FAMILY PLANNING IN TANZANIA

Enormous gains in family planning (FP) have been made in Tanzania over the past 25 years. The contraceptive prevalence rate (CPR) for any FP method quadrupled between 1991 and 2016, from less than 8% to 38%, and met need for FP through modern methods increased nearly fivefold over the same time period, from 7% to 32% (MOHCDGEC et al., 2016). The greatest gains in the voluntary use of long-acting reversible contraceptives (LARCs) and permanent methods (PMs) were over the past decade, with the percentage of currently married women using a LARC or PM increasing from 3% in 2004–2005 to 11% in 2015–2016.

However, national trends mask stark regional and district differences, and as the total demand for FP continues to rise, health facilities face a number of challenges to providing FP. Service efforts are hindered by a lack of skilled providers, stockouts of commodities and consumables, inadequate infrastructure, shortages in medical equipment, and insufficient funding. Given resource limitations, FP interventions targeting underserved areas with low FP uptake could make the greatest impact toward achieving national FP commitments.

THE RESPOND TANZANIA PROJECT

Building on more than a decade of FP work by EngenderHealth in Tanzania,1 the RESPOND Tanzania Project (RTP) supported the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) to advance access to and use of FP and reproductive health (RH) services, with a focus on the informed and voluntary use of LARCs/PMs. Activities encompassed the three components of EngenderHealth’s Supply–Enabling Environment–Demand (SEED) programming framework,2 using a targeted district approach: RTP identified 110 districts with low FP uptake and high unmet need and targeted them with varied packages of intensive FP programming. The increase in voluntary use of LARCs/PMs and shift in method mix between 2012 and 2017 are largely the result of this tiered approach.

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1. RTP continued over a decade of FP work by EngenderHealth in Tanzania, which began under the EngenderHealth-led global ACQUIRE Project (2003–2007) and continued under the ACQUIRE Tanzania Project (2007–2012).

2. The Supply–Enabling Environment–Demand (SEED) Programming Model™ is a holistic programming framework based on the principle that RH programs will be more successful and sustainable if they comprehensively address the multifaceted determinants of health and if they include synergistic interventions that: 1) attend to the availability and quality of services and other supply-related issues; 2) strengthen health systems and foster an enabling environment for RH-seeking behavior; and 3) improve knowledge of RH and cultivate demand for services.
IMPLEMENTING THE TARGETED DISTRICT APPROACH

District Selection
To select target districts, RTP calculated FP uptake per 10,000 women of reproductive age for each district, using data from the national health management information system. Based on this metric, districts were grouped into one of three levels. Districts in Level 1 had the lowest uptake of FP, while Level 3 districts had the highest. Based on the analysis, 110 districts were selected for RTP programming between 2012 and 2017, 83% of which fell into Levels 1 and 2 (Table 1).

Intervention Package
Level 1 districts had the lowest FP uptake and received the most intensive package of interventions. Activities included capacity building for facilities and local health authorities, in-service trainings, community mobilization, and direct support to LARC/PM service delivery via outreach, FP weeks, and service days. Level 2 districts received a less intensive package of interventions, with greater emphasis on partner collaboration to strengthen and deliver FP services. Interventions for Level 3 districts focused on building district capacity to take ownership of their FP/RH activities. Determining the activities required to produce the greatest impact was guided by the National Essential Package of FP Interventions, a MOHCDGEC document designed to help districts plan and budget for FP with their own funding.

FINDINGS
An intensive package of interventions resulted in greater utilization of FP in traditionally low-uptake districts.

Early into implementation, data showed an increase in FP uptake as a result of implementation of the targeted district approach. Compared with the previous year, voluntary use of any short-acting, long-acting, or permanent FP method increased overall by 11% in Year 1. By the end of Year 3, the number of districts with the lowest FP uptake (Level 1) started to decline (Table 1).

By the end of the project, the number of districts with the lowest FP uptake (Level 1) had decreased by 50%, and the number of districts with the highest FP uptake (Level 3) had increased by 121% (Figure 1). The numbers of districts at both Level 1 and Level 2 shifted to a higher level over time, with 56% of the 54 Level 1 districts graduating to Level 2 by Year 4 and 57% of the 37 Level 2 districts moving to Level 3. However, some districts did shift downward, with four of the 19 Level 3 districts moving to Level 2 by the end of the project.

The movement of districts to higher levels meant that more women adopted FP. The mean uptake of FP per

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Table 1: Number of districts, by level, between 2012 and 2017

<table>
<thead>
<tr>
<th>District level, by FP uptake per 10,000 women of reproductive age</th>
<th>Year 1 2012-2013</th>
<th>Year 2 2013-2014</th>
<th>Scale-up</th>
<th>Year 3 2014-2015</th>
<th>Year 4 2015-2016</th>
<th>Year 5 2016-2017</th>
<th>Full implementation of targeted district approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 (311–2,500)</td>
<td>51</td>
<td>54</td>
<td>(34+1)</td>
<td>17</td>
<td>(4)</td>
<td>na</td>
<td></td>
</tr>
<tr>
<td>Level 2 (2,501–4,500)</td>
<td>32</td>
<td>37</td>
<td>(4+7)</td>
<td>50</td>
<td>(4+4)</td>
<td>na</td>
<td></td>
</tr>
<tr>
<td>Level 3 (&gt;4,500)</td>
<td>7</td>
<td>19</td>
<td>(4+28)</td>
<td>43</td>
<td>(4+4)</td>
<td>na</td>
<td></td>
</tr>
<tr>
<td>Total no. of districts targeted</td>
<td>90</td>
<td>110</td>
<td>110</td>
<td>110</td>
<td>110</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The years in the table are based on a fiscal year beginning in October and ending in the following September. In Year 5, the implementation of directly funded activities ended in March 2017, but data for that period are not available (na). The numbers in parenthesis are the numbers of districts that moved to a level with higher FP uptake (+) or moved to a level with lower FP uptake (-).

3. This indicator was used to measure FP coverage in the absence of district-level CPRs. It is calculated as the number of users of modern FP methods divided by the number of women of reproductive age in the district and then multiplied by 10,000.

4. The National Essential Package of FP Interventions is an important policy-level advocacy document codeveloped by EngenderHealth through ATP, in collaboration with the MOHCDGEC. Since its launch in September 2010, the document has served as a valuable guide for districts in planning their comprehensive council health plans to include adequate financing for FP. (These plans are a decentralized financing mechanism by which districts plan and manage their budgets for all activities. Competing priorities for various interventions—e.g., education, infrastructure, or immunizations—often mean that FP activities are inadequately funded.)
10,000 women of reproductive age increased by 48%, from 3,037 at baseline to 4,486 during Year 4. In fact, targeted interventions resulted in a positive shift in the range of FP uptake across all districts. Among Level 1 districts alone, the lowest number of FP users per 10,000 women of reproductive age tripled, from 311 at baseline to 935 in Year 4 (Table 2).

Delivering quality LARC/PM services led to greater utilization and a shift in method mix.

In addition to increasing FP uptake across all intervention districts, the targeted district approach’s emphasis on voluntary and informed use of LARCs/PMs led to a shift in the method mix. Prior to the start of interventions, 12% or fewer of FP acceptors at any level were using a LARC/PM. By Year 4, one in three (37%) FP users in Level 1 districts and one in four (25%) in Level 3 had voluntarily chosen a LARC/PM as their FP method (Table 3).

By method, the number of women across all levels adopting a copper-T intrauterine device (IUD) in Year 4 was 600% higher than at baseline (from roughly 34,000 to 207,000), and the number of women receiving hormonal implants increased by 800% (from roughly 71,000 to 642,000). Women choosing minilaparotomy under local anesthesia also increased 128%, from 53,000 at baseline to 123,000 in Year 4.

At every level, implants showed the greatest increase among FP users, followed by the IUD and minilaparotomy (Figure 2). Among the districts that were in Level 1 in Year 1 (regardless of whether some graduated to levels 2 or 3), the number of implants inserted increased nearly 14-fold, from roughly 25,000 at baseline to 357,000 in Year 4. Conversely, fewer FP users in Level 1 districts opted for injectables or oral contraceptives. Compared with baseline, 45% fewer FP users in Level 1 districts chose the pill in Year 4, and 5% fewer chose injectables.

RTP-supported FP events were crucial contributors to LARC/PM uptake. Through a total of 989 outreach events, 707 FP weeks, and 785 special service days, more than 1.5 million clients accepted LARCs/PMs in targeted districts between 2012 and 2017, representing 40% of all LARC/PM clients served nationwide.

Table 2: Range of FP uptake per 10,000 women of reproductive age, by level, 2012–2016

<table>
<thead>
<tr>
<th>Level</th>
<th>Baseline</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>1</td>
<td>311–2,500</td>
<td>311</td>
<td>2,483</td>
<td>1,049</td>
<td>2,442</td>
</tr>
<tr>
<td>2</td>
<td>2,501–4,500</td>
<td>2,509</td>
<td>4,406</td>
<td>2,539</td>
<td>4,338</td>
</tr>
<tr>
<td>3</td>
<td>&gt;4,500</td>
<td>4,560</td>
<td>11,191</td>
<td>4,598</td>
<td>17,577</td>
</tr>
</tbody>
</table>

Table 3: Percentage of FP users among women of reproductive age who adopted a LARC/PM, by level

<table>
<thead>
<tr>
<th>Level</th>
<th>Baseline</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11.9%</td>
<td>37.4%</td>
</tr>
<tr>
<td>2</td>
<td>12.1%</td>
<td>27.4%</td>
</tr>
<tr>
<td>3</td>
<td>7.9%</td>
<td>24.7%</td>
</tr>
</tbody>
</table>

Note: Year 4 is October 2015 to September 2016.
Greater usage of LARCs/PMs averted millions of unintended pregnancies and prevented thousands of deaths.

Based on impact estimates, the FP services provided during direct, RTP-supported FP events averted 2.6 million unintended pregnancies and 778,000 unsafe abortions and likely saved more than $168 million in direct health care costs.

CHALLENGES AND LESSONS LEARNED

RTP's experiences implementing a targeted district approach revealed a number of challenges and lessons for future FP initiatives:

- Community mobilization is essential. Engaging the community prior to an FP event was crucial in disseminating information about services, addressing FP myths and misconceptions, and sensitized community members to access various methods, according to their informed choice.

- Data informed the adjustment of interventions and areas to target. Routine data collection and analysis was critical to monitoring the performance of districts and to adjusting targeted FP programming based on uptake. Additionally, focusing on FP uptake among women of reproductive age at the district level was a useful metric in determining FP coverage and in gauging progress.

- Interventions must be flexible. Factors contributing to FP uptake differ between districts, and strategies targeting district leadership may be required in some areas, while client mobilization may be more important in others. As the interventions were intended to target the district-specific factors contributing to low FP uptake, flexibility was key to adapting activities to the local context and priorities.

THE WAY FORWARD

RTP’s experience shows that a targeted district approach can improve the voluntary use of FP in areas with traditionally low FP uptake. The high participation in FP among female clients during FP weeks, one-day outreaches, and service delivery days emphasizes the need for FP access in hard-to-reach and underserved areas. FP programming that targets underserved areas could make the greatest impact toward achieving FP2020 goals and other national FP commitments.

REFERENCE

Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) [Tanzania Mainland], Ministry of Health (MoH) [Zanzibar], National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF. 2016. Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015-16. Dar es Salaam, Tanzania, and Rockville, Maryland, USA.

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