plan

In early 1996, the FPU hosted a three-day workshop to begin discussions on developing a NFPP evaluation plan. Six representatives from the MOH, comprised of nurse tutors, training coordinators, and the Research and Evaluation Coordinator of the FPU, and UMATI staff met with PRIME/Intrah staff. The workshop began by looking at levels of training evaluation (trainee, training activities, and program activities). The group identified appropriate indicators, why they were relevant and in which contexts, and determined from whom and how the information should be collected. In reviewing forms to collect training information, it was seen that while different report forms existed, none collected sufficient information to obtain the required indicators. All agreed that an expanded training management information system (MIS) would be useful and follow-up of a sample of trainees was desirable and feasible. Two types of reporting documents were also recommended—one report with selected indicators of particular interest to donors and a second report with more extensive indicators for use by program managers. Illustrative hierarchies and categories of indicators that were included in the MIS may be found in Appendix C.

6. Assessing abilities of peripheral service providers to provide RH services: the case of Health Attendants and improving research skills of the FPU

In preparation for the second five-year plan of the Tanzania National FP Program in 1994, it became clear during a meeting of Regional Medical Officers that there were not enough staff in the authorized categories to meet the demand for FP. In periphery service sites, there were limited numbers of authorized staff (and often no such staff) trained in FP service provision to allow for a full expansion of FP services. To expand FP/RH services, the MOH needed to identify additional cadres of service providers at peripheral levels of the health care system who could be trained to provide RH/FP services, since it was at these levels that the most potential FP/RH clients were seen. One interesting study that was designed and implemented by the FPU, with PRIME/Intrah assistance, was a feasibility study on whether health attendants could be trained to provide FP/RH services in peripheral service sites. Linked to the feasibility of adding a new cadre was the feasibility of training many providers located in geographically remote areas of the country.

As part of its training systems development approach, PRIME/Intrah worked with the FPU to design and conduct an operations research study to assess the potential of health attendants (HAs) as FP service providers and determine the best way of incorporating HAs into the FP service delivery scheme. Such research provided an opportunity for the FPU to build on the existing evaluation skills that would allow the Unit to be better able to adapt to new changes in health service delivery.

Adding new categories of providers authorized to provide FP. With the agreement of key stakeholders, the revised 1994 Tanzania National Policy Guidelines and Standards reflected the proposed change and health attendants were added to the list of authorized FP service providers. Health attendants in their expanded role would provide integrated reproductive and child health services, including: information, education and counseling to new and continuing FP clients; FP method provision, excluding IUDs; and, screening and referral of suspected cases of STIs for treatment.

DAPP assessment of health attendants

The 1994/95 training plan included pilot training for this group. However, no systematic documentation of this category of provider existed - who the health attendants were, what they did, what they were capable of doing. What were the gaps between the actual services provided by HAs and the additional services listed by the MOH? Such information was needed in order to develop a strategy and plans for training health attendants to provide FP and other selected RH services.

To define the service priorities and service gaps, Intrah, the MOH Family Planning Unit, and two health services researchers from Tanzania conducted a Diagnostic Assessment of Performance and Potential (DAPP) to assess the potential of health attendants for FP and RH services expansion in Tanzania. This innovative 1996 assessment, as conceptualized by PRIME/Intrah, would aid the MOH and Intrah to develop an HA training strategy. It would also guide the training plan and development of training materials that would be piloted in several rural, under-

served areas. After the pilot initiative, the finalized plan and materials would be used to expand HA training nationally.

The assessment analyzed the deployment, working environment, and knowledge and skills of health attendants in two geographically isolated regions in the country. Information was sought from the attendants' supervisors and instructors regarding preferred training approaches for this cadre. Perceptions of MCH clients and members of the community were also obtained regarding service providers and services provided at local health facilities.

The diagnostic study revealed that the Health Attendant cadre had the requirements to support the role as a dependable group of FP service providers: They were found to have basic MCH/FP/RH experience, knowledge and a skills base that could be developed to expand the services they offer and facilitate integration of FP services with other RH services. In addition they locally recruited and turnover was therefore expected to be relatively low (MOH, Tanzania 1996).

Distance-based learning approaches for health attendant training

The DAPP study also guided the training approach. Because the health attendants worked in geographically isolated areas and there were usually only one or two service providers at the work site, asking them to attend training of long duration would mean that service delivery would suffer while they were away from their post. Facility supervisors and the district health supervisor-trainers were available to provide on-the-job training, and the question was how best to use the human resources that were available to expand services.

An innovative distance education, group training, and supervision approach was developed by Intrah and the MOH, with USAID financial support. The pilot intervention effort was carried out in two isolated districts in rural Tanzania. The approach used an RH/FP Handbook, a solar-powered tape recorder, and training modules recorded on a set of audiocassette tapes as distance, self-learning materials. The training modules contained small case studies and trigger messages to enable the learner to apply knowledge and use the Handbook. The case studies reflected common problems that the trainee might encounter during service provision and asked the trainee to propose solutions.

Health attendants attended an initial, short training course to orient them to the distance self-learning method and to provide basic RH/FP information and theory found in the first training module. They returned to their sites and began studying the self-learning modules after clinic hours. As they practiced new skills during work hours, health attendants are asked to record observations, comments, and problems in a daily journal. The trainers and district health supervisors then visited the trainees at least once during this practicum period, to work with them to review what was learned, respond to questions that the health attendant had when working through the course lessons, and ensure that the materials were understood. The facility supervisor, who received training in RH updates and how to support the learning experience of the trainee, helped the trainee during the practicum period. Once training was completed, the trainees were able to offer a wider set of RH

services.

The pilot training approach, training curriculum for the first training module, and materials (Handbook) and trainee knowledge and skills were evaluated in 1999. The studies concluded that the distance-based learning approach, training methodologies, and tools (audiocassette tapes) were appropriate. The development and testing of the additional modules is planned. Eventually, the health attendant course in FP and other RH topics should be introduced nationally, and additional training modules will be introduced as they are pre-tested and finalized.

The evaluation of health attendant training have demonstrated that health attendants can develop the necessary skills to provide expanded RH services, including FP. Interviews and a review of service statistics at selected sites of trained and untrained HA in 1999 documented that trained health attendants provided a wider set of RH (particularly FP and STIs) services. This was achieved through innovative distance-based learning approach designed to bring appropriate knowledge and skills to periphery health workers and to improve their performance (MOH Tanzania, 1999).

7. Developing and implementing a strategic plan linking IST and PST institutions and tutors to maximize utilization of each system

In mid-1995, the FPU hosted a six-day workshop with nine tutors from PST institutions and one from an IST program. MOH Training Division, Catholic Church, and FP Association representatives met to address the national FP training strategy objective to maximize the contribution of pre-service training institutions and curricula in preparing new graduates as FP service providers.

During the workshop, the International Conference for Population and Development recommendations were presented. FPU staff provided an overview of current Tanzania FP service access issues and implications for training. The Tanzania policy guidelines for service delivery and training and clinical FP trainers' standards were reviewed. The group examined the roles and responsibilities of PST and IST and explored potential linkages that could promote maximum utilization of each system for preparation of competent FP and RH service providers.

The objectives and content of six PST nursing/midwifery, one rural medical assistant and one nursing health attendants curriculum were examined to determine the extent to which these curricula guided skills development for service providers in FP and to identify training needs. The curricula already had FP components, but guidelines for FP skills development were not explicitly stated. Additionally, learning opportunities for skills development were limited due to a lack of trainer and trainee FP training materials and aids and there was no real mechanism for monitoring FP instruction and skills development. Tutors responsible for FP in the PST schools that were represented felt that they were inadequately prepared. About 15% of all pre-service training schools were Catholic, requiring some students to get FP training elsewhere.

Based on the above reflections and analysis, a four-year strategy to improve PST training in FP was developed. Given the magnitude of activities, especially in the

first year, the FPU decided that it would allocate one training section staff member to oversee IST activities. The strategy focused on improving their pre-service training curricula of those service providers most likely to be in situations with potential FP clients: MCH Aides, Nurse-Midwives, and Public Health Nurses (B category). Elements of the strategy included conducting a training needs assessment of each cadre, modifying components of the respective curricula, and providing training to tutors and preceptors in clinical skills. To reach tutors who were physically distant from the capital, the strategy included developing a distance-based learning course for in-service training tutors. Infrastructure support was also included, such as providing training equipment to 28 schools.

Throughout 1996 and early 1997, training needs assessments were conducted and working groups revised the FP components in the various curricula, revised the trainer's guides for each curricula, and created training materials for use during IST training. A curriculum to update tutor skills for Public Health Nurse "B" tutors was developed.

In mid-1997, FPU, PRIME/Intrah, and selected tutors of IST and PST institutions met to review the revised IST and PST curricula for service providers (courses in Basic Clinical Skills, Public Health Nurse "B" Nurses, MCH Aides, and Medical Assistants) and a health update curricula for tutors of IST trainees. Besides technical and formatting suggestions, the group recommended that the NFPP make efforts to orient clinical heads of pre-service training institutions and key tutors to the curricula changes. To this end, the NFPP/FPU hosted a 1997 workshop for 28 nursing and midwifery council members and allied health science program examination officers. The participants were sensitized to the five-year RH and CH strategy framework and received technical updates in new intervention areas such as male involvement, adolescent sexuality and RH needs, and the integration STI prevention and treatment services into MCH/FP services. Workshop participants came up with a list of recommendations and agreements for identified issues and challenges in planning for and providing integrated R/CH services. The participants also developed a set of practical recommendations to strengthen RH and CH components in PST, IST, and at service delivery points with the aim of meeting R/CH client needs through accessible and quality services.

A pre-service training study conducted by PRIME/Intrah and the FPU in 1999 sought to document implementation of one of the revised curricula and an agreed-upon plan by tutors to develop a plan to implement the pre-service curriculum that matched RH skills and competencies of in-service curricula. They also received training in materials development during the RH update training course for tutors conducted in 1997. The evaluation of the implementation and concurrent field-testing of the revised Public Health Nurse "B" curriculum by four pre-service training institutions demonstrated that linkages between pre and in-service training could be made with minimal resources. The assessment documented that all schools used the revised curriculum, but experienced difficulties in teaching certain modules due to shortages in teaching staff. All used the materials development approach learned in the RH update training (the seven steps for experiential learning to develop lesson plans).

Suggested improvements included continuing coordination between the various training institutions, expanding the use of the revised curriculum to other schools, and orienting service providers, preceptors and site supervisors to the revised curriculum so that they could support new nursing graduates better at the work site.

Results

PRIME/Intrah, in collaboration with the FPU, conducted a final evaluation of the NFPP training strategy in 1999 (with main activities of the national strategies summarized in Table 3 on the next page). The evaluation documented the many achievements made during the second plan of operations, some which are highlighted below:

1. Improved training management and coordination capacity of the FPU

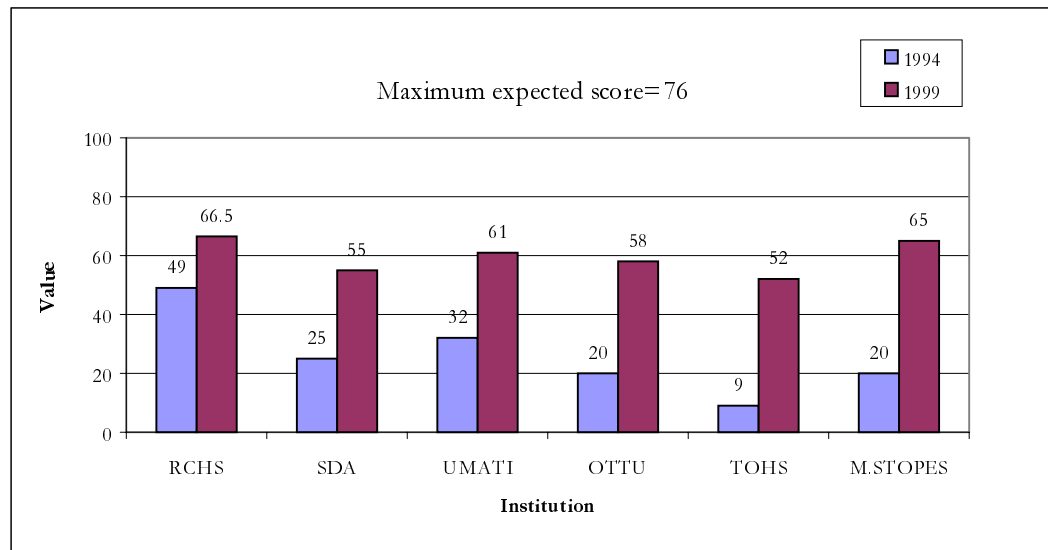
The FPU was challenged with co-ordinating the training activities of eight implementing partners, seven key NGOs, and the MOH. The extent of capacity building achieved for training by FPU and five NGOs was explored through a 19 item questionnaire that allowed for self assessment on five dimensions for training namely: legal and policy support for training; availability of resources for training; existence of training plans and curricula; organization/management capacity for training and community involvement in planning and execution of training activities. (Fort, 1999)

If an organization perceived optimum capacity in the 19 items for all five dimensions then the maximum expected score, based on a four-point scale is 76. The results of the self -assessment are shown in Figure 1 and Table 4.

As expected, FPU's training capacity was at a higher level (49 of 76) in 1994, compared to the five NGOs, given that the FPU is the lead FP training agency. The unit realized a 36% increase in it's training capacity between 1994 and 1999. Tanzania Occupational Health Services (TOHS) perceived the biggest growth in its capacity to train. The percentage increase in capacity building for training achieved between 1994 and 1999 was calculated at 478%. However its final score achieved (52 of 76) was the lowest among the group and suggests room for improvement. Not surprisingly, FPU and the five NGOs perceived favorable legal and policy support for training in 1999 compared to 1994. By 1999, national FP policies and standards were in place, and had been distributed widely for reference by all stakeholders involved in FP/RH training and service delivery.

The organizations rated the availability of updated training plans and curriculum optimally at 100% capacity in 1999 - up from 29% capacity in 1994. In 1999, many more standardized FP/RH training materials and curricula existed and had been distributed to regional and district level training entities. In addition, mechanisms existed to replace and update materials.

Figure 1: Capacity Building by Institution



By the time of the evaluation, individual training organizations were concluding training activities delineated in their respective training plans in readiness for the evaluation activity.

It is also worthy to note that the FPU (RCHS) and at least two other NGOs involved in training have recognized the value of involving the community in the planning and execution of training activities. On FPU's part, community perceptions about provider performance; quality of care received; and reasons for use/non use of contraceptives have been explored as part of needs assessments to guide development of training strategies and approaches.

The implementing partners during the evaluation said that they appreciated the coordination and technical support role of the FPU and CTT: The FPU's leadership role had grown among the various MOH bodies and the NGOs. The fact that fully 82% of the budget for training was disbursed indicated that coordination and adherence to the national training plan occurred.

Coordination within the government and between NGOs had greatly expanded, meaning that FP/RH service delivery following national guidelines had also continued to expand. Prior to 1994, the FPU had one main NGO partner and coordinated one training project; from 1994 through 1999 they have worked with 19 projects.

Linkages between the FPU, RHMTs, and DHMTs now occurred systematically in pilot regions, assuring that FP/RH training will be addressed in the decentralized MOH system.

Linkages between IST and PST groups resulted in joint and improved planning, curriculum development and sharing of practicum sites. This has helped to improve the effectiveness of training nationwide since more PST graduates will have the skills and competencies necessary to begin providing RH services immediately upon graduation.

2. Increased decentralization of decision-making for planning and training

One way that the extent of decentralization of training and training management skills was measured was by looking at the number of trained RH/FP trainers at regional and district levels. The results are mixed. While fully 78% of targeted regional trainers were trained over the plan's period, only 20% of district trainers and 24% of preceptors received training. Training of district level trainers depended on training by regional trainers, who only became fully functional and were able to operate independently late in the project period. In addition, there were selection problems of those who received training; too many people with an inadequate knowledge and training experience base were chosen for the training. That is, selection of candidates often did not follow established selection criteria.

District and regional health administrators were also targeted for training, and again regional level results were better than district level results. Fifty-two percent (52%) of zonal regional MCH officers received training while only 30% of DHMTs received training to improve planning, management, and evaluation of RH/FP training.

3. Expanded access to FP/RH services due to more service delivery points offering RH services and offering a wider mix of FP methods

The results of the many training activities paid off in terms of improved access to RH and FP services. In 1994, there were 691 trained providers; by 1999 there were 1,196 trained service providers, almost double the number from five years ago. One third (32%) of all facilities in the country have at least two trained providers in 1999, up from 24% in 1996.

The strategic training successfully focused on training cadres of providers most likely to be in contact with potential clients, that is, at the peripheral levels. For example, 67% of targeted nursing officers received training. Health attendants in the pilot areas are still being trained: 24% of targeted HAs have been trained. Seventy one percent (71%) of targeted community-based distribution agents were trained.

UMATI reflected that "working with PRIME/Intrah has made the Clinical/Assistant Clinical Officer cadre (ACO/CO) which was completely left out of the RH arena, to be involved, for improved access to RH services to rural communities."

The evaluation also indicated that the method mix was also expanding and a concerted effort underway to add long-term methods and IUCDs to the method mix at various levels has been helping to improve the availability and use of additional FP methods at periphery health facilities.

4. Improved quality and increased use of RH and FP services, due in part to training efforts

Much of the knowledge gained from training was retained by providers once they returned to their work sites. The number of service providers who were following national standards and guidelines in RH service delivery was measured as a way to assess service quality at the end of the plan's period. Adherence to national standards of several RH services (FP and STIs) had improved greatly since 1994: 42% of surveyed providers were adhering to standards in 1994 versus 58% in 1999 (60% was the cut-off

for acceptable performance). Particularly improved performance was noted in group education and new client FP counseling.

The 1996 Tanzania Services Availability Survey (TSAS), undertaken by the Bureau of Statistics with technical assistance by the EVALUATION Project, of the University of North Carolina at Chapel Hill found that if a hospital had at least two service providers trained in FP/RH, one could expect an increase in 7.23 acceptors per month at the site. The impact of training at both hospitals and dispensaries was even greater for re-supply clients. Having two trained providers caused an increase of 23.32 re-supply clients in hospitals and 11.12 re-supply clients in dispensaries (MEASURE Evaluation, 1998). During the 1999 FP training strategy evaluation, changes in FP use six months prior to training of providers at selected sites and six months after training were documented. Hospitals and dispensaries with at least two service providers trained in RH were shown to have about two times more new clients than hospitals and dispensaries without trained providers. Both studies indicated that training has helped to raise the contraceptive prevalence rate in the country.

Table 3: Summary of main activities in the development and expansion of training systems and related human resources (trainers and service providers)

1989 to 1993	1994-1999
National strategies	
<ul style="list-style-type: none"> - NFPP strategy: Accelerate training to create a critical mass of trained FP service providers - Complementary national training strategy developed by MOH and Intrah: Provide direct training to service providers while supporting the addition of new trainers at regional and district levels. 	<ul style="list-style-type: none"> - NFPP strategy: Institutionalize gains made in the first plan of operations, expand services further by involving other FP actors such as NGOs, and decentralize management and training further to include post-Cairo integrated RH services package - Complementary training strategy developed by MOH, PRIME/Intrah, and NGOs, other sectors of GOT: Decentralization of FP training and training management and supporting changes in services configuration by training new trainers and providers at peripheral levels, improving IST and PST linkages
Training systems development	
<ul style="list-style-type: none"> - Development of national training strategy (guided by national health and FP policies) and training plan - Development of FP service standards and guidelines - Development of simple training monitoring system to track service providers that received training - Creation of Central Training Team, using skilled clinical trainers from UMATI as the core group of trainers who trained and provided follow-up in the field 	<ul style="list-style-type: none"> - Development of national training strategy (guided by national health and FP policies) and training plan - Revision of FP/RH service standards and guidelines (to expand authorized cadres of FP service providers) - Formalizing annual reviews (and reinforcing esprit de corps) of training plans with implementation partners (MOH, NGO) - Creating linkages between PST and IST tutors: improving and linking PST and IST curricula, focusing on one cadre of provider having greatest impact on services (PHN B) - Improving practicum sites for PST trainees - Expansion of monitoring and evaluation system to include follow-up of trainees at service site, research to determine suitability of adding new cadres of service providers (HAs), tracking public and private sector training events

1989 to 1993	1994-1999
Human resources development (trainers)	
<ul style="list-style-type: none"> - Improving stand-up FP training and design skills of central training team (CTT) members (including placing a resident advisor in clinical FP training at the FPU) 	<ul style="list-style-type: none"> - Improving management and supervision skills of CTT members (to manage and support decentralized training), expand skills in MIS management and IEC, expanded RH and integrated training in FH/MH/CH - Developing stand-up training and supervision skills of existing and new trainers at regional and district levels - Improving skills of PST tutors in stand-up training, curriculum design, practicum training design - Improving skills of preceptors at practicum sites
Human resources development (service providers)	
<ul style="list-style-type: none"> - Upgrading skills of service providers already providing FP services (within MOH and UMATI) - Upgrading skills at centralized service delivery points, e.g, in hospital, health centers, and FP clinics 	<ul style="list-style-type: none"> - Upgrading skills of staff of new NGO partners in FP/MH/CH, and on new service providers not yet trained in FP (goal of at least 2 trained service providers in all facilities) - Developing/upgrading FP/MH/CH skills at periphery levels -- new service providers in dispensaries and CBD networks

Table 4: Capacity building for FP/RH training: FPU and NGO's assessment of capacity in five dimensions

	Legal and Policy support		Resources		Training Plans and Curriculum		Organizational Development		Community Involvement /Participation		Total		% increase
	Maximum expected score =12	1994	1999	Maximum expected score =24	1994	1999	Maximum expected score =8	1994	1999	Maximum expected score =4	1994	1999	
RCHS (formally FPU)	10	11	18	19.5	5	8	15	26	1	2	49	66.5	36%
SDA	0	10	5	11	3	8	16	26	-	-	25	55	120%
UMATI	6	9	10	17	3	8	12	25	1	2	32	61	91%
OTTU	7	8	0	13	0	8	12	27	1	2	20	58	190%
TOHS	0	9	5	13	1	8	3	22	-	-	9	52	478%
MARIE STOPES	2	16	8	16	2	8	18	25	-	-	20	65	225%
Overall % capacity	35%	87%	32%	62%	29%	100%	45%	90%	25%	50%	34%	78%	

- Data not available

Lessons Learned

Strategies and processes that worked well and those that Intrah and the government of Tanzania would do differently the next time

From the variety of activities and processes described in this case study, it is clear that developing a dynamic national training system requires a holistic view of training that moves beyond the singular action of training service providers. Political, organizational, and training issues and players need to be factored into the development of a training system, if the system is to function well and maintain flexibility to respond to changing needs. Through evaluation and reflection with counterparts, some lessons learned may be shared with readers of this case study.

- Establishing and maintaining substantive relationships with stakeholders is key to moving a national agenda forward.

The definition of stakeholders depended on the activity. The FPU and PRIME/Intrah clearly looked beyond traditional training actors. They defined who needed to be involved in which activities to support the process technically, programmatically, administratively, and politically. This strategic definition of stakeholders effectively allowed the FPU to maximize the effect of enablers and to minimize the effect of potential inhibitors to the training processes. The result was the creation of internal MOH and external-to-the-MOH support for new activities that were needed due to changing needs within the MOH.

Such a definition also helped the FPU and PRIME/Intrah to identify new stakeholders as decentralization proceeded, e.g., the RHMTs, the DHMTs, and the zonal education centers staff.

- A national training strategy is critical to guide training activities at different levels, and is particularly effective when roles and responsibilities of all FP/RH entities - both public and private - are clearly defined in the strategy.

PRIME/Intrah and the FPU made the strategy a living document by holding annual meetings to review progress and plan the upcoming years' activities with public and private sector actors involved in RH training. This created buy-in and a team spirit to accomplish the objectives set out in the national strategy.

- Placing an PRIME/Intrah resident advisor within the FPU worked very well. The placement made technical support immediately available when needed, as the CTT took on new training roles. Still, an in-house advisor with FP clinical skills (in addition to an advisor with management skills) during the second plan of operations would have helped to reinforce gains made during the first plan of operations.
- Developing a substantive relationship between the NFPP and NGOs created new and low-cost channels to expand standardized training and RH services.

Many of the NGOs that collaborated in the national training plan were active at the district level in a variety of domains, including service delivery, facility infrastructure Improvement, and community outreach activities (e.g., community-based

distribution of methods and information), as well as training. By including NGOs as partners in the training strategy, the NFPP extended its reach with minimal resources while standardizing FP/RH training at the same time.

Many of the NGOs also benefited by having access to technical assistance and material resources to improve training. The capacity-building approach to working with NGOs taken by the FPU and PRIME/Intrah (through UMATI), helped to establish more agencies with improved training capacity and consequently improved training and ability to function more independently, i.e., with less need for regular technical assistance. The 1999 assessment of organizational capacity of NGOs to plan and deliver training showed that NGOs had clearly improved capacity, particularly in developing curricula and in terms of legal and policy support for RH activities within the organization.

- By studying the potential of health attendants as FP/RH service providers and then piloting a distance-based learning course prior to expanding FP/RH services to the peripheral level, the NFPP created a knowledge base that allowed the rational introduction of FP and other RH services at the periphery.

This process provided a systematic and transparent example to stakeholders of how to apply research methods to understand a problem or issue from the perspective of the service provider and then develop and analyze the effectiveness of the solution. It also demonstrated that not all solutions are obvious (e.g., the application of distance-based learning) and that a systematic study can allow decision-makers to see alternatives that may not have been apparent before.

- The decentralization of training moved slower than planned over the five year period and the result of this was seen in terms of training management and service delivery: While 90% of RTTs were found able to function independently in the final evaluation only 20% of targeted DTTs were adequately trained. In retrospect, training district-level trainers should have been more of a priority in the training strategy than regional trainers, since district service delivery points were more critical to expanding access to RH services than regional points.
- Although still very rare in Africa, pre-service and in-service training linkages can be forged successfully along programmatic lines.

The logic of the linkage was understood by all. What made the difference in Tanzania was the MOH leadership in promoting, coordinating, and sustaining the linkages. It is a tribute to the MOH FPU and NFPP officials that this has been accomplished.

- Building capacity of trainers and training program managers to plan and use different training approaches allows national training systems to develop the necessary flexibility to adjust to changing health policies and service practices.

Training is relatively expensive but necessary to improve quality of services. To reduce cost while maintaining or improving quality, various approaches are needed. Different training approaches should be used to best fit the training needs of trainers and trainees (e.g., distance-based learning, group education, practicums). Different

methods of financing training and trainee follow-up activities need to be entertained, e.g., paying for training out of district budgets. Efforts must be made to create efficiencies in training systems, e.g., linking PST and IST activities, expanding collaborative activities between the FPU and the MOH-Training Division, working with NGOs. Because of conscious efforts by PRIME/Intrah to build capacity over a five-year period, the FPU and the NFPP staff have the skills, knowledge, and equally important, organizational outlook, to adjust in dynamic and innovative ways to changes brought about by health sector reform and decentralization.

Conclusions

The case study highlighted the processes and steps involved in creating training and human resources development systems responsive to a changing environment. The NFPP experiences offered an example of a holistic approach to training systems development in which systems elements were applied in one country: the use of training policies, standards, and norms to guide training; the standardization of training materials to ensure uniformity of trainer and service provider competencies; the maximization of linkages between PST and IST institutions to create efficiencies and common purpose; the systematic follow-up and support of trainees after training; the development of training program management capacity; and the evaluation and application of research to monitor, evaluate, and eventually improve future training.

To achieve a more holistic training system, human resources capacity had to be developed to a point where trainers and training managers could take a more flexible approach to training and systems development in order to respond to the changing policy and service delivery environment. PRIME/Intrah's and the NFPP FPU's approach to building capacity during both the first and second plans of operation of the NFPP was to provide training as well as a variety of applications to learn and fine tune different skills in training and service delivery and program management.

Several key outcomes have occurred as a result of developing a training and HRD system. National FP/RH policies and guidelines have clarified and helped address ambiguities in the health system. The development of a national training strategy has resulted in more focused and targeted training at all levels. With decentralization, the focus of this training has shifted to the regional and district levels, while the role of the central level changed to a technical assistance and coordination role. More people at all levels have skills in developing, conducting, and evaluating training. More people at all levels have additional skills in advocacy and resource mobilization, which are necessary to access resources in decentralized environments.

Linking pre-service and in-service institutions to maximize training resources has begun. The inclusion of various stakeholders to forward and support an RH/FP training agenda has created a sense of ownership outside of the MOH FPU and will help to sustain the training program.

Training materials have been developed that support training efforts. Guidelines and norms exist upon which to base training curricula, and standardized curricula linked to service provision have been developed for use at different levels of the NFPP. Different training approaches based on the country situation have been systematically developed and evaluated. Training materials are of higher quality than before.

The result of these varying efforts is a higher quality of training, which is standardized nationally. The evaluation of the national training strategy has also documented that such a training systems and HRD development approach has helped the MOH and NGO partners to increase the use of FP/RH services dramatically over a 10-year period, from under 7% in 1989 to an estimated at 17% in 1999.

Appendix 1

List of documents and personal communications used in developing the case study

1. GOT Bureau of Statistics Planning Commission and the Evaluation Project, Tanzania Service Availability Survey 1996
2. GOT Bureau of Statistics Planning Commission and Macro International, Inc., Demographic and Health Survey 1991/92
3. Intrah/MOH Family planning Training Project Evaluation 1994
4. PRIME/Intrah Trip Report #P-272 (to participate in the MOH FPU annual training review meetings and to assist the MOH Training Section to develop the 97/98 training plan and to assist in the AID CH assessment dissemination and planning meeting), April 1996
5. PRIME/Intrah Technical Report # 16, Capacity building in training: A framework and tool for measuring progress; Author: Alfredo L. Fort, November 1999, Chapel Hill, NC
6. PRIME/Intrah Trip Report #P-276 (to participate in the USAID 7-years strategic plan development and to conduct an administrative review with UMATI and the FPU), April 1996
7. PRIME/Intrah, PRIME Evaluation and Research Plan Volume 3: Tanzania Training Plan
8. PRIME/Intrah, Trip Report #P-20 (to finalize the USAID-sponsored 1995/96 training plan), April/May 1995
9. PRIME/Intrah, Trip Report #P-2018 (to assist the FPU to select 8 trainers and service providers to plan for a and pre-test the HA Handbook), September/October 1996
10. PRIME/Intrah, Trip Report #P-2035 (to provide TA in field-testing and revising an IST curricula), May 1997
11. PRIME/Intrah, Trip Report #P-2078 (to follow-up tutors oriented to the revised PHN certificate curriculum), January/February 1999
12. PRIME/Intrah, Trip Report #P-220 (to provide TA to the FPU to develop a 3 year (1995/98) master training program plan), March 1995
13. PRIME/Intrah, Trip Report #P-222 (to assist the FPU to plan, conduct, and evaluate a six-day workshop for regional health management teams), October 1995
14. PRIME/Intrah, Trip Report #P-225 (to assist the FPU to formulate an FP/RH PST strategy and implementation plan), November/December 1995
15. PRIME/Intrah, Trip Report #P-226 (to facilitate development of the HA curriculum, define major jobs and tasks in developing training materials and implementing and testing the curriculum), June 1996

16. PRIME/Intrah, Trip Report #P-232 (to assist the FPU, UMATI in the development of a training project evaluation plan), January 1996
17. PRIME/Intrah, Trip Report #P-234a (to assist the FPU to plan, review, and revise IST clinical curricula), September/October 1996
18. PRIME/Intrah, Trip Report #P-236 (to plan and conduct an annual clinic-based training program review for the NFPP), June 1996
19. PRIME/Intrah, Trip Report #P-240 (to assist in reviewing and revising two FPU/MOH training curricula and the FP Procedures Manual), March 1997
20. PRIME/Intrah, Trip Report #P-241 (to conduct a review of training implementation progress with the FPU and UMATI and plan next steps), January 1996
21. PRIME/Intrah, Trip Report #P-2005 (Providing Assistance to FPU in drawing up a strategy for Decentralization of planning and Decision-making for training in the districts. September 1996
22. PRIME/Intrah, Trip Report #P-289 (Assisting the Mbeya Health Management Team to conduct a decentralization workshop to enable Mbeya DHMTs make decisions and plans for FP/RH training. May, 1996
23. PRIME/Intrah, Trip Report #P-247 (to assist in reviewing and finalizing two curricula (one IST and one PST curricula), February/March 1997
24. PRIME/Intrah, Trip Report (to assist in assessing selected national FP curricula to ensure they include key RH, MH and CH components), June 1997
25. PRIME/Intrah, Trip Report (to provide TA to the CTT and HA trainers in planning, conducting, and evaluating the field test of the HA curriculum and materials), May/June 1998
26. PRIME/Intrah, Trip Report (to provide TA to the NFPP, CTT, RTTs, DTTs to plan, conduct, and analyze results of HA training and fielding testing activities), August and October 1998
27. MOH NFPP, Report of the R/CH Update Workshop for the Tanganyika Nurses and Midwives Council Members and Nurses and Allied Health Science Program Examination Officers, June 1997
28. MOH NFPP, Workshop report on drawing up a strategy for decentralization of FP/RH training to the districts, August, 1996
29. MOH, National FP Programme Strategic Plan: 1994-1999, 1994
30. MOH, Tanzania MOH Five-Year Strategy for FP Training: 1994-1999, 1994
31. MOH, Tanzania An Assessment of the Potential of Health Attendants for Family Planning and Reproductive Health Expansion in Tanzania, July 1996. Authors: Dr Michael Thuo, January Karungula, Fatu Yumkella

32. MOH, Tanzania National Policy Guidelines and Standards for FP Service Delivery and Training, 1994
33. MOH Tanzania Study on the impact of Health Attendant Training Strategy on the Performance of
34. Reproductive and Child Health Services, November 1999. Authors: Wambui Kogi Makau, Gaudy
35. Tibaijuka
36. Evaluation of the Tanzania 1994 –1999 Family Planning Training Strategy
37. December 1999. Authors: James P.M. Ntozi, January Karugula, Renalda Ndono, Fatu Yumkella
38. Training Resources Group (TRG), Report of the partnership and project start-up meeting, July 1995
39. Training Resources Group (TRG), Report of three-day partnership coordination and review meeting, July 1997
40. Training Resources Group (TRG), Report on consultancy to facilitate the annual partnership meeting and a conflict resolution meeting, July 1996

Personal Communications

1. Ms. Dana Vogel, Chief Officer of Population and Health REDSO/ESA (former Human, Population and Nutrition officer in Tanzania during the first and some of the second plan of operations period, April 1999)
2. Dr. Calista Sumbakalia, former FPU Program Manager, June 1999
3. Ms. Pauline Muhuhu, Intra Regional Director for Anglophone Africa, various discussions held between January and July 1999

Appendix 2

List of GOT/FPU documents (supported by PRIME/Intrah) that were outcomes of processes noted in this case study

A. Policies and standards

- National Policy Guidelines and Standards for FP Service Delivery and Training, 1994
- RH Client Management Guidelines, 1997

B. Curricula

- Comprehensive FP Clinical Skills Curriculum, Volume III, 1996
- Basic Training Skills Curriculum, 1996
- Basic RH Clinical Skills Curriculum, Volume I, 1996
- Public Health Nursing Certificate Curriculum, 1996
- Comprehensive RH Clinical Skills Curriculum, Volume IV, 1996
- FP/RH Update of Clinical Skills for PST Tutors Curriculum, 1996
- RH Clinical and Training Skills Update Curriculum for PST Tutors, 1996
- Contraceptive Technology, RH and Training Skills Update Curriculum, 1996
- Health Attendant Curriculum (English/Swahili versions), 1996
- RH Update /Preceptorship Skills Training Curriculum, 1997
- Integrated R/CH Clinical Skills Curriculum, Volume III, 1998
- Integrated R/CH Update for Clinical Officers and Assistant Clinical Officers Curriculum, Volume I, 1998
- Integrated R/CH Clinical Skills Curriculum, Volume II, 1998
- Integrated R/CH Clinical Skills Curriculum, Volume I, 1998
- Integrated R/CH Update and IUCD Insertion Skills Training Curriculum, 1998
- R/CH Update Curriculum for Nursing Officer, Volume I, 1998
- National Curriculum for CBD, 1998

C. Other training materials

- FP/RH Supervision and Monitoring Skills for MCH Coordinators, 1993/4
- RH Health Attendant Handbook (with accompanying audio-scripts), 1994
- FP Procedures Manual, 1995

D. Special studies and reports of activities

- FP services in Tanzania: An overview, 1993
- Report on Follow-up of Medical Assistants Trained in RH Updates, 1994

- An Assessment of the Potential of Health Attendants for FP and RH Expansion in Tanzania (DAPP): Final Report, 1996
- A Report of the Evaluation of the Tanzania Family Planning Training Strategy – 1994 – 1999, 1999

Appendix 3

Indicator Categories Found in the Tanzania National Training Management Information System

- *Trainee Evaluation*

Includes indicators to assess participant training needs, background and experience, progress during training, exit- level skills and knowledge, performance at work site, number of trainees who apply learned skills to their subsequent work

- *Training Activity Evaluation*

Includes indicators of relevance of training objectives, trainer effectiveness, training practicum and practicum conditions, training content, method, duration and structure

- *Baseline Training Level*

Includes indicators of institutional training capacity and capability

- *Baseline Service Level*

Includes indicators of service use, method availability, number of trained providers at a work site

- *Project Implementation Process*

Includes indicators of trainees being trained, new service sites being established, status of new and continuing clients, use of human, financial, and technical resources

- *Project Outputs*

Includes indicators to assess number of trained personnel, number of training courses conducted, number of training materials produced

- *Project Outcomes – Training Level*

Includes indicators to assess number of work sites with trained providers by type of competency

- *Project Outcomes – Service Level*

Include indicators of types of services offered after training, clients seen after training, number of users who switched methods after training, number of referrals made