THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

End-of-term Review of the 2010-2015 National Family Planning Costed Implementation Plan

December 2017

USAID FROM THE AMERICAN PEOPLE

fhi360 THE SCIENCE OF IMPROVING LIVES

Acknowledgments

The Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) would like to express sincere gratitude from numerous individuals and institutions involved in the end-of-term review of the 2010-2015 National Family Planning Costed Implementation Plan (NFPCIP).

First and foremost, a sincere appreciation goes to the U.S. Agency for International Development (USAID), through the Advancing Partners & Communities (APC) project, for providing financial support. The MOHCDGEC acknowledges the technical leadership role taken by FHI 360, for leading the NFPCIP performance review process. Sincere thanks go to the principal authors of this report: Christine Lasway, Eric Van Praag, and Sammy Musunga; Stella Mujaya (consultant); and Morrisa Malkin, Lisa Dulli, Patrick Olsen, Tara Miller, Dulle Robert, Kerry Aradhya, and Trinity Zan.

The MOHCDGEC would also like to acknowledge individuals from the government, nongovernment organizations, and donors who have participated in different expert consultations with the aim of providing inputs and opinions on performance in key priority areas of the performance review. These experts included MOHCDGEC representatives from the national and district levels; representatives from the Clinton Health Access Initiative (CHAI), Department for International Development (DFID), DKT International, Deutsche Stiftung Weltbevölkerung (DSW), EngenderHealth, Human Development Trust (HDT), Ifakara Health Institute (IHI), JHPIEGO, Johns Hopkins University-Advance Family Planning (JHU-AFP), Johns Hopkins University-Center for Communication Programs (JHU-CCP), John Snow, Inc. (JSI), Matumaini Youth Group, Marie Stopes Tanzania (MST), Pathfinder International, PSI, Tanzania Youth and Adolescent Reproductive Health Coalition (TAYARH), Tanzania Youth Alliance (TAYOA), Tanzania-Marketing and Communications Company Limited (T-MARC), United Nations Population Fund (UNFPA), and USAID.

Finally, the MOHCDGEC would like to acknowledge the leadership of the Reproductive and Child Health Section for leading the coordination of all family planning implementers in the development, implementation, and now performance review of the 2010-2015 NFPCIP. Specifically, the MOHCDGEC would like to acknowledge the following individuals who endorsed the performance review exercise: Former Ag. Assistant Director, Dr. Georgina Msemo; former National Family Planning Coordinator, Maurice Hiza; Ag. National FP Coordinator, Zuhura Mbuguni; and the Contraceptive Security Coordinator, Dr. Cosmas Swai.

Table of Contents

Acronyms and Abbreviations

ADDO	Accredited Drug Dispensing Outlet
AIDS	Acquired Immune Deficiency Syndrome
APC	Advancing Partners & Communities
ASRH	Adolescent Sexual and Reproductive Health
AusAID	Australian Agency for International Development
BTL	Bilateral Tubal Ligation
CCHP	Council Comprehensive Health Plan
CHAI	Clinton Health Access Initiative
CHMT	Council Health Management Team
CHW	Community Health Worker
CIDA	Canadian International Development Agency
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
DFID	Department for International Development
DHIS	District Health Information System
DHS	Demographic and Health Survey
DMPA	Depot Medroxyprogesterone Acetate
DSW	Deutsche Stiftung Weltbevölkerung
FP	Family Planning
GOT	Government of Tanzania
GFF	Global Financing Facility
HDT	Human Development Trust
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IHI	Ifakara Health Institute
ILS	Integrated Logistics System
IPC	Interpersonal Communication
IR	Intermediate Result
IUD	Intrauterine Device
JHU-AFP	Johns Hopkins University-Advance Family Planning
JHU-CCP	Johns Hopkins University-Center for Communication Programs
JSI	John Snow, Inc.
LAM	Lactational Amenorrhea Method
LAPM	Long-acting and Permanent Method
LARC	Long-acting Reversible Contraceptive
LGA	Local Government Authorities
m4RH	Mobile for Reproductive Health
mCPR	Modern Contraceptive Prevalence Rate
M&E	Monitoring and Evaluation
MOEST	Ministry of Education, Science and Technology
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MOHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department

MST	Marie Stopes Tanzania
MTEF	Medium-term Expenditure Framework
NARHS	National Adolescent Reproductive Health Strategy
NFPCIP	National Family Planning Costed Implementation Plan
NFPTWG	National Family Planning Technical Working Group
NGO	Nongovernmental Organization
NHIF	National Health Insurance Fund
NOGI	National Operational Guidelines for Integration of Maternal, Newborn, Child Health, and HIV/AIDS Services
OCP	Oral Contraceptive Pill
PSS	Pharmaceutical Service Section
RCHS	Reproductive and Child Health Section
SBCC	Social and Behavior Change Communication
SEED	Supply-Enabling Environment-Demand
SO	Strategic Objective
SPA	Service Provision Assessment
SR	Strategic Result
SRH	Sexual and Reproductive Health
SAA	Strategic Action Area
TAYARH	Tanzania Youth and Adolescent Reproductive Health Coalition
TAYOA	Tanzania Youth Alliance
TDHS	Tanzania Demographic and Health Survey
T-MARC	Tanzania Marketing and Communications Company Limited
TSh	Tanzanian Shilling
TWG	Technical Working Group
UMATI	Chama cha Uzazi na Malezi Bora Tanzania
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development

Executive Summary

After gains in the 1990s, the annual growth rate of modern family planning (FP) in Tanzania slowed to a near halt in the latter 2000s, coinciding with a stagnation in FP expenditures amid rapid population growth. To reverse these trends and reposition FP as a priority, the Government of Tanzania (GOT) established the goal of reaching 60 percent contraceptive prevalence by 2015.

In 2010, Tanzania became the first country in sub-Saharan Africa to launch a National FP Costed Implementation Plan (NFPCIP) to guide the national FP program toward this goal. The plan provided a blueprint of activities and resource requirements to increase the contraceptive prevalence rate (CPR) among women of reproductive age from 28 percent in 2010 to 60 percent by 2015. A set of strategic action areas (SAAs) with five-year cost estimates were defined in the 2010 plan, and later revised in 2013: contraceptive security (SAA I), capacity building (SAA II), service delivery (SAA III), advocacy (SAA IV), and health systems management (SAA V).

NFPCIP Performance Review

We performed a review of the NFPCIP implementation period to identify the factors that facilitated and hindered progress toward achieving key indicators, describe the extent to which NFPCIP implementation contributed to national FP goals, provide baseline information to assist with target estimation for the NFPCIP II, and generate actionable recommendations and considerations to inform One Plan II and the development of the NFPCIP II.

The review involved data analysis, a desk review of 53 articles from the scientific literature, and consultations with 18 stakeholders from seven organizations. In December 2016 and May 2017, additional stakeholder consultations were held in Dar es Salaam to review and discuss key findings and recommendations. The insights and information shared during the May meeting were also incorporated into the final version of the NFPCIP review.

Below, findings for data collected from July 2010 through June 2012 are organized around the original SAAs, before revisions were made to the NFPCIP in 2013. Additional findings are organized around the six areas of measurement used to assess progress under the SAAs. Selected key findings and recommendations are included, but the complete document also contains information on status and key issues prior to the NFPCIP, how the NFCIP addressed each area of measurement, and analyses of gaps.

Summary of Findings for Implementation Years 1 and 2

For all SAAs combined, original cost projections for Years 1 and 2 were approximately Tsh 40.5 billion. Reported expenditures were 248 percent higher, at nearly Tsh 100.5 billion. SAA 5 (health systems management, monitoring, and evaluation) was the only SAA for which reported expenditures did not exceed projected expenditures.

SAA I: Contraceptive Security

Intense outreach to basket funders proved successful in mobilizing additional required resources. During 2010/2011, an expenditure of TSh 26 billion was reported for contraceptive commodities, compared with TSh 9.6 billion the previous year. The government also increased the amount of resources released, to TSh 14 billion. To help strengthen the supply chain system at all levels, the automated Integrated Logistics System (ILS) Gateway was introduced in four regions in Year 1 and scaled up to 14 regions in Year 2. During this period, Jadelle was also approved for public use, and emergency contraceptives received registration approval. Challenges acquiring data from service utilization continued to impede forecasting exercises. Some facilities also continued to report stockouts.

SAA II: Capacity Building

A total of 1,349 tutors were trained to train providers to provide short-acting methods and long-acting and permanent methods (LAPMs). However, challenges to increasing access and uptake of LAPMs continued, and not all health centers and hospitals had personnel who met the training requirements to provide LAPMs. In addition, council health management teams were trained on planning and budgeting, FP champions and representatives from adolescent-servicing organizations were trained on advocacy, and providers were trained on comprehensive post-abortion care.

SAA III: Service Delivery

To expand opportunities in the private sector, FP services were introduced in 236 private facilities, which also received capacity building and other support. Also, in the first year of the NFPCIP, more than 350,000 people accessed LAPM and short-acting method services in selected districts in 20 regions through outreach activities to increase access to FP for low-income and vulnerable groups. Year 2 efforts focused on developing guidelines for integrating FP and HIV/AIDS services and revisiting the community-based approach to delivering FP services.

SAA IV: Advocacy and Strategic Communication

Key policy and advocacy gains at the highest levels of the national development agenda included the integration of targets to reduce total fertility and population growth rates in the National Development Plan (MKUKUTAII) and the establishment of a separate FP target (budget line item) in the Ministry of Health and Social Welfare (MOHSW) medium-term expenditure framework. In Year 2, a national campaign for behavior change communication, Jiamini, was launched to address obstacles to FP use such as partner/spousal disapproval, myths, rumors, and misinformation.

SAA V: Health Systems Management, Monitoring, and Evaluation

Limited activities included funding support to the FP unit of the Reproductive and Child Health Section to cover administrative and operational costs, and support of zonal and district-level health teams to conduct supervision visits in various regions. In selected districts, support was also offered to facilitate data transmission from health facilities to the district level, and data quality improvement exercises emphasized MTUHA—Tanzania's health management information system (HMIS). Despite this progress, data on service utilization were not regularly available for compilation at the national level, data from outside health facilities or private

facilities were not always entered into the HMIS, personnel with the skills to manage sexual and reproductive health data were lacking, and data were not utilized appropriately.

Area of Measurement 1: Adolescent Pregnancy

Findings

- The adolescent fertility rate increased between 2010 and 2015. The rate was twice as high among rural adolescents (162 per 1,000) than among urban ones (82 per 1,000), and three times as high among adolescents with only a primary education (171 per 1,000) than among those with a secondary education (55 per 1,000).
- Gains made toward reducing adolescent pregnancies were lost, with adolescent pregnancy rates increasing in both urban and rural areas. In 2015, the national adolescent pregnancy rate was 27 percent—nearly 4 percentage points higher than in 2010.
- Use of modern contraceptive methods among all adolescents declined slightly from 2010 (9.4 percent) to 2015 (8.6 percent). Use increased slightly among married adolescents and declined slightly among unmarried sexually active adolescents. Injectables were the most common method among married adolescents, and male condoms the most common among unmarried adolescents. Barriers contributing to low contraceptive use included initiation ceremonies, early marriages, gender disparities, and a lack of skilled service providers to educate young women on their sexual and reproductive rights.

Recommendations

1. Make young people a central focus of the national planning and strategic guidance, with clear measurable goals.
2. Adopt a multi-sectoral approach, with inclusion of evidence-based interventions.
3. Ensure that interventions reflect the diversity of contexts and the needs of different adolescents.
4. Implement interventions to influence sociocultural factors and powerful gender norms that perpetuate girls' risk.
5. Rebrand the Green Star Campaign, as it does not resonate with young people.
6. Enhance advocacy efforts to garner broader awareness of adolescent pregnancy and its consequences, and to support contraceptive use among this age group.
7. Mainstream youth-friendly services into broader FP service delivery, as well as relevant FP services into youth-friendly services.
8. Improve coordination among implementing partners.

Area of Measurement 2: Contraceptive Security

Findings

- Data from service provision assessments showed that the percentage of contraceptive methods offered at facilities in all eight zones decreased from 2006 to 2014/2015, except for implants. Stockouts decreased for all commodities except CycleBeads, and the largest increases in contraceptive commodities offered and available on the day of the assessments were for emergency contraceptives, intrauterine devices (IUDs), implants, and female condoms.

- Modern CPR (mCPR) projections were calculated into the commodity quantification process, which increased commodity forecasts.
- Because of the ILS, requesting orders became informed by service utilization data, which informed quantification and forecasting. The ILS also improved supply management and the timeliness of report submissions.
- A special provision in the 2011 Public Procurement Act was added to fast track procurement of essential medicine and supplies, including FP commodities.
- Following the establishment of a specific line item for FP in 2010, the government's funding allocation for contraceptive commodities more than doubled from Tsh 0.5 billion in 2010/2011 to Tsh 1.2 billion in 2011/2012. However, funds from the government decreased for the next two years, with donors providing the majority of funding for commodities.
- Collaboration and coordination between providers, between the GOT and partners, and between the Contraceptive Security Task Force and partners improved.

Recommendations

1. Strengthen the total market approach to reduce the service burden on public facilities.
2. Increase availability of long-acting reversible contraceptives in social marketing.
3. Reinforce and expand ILS training to health care providers.
4. Continue training and medical detailing to all FP dispensers along with provision of screening checklists and other job aids.
5. Continue support from GOT for quantification meetings.
6. Continue advocacy efforts to fund commodities and meet the needs of the FP program.
7. Assess the feasibility of ordering FP commodities at the district level.
8. Establish a high-level FP commodities champion for sustainable advocacy efforts.
9. Improve coordination between public-private sectors.
10. Capture data from accredited drug dispensing outlets (ADDOs) and pharmacies in the district health information system (DHIS)-2.
11. Ensure that FP continues to be included in pertinent policies.

Area of Measurement 3: Demand Generation

Findings

- Although the majority of Tanzanians source their contraceptives methods from government/parastatal facilities, where they are free, the percentage of women who accessed FP services from non-government facilities rose from 32 percent to 39 percent between 2004/2005 and 2015.
- Tanzania doesn't have a national social and behavioral change communication (SBCC) strategy for FP, although Jiamini and the Green Star Campaign were specific to FP.
- A total of 5,239 retail outlets (surpassing the target) were identified. The number of ADDOs selling oral contraceptive pills and condoms greatly exceeded the target (3,586 percent of the target met), and the number of pharmacies selling IUDs, implants, oral contraceptive pills, injectables, and emergency contraceptives also exceeded the target (398 percent of the target met).
- FP interpersonal communication sessions were conducted during public events and through community group meetings in six regions with a low CPR. Twenty-nine coordinated demand-creation campaigns in low-CPR districts/regions were conducted (207 percent of the

target met), and 12 national events that promoted FP were conducted (133 percent of the target).

- Running for six months from April through September 2012, the SBCC campaign Jiamini empowered women to initiate and continue use of modern methods of FP, and encourage male support of FP. Guided by the NFPCIP, the Green Star Campaign was also re-launched nationally in 2013 to emphasize FP, and either met or nearly met most of its targets.
- Workshops were held to orient 93 FP champions (13 percent of the target) and 21 journalists (12 percent of the target). Only 70 service providers (2 percent of the target) were trained on male and couples counseling, and only 144 champions (7 percent of the target) were trained on how to influence men in FP at the community level. However, the target was exceeded (125 percent of the targeted men reached) for community outreach events.
- Only 391 peer educators (19 percent of the target) were oriented to carry out community events to increase youth uptake of FP services, and only 357 (18 percent of the target) were supported to conduct the events. In 2014, T-MARC re-trained 186 attendants to conduct FP talks. Starting with 21 salons in the Dar es Salaam Region in 2009, the program expanded to the Mbeya, Iringa, Geita, Shinyanga, Mwanza, Tabora, and Mara Regions.

Recommendations

1. Ensure that SBCC interventions under the NFPCIP II are informed by segmentation analysis and address issues of behavior, attitude, and practice.
2. Continue to include activities related to champions in the NFPCIP II, but make sure that the activities have clear action plans and indicators and that they are monitored and documented.
3. Improve message packaging by including more messages about FP use among men, addressing FP benefits in a broader context, and making sure the messages are realistic to prevailing social norms.
4. Continue re-launching the Green Star Campaign in the remaining regions and consider rebranding it to resonate better with young people.
5. Explore underutilized mass media approaches (e.g., different social media and TV in urban areas) in the NFPCIP II.
6. In the NFPCIP II, include activities that will involve community health workers (CHWs) in FP demand-generation activities at the household level.

Area of Measurement 4: Enabling Environment

Findings

- Tanzania mobilized and spent TSh 177 billion—almost half of the targeted amount—for the FP program over the past six years. The FP program continued to be supported by international donors, and the government committed its own source of funding to the program. Insurance schemes and the Global Financing Facility are other possible mechanisms for increasing resources.
- Several key national policies and budget tools incorporated FP language. Multi-sectoral coordination of the NFPCIP was observed, although mostly within the health sector.
- With the aim of increasing equitable and affordable access, several key policies, guidelines, and strategies were developed or amended. Three studies were also conducted to generate

evidence on task shifting of FP services. Although the studies demonstrated the feasibility of task shifting, the barriers that prevent task shifting have not been removed.

- In 2013, the MOHSW in collaboration with implementing partners of the national family planning technical working group organized a three-day national FP research forum in Dar es Salaam, and as a result **the** Tanzania National FP Research Agenda 2013–2018 was developed. In 2010, the National Package of Essential FP Interventions for the council comprehensive health plans was developed to help council health management teams better plan and budget for FP services.
- Four task forces, each composed of a leader from the MOHSW and partners, were formed to foster implementation of the NFPCIP: 1) Resource Mobilization Plan and Implementation; 2) Advocacy Coordination and Implementation; 3) Monitoring Resource Mobilization, Activity Implementation, and Results; and 4) Engaging the Media to Advance the NFPCIP Agenda. A Parliamentarian FP Club was also formed, and several religious leaders were trained on FP.

Recommendations

1. Sustain advocacy to ensure adequate financing for FP, advocate at the government level to avoid fluctuations, advocate for clear transparency on funding from all sources, explore other funding mechanisms, and advocate for GOT funding to move from supporting contraceptives to other program areas.
2. Create clear transparencies so that funding contributions can be accessed by everyone from one common source.
3. Strengthen public-private partnerships and advocate for more FP resources from them.
4. Include activities in the NFPCIP II that focus on demonstrating good governance, leadership, and accountability.
5. Give task shifting priority in the NFPCIP II.
6. Improve monitoring and implementation of the NFPCIP II to include realistic targets/indicators, budget estimates, and timing of reports.
7. Reinvigorate advocacy among the new leadership at national and district levels to sustain political commitment, and strengthen multi-sector coordination. Advocacy partners should have access to the HMIS so that it can be used for advocacy and planning purposes.
8. Ensure supportive policies by reviewing available evidence and guidelines to determine barriers, and advocate for the GOT's monitoring framework to include more FP indicators.

Area of Measurement 5: Impact on Contraceptive Prevalence

Findings

- To build capacity, an assessment compared the performance of trained clinical officers versus assistant medical officers to conduct bilateral tubal ligation through outreach services, a pre-service IUD core competencies curriculum was developed and integrated into the teaching curriculum at three nursing schools, and a workshop was conducted to develop operational guidelines and training and job materials.
- Many achievements helped to strengthen service delivery, including developing and launching national guidelines for outreach services and reaching 744,385 people with FP services through outreach. Extensive support was given to CHWs, including training 2,400 CHWs and 115 supervisors, providing materials support, and providing supportive supervision visits for community-based FP in 69 districts. Targets were surpassed for the

number of dispensers at ADDOs and pharmacies who were trained on contraceptive methods and the number of ADDOs and pharmacies that stocked methods that expanded the available method mix.

- The mCPR among all women increased from 27.4 percent to 32.0 percent, driven largely by increases in mCPR in rural areas. Unmet contraceptive need decreased slightly among married women, and public health facilities remained the main source of contraceptive users.

Recommendations

1. Support the delivery of FP at the community level by ensuring that support is in place at all levels.
2. Determine the reason behind the stalled urban mCPR.
3. Make adolescents a clear focus in the NFPCIP II, as they will be very important in increasing the national mCPR.
4. A more targeted approach is needed to address regional variation and urban versus rural variation in mCPR among different segments of the population.

Area of Measurement 6: Method Mix

Findings

- Total CPR among married women ages 15–49 grew by only 4.6 percentage points, increasing to 32.4 percent in 2015. Reduction in the price of contraceptive implants allowed the government to procure more, and overall use of implants increased. CycleBeads were introduced in one region, and overall use of oral contraceptive pills decreased. Injectable and condom use remained largely unchanged.
- Research showed that CHWs in Tanzania can safely distribute and administer injectable contraceptives, although policy makers chose not to allow a proposed task-sharing policy to permit community-based distribution of injectables by trained lay people.
- The proportion of health care facilities offering FP methods and the proportion of those facilities that had individual methods available improved, particularly for IUDs and implants.
- Efforts were made to expand social marketing to include long-acting methods, injectables, and emergency contraception.

Recommendations

1. More efforts are needed to promote vasectomy and bilateral tubal ligation as safe and effective methods for men and women who do not wish to have additional children.
2. For women who do not wish to undergo bilateral tubal ligation but do not want more children, the IUD should be promoted as a highly effective method.
3. The reasons for the drop in oral contraceptive use should be identified, and monthly injectables could be promoted as an alternative to pills.
4. Dual method use should be promoted given the low rates of condom use.
5. Ensure that providers are adequately trained on a full range of methods, method selection by women and couples is informed, and all offered methods are readily available.
6. Perform in-depth segmentation analysis of contraceptive users and promote methods based on the results.

Zonal and Regional Analyses

When results were analyzed by zone and region, some variation was highlighted. For example, zonal analysis found that the adolescent pregnancy rate increased in Central and Southern Highlands Zones but remained relatively unchanged in Eastern, Northern, Southwest Highlands, and Western Zones. The CPR among young women ages 15–19 or 20–24 increased in Eastern, Southern, Southern Highlands, and Western Zones. It also increased in Lake Zone but remained below the national average there. In Central Zone, it stayed the same, and in Southwest Highlands and Northern Zones, it decreased. Implant use increased substantially (up to 25 percentage points) in seven of the eight zones. Use of injectables increased in Southern Zone.

According to regional analysis, the adolescent pregnancy rate increased by about 12 percentage points in Dodoma and Mbeya Regions. It remained high, above the national average, in Mara and Tabora Regions and decreased slightly in Dar es Salaam Region. CPR among young women ages 15–19 or 20–24 increased in some regions but did not always rise above the national average. The total fertility rate decreased in some regions and stayed high in others, such as Mara Region, where it remained approximately seven children per woman.

1. BACKGROUND

Since modern family planning (FP) was first made available in Tanzania in the 1950s by the International Planned Parenthood Federation affiliate Chama cha Uzazi na Malezi Bora Tanzania (UMATI), the country has experienced both gains and losses in the momentum of the FP program. Between 1992 and 2010, modern method use quadrupled from 6.6 percent to 27.4 percent, representing some of the largest annual increases in contraceptive prevalence rate (CPR) in the east Africa region at the time.[1] The majority of these gains were realized in the 1990s. However, the latter 2000s were marked by stagnancy in the annual growth rate of modern FP use, which changed by less than 1 percent. At the same time, expenditures for FP also slowed to a near halt, dropping from 54 percent of reproductive health spending in 2003 to just 8 percent in 2006.[2] The losses in the national FP program have occurred in parallel to rapid population growth. Some of the reasons for this growth are positive, such as declining infant mortality rates and higher life expectancy. However, other factors such as rapid urbanization, high rates of adolescent pregnancy, and a relatively high total fertility rate (5.4 in 2010–2015 versus 4.9 for the east Africa region)[3] will challenge Tanzania with a projected population of 65 million people by 2025.[2]

In an effort to reverse these trends and reposition FP as a priority, the Government of Tanzania (GOT) established the goal of reaching 60 percent contraceptive prevalence by 2015 within the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008–2015 (i.e., One Plan), in addition to doubling the number of FP users as part of the country's FP2020 commitments. Although the One Plan was partly responsible for returning FP to the forefront of the national development agenda, it did not provide direction as to how Tanzania might reach the CPR goal or the resources that would be required to do so. In an effort to reach the One Plan goal and other commitments, in 2010 Tanzania would become the first country in sub-Saharan Africa to develop and launch a National FP Costed Implementation Plan (NFPCIP) — a powerful blueprint of activities and resource requirements to guide the national FP program over the next five years.

The explicit goal of the NFPCIP 2010–2015 was to increase the CPR among women of reproductive age from 28 percent in 2010 to 60 percent by 2015. (For a more detailed description of the original NFPCIP, see Section 4.1.) To this end, a set of strategic action areas (SAAs) with five-year cost estimates were defined in the 2010 plan, and were later revised in 2013 to include:

- SAA I: Contraceptive Security
- SAA II: Capacity Building
- SAA III: Service Delivery
- SAA IV: Advocacy
- SAA V: Health Systems Management

Each SAA included sets of strategic actions, which were further divided into specific activities with time lines, targets, and resource requirements. The activities and financial inputs served as a mechanism for resource mobilization, monitoring progress, and measuring impact. The revised 2013 NFPCIP also included a realignment of priority interventions and modifications based on lessons learned, emerging issues, and updated projections from data published after the 2010 launch.

The NFPCIP has made some unprecedented gains over the implementation period, among them the establishment of a new line item for FP in the national budget and a subsequent doubling of funding for contraceptive commodities (US$9.3 million) in 2010–2011 compared with the previous five years.[4] Gains were not realized without challenges, however, and Tanzania's experience implementing the first national CIP in sub-Saharan Africa offers a wealth of lessons to guide the next phase of the national FP program, moving into 2020 and beyond.

2. PURPOSE AND OBJECTIVES

The purpose of this review was to assess the implementation of the NFPCIP 2010–2015, examine planned targets vis-à-vis outcomes, and describe the extent to which achievements may have contributed to national FP goals. The specific objectives of the review were to:

1) Describe the factors that both facilitated and hindered progress toward achieving key indicators.
2) Describe the extent to which NFPCIP implementation helped contribute to national FP goals.
3) Provide baseline information to assist with target estimation for the NFPCIP II.
4) Generate actionable recommendations and considerations to inform and strengthen subsequent versions of the One Plan and the development of the NFPCIP II.

3. METHODOLOGY

The methodology for this review was a multi-step collaborative and consultative process involving a range of stakeholders. Data analysis, desk reviews, and stakeholder consultations were all used to delve into the NFPCIP implementation process and assess the degree to which the activities and investments of resources contributed to broader FP goals.

Review findings are presented in two parts to reflect the period of NFPCIP implementation prior to the 2013 revision, as well as the period afterward. Findings were separated into these two periods because targets were revised. Years 1 through 2 of implementation are presented first, followed by the larger section of findings for Years 3 through 5. The review of the latter period is primarily organized around six areas of measurement, used to assess progress under each of the SAAs. The areas of measurement are 1) adolescent pregnancy, 2) contraceptive security, 3) demand generation, 4) enabling environment, 5) contraceptive utilization, and 6) method mix.

The review team also conducted an analysis of performance (output-level) and financial (input-level) targets, based on data collected through the Online Monitoring Tool for the National FP Costed Implementation Plan (NFPCIP) over the five-year period. This is a tool for reporting data on implementation of the NFPCIP, with information provided by various implementing partners and the government. Using information extracted from the Online Monitoring Tool, the review team examined key performance and financial indicators against targets to create a picture of achievements and gaps**.**

In December 2016, a stakeholders meeting was held in Dar es Salaam to 1) share the methodology and preliminary findings from the ongoing assessment, 2) facilitate a discussion to complement the information gathered to date, and c) develop recommendations for future programming.

In addition to reviewing data from the demographic and health survey (DHS), a comprehensive desk review of scientific literature was conducted to gain a more comprehensive view of the CIP landscape in Tanzania and better understand developments within each of the indicators throughout CIP implementation. Databases searched were PubMed, Popline, Global Health, and Africa-Wide Information with a period of 2010 to present.

Various FP-relevant search terms were used to extract 399 articles, which were further evaluated based on titles, abstracts, and elimination of duplicates. After reviewing each article per indicator, 53 articles were chosen for the report.

To complement the various analyses, the review team conducted stakeholder consultations to discuss the contextual factors that either positively or negatively affected progress toward achievement of key performance indicators, as well as considerations for what was done well and what could have been improved upon. The review team conducted discussions with 18 individual stakeholders from seven organizations, including representatives from the MOHDGEC Reproductive and Child Health Section (RCHS). Participants were selected to represent the different perspectives of various areas within the MOHDGEC, nongovernmental organizations (NGOs), civil society organizations (CSOs), and donors. The insights gathered during these consultations were incorporated into the draft report.

In May 2017, a second stakeholders meeting was held in Dar es Salaam to 1) review and discuss the key findings and recommendations resulting from the performance review, 2) discuss and identify key challenges associated with the FP program, 3) discuss and agree on recommendations for the FP program to achieve 2020 goals, and 4) share and discuss perspectives of key issues and recommendations for FP program implementation at the regional level. Stakeholders at the meeting also worked to develop a problem tree and outline recommendations for the forthcoming NFPCIP II.

Following this meeting, all the information collected from the analyses, desk review, and stakeholder consultations was synthesized to produce an overall picture reviewing the performance of the NFPCIP vis-à-vis its targets and overall goal, and to generate recommendations to inform future FP programming. The insights and information shared during the May meeting were also incorporated into this final version of the NFPCIP 2010–2015 review.

4. FINDINGS

4.1 Summary of NFPCIP Implementation Years 1 and 2 (July 2010–June 2012)

4.1.1 Overview of Monitoring Efforts

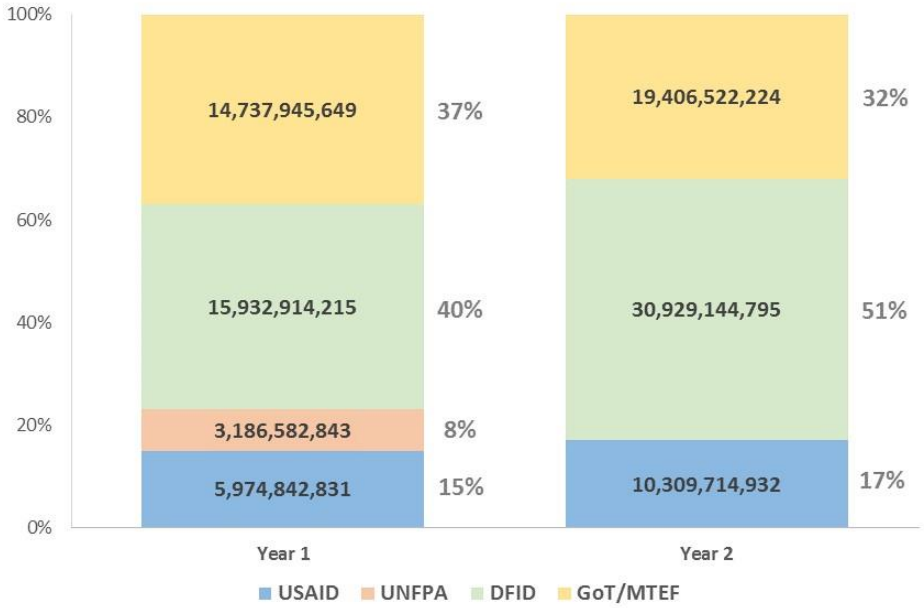
Efforts to monitor the progress of NFPCIP implementation began in July 2010. The purpose of this monitoring effort was to assess progress in two areas: 1) whether the financial resources needed to implement the plan were mobilized and expended and 2) whether the established program targets were achieved. The monitoring effort faced several limitations that were inherent to the original NFPCIP, such as the inability to generate accurate targets because of a lack of baseline data. For example, determining how many providers were needed to meet demand was difficult to ascertain without data on the number of currently trained providers. Furthermore, the ambitious nature of the CPR target—a national CPR of 60 percent for all methods for all women of reproductive age by 2015—made implementation of some other activities with high targets unfeasible given the limited time frame. There were also challenges in data reporting, such as underreporting and "early" reporting of work completed for activities that were targeted for implementation in subsequent years.

1.1.2 Summary of Progress by Strategic Action Area (Years 1–2)

This section of the document highlights progress and challenges during Years 1 and 2, using data collected from July 2010 through June 2012, and is organized around the original NFPCIP SAAs and related activities. Note that the priority interventions and targets were revised after the first two years of implementation based on 1) the findings of the 2010 Tanzania DHS (TDHS);[5] 2) information gathered through monitoring NFPCIP activities, which clearly indicated that the original projections were underestimated; and 3) the specific recommendations and key considerations expressed by the Ministry of Health and Social Welfare (MOHSW) and the National FP Working Group regarding required strategic actions and resources to reposition FP in Tanzania. The 2013 revision of the NFPCIP provided an opportunity to update the financial projections, and to clarify and modify the targets and focus of the interventions.

Financial information about the original projections, the reported expenditures, and the percent of projections to expenditures are provided for all the SAAs combined, and for each SAA separately, in Tanzania shillings (TSh). Figure 1 shows the contributions of donors who supported the implementation of the NFPCIP during the first two years. The amounts are shown in TSh and percent of the total for each year.

Figure 1. Donor Contributions to NFPCIP Implementation Years 1 and 2 (Tsh)



All SAAs Combined: Years 1 and 2 Original Projections (TSh): **40,554,339,479**	Reported Expenditures (TSh): **100,477,667,489**	Percent of Original Projections to Reported Expenditures: **248%**

SAA I: Contraceptive Security

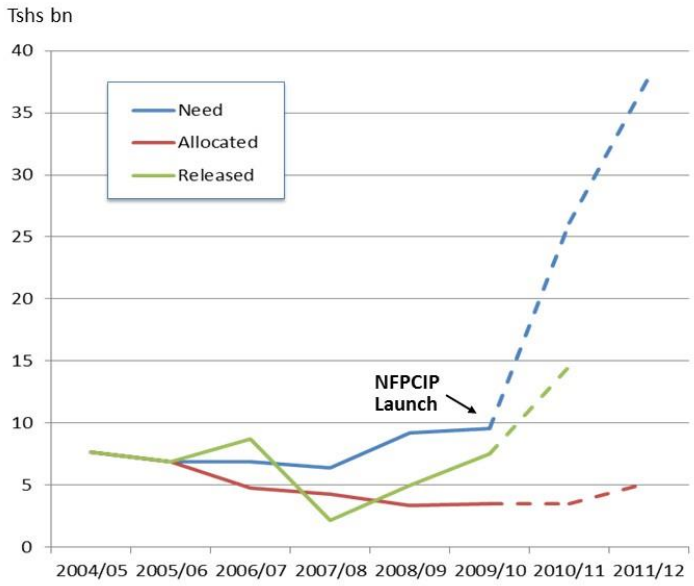
Maintaining an adequate supply of contraceptive commodities to meet clients' needs, prevent stockouts, and ensure contraceptive security was a priority for the program when the plan was developed and launched. As such, activities for Year 1 focused on mobilizing adequate resources to fill the pipeline and conducting regular meetings and supervisory visits to assess commodity procurement and distribution at all levels. The development of the NFPCIP allowed stakeholders to have a better understanding of the commodity needs and related costs. Intense outreach to traditional basket funders, such as the Department for International Development (DFID), proved successful in mobilizing additional required resources. During 2010/2011, an expenditure of TSh 26 billion was reported for contraceptive commodities, compared with TSh 9.6 billion during the previous year (i.e., 2009/2010). The government also increased the amount of resources released to TSh 14 billion (Figure 2).

Efforts to strengthen the supply chain system at all levels also took precedence, with the an automated system to capture facility-level logistics—the Integrated Logistics System (ILS) Gateway—introduced in four regions in Year 1 and scaled up to 14 regions in Year 2. During this period, Jadelle was also approved for public use, and emergency contraceptives received

registration approval. The introduction of Jadelle allowed the U.S. Agency for International Development (USAID) to contribute to implant procurement, increasing the supply of an increasingly demanded product. Previously, Tanzania was only procuring Implanon, which at US$26 per kit limited the amount that could be supplied to meet needs.

Challenges acquiring data from service utilization continued to impede forecasting exercises. In spite of efforts to fill the contraceptive pipeline, some facilities continued to report stockouts, signaling a need to focus interventions on the last mile.

Figure 2. Contraceptive Commodity Financing Performance



SAA I: Years 1 and 2 Original Projections (TSh): **33,875,049,402**	Reported Expenditures (TSh): **84,767,398,822**	Percent of Original Projections to Reported Expenditures: **250%**

SAA II: Capacity Building

Building the capacity of providers to ensure that FP methods and services were provided in a safe and effective manner was another critical area that required focused attention. A baseline survey of FP services in 2004–2005 found low levels of provider knowledge, clinical skills, and counselling capability to provide quality FP services for both short- and long-acting methods. Further, the survey showed that very few providers had been trained on FP clinical procedures, which impeded provision of long-acting and permanent methods (LAPMs).[6] The NFPCIP included activities for building capacity of in-service providers and rehiring retired health workers.

During the first two years of NFPCIP implementation, 1,349 tutors were prepared to train both in-service and pre-service providers to provide short-acting, long-acting, and permanent methods. Great emphasis was placed on training providers on LAPMs; of all providers who were reported to receive in-service training, 51 percent were trained on LAPMs, and 30 percent were trained on short-acting methods.[7] Training was also provided for council health management teams (CHMTs) on planning and budgeting, for FP champions and representatives from adolescent-servicing organizations on advocacy, and for providers on comprehensive post-abortion care. In addition, the FP procedures manual and the in-service training curricula were updated, although distribution was limited.

In spite of the considerable investments and capacity building efforts, great challenges to increasing access and uptake of LAPMs—especially the intrauterine device (IUD)—continued to exist. For a variety of reasons, but primarily the human resource crisis, not all health centers and hospitals had personnel who met the training requirements to provide LAPMs.

SAA II: Years 1 and 2 Original Projections (TSh): **2,830,650,533**	Reported Expenditures (TSh): **4,685,726,327**	Percent of Original Projections to Reported Expenditures: **165%**

SAA III: Service Delivery

Maximizing access to quality services was a fundamental priority of the NFPCIP. When the plan was developed, FP provision through the facility-based system had been negatively affected by a lack of adequate and qualified providers, inadequate and irregular supply of commodities, and poor infrastructure, among other weaknesses. Further, other channels such as community-based provision was limited to few geographical areas of the country. Private-sector provision was minimal, although showed an increasing trend. In 1996, 25.8 percent of users acquired FP services from non-government sources (which included the private sector),[8] compared with 31.6 percent in 2004/2005.[9]

The 2010 TDHS confirmed that the public sector was still the major source of modern contraceptive methods, with 65 percent of users obtaining methods from government-sponsored services. Meeting the unmet need for FP required solutions that improve the public sector (e.g., provision of integrated community-based services) and creatively exploit opportunities in the private sector (e.g., social marketing of injectable contraceptives). In keeping with the goal of expanding opportunities in the private sector, FP services were introduced in 236 private facilities, which also received capacity building and other support. Furthermore, the 2010 TDHS showed that youth—the largest proportion of the Tanzanian population—continued to face huge challenges accessing FP services. Sixteen percent of youth ages 15–19 had an unmet need for FP, but CPR for modern methods among this population was only 9 percent.[5]

During the first two years of NFPCIP implementation, activities were implemented under all eight strategic actions in this area. Outreach activities under strategic action 7—develop, promote, and implement approaches to ensure increased access to FP for low-income, hard to

reach and vulnerable groups—were heightened to reach people in remote and low-CPR regions. In the first year alone, more than 350,000 people accessed LAPM and short-acting method services in selected districts in 20 regions through outreach activities. Year 2 featured efforts focused on developing guidelines for integrating FP and HIV/AIDS services and revisiting the community-based approach to delivering FP services.

SAA III: Years 1 and 2 Original Projections (TSh): **1,383,126,033**	Reported Expenditures (TSh): **7,462,771,597**	Percent of Original Projections to Reported Expenditures: **540%**

SAA IV: Advocacy and Strategic Communication

Policy-related issues that directly affected the delivery of contraceptive methods and services also received great attention, particularly the lack of FP in national health agendas, plans, and budgets. The first two years of NFPCIP implementation featured enhanced advocacy efforts, including highlighting the issue of FP with relevant parliamentary committees, that resulted in several key policy and advocacy gains at the highest levels of the national development agenda. These included the integration of targets to reduce total fertility and population growth rates in the National Development Plan (MKUKUTA II) and the establishment of a separate FP target (budget line item) in the MOHSW medium-term expenditure framework (MTEF). At the district level, the inclusion of FP in council health planning guidelines resulted in increases in FP resource allocations in several districts. For example, in 2011, 49 districts budgeted for FP in their plans; "health basket funds" (i.e., central-level funding to the districts for specific health work) were the main source of funds for financing FP services.

According to the 2004–2005 DHS,[9] 96 percent of all women and 97 percent of all men had heard of FP, but there were many obstacles preventing the use of FP methods. Obstacles that prevented adoption of FP among those who knew about it included actual or feared partner/spousal disapproval, myths, rumors, and misinformation about FP in general and about specific methods, fears of side effects and health concerns, poor access to services and methods, and concerns about costs. To address these concerns, in Year 2, the national campaign for behavior change communication, Jiamini, launched and disseminated FP information through various types of media including TV spots, m4RH text messages, episodes of the Mini-Buzz TV program, leaflets, T-shirts, and posters.

SAA IV: Years 1 and 2 Original Projections (TSh): **1,713,371,910**	Reported Expenditures (TSh): **2,879,630,925**	Percent of Original Projections to Reported Expenditures: **168%**

SAA V: Health Systems Management, Monitoring, and Evaluation

One of the key issues that affected the FP program at that time was the diversion of key human resources to the fight against HIV/AIDS. In this environment, management infrastructure and systems at all levels needed to be strengthened if the plan was going to meet its goals. During the first two years, progress was made to strengthen the health management information systems (HMISs) at all levels; however, activities under this SAA were limited. Funding support was provided to the FP unit of the RCHS to cover administrative and operational costs. Zonal and district-level health teams were supported to conduct supervision visits in various regions countrywide. In selected districts, support was offered to facilitate data transmission from health facilities to the district level, where CHMT capacity to use FP/reproductive health data for planning purposes was enhanced. Data quality improvement exercises were conducted, with a particular emphasis on quality improvement for MTUHA—Tanzania's HMIS.

Despite this progress, the monitoring and evaluation (M&E) system for FP faced major challenges. Data on service utilization were not regularly available for compilation at the national level. Data from outreach and community services or from private facilities were not always entered into the HMIS. Personnel with skills to manage sexual and reproductive health (SRH) data were lacking. Data were not being utilized appropriately during council comprehensive health plan (CCHP) planning, progress monitoring, provision of feedback, or advocacy for change.

SAA V: Years 1 and 2 Original Projections (TSh): **752,141,600**	Reported Expenditures (TSh): **682,139,817**	Percent of Original Projections to Reported Expenditures: **91%**

4.2 Area of Measurement 1: Adolescent Pregnancy

Definition

Adolescent pregnancy is pregnancy that occurs among women younger than 20 years of age. According to the DHS, teenage (adolescent) childbearing is defined as a proportion of women 15–19 years of age who have had a live birth or are currently pregnant.

Key Insights

- Lack of clear measurable targets for reducing adolescent pregnancy
- Insufficient budget and activities for youth-specific interventions
- Inadequate coordination of youth efforts and resources
- Underperformance of youth-specific strategic results
- Less effective activities to improve the adolescent sexual and reproductive health (ASRH) policy environment and ASRH service delivery

Recommendations

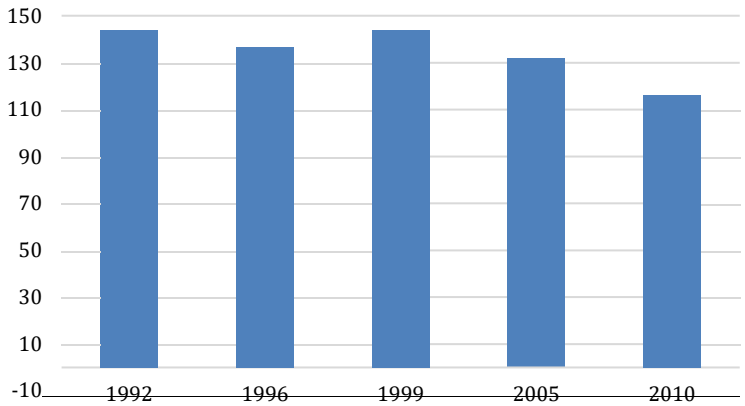
- Make young people a central focus in the next NFPCIP, with clear measurable targets.
- Adopt a multi-sectoral strategic approach, with inclusion of evidence-based interventions.
- Ensure that interventions reflect the diversity of contexts and needs of different adolescents.
- Implement interventions to influence sociocultural factors and powerful gender norms that perpetuate girls' risk.
- Rebrand the Green Star Campaign to resonate better with young people.
- Enhance advocacy efforts to garner broader awareness of adolescent pregnancy and its consequences, as well as support for contraceptive use among this age group.
- Mainstream youth-friendly services into broader FP service delivery as well as relevant FP services into youth-friendly services.

Adolescent pregnancy is a pregnancy that occurs among women younger than 20 years of age. For the purposes of measuring pregnancy rates among adolescent women, DHS data are collected and reported on pregnancy among adolescent women ages 15–19 years. Teenage (adolescent) childbearing is measured as the proportion of all women ages 15–19 who have had a live birth or who are currently pregnant. It is important to note that this measure does not capture the number of adolescent women who have been pregnant but whose pregnancies ended in miscarriage or abortion. The full extent of adolescent pregnancy may, however, be underestimated given recent estimates of 21 abortions out of every 100 live births among women ages 15–49 years.[10]

4.2.1 Status and Key Issues Prior to the NFPCIP

Reducing adolescent pregnancy was a priority during the development of the NFPCIP given the sheer size of the adolescent population, high rates of early childbearing and fertility, and high unmet need for contraception among this population. Female adolescents ages 15–19 years represent 22 percent of the population of women of reproductive age, as reported by the 2012 Tanzania Population and Housing Census.[11] Although the adolescent fertility rate has declined over the past 18 years, it remained high at 116 pregnancies per 1,000 women in 2010 (Figure 3).

Figure 3. Trends in Adolescent Fertility Rates, 1992–2010

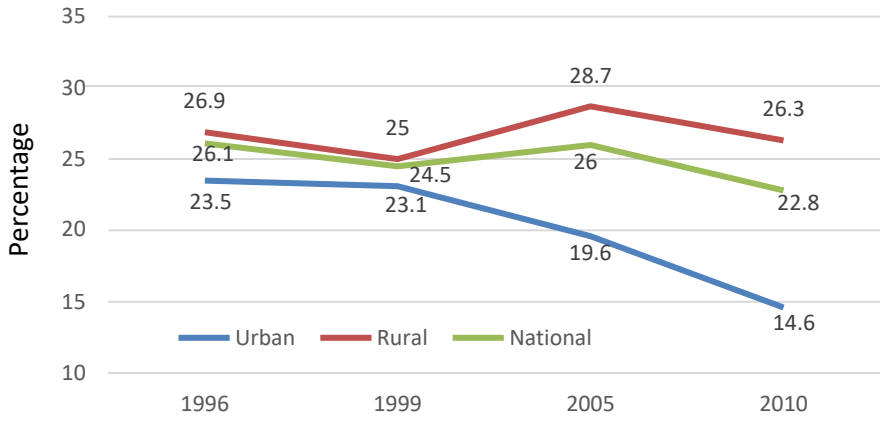


The decrease in the adolescent fertility rate was noted in every region, social class, and zone except for the Western Zone.[12] Early marriage seems to be a strong factor underlying adolescent fertility in the country. The relative contribution of adolescent fertility was highest in Mtwara, Lindi, and Morogoro Regions, where early marriages (below 18 years of age) are common.[11] The mean age at first marriage for women was 22.3 years, suggesting that there were plenty of marriages of younger women.[11]

Nationally, pregnancy rates among adolescent women ages 15–19 years also declined slightly between 1999 and 2010 (26.1 percent and 22.8 percent, respectively) (Figure 4). This decline was largely driven by a substantial decline in pregnancy rates among urban adolescent women; despite some fluctuation, rural pregnancy rates among adolescent women remained essentially

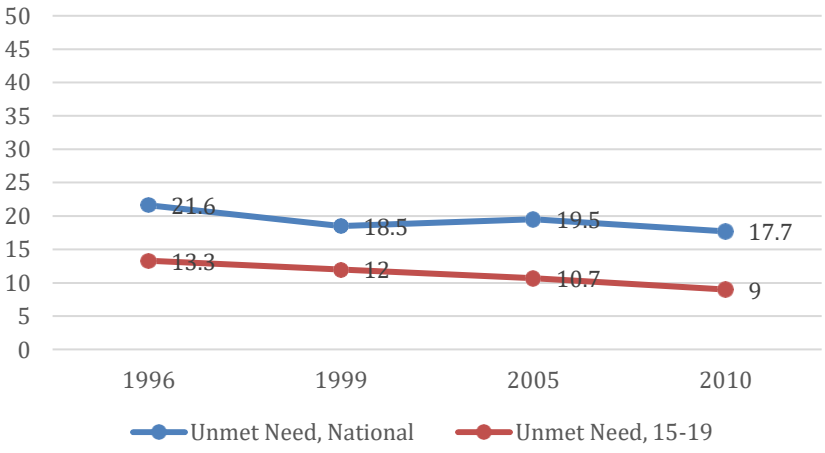
unchanged during this period. Within the adolescent age group, more than a quarter of older adolescents—ages 18 and 19 years—were more likely to have begun childbearing than their younger counterparts. Among adolescents ages 18 and 19 years, 39.2 percent and 44.3 percent, respectively, had begun childbearing.[5]

Figure 4. Trends in Adolescent Fertility Rates, 1996–2010



In 2010, about one in every 10 adolescent women ages 15–19 (10 percent) had an unmet need for contraceptives (Figure 5), which was lower than that of all women ages 15–49 (18 percent).[5] However, high unmet need among all adolescents was only slightly declining; within the 10-year period before the NFPCIP launched, unmet need declined from 12 percent in 1999 to 9 percent in 2010. Compared with demand among all women, demand for FP services among adolescents remained stable over time.

Figure 5. Trends in Unmet Need among Women Ages 15–19 Versus 15–49, 1996–2010



Further, in 2010, contraceptive use among adolescents was very low, with 9.4 percent of all adolescent women using a modern method of contraception. However, when examining use among sexually active adolescents, those who were unmarried were almost three times (34.5 percent) more likely to be using modern contraceptives than those who were married (12 percent). Figures 6 and 7 show recent trends in demand for and use of contraceptives among adolescent women in Tanzania. Adolescents have a lower unmet need when compared with national levels of unmet need among all women ages 15–49 years.

Figure 6. Trends in Total Demand for Contraceptives among Women Ages 15–19 Versus 15–49, 1996–2010

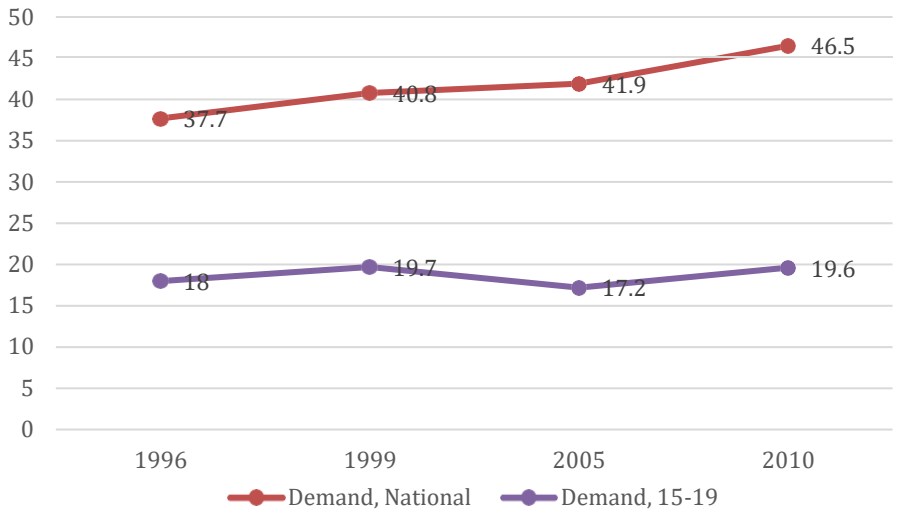
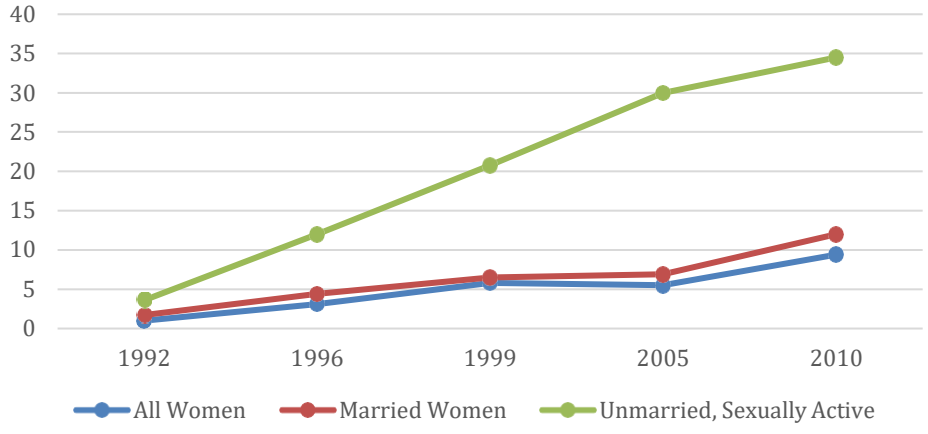


Figure 7. Modern Contraceptive Use among Adolescent Women Ages 15–19, 1992–2010



4.2.2 How the NFPCIP Measured Adolescent Pregnancy Trends

The NFPCIP did not set a measurable target for adolescent pregnancy. However, One Plan II has set targets for adolescent health to be reached by 2015 and 2020, shown in Table 1. (Of note, even One Plan II did not set a specific target for adolescent pregnancy.)

Table 1. One Plan II Goals for Adolescent Health

Indicator	2013-2014 Level	2015 Target	2020 Target
Adolescent fertility rate (ages 15-19)	128 per 1,000 women	< 100 per 1,000 women	< 100 per 1,000 women
Adolescent birth rate (have started childbearing by age 19)	44%	39%	30%
Proportion of health facilities providing adolescent-friendly SRH services	30%	80%	80%
Proportion of service delivery points outside health facilities providing youth-friendly services	-	-	50%
Sexually active adolescents (ages 15-19) CPR Unmet need for FP Demand for FP satisfied % who used condom at last sex	 12% 16% 48% 50%	 - - - -	 20% 10% 60% 65%
% ages 15-19 who are married/ cohabitating	18%	-	30%

During the development of the NFPCIP, the National Adolescent Reproductive Health Strategy (NARHS) 2010–2015 was also in development. The strategy had four strategic objectives: 1) strengthening the policy and legal environment; 2) increasing access and utilization of reproductive health services, including FP among adolescents; 3) promoting positive attitudes and behavior change among parents, adolescents, and the community; and 4) building stakeholders' capacity to deliver effective and efficient ASRH programs.

A decision was made not to duplicate efforts to include comprehensive ASRH interventions in the NFPCIP, but instead to focus on supporting implementation of the approved NARHS. Nevertheless, the NFPCIP prioritized specific youth interventions under SAA III (Service Delivery) and SAA IV (Advocacy and Strategic Communication). Although activities in other SAAs included youth, they were not as explicit and tended to be embedded within other efforts.

SAA III: Service Delivery

Service delivery includes meeting the needs of adolescent clients, who are considered to have special FP needs since they are at high risk of an unintended pregnancy because of biological and social-cultural conditions that may hinder their access to FP services and use of FP methods. Under strategic result (SR) 4, the NFPCIP aimed to increase access to and use of FP services by young people, ages 10–24 years. The following outputs were achieved. It is important to note that the numbers presented below are a compilation of reports from different implementers and may seem low if some of the partners conducted the same activities but did not submit their reports:

- 258 service providers were trained on the provision of youth-friendly services, including addressing barriers to the provision of services to youth, meeting 17 percent of this target.
- 391 peer educators were recruited and oriented on increasing youth uptake of FP services, meeting 19 percent of this target.
- 357 peer educators were supported, meeting 18 percent of this target.
- 23 health facilities were equipped and delivering youth-friendly services, meeting less than 1 percent of this target.

SAA IV: Advocacy and Strategic Communication

Re-invigorated advocacy increases visibility and support for FP as a key investment for improving the lives, health, and well-being of Tanzanians. This SAA included efforts to improve the policy environment for FP, including the environment related to adolescent reproductive health. Under SR 2, the NFPCIP aimed to improve the policy environment for FP service delivery. As such, seven meetings were held to conduct advocacy for the implementation of the NARHS 2011–2015, exceeding this target by 233 percent. Efforts were also made to advocate for implementation of the NARHS 2011–2015, including dialogues with the Ministry of Youth; sensitization of religious leaders in Zanzibar on contraceptive use among young people; and support of youth to engage in the development of the One Plan.

The Mobile for Reproductive Health (m4RH) SMS service was modified to include youth-specific content, and was promoted widely nationwide. There were also considerable outreach efforts to university students and the use of magazines, television shows, and discussion platforms such as the 2000 fema clubs (which operate in secondary schools, with out-of-school groups, and within local community-based organizations) to communicate about FP and reproductive health.

4.2.3 Results of the NFPCIP

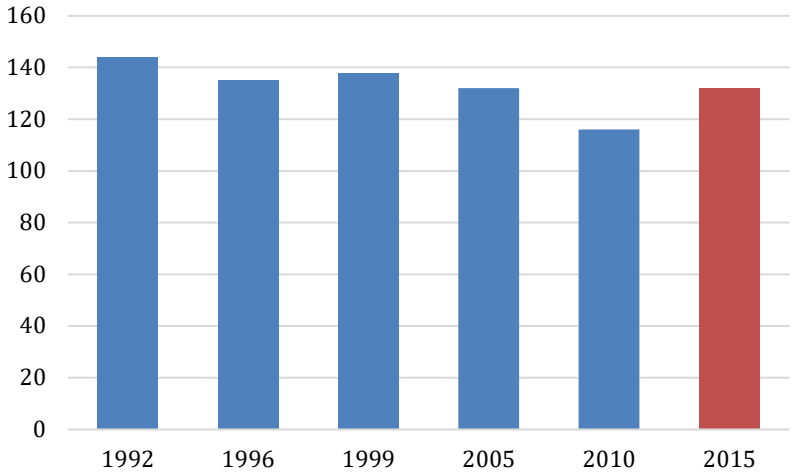
Despite a focus on adolescents in the NFPCIP, little progress was made on key indicators. In some areas, such as unmet contraceptive need and adolescent pregnancy, gains over the past decade were actually lost.

Adolescent Fertility Rate

As reported in the 2015 TDHS,[13] the adolescent fertility rate has reversed, from 132 in 2005 down to 116 in 2010, and then back up in 2015 to 132 (Figure 8). The fertility rate is rising across both rural and urban adolescents. However, the fertility rate among rural adolescents (162 per 1,000) is twice that of urban adolescents (82 per 1,000). There is also a huge regional

disparity, from a low of 46 per 1,000 adolescent women (ages 15–19) in Dar es Salaam to 209 per 1,000 women in Simiyu Region. Most regions in the Western and Southern West Highlands continue to report high adolescent fertility rates. Adolescents with only a primary education have more than three times the fertility rate (171 per 1,000) of those with a secondary education (55 per 1,000).

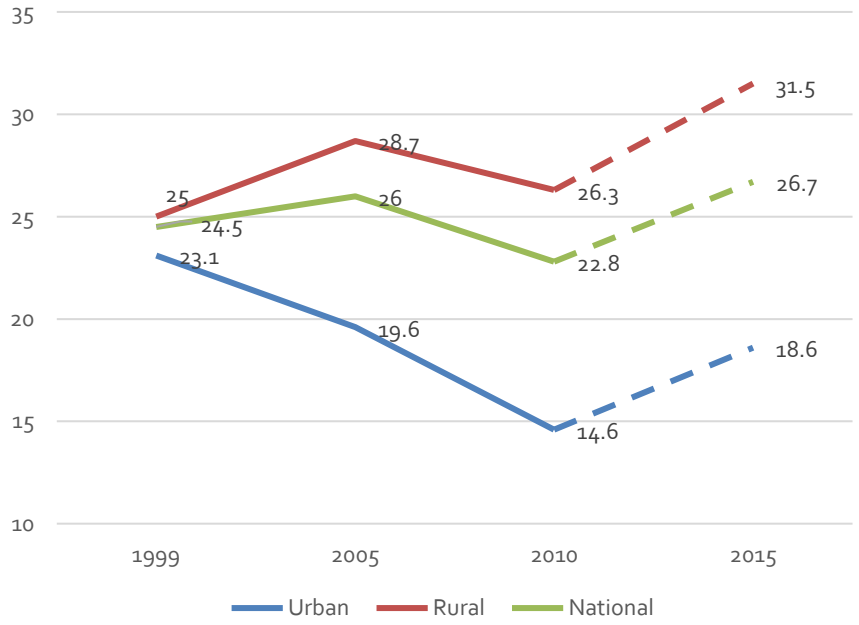
Figure 8. Trends in Adolescent Fertility Rate, 1996–2015



Adolescent Pregnancies

The gains made toward reducing adolescent pregnancies that was observed between 1999 and 2010 in urban areas has been lost, with adolescent pregnancy rates increasing substantially in both urban and rural areas (Figure 9). In 2015, the national adolescent pregnancy rate was 27 percent—nearly 4 percentage points higher than it was in 2010. Rural adolescents continue to experience pregnancy nearly 1.7 times the rate of urban adolescents. A 2013 participatory study among 82 girls (ages 12–17) in rural Tanzania found that transactional sex with older men was common for many of the girls surveyed, as it was one of few sources of income that allowed these girls to meet basic needs, even though it increased the risk of unintended (early) pregnancy. Parents and adult community members in the study blamed the girls alone for putting themselves at risk for pregnancy.[14] Further, a 2011 cross-sectional survey of 2,183 random households in three Tanzanian districts of Rufiji, Kilombero, and Ulanga showed that only 54.1 percent of the respondents reported that their last pregnancies were intended. Among all age groups of women, women ages 20 years or younger had the highest percentage of unwanted and mistimed pregnancies, and the lowest percentage of intended pregnancies.[15]

Figure 9. Trends in Adolescent Pregnancies, 1999–2015



When comparing trends in adolescent pregnancies across the different regions of Tanzania between 2010 and 2015, the adolescent pregnancy rates in the majority of regions were increasing faster than the adolescent pregnancy rate at the national level (Figure 10). Despite this trend, in seven regions—Dar es Salaam, Kagera, Kilimanjaro, Mara, Rukwa, Lindi, and Southern Zanzibar—the rates of adolescent pregnancy were falling. Further, the Western Zone and South West Highlands Zone had the highest levels of adolescent pregnancies (38 percent and 34 percent, respectively) in 2015.

Contraceptive Use among Adolescents

Use of modern contraceptive methods among all adolescents declined slightly from 2010 (9.4 percent) to 2015 (8.6 percent) (Figure 11).[5, 13] Use increased slightly among married adolescents, from 12 percent to 13.3 percent, and declined slightly among unmarried sexually active adolescents, from 34.5 percent to 33.1 percent. Among married, current users of modern contraception in this age group, the most common methods used were injectable contraceptives (51.1 percent), implants (20.3 percent), and male condoms (11.3 percent). However, among unmarried adolescents, the most common methods were male condoms (50.4 percent), injectables (24 percent), and implants (21 percent).

Figure 10. Changing Trends in Adolescent Pregnancy Rates by Region, 2010–2015

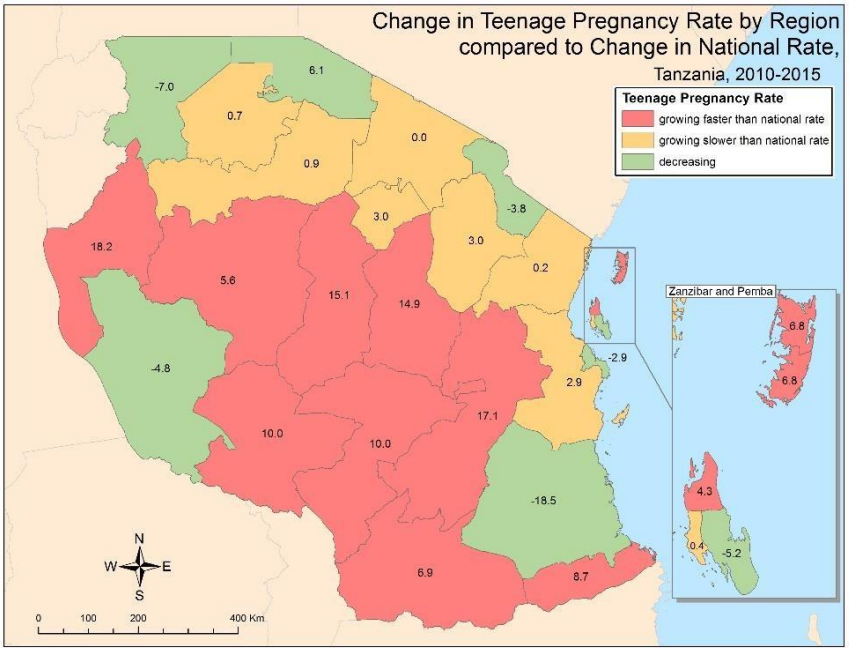
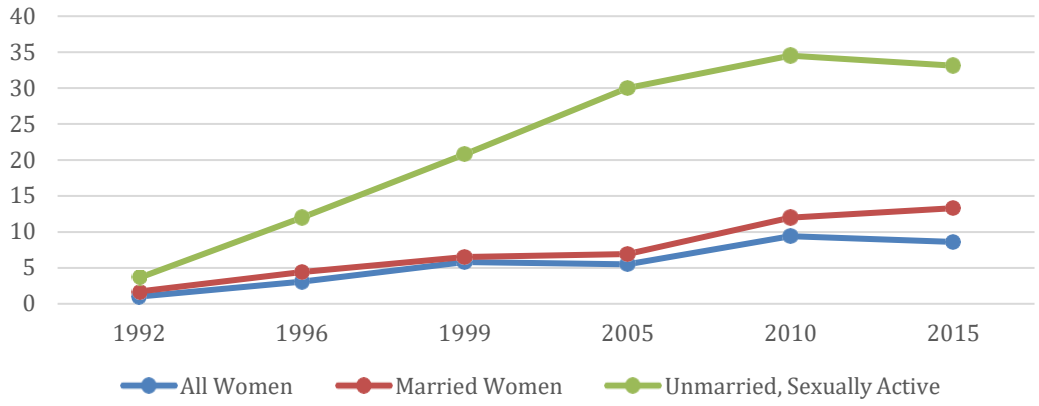


Figure 11. Modern Contraceptive Use among Adolescents Ages 15–19, 1992–2015



Several barriers have been documented contributing to low contraceptive use among adolescents, including a lack of skilled service providers who can educate young women on their sexual and reproductive rights, as well as initiation ceremonies, early marriages, and gender disparities:[16]

- One study showed that girls had limited control over the use of contraceptive methods. Condoms were said to be the most widely accessible form of contraception, but that "*there is stigma attached to girls and women purchasing condoms or insisting on their use*," particularly in relationships with older men: *"The way these children start having*

sex at an early age and the tamaa they have for money, they have no power to tell a man to use a condom and so they don't use condoms." -- Mother, focus group discussion[14]

- A 2011 participatory study showed that being in a lower class and attending co-education schools were predictors of inadequate knowledge of FP services; 71.2 percent of respondents reported that FP services should not be used by adolescents and mentioned several reasons against their use. Less than 6 percent (18/316) of all respondents had used FP in their lifetime, 44.4 percent in the past month, 33.3 percent in the past year, and 22.3 percent in the past five years. This showed that most secondary school students do not utilize FP services despite adequate levels of knowledge about them.[17]
- One "mystery client" study conducted in 33 health facilities in 2014 found that barriers to adolescent's access to FP services included poor signage and reception for services; lack of confidentiality and privacy in clinics; paternalistic attitudes and limited knowledge about ASRH services among health care workers; and discouragement from health care workers on FP use for adolescents, including condoms and FP methods.[18]
- Thirty-five focus group discussions exploring close-to-community provider experiences with and attitudes toward adolescent reproductive health service provision were carried out in two districts in Northern Tanzania. Close-to-community cadres providing reproductive health services were drug shop operators, traditional healers, traditional birth attendants, and village health workers. They reported being the first port of call for adolescents seeking reproductive health services, but their knowledge of adolescent reproductive health needs was poor. They had negative attitudes toward, and lacked the necessary resources for, the provision of such services. Some were particularly unwilling to provide condom services and were prejudiced against adolescents using them. There was poor integration between the close-to-community providers and the formal health sector, further limiting the providers' ability to provide adequate services.[19]
- Young women in a 2015 qualitative study in a rural district in Tanzania were fearful of seeking FP services at health facilities because they feared stigma from providers. They opted for oral contraceptives (easily obtained at a pharmacy) instead.[20]

4.2.4 Analysis of Gaps

Lack of Clear Measurable Goals

Despite acknowledging low contraceptive use among adolescents as a key problem, a concerted focus on interventions to reduce adolescent pregnancies was lacking. Although the NFPCIP had a national CPR goal, it lacked subgoals (e.g., a goal for teenage pregnancy and contraceptive use) that could be tracked during NFPCIP performance-monitoring efforts. This contributed to a lessened emphasis on youth programming, and less tailoring of other FP interventions to address the unique needs of adolescents.

Insufficient Budget and Activities for Youth-specific Interventions

Despite the fact that adolescents account for 22 percent of women of reproductive age and that this proportion is increasing, a considerably small budget was allocated for youth-specific activities. Direct interventions targeting adolescents were placed under the strategic theme of service delivery, with an estimate of 4.3 percent of the entire NFPCIP budget. Only approximately 1 percent of the entire NFPCIP expenditures for Years 3–6 was spent on activities directly related to adolescents. Further, of the TSh 13 billion that were supposed to be spent for

direct adolescent activities, only 5.7 percent was indeed spent. Few interventions were included for service delivery and advocacy, and none for demand creation—a missed opportunity at a time when demand for contraceptives among adolescents had at best flatlined. Targeted advocacy for implementation of the NARHS was only 0.2 percent of the SAA for advocacy and strategic communications. Key advocacy efforts, such as raising the minimal age of marriage form 15 years to 18 years, were not reflected in the plan. Further, resource mobilization efforts for ASRH activities at all levels were generally weak. Advocacy efforts focused on only 10 of the 24 mainland regions, reducing the scale potential of interventions worldwide.[21]

Inadequate Coordination of Youth Efforts and Resources

Despite the fact that Tanzania has an ASRH technical working group (TWG), stakeholder coordination was, and continues to be, weak. In addition, lack of coordination within sectors/ministries in addressing ASRH issues has been observed. First, some implementing organizations working on youth efforts are not familiar with the NARHS. Second, there appears to be misalignment between development partners who provide financial resources and the priorities of the NARHS. Finally, the lack of coordination contributed to implementation of mini-projects scattered in different regions without leverage of economies of scale that come about when partners coordinate and jointly execute activities:

"If all partners were implementing interventions that are outlined in the national strategy, we would not have seen the results we are seeing on DHS. The problem is that donors/partners have different interests, they come with their own interests and are not able to implement what's outlined in the national strategy, and this is a challenge."

-- Participant, stakeholder consultation, ASRH TWG

"Implementing partners keep talking that there is a lot of commitment among youth people but not sure if they are turning it into anything that is attributable. I would like to see a real commitment for young people."

-- Participant, stakeholder consultation, ASRH TWG

Underperformance of Youth-specific Strategic Results

SAA III: service delivery

None of the eight explicitly youth-related indicators in this SAA met their Years 3–6 targets. Progress toward meeting targets ranged from 0 percent for updating FP trainers on strategies for youth-friendly services and adapting m4RH to include information for young people, to 60 percent for the number of community health workers (CHWs) trained, including youth workers. With the exception of these and one other target (i.e., supporting CHWs, including youth workers, at 44 percent met), all other indicators in this SAA fell below 20 percent. Financially, none of the targets in this SAA can be considered met, as all fell below 13 percent for Years 3–6. It is evident that even in the SAA in which youth were prioritized, the amount of funding expended to date is insufficient to implement activities and realize any of these targets.

SAA IV: advocacy and strategic communication

Several efforts were made to advocate for implementation of the NARHS 2011–2015. However, the activities outlined in this SAA may not be effective enough at improving the policy environment for ASRH. More concrete activities are needed to ensure that such advocacy actually results in positive change in terms of programming and implementation. Further, stand-alone policies in each sector beyond health (including conflicting clauses in policy and strategy documents, and allocation of resources for coordination units of respective ministries) continue to remain challenges in achieving joint collaboration and implementing multi-sectorial efforts toward reducing teenage pregnancies.

4.2.5 Key Recommendations

1. Young people should be a central focus in the next NFPCIP, with clear measurable goals.

Elevate the focus on young people to a strategic priority. The NFPCIP did not reflect a reasonably sized adolescent portfolio, with respect to specific innovative interventions and the associated budget, relative to the size of the population and the problem of adolescent pregnancy. Direct interventions targeting adolescents were placed under the schematic theme of service delivery, with a budget estimate of TSh 104 billion (US$77 million) during the NFPCIP period; of this total budget, 13.2 percent (TSh 13 billion/US$10 million) was dedicated to adolescent interventions. The next NFPCIP should not only increase the budget for adolescent interventions but also increase the importance, and thus visibility, of this new strategic priority.

Include adolescent sexual and reproductive health as a key component in the NFPCIP. During the development of the NFPCIP, the NARSH had just been released; it was thus deemed that including a comprehensive ASRH portfolio under the NFPCIP would be a duplication of resources. Although this was a reasonable decision, the resulting effect was that the execution of the ASRH plan was disjointed from the NFPCIP, and was under less consideration in the portfolios of FP implementers. Further, there were no clear goals for adolescent pregnancy or contraceptive use among this population, which made tracking progress difficult. Programming challenges ranged from policy restrictions to working with non-health ministries (e.g., Ministry of Education), which made it difficult to work with in-school adolescents at primary and secondary levels. Thus, interventions were focused on youth in institutions of higher learning (the majority of whom are no longer adolescents), where these restrictions did not exist. The next NFPCIP should mainstream ASRH into the FP agenda, and also put in mechanisms to facilitate closer working relations between the ASRH and FP government units and partner TWGs.

2. Adopt a multi-sectoral approach, with inclusion of evidence-based interventions.

Nurture and establish a common vision for a multi-sectorial approach to pregnancies among young people. The next NFPCIP should not approach the adolescent pregnancy issue solely as a health issue with responsibility confined to the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC), but as a multi-sectoral issue. Different ministries including the Ministries of Youth, Finance/Economics, Gender, Health, and Education will need to work together to elicit the desired change in a

holistic manner. Stakeholders have also suggested involving youth in the design of interventions. The different ministries will also need to receive endorsements for joint work at a higher level so that they can have a common vision on the issue, on how to solve it, and on defining their respective roles. Policy statements across the ministries will also need to be aligned, for example between the MOHCDGEC and the Ministry of Education, Science and Technology (MOEST), in regards to how to provide contraceptive education and provision for in-school adolescents. For example, the MOHSW's 2013 National Family Planning Guidelines and Standards state that people from 10 years of age should not be denied access to contraceptive information and services;[22] however, people ages 10 to 18 years are in primary and secondary schools, where inadequate SRH information is provided. Development of the NFPCIP should also include a bottom-up approach that includes youth groups to provide input on the proposed interventions.

Protective benefits of formal education should be increasingly leveraged to reduce teenage pregnancies. Formal education is necessary to enhance social status and reproductive health outcomes, especially for young girls, and unmarried girls should be particularly targeted. Concerted efforts to reduce teen marriage, prevent early pregnancy (before age 20), and improve retention of girls through secondary school will likely lead to the greatest gains. According to the 2015 TDHS, only 7.2 percent of Tanzanian girls complete secondary school, and rural girls are almost five times less likely to complete secondary school than their urban counterparts.[13] Devising economic empowerment opportunities to enhance the economy of women's families is also worthwhile, as better economic well-being reduces the odds of adolescent pregnancies.

Prioritize evidence-based interventions. Review of the interventions included in the NFPCIP showed that they were not the most strategic evidence-based interventions. For example, peer education and dedicated youth-friendly corners were shown not to work very well in some settings. ASRH stakeholders, however, arrived at a consensus that local research is needed to investigate the effectiveness of interventions such as peer educators and youth corners in the Tanzanian context. On the other hand, some stakeholders felt that peer education has failed to address behavior change for young people. Research should also be directed to assess whether interventions are being conducted correctly and at an appropriate scale to effect change:[21]

"Although peer education is said to be an old fashioned intervention, it would be good to study its effectiveness in our context. Also, assess whether we are doing it right? How are we supporting these trained peer educators? Do they have conducive environment to perform youth activities, and are we tracking what they are doing and provide feedback? I think before we decide to say this is not an effective intervention we need to conduct research to inform this suggestion."

-- Member, ASRH TWG, March 2017

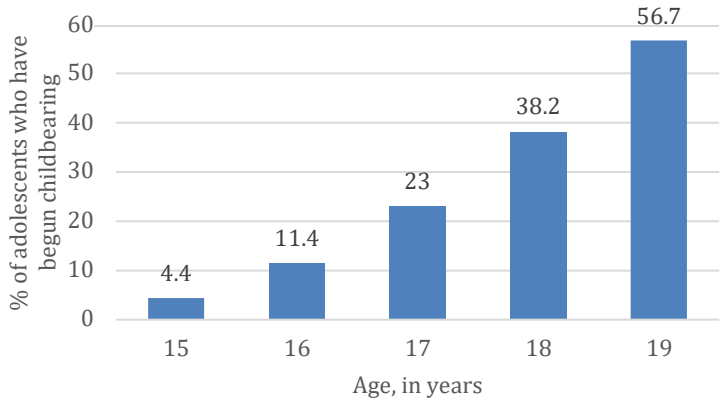
"There is a need to strategize on how to use private outlets to reach young people/adolescents with FP methods of their choice. Study needs to be done on where do youth prefer to get their FP methods to inform strategies and approaches for delivering FP services to the adolescent and young people."

-- Participant, NFPCIP workshop, May 2017

3. *Interventions should reflect the diversity of contexts and the needs of different adolescents.*

Adolescents should not be viewed as a homogenous group. Thus, interventions should be designed with a solid understanding of the diversity of contexts and the needs of different segments of the adolescent population. For example, rural versus urban, in-school versus out-of-school, and married versus unmarried adolescents require different intervention packages. Analysis of demand for FP, for example, has shown distinct needs. In 2015, demand for FP among sexually active unmarried adolescents was four times higher (81.6 percent) than among all adolescents (21.1 percent). Similarly, unmet need among sexually active unmarried adolescents was 42.4 percent, while it was 10.8 percent among all adolescents.[24] Regional variations in adolescent pregnancy should also be taken into consideration in resource planning. Of the top 10 regions with adolescent pregnancies in 2015, seven were from the Lake and Western Zone: Katavi (45 percent), Tabora (42.6 percent), Kigoma (32 percent), Shinyanga (33 percent), Mara (37 percent), Simiyu (30 percent), and Geita (29.7 percent).[13] Furthermore, it is important to note that most adolescent pregnancies occur among those ages 18 and 19 years. The occurrence of adolescent pregnancies approximately doubles every year up to 19 years of age (Figure 12).[23]

Figure 12. Adolescent Pregnancy Rate by Age



Furthermore, interventions that focus on parents and orient them on how and when to communicate with their children are needed. In a cross-sectional descriptive analytical study that targeted all girls in secondary schools in Tanga Municipality, 82.6 percent of respondents reported they get sexual health education from parents and health centers, while schools and peer groups contributed only 29.1 percent and 7.2 percent, respectively.[23]

4. *Implement interventions to influence sociocultural factors and powerful gender norms that perpetuate girls' risk.*

Adolescent pregnancies in Tanzania are a result of sociocultural factors and gender norms, which put girls at a heightened risk of unintended pregnancy. Risk factors for adolescent pregnancy include younger age, poverty, poor school performance, lack of schooling, economic disadvantage, older age of male partner, and having single or teen parents. Poverty pushes girls into having sex to meet basic needs and to meet the sexual expectations of older men and of boys their age, which can lead to rape and coercive sex (including sexual abuse from an early age) and unintended pregnancy. In one study among Tanzanian girls ages 15–19 years, nearly a quarter (23.8 percent) had experienced violence since the age of 15, and 13.2 percent reported at least one experience of sexual violence. Ten percent of Tanzanian women ages 15–49 also reported that their first sexual experience was forced, and this proportion was even higher when sexual initiation before the age of 15 was included.[14]

Transactional sex with older men is one of the few available sources of income that allows adolescent girls to meet their basic needs, making this a common choice for many girls, even though it increases the risk of unintended (early) pregnancy. Further, unprotected premarital sex is common among adolescents in Tanzania. At least 27.8 percent of female adolescents and 36 percent of male adolescents reported having had sexual intercourse within the year of the 2015 TDHS.[13] Of these, only 37.1 percent and 34.6 percent, respectively, had used a condom during their last act of sexual intercourse. In a landmark decision, the High Court of Tanzania ruled in July 2016 that the Law of Marriages Act be revised to eliminate inequality between the minimum ages of marriage for boys and girls. The former act allowed girls to marry at the age of 14 with the consent of the court, and at the age of 15 with the consent of their parents. The amendment set the minimum age for marriage at 18 years. Despite this hailed victory, much remains to be done at the grassroots level to change community attitudes and practices around early marriage.

5. ***The Green Star Campaign should be rebranded, as it does not resonate with young people.***

The Green Star Campaign (i.e., the renowned social and behavior change campaign) and the associated words *"uzazi wa mpango"* need to be rebranded to reach and resonate with adolescents. The benefits of FP need to be communicated to adolescents in a way that addresses their key needs and concerns. The mass media campaign should also explore newer channels, including engaging adolescents on social media with SRH issues. A 2014 study of social media use among adolescents ages 15–19 years in two urban cities in Tanzania—Dar es Salaam and Mtwara—showed that 52 percent used the Internet more than once a week, and 73 percent used Facebook.[24] However, these channels are more likely to reach older adolescents than younger ones. Further, in 2015, at least 3.4 percent of adolescents received FP messages via a mobile phone—the majority of whom were from urban areas.[13]

6. ***Enhance advocacy efforts to garner broader awareness of adolescent pregnancy and its consequences, as well as support for contraceptive use among this age group.***

Advocacy efforts should focus on health consequences of adolescent pregnancies (e.g., fistula and abortions, miscarriage) as well as economic consequence. They should also focus on reaching key influential members of parliament to garner broad awareness of the issue and support for birth control among adolescents at all levels (i.e., policy, programmatic, service delivery).

7. Mainstream youth-friendly services into broader family planning service delivery.

Although progress has been made in recruiting, training, and supporting community-based providers, including youth workers, few FP trainers have been updated on key strategies for youth-friendly services and peer education. Thus, action in this area needs to be taken so that gains made in other activities are not undermined. Providers have been trained on youth-friendly services, but negative attitudes or bias against use of contraceptives by young people prevails. Another stalled activity is establishing an infrastructure for youth-friendly services at dispensaries, health centers, and district hospitals; only 1 percent of this target has been met. Further, some districts have shown that having special service days for adolescents/young people works to increase access, but this effort has been limited to a few districts and should be scaled nationwide. Integration of FP into other health services should also be used as a means to attract young people to FP. For instance, comprehensive post-abortion care provides an opportunity to provide FP education, although the service is currently provided at a fee, limiting access by youth. ASRH services should also be mainstreamed to the private sector, where some may be better poised to handle young people.

8. Improve coordination among implementing partners.

One of the weakest points of adolescent FP efforts is coordination, resulting in many missed opportunities, such as gaining economies of scale. Therefore, there is a need to strengthen coordination, management, and partnership mechanisms of the ASRH program at the central and subnational levels to improve efficiency and effectiveness of the program.

4.3 Area of Measurement 2: Contraceptive Security

Definition

Contraceptive security is realized when an uninterrupted supply of a variety of FP options are readily available, allowing individuals to choose, obtain, and use high-quality contraceptives for FP to meet their reproductive health needs.

Key Insights

- Frequent stockouts of FP commodities at the facility level a challenge to reaching national and regional CPR goals
- Decrease in GOT financing over the years compared to other donors
- Forecasting difficulties due to challenges in acquiring accurate service utilization data as a result of incomplete or inaccurate reporting from the facility level
- Additional refresher trainings needed on ILS Gateway for facility-level providers to improve efficiency in ordering and reporting FP commodities

Recommendations

- Strengthen the total market approach to reduce the service burden on public facilities.
- Increase availability of long-acting reversible contraceptives (LARCs), such as IUDs and implants, in social marketing.
- Continue and sustain advocacy efforts to fund FP commodities, including establishing a high-level FP commodities champion.
- Capture data from accredited drug dispensing outlets (ADDOs) and pharmacies in the district health information system (DHIS)-2.
- Reinforce and expand ILS trainings to health care providers.
- Continue support from GOT for quantification meetings.
- Improve coordination between public-private sectors.

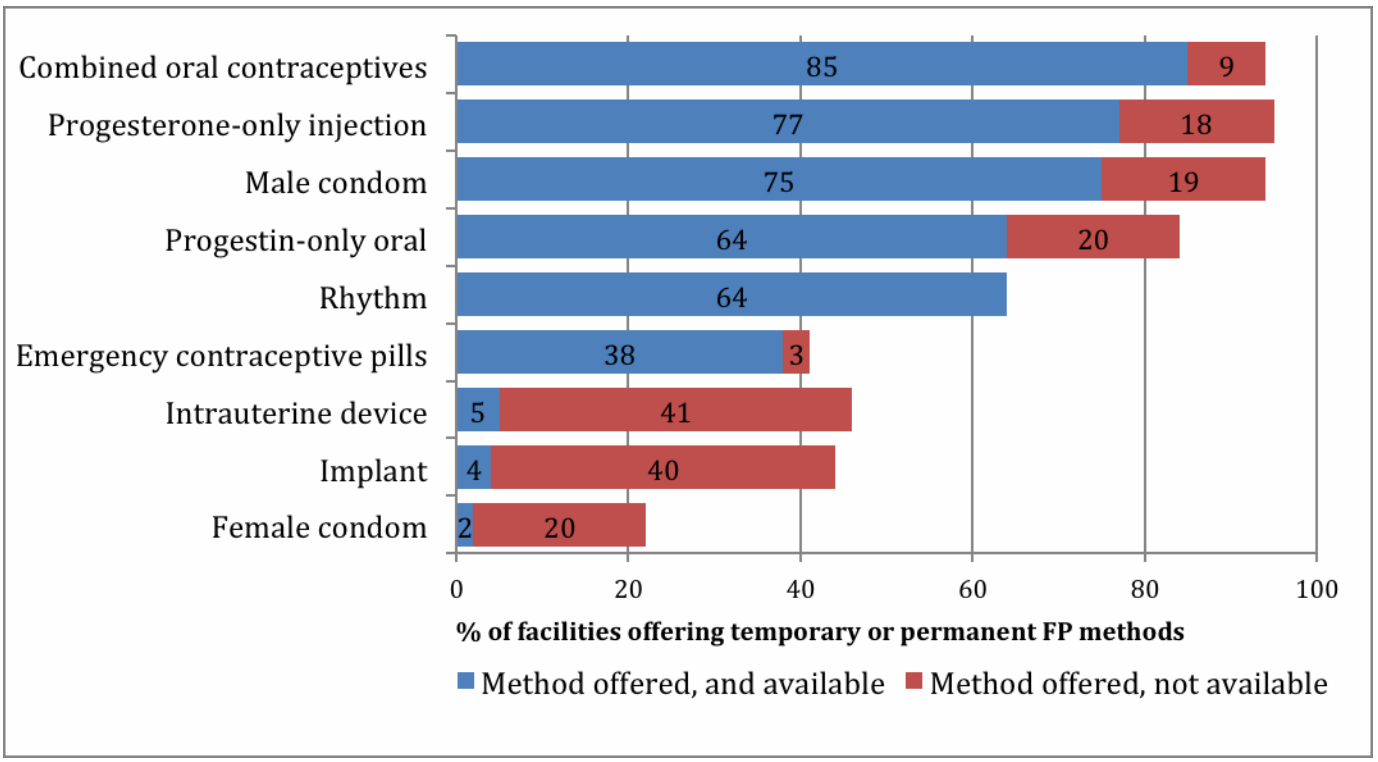
Contraceptive security is realized when an uninterrupted supply of a variety of FP options are readily available, allowing individuals to choose, obtain, and use high-quality contraceptives to meet their reproductive health needs.[25-27] Three elements essential to contraceptive security are 1) a full range of contraceptive commodities, 2) necessary medical equipment and supplies, and 3) staff or health care workers who are trained in the provision of each FP method.[28] Achieving contraceptive security requires diligent preparedness and commitment on every level—from community health centers up to national governments—and is a sign of political support to meet a country's FP goals. To monitor progress toward contraceptive security, countries must take into account the following key variables:[27]

4.3.1 Status and Key Issues Prior to the NFPCIP

Available Commodities

Offering a variety of contraception methods (both long-acting and short-term) allows individuals to choose the method that is best for them, and helps to ensure more FP users.[28, 29] Prior to NFPCIP implementation in Tanzania, available temporary and short-term methods included oral contraceptive pills (OCPs) (both combined and progestin-only), injectables (both combined and progestin-only), condoms (male and female), spermicide, diaphragms, and counseling on the natural (rhythm) method. Available long-term methods included IUDs, implants, and sterilization (female and male).[30] Emergency contraception was also available at approximately 40 percent of health facilities prior to the NFPCIP.[30] A 2006 countrywide assessment of health facilities (i.e., hospitals, health centers, dispensaries) showed that approximately 75 percent of all facilities surveyed offered some temporary FP methods.[30] Figure 13 demonstrates those commodities that were offered and available on the day of the survey; however, the majority of facilities mentioned to be offering long-term methods such as IUDs and implants had no stock of these methods.[30]

Figure 13. Contraceptive Methods Offered, and Their Availability, on the Day of the Survey (N=479)

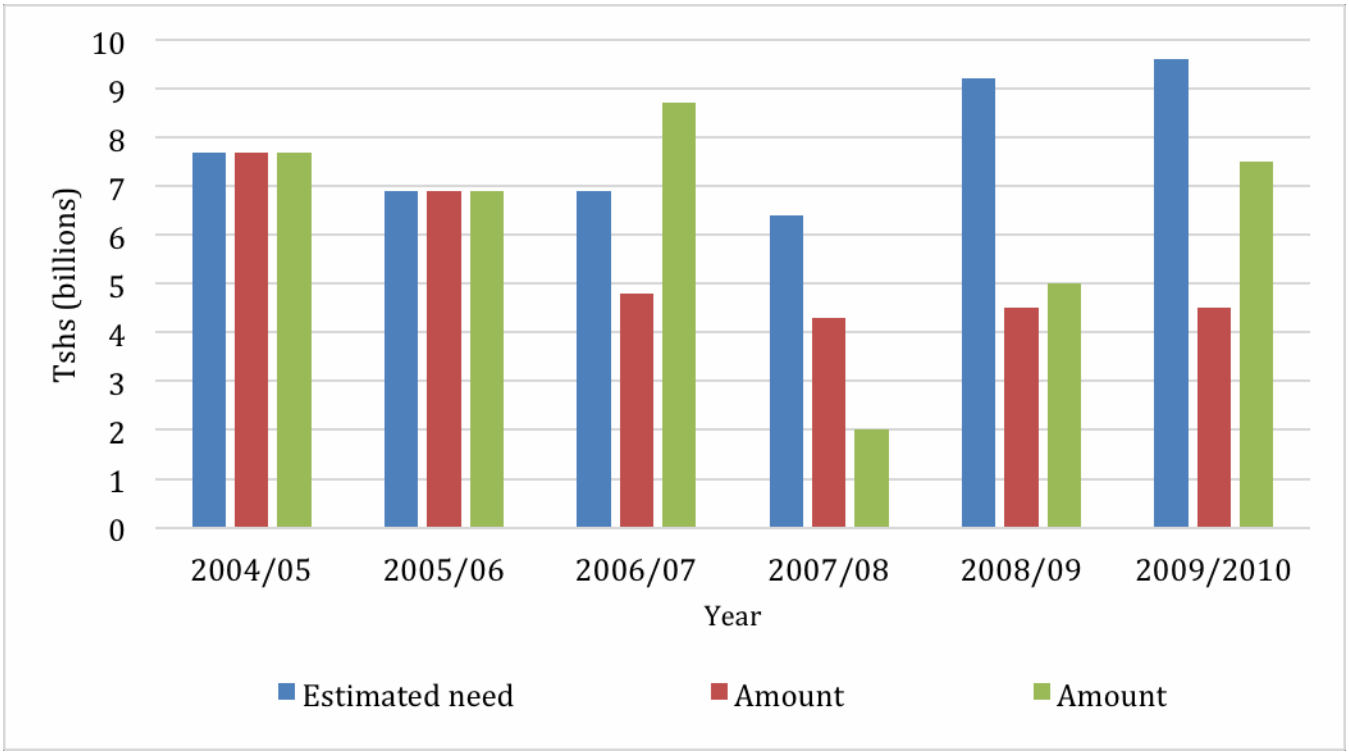


Source: TSPA 2006

Finance and Procurement (Capital)

Consistent and adequate funding is essential to ensure contraceptive security.[29] In Tanzania, there are two primary sources for procuring contraceptives for the public sector. The first is the GOT, including internally generated funds (i.e., public sector sources, taxes, user fees), health basket funds, World Bank credit or loans, and other donor funds given to the government. The second source is donations and donor funds, including in-kind donations of contraceptives from USAID or the United Nations Population Fund (UNFPA), Global Fund donations used to procure condoms, and Global Fund donations used to procure contraceptives beside condoms. On an annual basis, the GOT allocates funds for FP commodity procurement based on projected need; however, the amount allocated for commodity spending has not always aligned with actual expenditure, as demonstrated in Figure 14. For example, although FP funding needs were met or exceeded from 2004 to 2006/2007, there were dramatic funding declines in 2007/2008 and 2008/2009 due to a lack of political commitment on FP issues, competing priorities within ministries, and financial constraints among development partners.

Figure 14. Funding for Contraceptive Commodities 2004–2010



Source: Muzambe University Directorate of External Linkage and Community Engagement, 2011.

Political Commitment

Prior to the NFPCIP, there were no policies that required the allocation of a specific proportion of the national health budget to FP services or commodities. As a result, the MOHSW independently made decisions about FP budget allocations and had no policy guidance to help determine adequate proportions of funding to dedicate to FP. For example, FP commodities did not receive the same competitive allocations as commodities for curative services. In addition, the MTEF did not include a budget line item for FP, and private national health insurance schemes and the four publicly owned schemes—National Health Insurance Fund (NHIF), Social Health Insurance Benefit under the National Social Security Fund, the Community Health Fund, and Tiba Kwa Kadi—did not cover FP. The GOT also did not have a strategy to address how to include insurance as a source of financing for FP.

Further complicating matters, government guidelines and processes for both public and private facilities to use to procure and distribute products were unclear and inconsistent. Tanzanian law requires that contraceptive products are both approved by the MOHSW and registered by the Tanzania Food and Drugs Authority before they can be distributed in health facilities—a timely process that can inhibit product distribution if both parties do not agree. For example, although the Jadelle implant was registered by the Tanzania Food and Drugs Authority, it was not approved for public use by the MOHSW. Instead, the MOHSW approved Implanon—a much higher-priced implant than Jadelle.

Finally, the 2004 Public Procurement Act implemented uniform procurement procedures (from tendering to actual procurements) for all goods, but they did not include a provision to put the procurement of essential medicines—including contraceptive commodities—on a fast track, which further prolonged procurement. Without an enabling policy environment, contraceptive stockouts at central and facility levels are likely to occur.

Forecasting and Supply Chain Capacity

Accurate data on consumption and existing stock, and the ability to use that data, are critical to forecasting future contraceptive commodity needs and determining future funding requirements.[31, 32] In Tanzania, commodity quantification and forecasting are the responsibility of the MOHSW and are completed on an annual basis, with a mid-year review prior to developing the MTEF. Prior to the NFPCIP, inaccuracies in reporting from health facilities paired with a paper-based reporting system resulted in reporting delays, which caused grossly underestimated projections for commodity needs at all levels. Also, the capacity within the MOHSW to carry out commodity quantification and forecasting was limited and depended strongly on external technical assistance from the USAID-funded DELIVER project, led by John Snow, Inc. (JSI). Further, a 2011 report showed that approximately one-fourth of all USAID funding in Tanzania went to reproductive health commodities and that the GOT had limited involvement in forecasting for FP commodities funded by the U.S. government.[33]

The Medical Stores Department (MSD) is responsible for procuring, storing, and distributing contraceptive commodities, while the supply chain is managed by multiple GOT departments. Lack of adequate communication and uncoordinated efforts between the MSD and the GOT hindered supply distribution prior to the NFPCIP. Bottlenecks included poor forecasting as well as long procurement times for supplies, particularly international supplies, which could take up to nine months to obtain.[30] In addition, the MOHSW Pharmaceutical Unit is responsible for overseeing the MSD's distribution activities, but the unit lacked the capacity to successfully fulfil this role before the NFPCIP.[34] Inefficiencies in the supply chain ultimately prevented accurate and timely distribution of commodities to health facilities from warehouses at central and zonal levels.

A 2007 contraceptive security assessment revealed that, in the year prior to the assessment, more than half of the facilities sampled experienced a stockout of at least one FP product for 30 days or longer.[35] This same report showed oral contraceptives as the commodity most often out of stock in all facilities assessed, followed by Depo-Provera, condoms, and IUDs. The report also showed that stockouts were more likely to occur in public-sector facilities than in private-sector ones.

Leadership and Coordination

At the central level, the GOT established a Contraceptive Security Committee in 2004, with the RCHS as the chair. The goals of the committee were 1) coordinating solutions to contraceptive security issues and monitoring contraceptive stock status at the central and zonal levels, 2) monitoring actual contraceptive distribution rates versus projections, and 3) monitoring the status of ongoing procurements and upcoming shipments of contraceptive supplies and equipment.[35] Despite these goals, the committee did not have the authority to make higher-level decisions

(e.g., budget allocations) and was unable to effectively facilitate coordination of government and donor-funded commodity-related forecasting activities.[35]

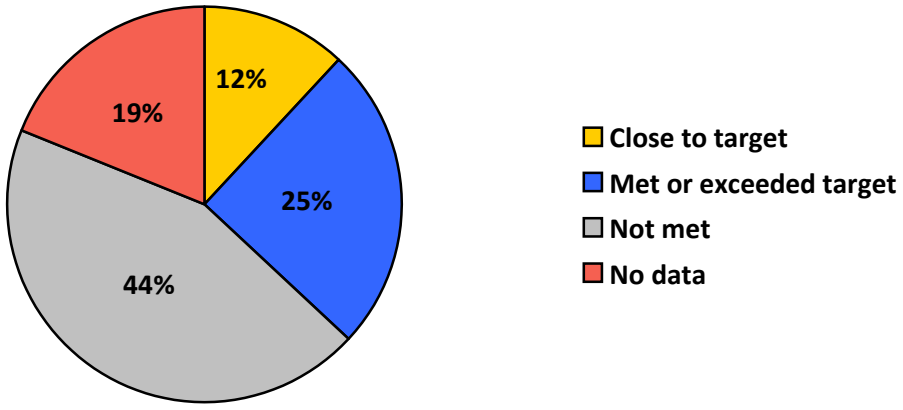
4.3.2 How the NFPCIP Addressed Contraceptive Security

Expanding the availability and choices of safe, effective, acceptable, and affordable contraceptive methods was one of the priority areas in addressing the issues and challenges related to repositioning FP as a national priority for health and development. Contraceptive security (SAA I) was the first among the five strategic priorities in the NFPCIP, with subsequent indicators ensuring that the goals of this SAA were accomplished. Activities within the NFPCIP under SAA I focused on prioritizing contraceptive security at all levels by maintaining adequate procurement, supply, and distribution of FP commodities to meet clients' needs and prevent stockouts. A few activities and indicators related to contraceptive security were also included under SAA III and SAA IV.

SAA I: Contraceptive Security

To achieve contraceptive security, an adequate and consistent supply of contraceptive commodities must occur at all levels. This includes activities to strengthen the accuracy of contraceptive commodity forecasting and monitoring to inform resource mobilization for procurement of commodities. Under SR 1, the NFPCIP aimed to procure adequate contraceptive commodities and supplies to meet country needs. Under SR 2, it aimed to achieve an adequate and consistent supply of contraceptive commodities at all levels. And under SR 3, the plan aimed to broaden the contraceptive method mix by introducing new methods. Figure 15 shows overall indicator progress for NFPCIP implementation in Years 3–6. As observed, only 25 percent of activities under SAA I met or exceeded the target, and 12 percent of activities nearly met the target.

Figure 15. NFPCIP Activity Indicator Progress for Years 3–6 (Number of Activities)



Available Commodities, Finance, and Procurement (Capital)

Throughout NFPCIP implementation, a range of contraceptive commodities were procured both for public distribution and for distribution through private-sector facilities, including those participating in social marketing programs. As shown in Figure 16, during this time, the procurement of some contraceptive commodities exceeded their estimated NFPCIP targets (i.e., female condoms 102 percent, male condoms 859 percent, IUDs 135 percent, implants 263 percent of targets), while other commodities were procured at quantities less than the targeted amounts (i.e., pills 30 percent, CycleBeads 34 percent, emergency contraceptives 54 percent, injectables 56 percent). Figure 17 shows the total commodities procured by source (public versus socially marketed commodities), where publicly procured commodities exceeded socially procured commodities across all methods, with the exception of female condoms.

Figure 16. Target and Procured Family Planning Commodities, Years 1–6

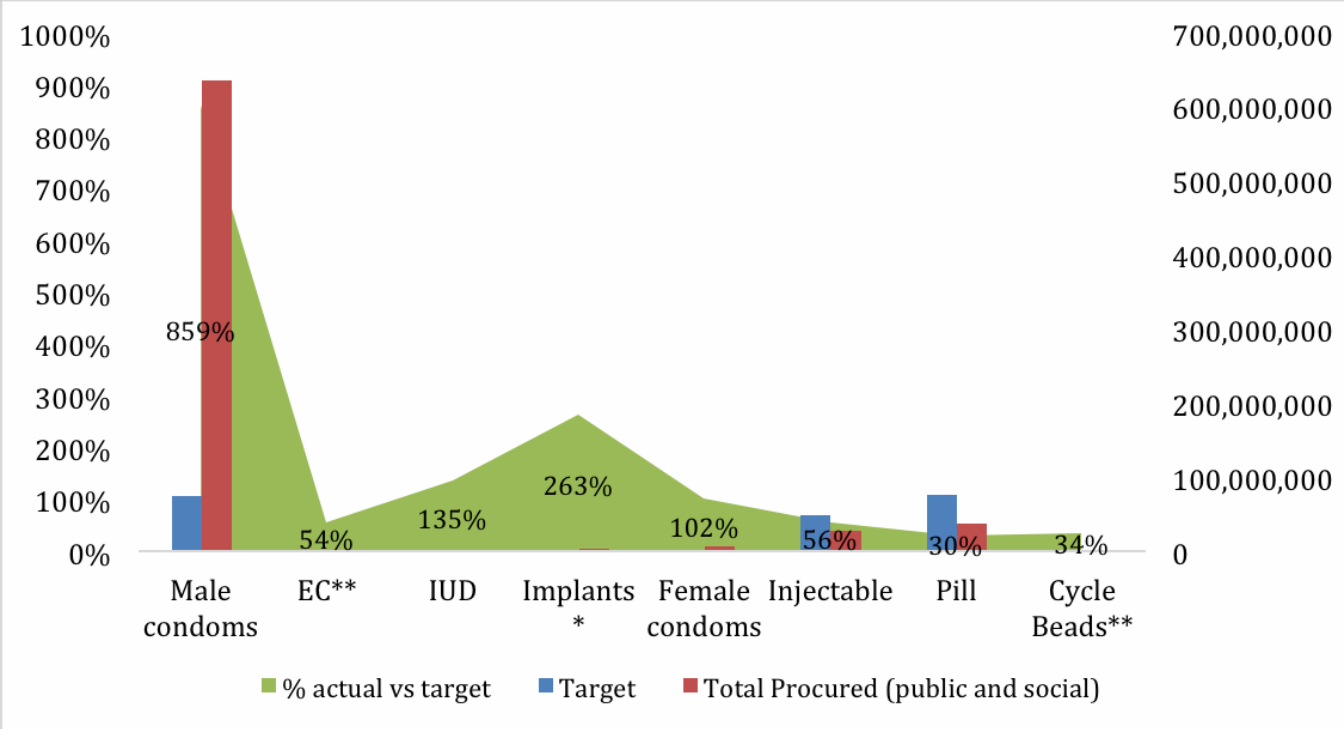
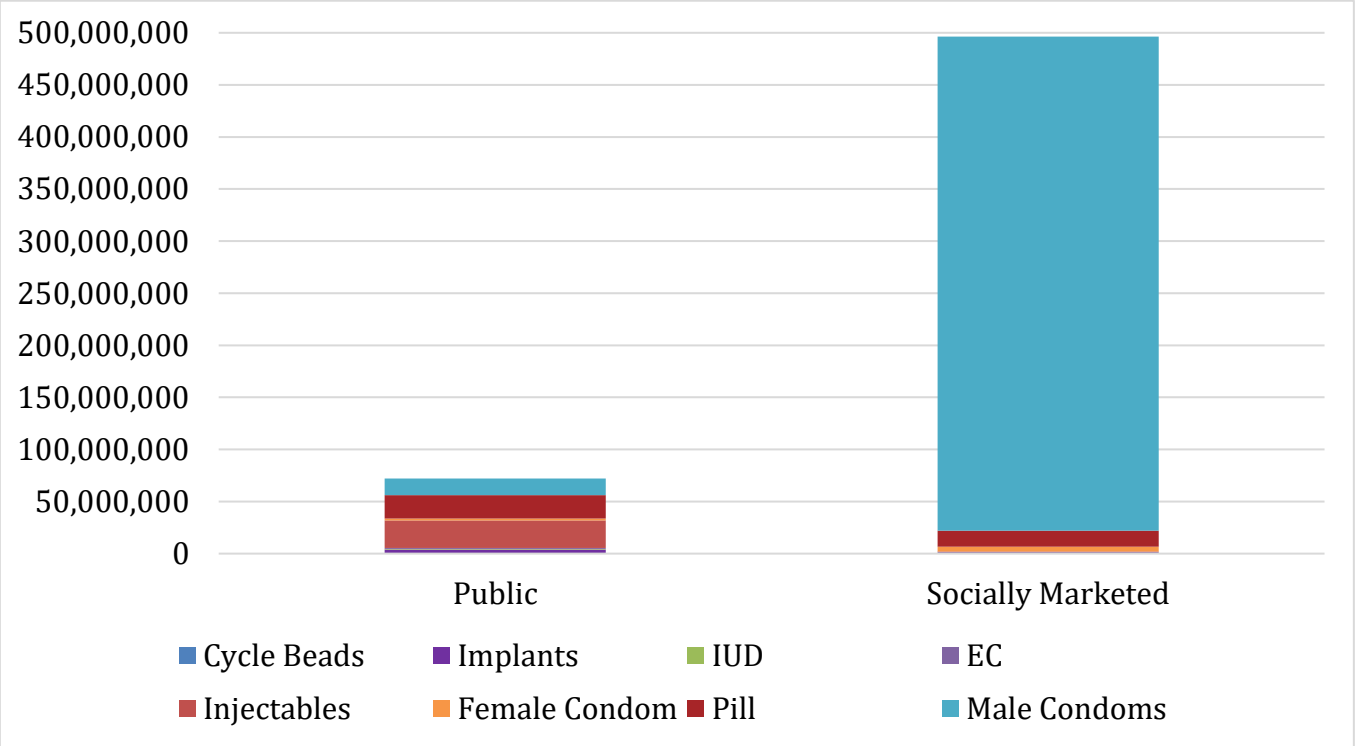


Figure 17. Total Commodities Procured by Source, Years 1–6



In Year 1, 99 percent of the financial resources for SAA I were spent on procuring commodities; in Year 2, costs for commodities exceeded allocated resources by 187 percent. The NFPCIP also addressed capital in SAA I through the following:

- In Year 2, a rapid assessment was conducted with selected private-sector companies, and advocacy activities were conducted to solicit funds.
- In Year 2, 25 CSOs were trained on fundraising and resource mobilization.
- In Years 3–6, 25 percent of the financial targets in SAA I were met or exceeded.
- In Years 3–6, only 30 percent of the financial target was met to procure adequate contraceptive commodities and supplies to cover all country needs, including method-mix projections to meet the One Plan target by 2015.

Forecasting and Supply Chain Capacity

Throughout NFPCIP implementation, capacity building to enhance quantification and forecasting skills occurred with health care workers and pharmacists, including through training on the ILS Gateway. The ILS Gateway, a medicine and supply management system, transitioned the commodity supply and delivery system from the scheduled delivery of fixed quantities of

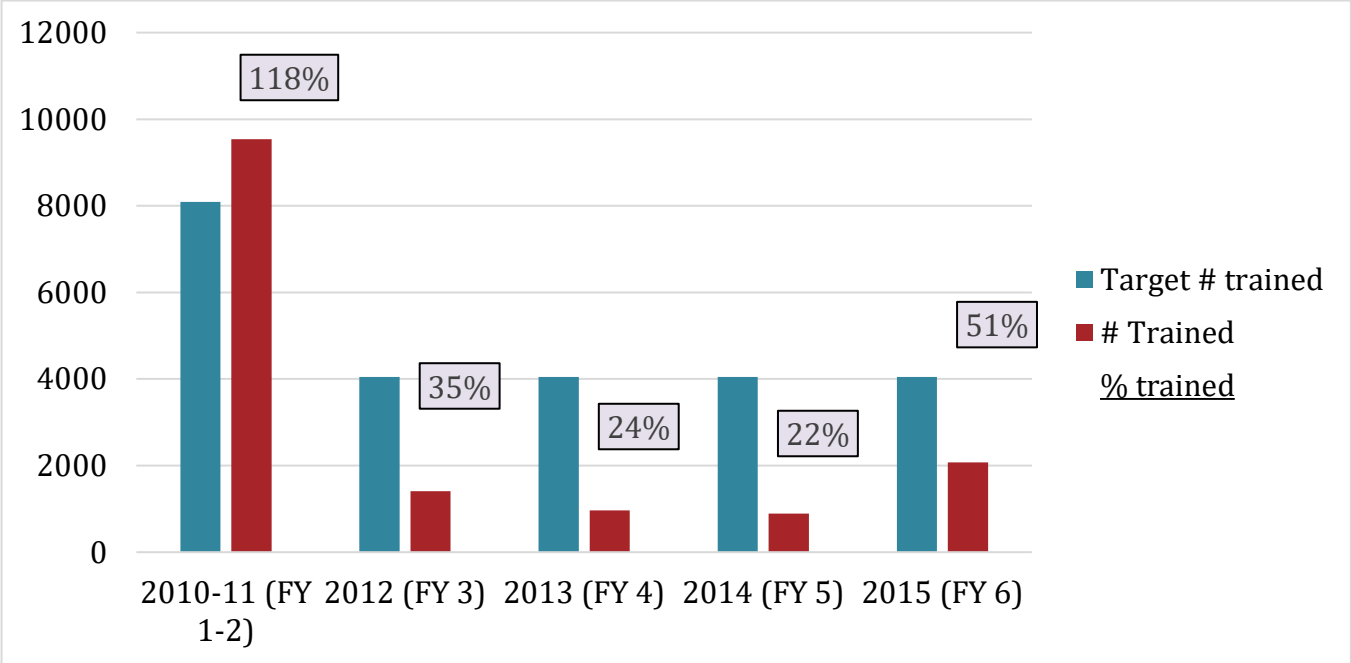
medicines and supplies to health facilitates, to a system in which facilities ordered their own supplies based on projected need.[36] The MOHSW's ILS Gateway was developed and piloted in four regions in Year 1, and it was subsequently scaled to 14 regions in Year 2. The system has proven to be more efficient and effective than the previous, paper-based option.[36] Results include the following:

- In Year 2, 291 quarterly and 54 monthly visits were made to network health care facilities to ensure no stockouts had, or would, occur.
- In Year 3, 38 district and regional pharmacists attended an ILS Gateway training of trainers.
- In Years 3–6, under SR 2, 76 trainings were held to build the capacity of public- and private-sector officials at the national level to effectively quantify and forecast contraceptive commodities. The trained officials were from the RCHS, Pharmaceutical Service Section (PSS), MSD, Tanzania Marketing and Communications Company Limited (T-MARC), PSI, Marie Stopes Tanzania (MST), and UMATI (63 percent of the target of 120 trainings).
- In Years 1–6, 14,876 health care workers from all districts in Tanzania's mainland were trained to use the ILS Gateway (target was 24,270) (Figure 18).
- In Years 3–6, 31 supportive supervision and on-the-job trainings were held for staff at MSD headquarters, zonal MSD, health facilities, pharmacies, retail outlets, and drug shops for contraceptive commodities.

Leadership and Coordination

In Years 1–6, 15 quarterly meetings were held with a team of logistic and supply chain focal people from MSD, the RCHS, PSS, the World Bank, JSI Deliver, and the MOHSW's Procurement Unit to discuss technical issues pertaining to forecasting, procurement, storage, distribution, and reporting on FP commodities.

Figure 18. Number of Health Care Workers Trained on ILS Gateway versus NFPCIP Targets, Years 1–6



4.3.3 Results of the NFPCIP

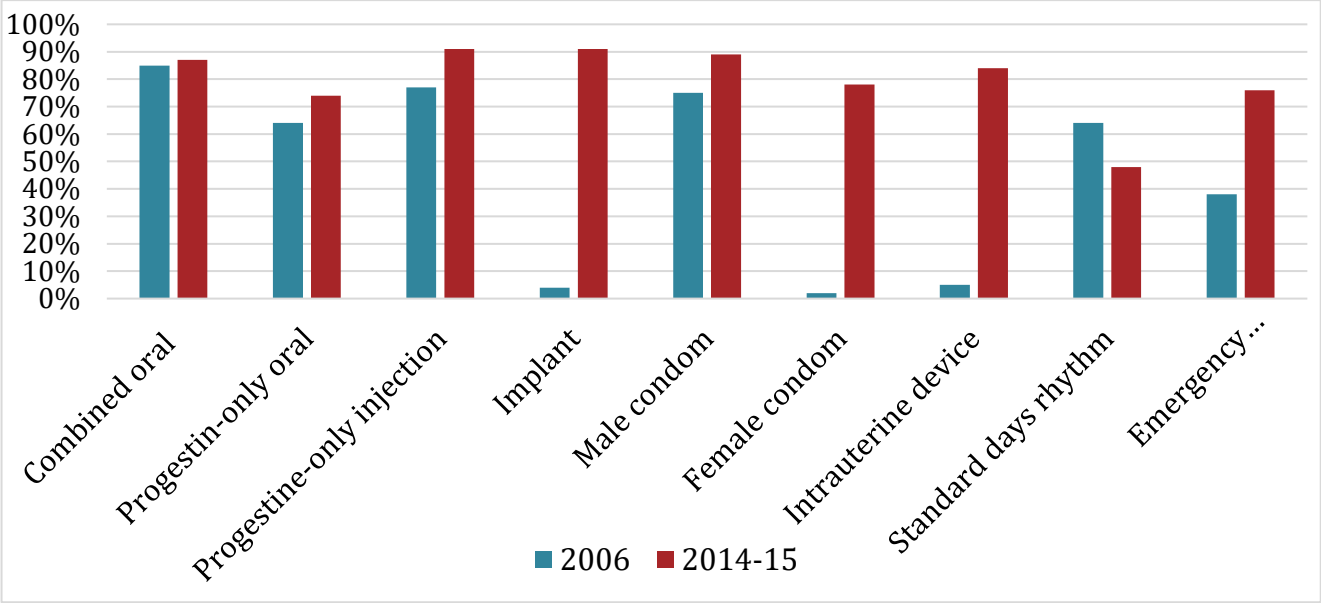
Available Commodities

- According to end-use verification reports from John Snow, Inc. (JSI) for 2012–2015, 87 percent of facilities that provide combined oral contraceptives had the pills in stock.[37] Eighty-nine percent of facilities that provide male condoms had them available on the day of the assessments. Nationwide, only 60 percent of facilities that reported providing FP methods had every method that they provide available on the day of the visits. Stock of these methods was mostly reported at faith-based (71 percent), private for-profit (64 percent), government (59 percent), and parastatal (54 percent) facilities.

- Data from the 2006 and 2014/2015 service provision assessments (SPAs)[30,36] examined the types of contraceptive methods offered and available on the day of the survey at facilities in all eight zones. The assessment evaluated hospitals, health centers, and dispensaries (managed by government, private, faith-based, and "other") in all eight

zones in 2006 and 2014/2015. Since NFPCIP implementation, most commodities are available at the MSD central warehouses. The data suggest stockouts decreased across all commodities except for CycleBeads for the "standard days rhythm method" (which is how it was labeled in the SPA, even though the Standard Days Method and the rhythm method are two separate methods). The largest increases in contraceptive commodities offered and available were for implants, female condoms, IUDs, and emergency contraception. [30, 36]

Figure 19. Percent of Contraceptive Commodities Offered and Available on the Day of Survey, All Facilities, by Method



Source: TSPA 2006 & 2015

Forecasting and Supply Chain Capacity

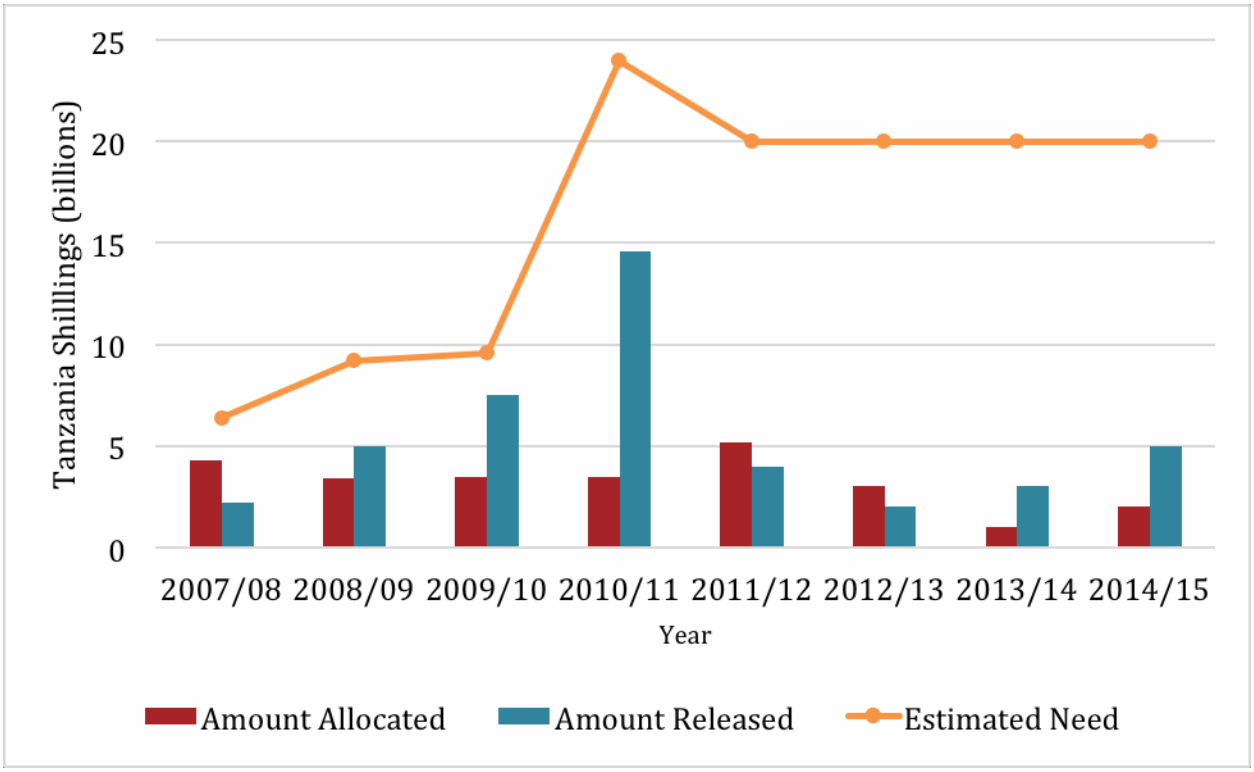
- After NFCIP implementation, national modern CPR (mCPR) projections were calculated into the commodity quantification process. As a result, commodity forecasts were increased to include projections necessary to cover increases in modern contraceptive method use and improved estimations of the financial resources needed for procuring commodities in each year.
- With the introduction of ILS and rollout of ILS trainings to health care workers throughout all regions, users of ILS are reporting complete, timely, and accurate data on commodity consumption, and requesting orders are now informed by service utilization data.

- Available service utilization data now inform the quantification and forecasting processes.
- A special provision in the 2011 Public Procurement Act was added to fast track procurement of essential medicine and supplies, including FP commodities.
- The ILS has improved the timeliness in report submissions by sending SMS reminders to health care workers' mobile phones when it is time for them to submit their reports.
- The ILS has also improved supply management as district pharmacists and the zonal and central MSD now see the supply status of commodities status at each level.

Finance and Procurement (Capital)

- The commodity budget nearly tripled from Tsh 9.2 billion in 2008/2009 to Tsh 24 billion in 2010/2011. Following the establishment of a specific line item for FP in 2010 in the GOT national health budget, the GOT funding allocation for contraceptive commodities more than doubled, from Tsh 0.5 billion in 2010/2011 to Tsh 1.2 billion in 2011/2012. Unfortunately, in 2012/2013 the GOT did not allocate any funds for FP, but in fiscal year 2014/2015 the GOT allocated Tsh 2 billion for contraceptive commodities procurement. Figure 20 shows FP funding for commodities in Tanzania by need, allocated amount, and amount released.
- A special budget line item for FP was included in updates to the MTEF.

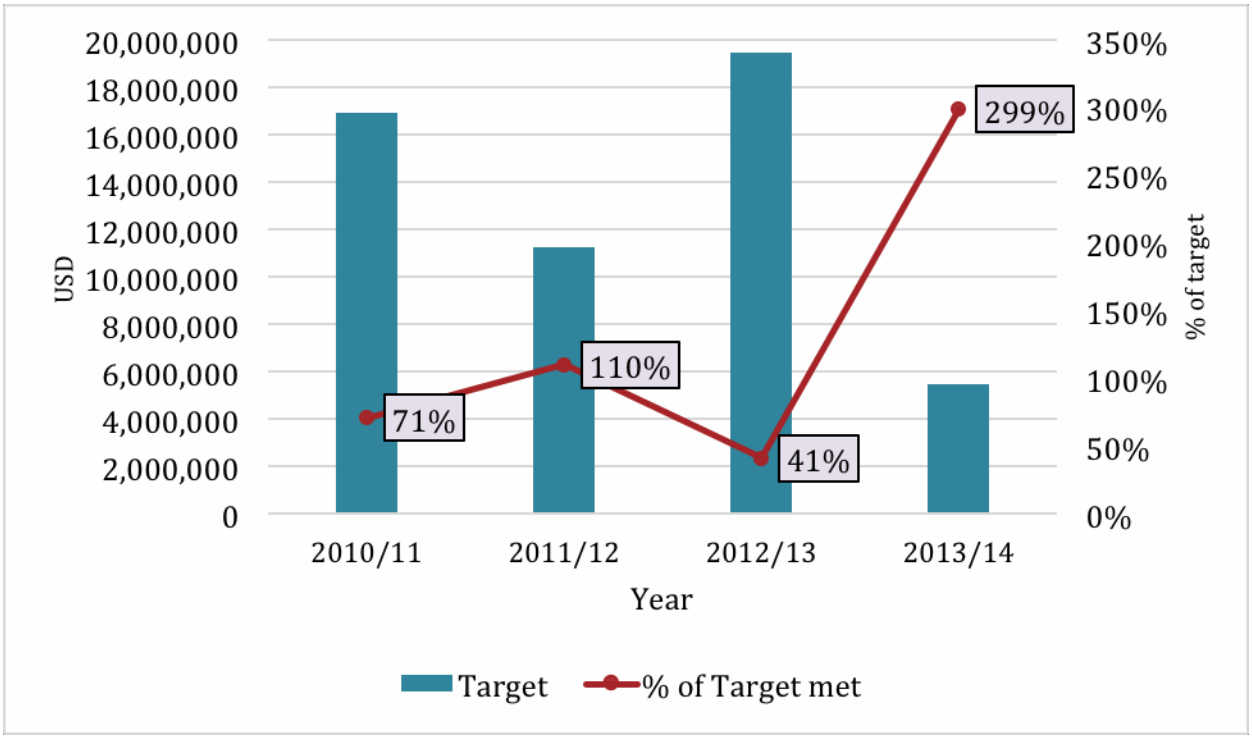
Figure 20. Trends in Contraceptive Commodities Funding in Tanzania, 2007–2015



Source: MOHCDGEC-RCHS commodity expenditure data

Figure 21 shows the country's estimated dollar value of contraceptives that needed to be procured for the public sector for particular fiscal years and the percent of the target that was mobilized. The information is from JSI's Tanzania Contraceptive Security Indicator Dashboard,[37] and since the project ended before the NFPCIP did, only the data for the four years of implementation (missing Years 5 and 6) are presented. As observed, in two of the four years (2010/2011 and 2012/2013), the country did not meet the required estimated budget.

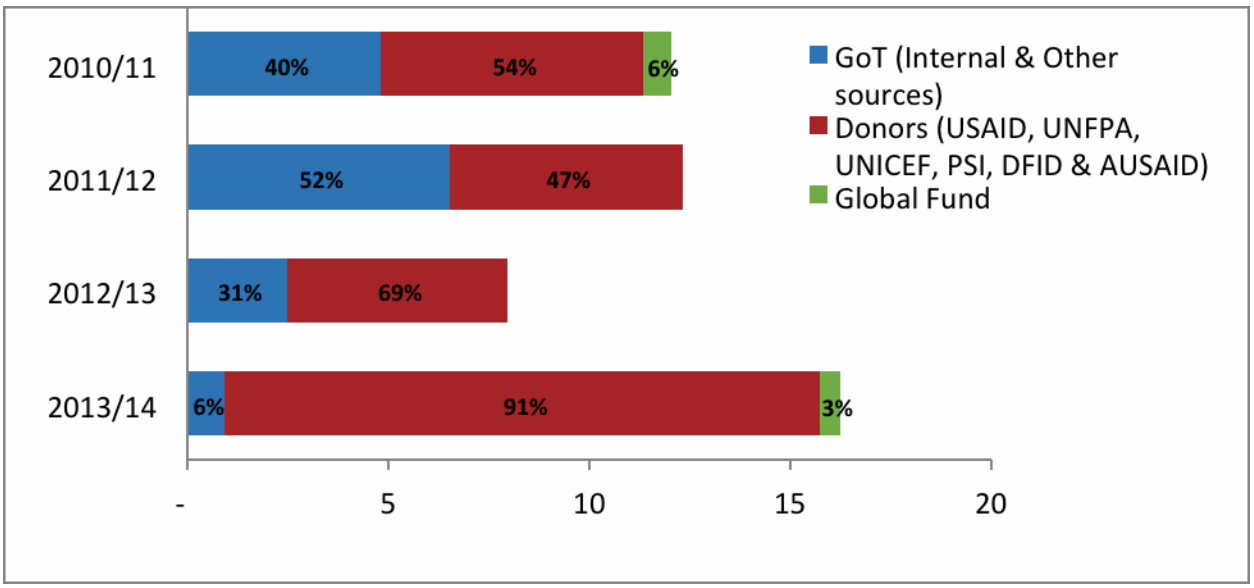
Figure 21. Targeted Amount to Be Spent on Contraceptives and Percent of Targeted Amount Mobilized, per Fiscal Year



Source: Tanzania Contraceptive Security Indicator Data Dashboard (JSI)

Figure 22 presents information on contraceptive financing. The graph shows the total amount spent (in US$ million) to finance contraceptives in each of the four fiscal years, with the percent contribution from different funders. Encouraging results were observed for GOT financing on contraceptives compared with allocations prior to the NFPCIP. However, government funding started off strong in the first two years but decreased over the next two years, with donors providing the majority of funding for commodities in most years.

Figure 22. Total Amount Spent per Fiscal Year (US$ Million)



Source: Tanzania Contraceptive Security Indicator Data Dashboard (JSI)

Leadership and Coordination

- Increased collaboration between FP providers occurred after NFPCIP implementation. For example, district coordinators now communicate the status of their stock to each other. In cases of excess commodities or a commodity shortage, an exchange occurs: a facility with excess supply re-distributes that excess to a facility (or facilities) with a commodities shortage.
- Districts now agree to allot funding for FP activities, due to advocacy efforts with district leadership.[38]
- Experts from GOT and partners are now collaborating in quantification and forecasting activities for both public and private distribution of contraceptive commodities.
- Implementing partners are better coordinated at the district level than prior to the NFPCIP. They share their outreach plans with district coordinators to facilitate on-time and adequate supply and availability of commodities. Supportive supervision of this process now occurs, including follow-up on decisions.
- With the introduction of CCHPs, districts and councils are now increasingly budgeting and allocating funds from their own sources for FP commodity procurements. A more open discussion and dialogues are ongoing to advocate for inclusion of FP in health insurance plans.
- The Contraceptive Security Task Force, GOT, implementing partners, and development partners now collaborate and discuss contraceptive security issues. Contraceptive task force meetings occur regularly and frequently, and decisions are made at those meetings (and action taken thereafter) to prevent expiration and stockouts of commodities in both public- and private-sector facilities.

4.3.4. Analysis of Gaps

Forecasting and Supply Chain Capacity

- There are still challenges to acquiring service utilization data, impeding forecasting exercises.
- Continued efforts are needed to implement evidence-based approaches to ensure increased access to all FP methods for low-income and vulnerable groups.
- Some providers are still unable to forecast for FP commodities.[38]
- Determining the target population in need of FP commodities and services (for forecasting) has not been consistent, particularly in urban areas where migration is high. This results in quarterly forecasting that may end up being insufficient.[38]
- The goal of SR 5 in SAA III was to orient 600 CHMTs, zonal training institutions, and The Association of Private Health Facilities of Tanzania on the plan and their expected roles to support implementation and to expand and strengthen the private sector. This goal was not met, and no representatives were reported as trained.
- Training on the ILS was inadequate for health care workers and pharmacy staff.

Finance and Procurement (Capital)

There is a lack of adequate infrastructure, including lack of space to provide FP services at some facilities.

Leadership and Coordination

- In SR 1 of SAA IV, the goal to conduct a one-day advocacy meeting with high-level decision makers from the public sector to mobilize government and donor funds to cover all public-sector contraceptive commodity needs in the country was not met. This meeting was not reported as occurring.
- Implementing a coordinated advocacy strategy that acts on information gathered during activities and assessments continues to be a challenge.
- There is a shortage of commodities at private facilities (those not under the MSD system) due to a recent directive requiring districts not to order contraceptive commodities for private facilities. This is a particular concern because many women in urban areas are served by these private facilities.[38]
- There continue to be challenges in communication between health facilities, ADDOs, and pharmacies. There is also a lack of clarity at ILS trainings about who should order FP commodities (pharmacists versus district reproductive and child health coordinators).[38]

Political Commitment

Local ownership to ensure sustainability has not fully been established. There is still heavy reliance on global/implementing partners.[38]

4.3.5. Key Recommendations

1. Implement interventions to strengthen a total market approach to increase the number of available options for those who can afford to buy FP commodities from private facilities.

This will be particularly important for those in urban areas. Strengthening a total market approach will also reduce the service burden on public/parastatal health facilities.

2. ***Improve the availability of LARCs (i.e., IUDs and implants) through socially marketed channels.***

3. ***Ensure data on contraceptive use from ADDOs and pharmacies are captured in the DHIS-2.***

   This can happen through developing a tool to capture data reported by ADDOs and pharmacies and conducting trainings for workers on how to use the tool, including monitoring the progress of reporting.

4. ***Provide support to health care workers trained in the ILS.***

   Opportunities for support must continually be identified and cultivated to meet ever-expanding needs

5. ***Continue training and medical detailing to all FP dispensers, along with provision of screening checklists and other job aids.***

   This will help ensure the quality of FP services. Periodic monitoring of the service quality by CHMTs will be essential.

6. ***The GOT should support quantification meetings, including supporting health care providers to be trained on using the ILS Gateway.***

7. ***Continued advocacy is needed to ensure that adequate funding is allocated to meet the evolving needs of the FP program.***

8. ***Assess the feasibility of ordering FP commodities at the district level.***

9. ***Promote public-private partnerships in FP resource mobilization.***

   This will require broader involvement of insurance companies in the FP agenda. It will also require better communication about FP commodities. For example, if private facilities have commodity stockouts and the government has an excess of commodities, then district reproductive and child health coordinators should collaborate with the private sector to ensure that adequate FP commodities are available to both the public sector and the private sector.

10. ***Establish a national high-level FP/contraceptive commodities champion to ensure sustainable advocacy efforts for increasing commodity availability on both local and central levels.***

11. Ongoing vigilance is required to ensure that FP continues to be included in pertinent policies.

4.4 Area of Measurement 3: Demand Generation

Definition

Demand generation for FP can occur in three ways: 1) creating users, 2) increasing demand among existing users, and 3) taking market share from competing behaviors and competing products or services.

Key Insights

- Not enough demand generated from targeted communication campaigns
- Less performance on use of commercial marketing approach vs. social marketing
- Less performance on activities related to training and monitoring on ADDOs
- Whether social and behavior change communication (SBCC) efforts address issues of behavior, attitude, and practice needs to be further investigated
- A need to focus efforts on high-impact interventions

Recommendations

- Ensure that SBCC interventions under the NFPCIP II are informed by segmentation analysis and address issues of behavior, attitude, and practice.
- Continue to have activities related to champions under the NFPCIP II, but make sure the activities have clear action plans and indicators, and that the activities are monitored and documented.
- Explore underutilized mass media approaches (e.g., different social media and TV in urban areas) in the NFPCIP II.
- Include activities that will involve the CHW cadre in FP demand-generation activities at the household level.
- Continue re-launching the Green Star Campaign in the remaining regions and consider rebranding it to resonate better with young people.

Demand generation is one of the key priority areas in any FP program. Demand generation increases awareness of and demand for health products or services among a particular intended audience through SBCC and social marketing techniques. It can occur by creating new users, increasing demand among existing users, and taking market share from competing behaviors and competing products or services.[39]

4.4.1 Status and Key Issues Prior to the NFPCIP

Reaching a CPR of 60 percent by 2015 required the need to generate new demand for FP services. Tanzania was already facing rising demands for FP services prior to the development of the NFPCIP—from 38 percent in 1991–1992 to 51 percent in 2004–2005.[40, 9] Hence, priority was given to fulfilling the unmet need at that time and then subsequently focusing on generating new demand.

Although no measurable targets were described in the NFPCIP, the plan intended to measure the following indicators under the TDHS and look at the status prior to, and over the period of, the NFPCIP. Results for each of the following indicators are presented below:

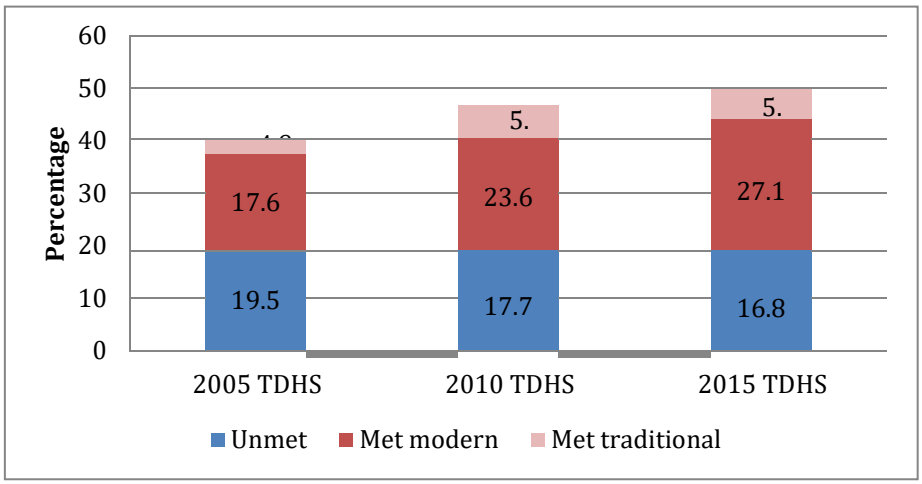
- Total demand for FP
- Unmet need
- Demand satisfied
- Exposure to FP messages through mass media
- Knowledge of a broad range of contraceptive methods
- Future intent to use contraceptives

FP demand is represented as the combined need for FP—both met need for modern and traditional contraceptive methods, and unmet need. Data from the TDHSs conducted in 2004, 2010, and 2015 were used to observe the following trends.

Moderate Increase in Total Demand

Over the past 10 years, and particularly between 2010 and 2015, there were modest increases in total FP demand among all women (Figure 24). Demand grew by only 7 percentage points between 2005 and 2015 (from 42 percent to 49.2 percent) and by 2.7 percentage points between 2010 and 2015 (a pace slightly slower than that of 4.6 percentage points between 2005 and 2010).[9, 5, 13]

Figure 24. Trends in Total Demand among All Women (Currently Married and Sexually Active Unmarried) Ages 15–49



Decrease in Unmet Need

Unmet need is decreasing at a slow pace, with a decrease of 1.8 percentage points between 2005 and 2015 and an even smaller decrease between 2010 and 2015. On the other hand, an increase in need met by modern methods is encouraging. This may mean that the increase in modern contraceptive use observed during the 2015 TDHS may have come from those with no contraceptive needs previously, since there was a slight change in the proportion with unmet need; however, the proportion using traditional methods was relatively unchanged. Or, based on stakeholder opinion, this may have been the result of a subset of those who had unmet need shifting to contraceptive use and a subset who previously had no contraceptive needs shifting to having unmet need. Overall, as far as total demand is concerned, results are not discouraging. Unmet need is declining, though at a very slow pace, and met need continues to increase at a slower pace.

Increase in Total Demand Satisfied by Modern Methods

The gap between the percentage of total demand and the percentage of demand satisfied with modern methods is getting narrower. More married women are now satisfied (63 percent), and the majority of those satisfied (53 percent) are using modern methods to satisfy their demand.[13]

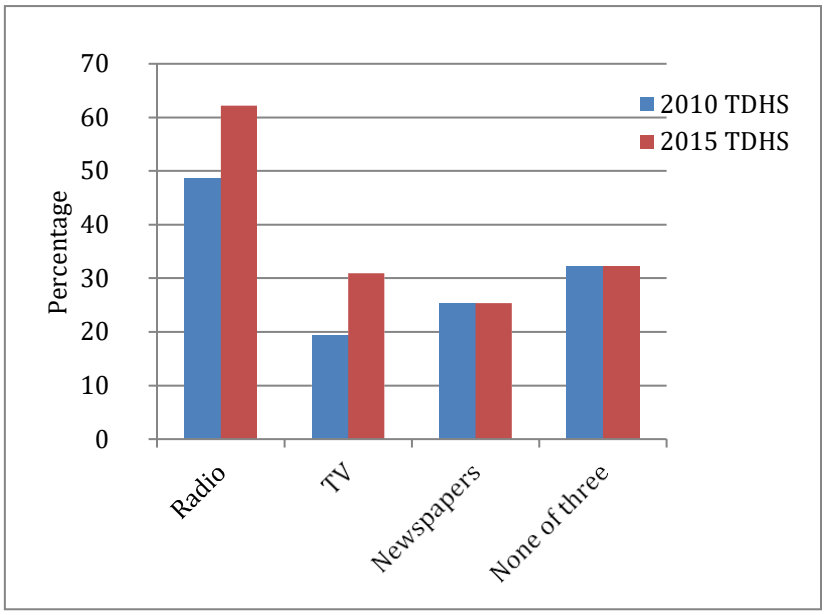
Increased Exposure to Family Planning Messages

Ensuring that individuals receive FP information and messages from a variety of sources is one of the key elements for creating and increasing demand. According to data from the TDHSs conducted in 2010 and 2015 (Figure 25), the percentages of women and men who have received FP messages from radio and television has increased. Radio remains the most common source of FP messages for both men (75 percent) and women (62 percent).

The recent TDHS (2015) also looked at respondents' general exposure to mass media and Internet use. Radio was found to be the most frequently accessed form of media among the three types (i.e., radio, newspaper, TV); 45 percent of women and 60 percent of men listen to the radio

at least once a week. A small proportion of men and women reported to have ever used the Internet in the past 12 months (8 percent of women and 19 percent of men); although the percentage was higher among men, more of the women (51 percent) than the men (44 percent) who had used the Internet at all in the past 12 months reported to have used it almost every day.

Figure 25. Percent of Men and Women Who Have Received Messages about Family Planning from Three Media Sources



For the first time, the 2015 TDHS also looked at mobile phones as a source of FP messages. At least 5.2 percent of women and 6.2 percent of men reported receiving messages by mobile phone.[13]

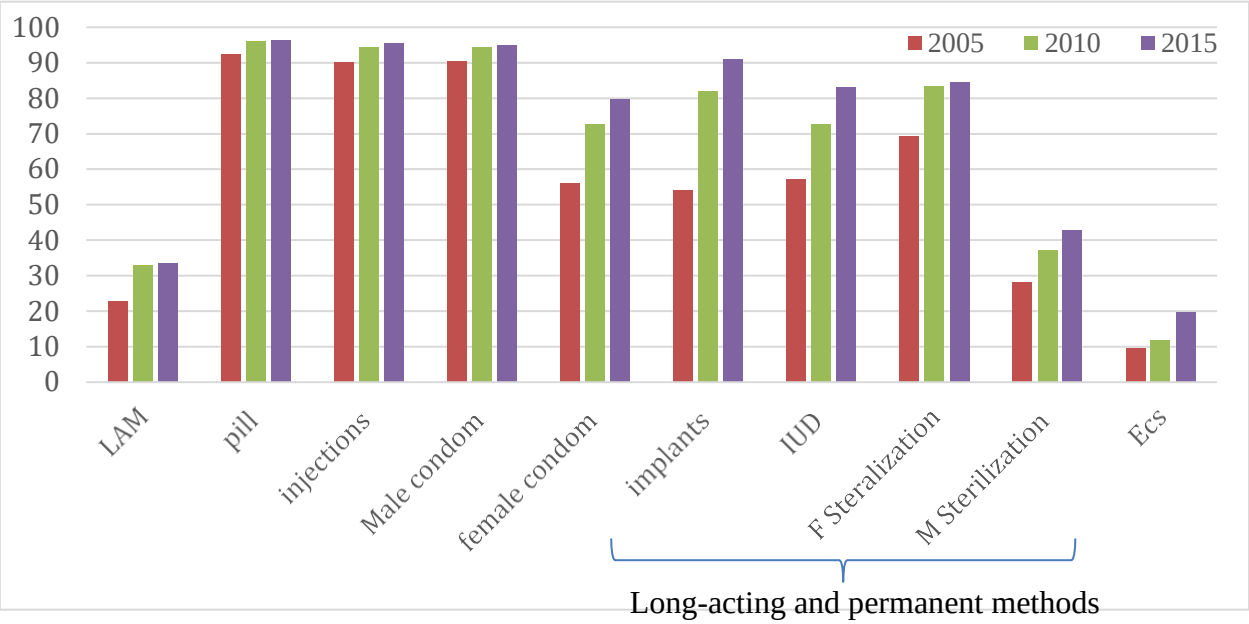
Increased Knowledge of a Broad Range of Contraceptive Methods

Ninety-eight percent of both men and women reported knowing at least one contraceptive method in the 2015 TDHS; the mean number of methods known was high, at 8.7. The most well-known methods were pills, male condoms, injectables, and implants (Figure 26). These results are the same as those of the 2014/2015 SPA,[36] in which exit clients who received, were prescribed, or were referred for the indicated method were interviewed to learn the percentage who knew the correct response to a question pertaining to the method. The SPA report revealed that high percentages of clients gave correct responses to questions about pills, female and male condoms, injectables, and implants. Clients were less successful in answering the question about the IUD, and this was more prominent among urban clients than rural clients and among those at private for-profit facilities than those at government and faith-based ones.

Over the years, however, long-acting methods have become increasingly popular among married women. Awareness of implants has risen considerably, while that of IUDs and male sterilization

have risen more steadily. Emergency contraceptives are also becoming increasingly popular (Figure 26).

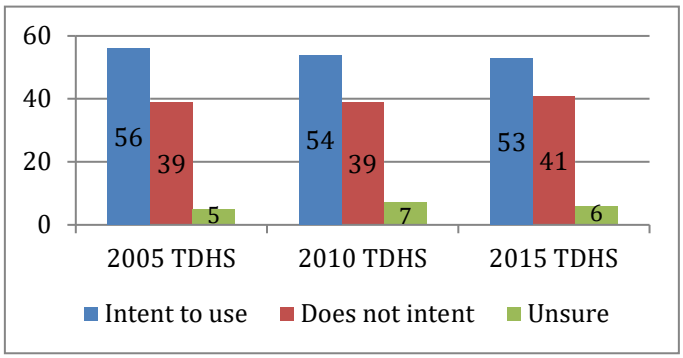
Figure 26. Knowledge of Contraceptive Methods, 2005–2015



Decrease in Future Intent to Use

Intent to use is an important indicator of potential demand for FP. As shown in Figure 27, in the 2015 TDHS, more than half of the currently married women who reported not using any FP method (53 percent) said that they intended to use a FP method in the future, 41 percent had no intention to use contraception, and 6 percent were unsure.[13] We observed a decrease in the number of currently married women who intended to use a method in the future—a slight decrease of 2 percentage points from 2005 to 2010, and a slighter decrease of 1 percentage point between 2010 and 2015. On the other hand, we observed a slight increase in women who did not intend to use a method, of 2 percentage points, from 2010 to 2015.

Figure 27. Future Use of Family Planning



4.4.2 How the NFPCIP Addressed Demand Generation

The NFPCIP prioritized demand generation activities mainly in SAA IV (Advocacy and Strategic Communication) with the focus of addressing the knowledge-use gap and demand for FP that must go beyond maintaining current levels of use and meeting unmet needs in the country. The NFPCIP did this through implementing comprehensive SBCC campaigns that addressed key barriers to FP use, including fear of side effects, preferences for high fertility, and myths and misconceptions. On the other hand, SAA III (Service Delivery) had few activities that looked at expanding FP through social marketing and commercial sectors, and activities that looked at increasing acceptability and utilization of FP services by men.

Figure 28 shows the six elements of demand under EngenderHealth's Supply-Enabling Environment-Demand (SEED) Programming Model.[41] These six elements, described in more detail below, were used as indicators to assess demand-generation activities in contributing to the increasing demand and adoption of contraceptive methods over the five-year performance period of the NFPCIP.

Figure 28: SEED Model: Elements of Demand

- ✓ **The program reduces the cost of FP to increase demand.**
- ✓ **An SBCC strategy for FP is in place.**
- ✓ **Commercial and social marketing are used to create demand.**
- ✓ **The FP program utilizes mass media SBCC approaches.**
- ✓ **The FP program engages communities and champions in SBCC.**
- ✓ **The FP program utilizes peer education.**

Element 1: The program reduces the cost of family planning to increase demand.

FP services and commodities in Tanzania were provided free of charge at public facilities even before NFPCIP implementation. Indeed, TDHS reports over the past 20 years (1992–2005) have shown that cost is not a reason for not intending to use contraception. Looking at data from 2015, cost scored the lowest, by 0.6 percent among 12 reasons for not intending to use contraception.[13] Reasons with the highest scores were "wanted to get pregnant" (38 percent) and "side-effects/health concerns" (26 percent).

The majority of Tanzanians source their contraceptives methods from government/parastatal facilities, where they are provided for free. However, non-government facilities are on the rise as a source of FP methods. Between 2004/2005 and 2015, the percentage of women who accessed FP services from non-government facilities rose from 32 percent to 39 percent.[9, 13] Although contraceptives at the non-government facilities are procured through the public-sector system and supplied for free, these facilities can charge a nominal service/consultation fee that may impose a barrier to access.

Further, neither private nor public insurance in Tanzania includes FP in its benefit package. Hence, one of the activities under the NFPCIP was to advocate for evidence-based financing strategies such as private and public health insurance, with the aim of enhancing and sustaining adequate FP resources. These advocacy efforts yielded very small advancement—the private insurance company AAR recently (in 2015) agreed to cover FP services and commodities in its health insurance benefits package. The government health insurance scheme—the NHIF—boasts the highest coverage (22.7 percent of the population)[42] but does not cover FP services. More advocacy needs to be done to support inclusion of FP coverage under health insurance packages offered by private, public, and community companies, especially as the private sector takes on a more active role in providing contraceptive services. In addition, since NHIF covers more pharmacies and ADDOs than other insurance companies, and since the private sector is increasingly providing more short-acting methods (mainly from pharmacies and ADDOs), it is important for the inclusion of FP coverage under the NHIF, which also manages the Community Health Fund.

Element 2: An SBCC strategy for family planning is in place.

National health communication and strategies to create demand for FP can inform people about FP services available in their communities, combat myths and misconceptions that inhibit use, and increase knowledge about contraceptives. The NFPCIP prioritized activities that focus on conducting sustained national FP advocacy campaigns under SAA IV (Advocacy and Strategic Communication).

The country does not have a national SBCC strategy for FP. Several adolescent SBCC working groups were created within the RCHS but not for FP services and products. Specific FP campaigns that included SBCC strategies were Jiamini and the Green Star Campaign.

Element 3: Commercial and social marketing are used to create demand.

An effective demand-generation program uses commercial and social marketing approaches to create demand. Commercial marketing uses various forms of media to sell products, as per the

SEED guide.[41] "Commercial marketing involves audience research, product analysis, message design, distribution, advertising, and evaluation." Social marketing refers to "an approach used to develop activities aimed at changing or maintaining people's behavior for the benefit of individuals and society as a whole."[43]

While the sixth strategic action of SAA III (Service Delivery) under the initial NFPCIP[2] included activities to expand FP through social marketing and the commercial sector (private sector), the eighth strategic action of SAA III under the amended NFPCIP[44] also included an activity to increase awareness through promotional activities on demand creation (i.e., mass media, interpersonal communication [IPC]).

Activities reported by implementing partners during NFPCIP implementation focused less on marketing strategies that were used for specific products or services related to FP to get people to want to use them. In other words, fewer activities were reported in that area than in an area focused on selling subsidized products (number of outlets selling products) with the aim of expanding access.

Results of reported activities under SAA III included the number of identified retail outlets for distribution of socially marketed contraceptive products. A total of 5,239 retail outlets (surpassing the target) were identified. The number of ADDOs selling OCPs and condoms greatly exceeded the target (3,586 percent of the target met), and the number of pharmacies selling IUDs, implants, OCPs, injectables, and emergency contraceptives also exceeded the target (398 percent of the target met).

Reported activities that focused on promoting demand generation under strategic action 8g of SAA III included FP IPC sessions and FP counseling conducted during public events (e.g., White Ribbon Day event, sabasaba) and for salon attendants. FP IPC sessions were also conducted through community group meetings in six regions with a low CPR, reaching 1,432 people from 50 community groups with FP information. Twenty-nine coordinated demand creation campaigns in low-CPR districts/regions were conducted (207 percent of the target met), and 12 national events that promoted FP were conducted (133 percent of the target met) during the NFPCIP.

Other activities included a medical detailing campaign to educate and promote medical products to ADDOs and pharmacies, and yearly meetings with outlet owners to share experiences, promote products, and provide lists of nearby referral facilities.

Element 4: The family planning program utilizes mass media SBCC approaches.

"Mass media channels are an effective way to communicate with broad audiences about FP; numerous studies have shown that well-designed mass media campaigns for FP are associated with increased contraceptive use."[41]

One of the NFPCIP activities under SAA IV (Advocacy and Strategic Communication) was to develop, launch, and implement a national FP communication strategy that revitalized the

original Green Star Campaign, which had used effective communication strategies and related media initiatives during the 1990s.

In 2012, the Johns Hopkins University Center for Communication Programs (JHU-CCP) formulated a national SBCC campaign known as Jiamini (which was eventually replaced by the renewed Green Star Campaign). Running for six months from April through September 2012, Jiamini was designed to empower women to initiate and continue use of modern methods of FP, and encourage male support of FP. The campaign used different communication channels including radio, TV spots, magazines, an SMS platform, and promotional materials, and it included an evaluation component. In addition to reaching the targeted audience (women and couples with unmet need), Jiamini also reached the important demographic segments of men and of individuals living in rural areas.[45]

Guided by the NFPCIP, the Green Star Campaign was re-launched in 2013. The revitalized campaign emphasized the importance of healthy timing and spacing of pregnancy, disseminated information on available FP methods, and used mass media approaches to address concerns on side effects, myths, and misconceptions. SBCC approaches used during the re-launch included the following:

- Radio and TV spots
- Provision of free FP information through an SMS system (m4RH)
- Production and distribution of a series of brochures describing FP methods
- Promotional items and branding of health facilities with Green Star signage
- Dissemination of the national FP message guides to ensure accuracy and consistency in messages across communication channels
- A community resource kit designed for implementation by community volunteers

The Green Star Campaign was re-launched at the national level followed by regional re-launches in 10 of 30 regions in Tanzania during both phase I (Oct 2013) and phase II (Oct 2014). In addition, a national, household-based cross-sectional survey was conducted in 2014[44] to assess the impact of the campaign. Approximately half of the respondents reported exposure to the campaign within the previous six months, and exposure to the campaign was significantly associated with increased knowledge of FP methods, with those exposed being much more likely to talk to their partners about FP.

As a result of the launch, 23,630 radio spots on FP (99 percent of the target met) were produced and aired; however, no TV spots were produced and aired. The production and distribution of revised FP materials was successful, with the number of materials produced exceeding the target (771 percent of the target met) and the number of materials distributed close to the target (98 percent of the target met). The target for the number of printed messages produced to reach men in all regions was not met, while only 3 percent of the target was met for the number of radio spots aired to reach men in all regions. Using mobile phone technologies and social media to increase demand and to support method continuation were also among the activities under SAA IV, and these initiatives have been successful in reaching their targets. The number of reported hits to the SMS system (m4RH) was close to the target (97 percent of the target met), and 100 percent of the target was met for the number of reported subscribers.

Element 5: The family planning program engages communities and champions in SBCC.

Although the NFPCIP included several activities to establish and support a network of champions under SAA IV (Advocacy and Strategic Communication), most reported activities focused on establishing, orienting, and training rather than on supporting the actual work of champions. Reported activities included conducting workshops to build the capacity of FP champions and to orient journalists; 93 FP champions (13 percent of the target met) and 21 media champions (i.e., journalists) (12 percent of the target met) were oriented.

Addressing demand also includes training providers and champions to recognize gender-related obstacles to effective use of FP. Reported activities showed poor advancement in this area, as only 70 service providers (2 percent of the target) were trained on male and couples counseling, and only 144 champions (7 percent of the target) were trained on how to influence men in FP at the community level.

SAA III (Service Delivery) of the NFPCIP included community and workplace (e.g., mining, fishing camps, construction) outreach events targeting men, with the aim of increasing male acceptance and utilization of FP services. For community outreach events, the target was exceeded (125 percent of the targeted men were reached). The number of outreach events conducted to reach men at their workplaces was close to the targeted number (76 percent), although the number of men who received FP services through these events was poorly reported.

Element 6: The family planning program utilizes peer education.

Evidence shows that people, especially youth, often trust information from peers more than information from non-peers.[46] Peers are often considered better, more trusted communicators of FP messages and have a demonstrated positive effect on knowledge, attitudes, social norms, motivation, and behaviors related to FP.[46]

The NFPCIP recognized the importance of training and supporting peer educators, with the aim of increasing access and use of FP services among youth. Reported results from NFPCIP implementation showed modest advancement in this area. Although the target under SAA III (Service Delivery) was to orient and support 2,040 peer educators who were to carry out community events to increase youth uptake of FP services, only 391 (19 percent of the target) were oriented, and 357 (18 percent of the target) were supported to conduct community outreach events.

In 2009, T-MARC started the *Jipende!* program to provide training to salon attendants on issues pertaining to women's health, including FP, breast and cervical cancer, correct male and female condom use, and protection from sexually transmitted infections. The salon attendants are trained as peer educators to pass on this knowledge to their clients, and they sell Lady Pepeta and Dume brand condoms in their shops. More than 250 salon attendants have already graduated as peer educators from more than 140 salons. In 2014, T-MARC re-trained 186 attendants to conduct FP talks. Starting with 21 salons in the Dar es Salaam Region in 2009, the program has expanded to the Mbeya, Iringa, Geita, Shinyanga, Mwanza, Tabora, and Mara Regions.

4.4.3 Analysis of Gaps

- The country FP program lacks a national SBCC strategy. In addition, although the NFPCIP planned to conduct beneficiary segmentation analysis, this did not happen. Stakeholders interviewed were not aware of any report on segmentation analysis and felt that demand-generation messages/interventions were not segmented/stratified for various audiences (i.e., married, male, female, unmarried, urban, rural, educated, uneducated, youth).

- The SBCC efforts raised awareness but did not address issues of behavior, attitude, and practice to close the "know-do" gap.

  "We think that FP often is a one-time behavior, but it's a 20-year behavior, you may stop using FP and have your kid but you want to get back at it, where as you are 17 and starting and you do not want a kid until you're 22 you need to do it every day and every month or hopefully with long-acting methods. We need to reframe the way we think about FP and look more around behavior attributes when designing strategies."

  -- Participant, stakeholder consultation, demand generation group

- Monitoring and tracking of activities conducted by champions was lacking.

- Mass media channels like social media and TV, especially for the urban population, were underutilized.

- Green Star re-launch activities were sporadic and accompanied by intensified commodity supply, with slower momentum after the campaign ended.

- Indirect costs were too high. They could be reduced by advocating for health insurance (i.e., public, private, community-based) to include FP services in their packages.

4.4.4 Key Recommendations

1. Strengthen and improve available demand generation interventions.

Champions should continue to be part of the NFPCIP II. However, new champions in the next version of the plan should be well-versed in FP methods (e.g., satisfied users, community gatekeepers, religious leaders, influential people). Investment should focus more at the community level than at higher levels. Also, using the word "champions" suggests higher-level individuals; calling them "satisfied users" might be more successful. In addition, clear indicators should be developed for partners to report on activities conducted by the identified and selected champions.

SBCC efforts should address issues of behavior, attitude, and practice. Some of the concerns during the stakeholder's consultative meetings were whether SBCC efforts fully address issues of behavior, attitude, and practice to close the know-do gap. Under the NFPCIP II, efforts should be re-examined to ensure they go beyond knowledge and

include techniques that address behavior, attitude, and practice (e.g., people's need for contraception and their intent to use).

SBCC efforts should be informed by segmentation analysis. SBCC interventions should be evidence-based. A segmentation analysis should be conducted to inform SBCC interventions (e.g., examining different messages for different population groups).

"It is a waste of time and misuse of resources to feed a group of people messages that should not have been fed to them."

-- Participant, stakeholder consultation, demand generation group

Improve message packaging. During the NFPCIP, much of the emphasis was on women, and although the Green Star Campaign had one message targeting men—"Men, bring your partners to the clinic"—this did not focus on male FP utilization and its significance to the family in general. In addition, there is a need to shift package messaging on FP from always focusing on individual benefits to focusing on benefits such as opportunities for self-advancement, risks of more than four children, and late or early child bearing. Messages should address the FP benefits in the broader context within multi-sectoral collaboration. In addition, realistic messages need to be developed, as many times messages are not realistic to prevailing social norms:

"I don't think we have given our target audience enough credit a lot of times, they get the basics we don't need to talk so much about the benefits anymore, Green Star spent a lot of time talking about benefits that's something everyone can agree it's harmless… but what people really want to know is that am I going to have cancer? Or this and that, and so we need to address those things."

-- Participant, stakeholder consultation, demand generation group

Expand and improve the Green Star Campaign. Since the Green Star Campaign was re-launched in only 10 regions, regional re-launching to the remaining regions should continue under the NFPCIP II. In addition, during the original NFPCIP, there was a lack of coordination within the FP campaigns, which were driven more by partners than the government and had weak buy-in, particularly with local government authorities (LGAs). The NFPCIP II should include advocacy toward the LGAs to sustain these FP campaigns. In the future, FP campaigns need to be initiated by the government and invite partners for support, and not the other way around. Local resource mobilization within regions/districts should be used to sustain these campaigns at the subnational level.

Intensify other mass media channels. Common mass media channels (e.g., radio and TV stations) should continue to be used, but social media and television use for urban populations should be intensified. Other avenues need to be considered for reaching different segments with FP messages (e.g. reaching youth and adolescents through mobile phones, Facebook, and Instagram).

2. Explore demand generation opportunities for community health workers.

The NFPCIP II should include demand-creation activities by CHWs. There is a need to figure out how to involve the CHW cadre in health promotion to help create demand.

4.5 Area of Measurement 4: Enabling Environment

Definition

A supportive or enabling environment for a FP program requires a minimum of three characteristics: 1) adequate financial resources; 2) supportive policies; and 3) good governance, management, and accountability.

Key Insights

- Insufficient mobilization and tracking of financial resources. Not all LGAs have included FP from their own sources, and more needs to be done to explore other financing mechanisms, such as more insurance companies and the Global Financing Facility (GFF).
- FP visibility and the mention of FP in several national documents and policies. However, there is a need to operationalize those policies and guidelines and involve other ministries.
- Good job advocating for a FP agenda at the higher level and gaining support from the MOHSW, the national and district levels, and government leaders. However, changes in leadership will require new advocacy efforts.

Recommendations

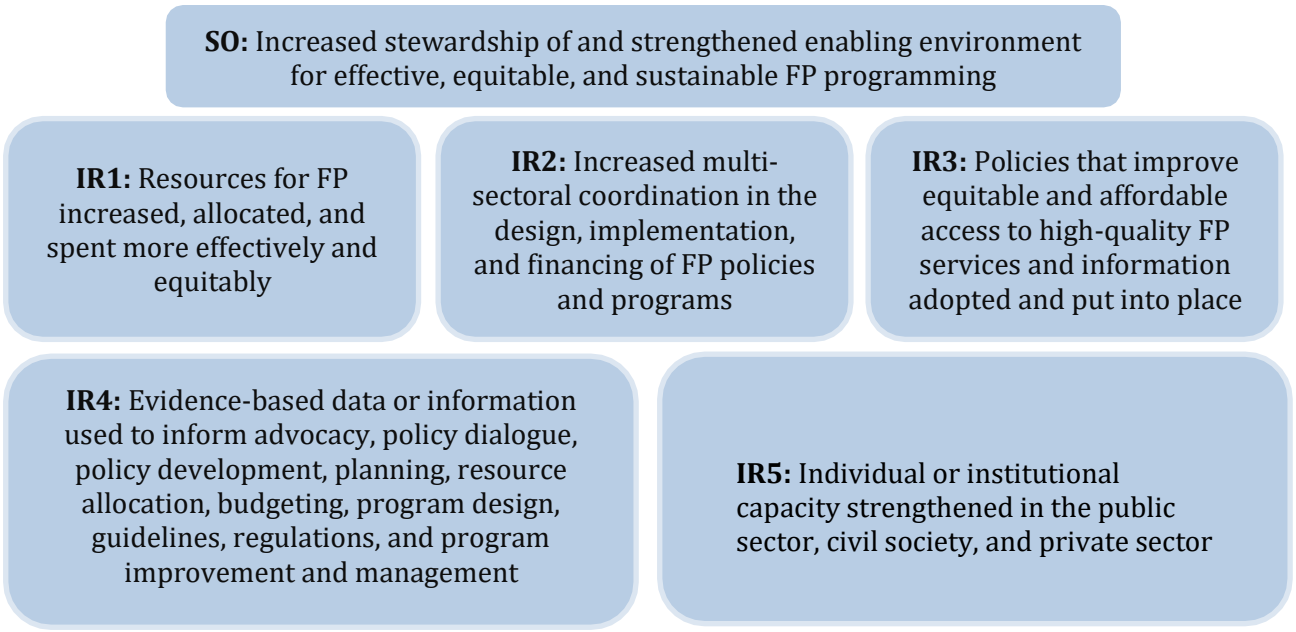
- Sustain advocacy to ensure adequate financing for FP, advocate at the government level to avoid fluctuations, advocate for clear transparency on funding from all sources, explore other funding mechanisms (e.g., the NHIF), and advocate for GOT funding to move from supporting contraceptives to other program areas.
- Ensure supportive policies by reviewing available evidence and guidelines to determine barriers, and advocate for the GOT framework to include more FP indicators.
- Reinvigorate advocacy among the new leadership at national and district levels to sustain political commitment, and strengthen multi-sector coordination.
- Improve monitoring and implementation of the NFPCIP II to include realistic targets/indicators, budget estimates, and timing of reports.

An enabling environment for a national FP program requires 1) adequate financial resources that are allocated effectively; 2) supportive policies that outline a cohesive framework for the FP program; and 3) good governance and transparent, accountable management of resources.

To assess whether the implementation of the five-year NFPCIP made considerable progress in creating a supportive enabling environment, the assessment team used the Framework for Monitoring and Evaluating Efforts to Reposition FP (also known as the M&E framework**),**[47] developed by Measure Evaluation.

The M&E framework (Figure 29) aims to measure the success of efforts to reposition FP. The overall strategic objective (SO) is "increased stewardship and strengthened enabling environment for effective, equitable, and sustainable FP programming." The framework also has five intermediate results (IRs) that describe key elements that facilitate an enabling environment for the FP program.

Figure 29. M&E Framework



4.5.1 Status and Key Issues Prior to the NFPCIP

Tanzania had a successful FP program during the 1990s, but the program started losing its momentum from the beginning of 2000. A few documented factors[48] that contributed to this loss of momentum were decentralization and integration of health programs, donor shifting of FP funding from targeted geographic programs to basket funding, and multiple competing priorities (e.g., HIV/AIDS, malaria, infant mortality). All of these factors eventually led to a decline in FP priority, visibility, and financial support.

Efforts to reposition FP in Tanzania started after 2002 with the goal of ensuring that FP remains a priority and increasing political and financial commitment to the program. In 2008, the National FP TWG (NFPTWG) was established; the same year, the One Plan recognized FP as an important strategy for reducing maternal and child mortality, hence setting a goal of increasing contraceptive use to 60 percent by 2015. The missing link was lack of a road map to help advocates argue for more FP resources.

4.5.2 How the NFPCIP Addressed the Enabling Environment

The assessment team used the M&E framework to assess the performance of NFPCIP implementation regarding an enabling environment for the FP program. The team examined activities that were conducted in each of the SAAs that may have had a direct impact on the overall SO and the five IRs of the M&E framework; these activities were mainly from SAA IV (Advocacy and Strategic Communication) and SAA V (Health System Management). While activities under SAA IV sought to increase visibility and support for FP, activities under SAA V looked to ensure that financial resources were made available in a timely manner, and that activities and deliverables implemented were regularly tracked to improve program performance. Other remaining SAAs (Capacity Building and Service Delivery) had few activities that would have a direct impact on the overall SO and the five IRs.

This section presents findings from the application of the M&E framework. Findings are presented according to the overall SO and the five IRs, highlighting activities that were implemented during the NFPCIP period that facilitated achievement or directly affected the framework indictors.

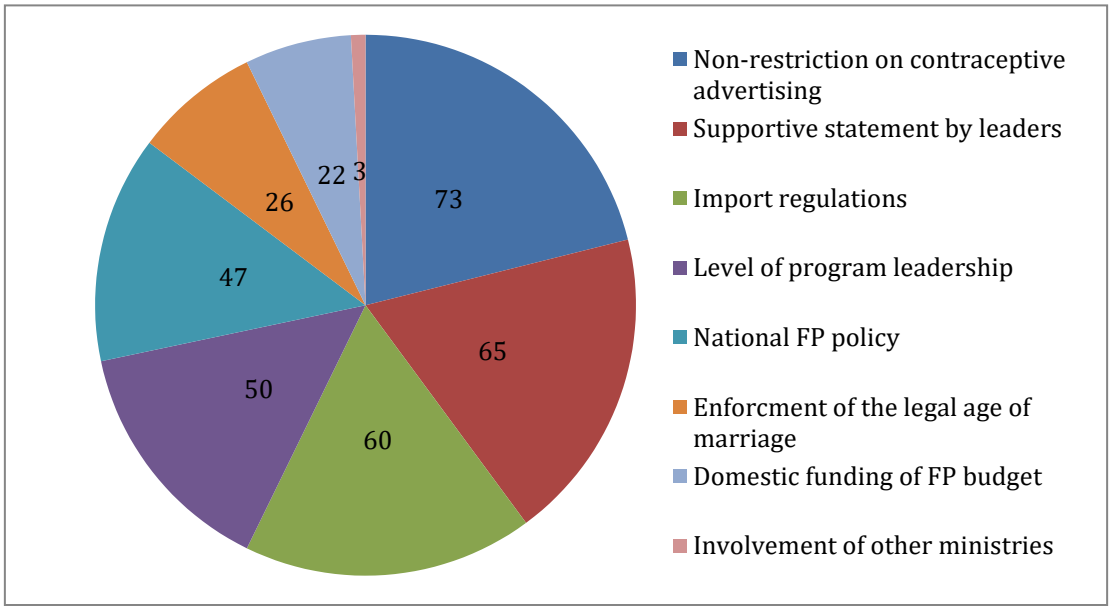
Strategic Objective

SO : Increased stewardship of and strengthened enabling environment for effective, equitable, and sustainable FP programming	• Instances of a government-led council, coalition, or entity that oversees and actively manages the FP program • Evidence of documented improvement in the enabling environment for FP, using validated instruments

The FP program is coordinated and managed by the FP unit under the RCHS of the MOHSW. In 2008, the NFPTWG was established with a role of planning and overseeing the FP program. The TWG is a multi-sectoral advisory entity chaired by the national FP coordinator, who reports to the assistant director of the RCHS under the director of preventive services. The NFPTWG has successfully worked to increase FP visibility and advance FP goals. For example, in 2009–2010, the working group developed, launched, and implemented the NFPCIP. Guided by the NFPCIP, the group successfully conducted advocacy activities at the higher level and recruited champions at the national level to help push the FP agenda forward. Former President Jakaya Mrisho Kikwete was a good advocate for FP. In 2012, Hon Kikwete was among leaders from 150 countries who attended the London Summit and as a result made six commitments that would double contraceptive users and attain national goals for FP programming in Tanzania, which was encouraging progress in the area of political leadership and commitment.

The FP effort index (a validated instrument) has been applied every five years to assess the strength and coverage of the national FP program by examining four main components: policies, services, evaluation, and method access. A designed questionnaire is completed by about 10–15 individuals per country. In 2014, the overall FP effort score (for all the components) for Tanzania was 46,[49] which is one point lower than it was in 2009. For the policy component, even though the average total score was lower in 2014 (47) than it was in 2009 (51), high scores were given to non-restriction on contraceptive advertising (73), supportive statements by leaders (65), import regulations (60), and level of program leadership (50). On the other hand, the lowest score under the policy component was on involvement with other ministries (3) (Figure 30).

Figure 30. Family Planning Effort Scores by Policy Subcomponent, 2014



Although Tanzania has reported good political and leadership support of the FP program according to both the analysis of implemented activities during the NFPCIP and analysis of desk reviews, stakeholders expressed concerns in sustaining this political commitment during interviews. This was thought to be greatly associated with low interest in FP among some of the national leaders but more so on changes in leadership that happened at all levels during the NFPCIP period (i.e., at the district, regional, and national levels and at the MOHSW, including the RCHS and the FP unit). Stakeholders recommended a need for the NFPCIP II to re-invigorate advocacy efforts to attain political leadership and commitment.

Intermediate Result 1

IR1 : Resources for FP increased, allocated, and spent more effectively and equitably

- Total resources spent on FP by source and activity/program area
- Total resources allocated for FP by source and activity
- Evidence of new financing mechanisms for FP identified, tested, or scaled up
- New or increased resources committed to in the past two years

The first IR of the M&E framework examines resources for FP; it outlines four specific indicators that contribute to the overall achievement of the IR. Possible mechanisms for increasing a pool of resources include line items in budgets, money from government budgets, donor funds, user fees, privatizations, and health insurance themes. Below are some of the NFPCIP-implemented activities that are thought to have contributed to the achievement of this IR.

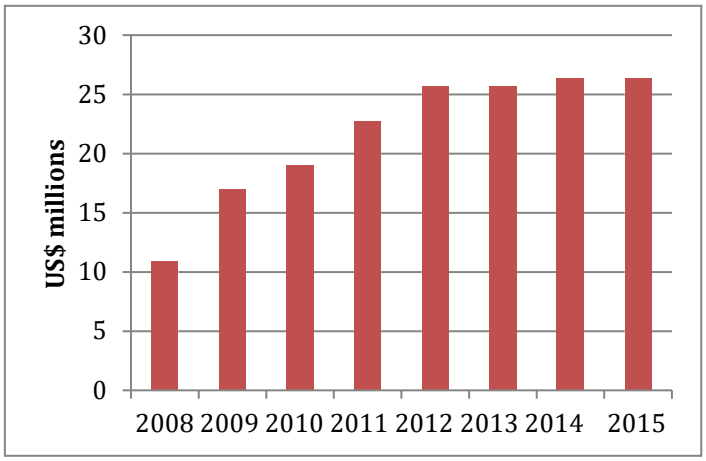
Through one of the activities under SAA V (Health System Strengthening), the FP program was able to track total resources spent on FP by activity/program area (Table 3). Data collected from the FP implementers revealed that over the past six years, Tanzania has been able to mobilize and spend TSh 177 billion[50]—almost half of the targeted amount (47 percent)—for the FP program. A substantial portion of expenditures (77 percent) was spent on making commodities available. In terms of program areas, contraceptive security and management systems are the areas were the FP program was able to mobilize/spend amounts that were close to the targets (65 percent and 68 percent, respectively). The least mobilized area was service delivery (19 percent of target), followed by capacity building (28 percent of the targeted amount).

Table 3. Total Resources (TSh) Spent on Family Planning by Activity/Program Area during the NFPCIP (Years 1–6)

Program Area	Target	Actual Amount Spent	% of Target	% of Overall Amount
Contraceptive Security and Logistics	210,833,708,742	136,245,262,714	65%	77%
Capacity Building	39,759,576,292	10,995,872,595	28%	6%
Service Delivery	107,002,849,534	20,740,881,388	19%	12%
Advocacy and Strategic Communication	15,513,753,254	6,780,163,258	44%	4%
Management System M&E	3,393,648,506	2,316,652,022	68%	1%
Total	376,503,536,328	177,078,831,977	47%	100%

Sustained advocacy efforts to mobilize adequate resources for FP at all levels (i.e., international donors, line items at the national and district level, other financing strategies) is the first SR under SAA IV (Advocacy and Strategic Communication, strategic activities 1b –1f). The monitoring report showed that FP resource allocation from international donors continued to increase. USAID, as an example, increased funding for FP and reproductive health programs in Tanzania from US$17 million prior to implementation of the NFPCIP to US$26.4 million in 2015[51] (Figure 31). In addition to USAID and UNFPA, international donors such as DFID, AusAID, CIDA, UNICEF, and PSI helped fund the FP program during the NFPCIP.[51]

Figure 31. Annual USAID Funding for Family Planning and Reproductive Health in Tanzania, 2008–2015



In mid-2011, efforts were geared toward advocating for creation of a specific FP "target" and corresponding "budget line item" to be added to the MTEF. As a result, the 2011/2012–2013/2014 MTEF included a specific FP target measured by CPR growth.

Advocating for evidence-based financing strategies, such as insurance schemes, was also part of the NFPCIP activities that culminated in the development of One Plan II (2016–2020). In 2015, a rapid assessment[53] was conducted to substantiate the integration of private health insurance services with FP and to review opportunities for private health insurance to invest in FP. As a result, in 2016 one of the private health insurance companies, AAR, integrated FP services into its insurance benefit package and wellness program outreach services.

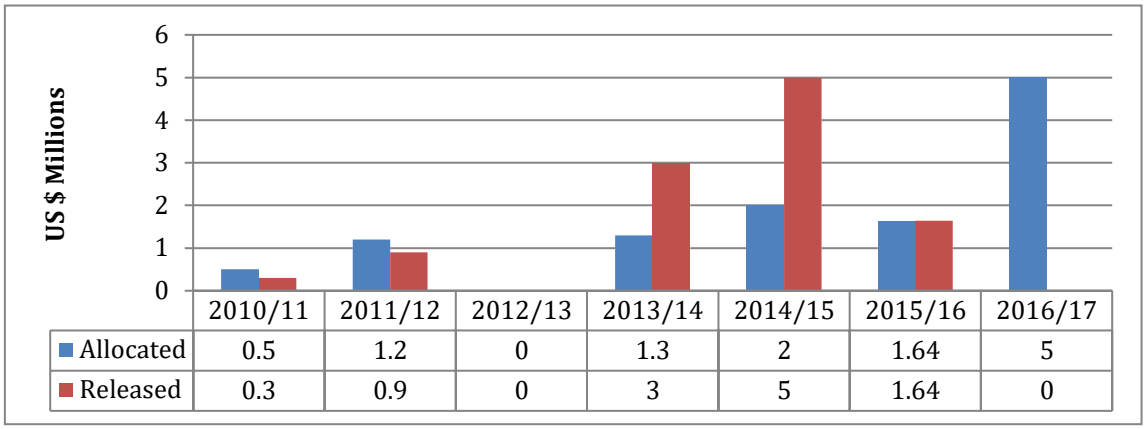
Advocating for increased FP resource allocation from the government's own sources at both the national and subnational levels has been part of SAA IV (Advocacy and Strategic Communication) and has led to encouraging results. At the subnational level, LGAs are increasingly making encouraging allocations for FP (30 LGAs in 2013/2014). Similarly, commitment has been observed at the national level (Figure 32), although there have been fluctuations.

Interviews with stakeholders suggested several reasons for observed fluctuations. While some thought fragmented advocacy (especially within the Planning Department of the Ministry of Finance) could be the main reason for these fluctuations, others felt that the decision on how much should be allocated from the government's own sources was influenced not only by competing priorities but also by funding from development partners:

"Allocations are determined by ceilings, and this fluctuates every year. Also not all partners announce the amount of financial support they will give due to the differences in development partners' financial years, so when there is always extra or unexpected development partner funding available or partner [funding] has [been] withdrawn, this may cause fluctuations."

-- Participant, stakeholder consultation, enabling environment group

Figure 32. Central Government Resource Allocation during NFPCIP Implementation

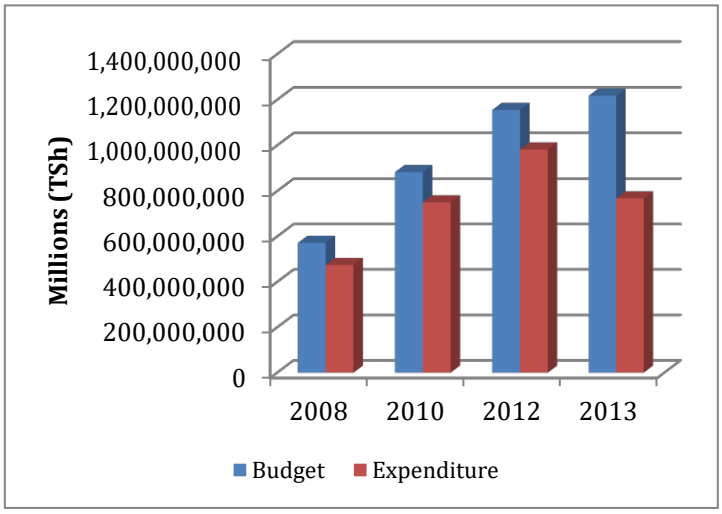


	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Allocated	0.5	1.2	0	1.3	2	1.64	5
Released	0.3	0.9	0	3	5	1.64	0

EngenderHealth conducted two assessments of the CCHPs during implementation of the NFPCIP, to determine how much money was budgeted for FP services in the district health budgets. Results of these assessments revealed that the number of districts allocating funds to FP services has been steadily increasing since 2008. Findings also indicated a steady increase in the amount of the FP budget allocations (Figure 33). A shift in where money is spent was also observed in these assessments—a shift from spending the majority of funds on capacity building activities (prior to the NFPCIP) to spending funds on other program activities as well.[8] Findings from the district-level budget analysis also revealed that districts have started using locally generated revenue through community health funds, user fees, health insurance, and local taxes to finance FP services.

Stakeholders interviewed at the district level mentioned they had observed improvement in FP budget allocation at the district level over time. When asked what types of activities were being funded now compared to before, they mentioned activities such as sensitization, outreach, mentoring, and coaching.

Figure 33. Total Family Planning Budget for All Districts (EngenderHealth CCHP Budget Analysis)



Another effort that was taken to finance the FP program in Tanzania was the GFF. Although the MOHSW successfully included the strongest FP language in the GFF investment case for Tanzania and agreed upon foundational activities for reimbursement, no FP activities were included (although activities aimed at equipping facilities to provide emergency obstetric care were). Stakeholders from the MOHSW still felt there was room to utilize some of the GFF funding for FP activities:

"The directive from the ministry is to use the first round of GFF disbursement ($US 2 million), which was disbursed early this year, to scale up reproductive health councils, to construct and equip additional health centers to perform comprehensive emergency obstetric and newborn care services."

-- Participant, stakeholder consultation, enabling environment group

"If we would have used the NFPCIP as a strategic document on the investment case, FP would have benefitted from GFF funds, but unfortunately the NFPCIP ended in 2015 and One Plan II was used instead, and so spending will always depend on the priority at that particular time."

-- Participant, stakeholder consultation, enabling environment group

In summary, it is evident that resources for FP increased during the NFPCIP; the program was able to track the total amount of resources spent by activity/program area in the past six years. The FP program continues to be supported by donors. Furthermore, since NFPCIP implementation, the government's commitment to the FP program (i.e., its own source of funding) at both national and subnational levels has been encouraging, although it needs to be sustained. During the NFPCIP, the program also documented other possible mechanisms for increasing a pool of resources, including insurance schemes and the GFF. However, coverage

was not substantial for the insurance scheme, and the FP program has still not benefited from GFF funding.

Intermediate Result 2

IR2: Increased multi-sectoral coordination in the design, implementation, and financing of FP policies and programs	•Evidence of FP programs incorporated into national strategic and development plans •Evidence of the government engaging multiple sectors in FP activities •Evidence of multi-sectoral structures that are established or strengthened to promote FP policies •Evidence of government support for the private sector

IR2 assesses the extent to which various disciplines are involved in moving the FP agenda forward. Multi-sectoral structures may include entities, bodies, and partners made up of groups or individuals from different sectors (e.g., government, non-government, civil society) and different disciplines (e.g., health, education, environment) involved in FP policy making and implementation. This IR also looks entities representing community and religious groups that will help strengthen the enabling environment for FP (i.e., acceptance and interest in the communities).

Increasing FP visibility was one of the main objectives of SAA IV (Advocacy and Strategic Communication, strategic area 2b). Several key national policies and budget tools incorporated FP language during NFPCIP implementation. For example, targets to reduce total fertility and population growth rates were integrated into the 2010–2015 National Strategy for Growth and Reduction of Poverty II; FP and reproductive health issues were incorporated into the Five-year Development Plan II, 2016/2017–2020/2021; and FP was integrated into PlanRep 3—a tool used in planning at the district level. Furthermore, FP is now a number one priority on the list of four identified high-impact interventions in One Plan II (2016–2020). It is also included in the Health Sector Strategic Plan IV 2016–2020 and the National Policy and National Management Guidelines for the Health Sector Prevention of and Response to Gender-based Violence, 2012.

During NFPCIP implementation, several multi-sectoral structures were established or strengthened to promote FP policies (e.g., working with the prime minister's office and the Ministry of Finance). In 2012, the Tanzania Association of Parliamentarians for Population and Development formed a Parliamentarian FP Club comprised of 15 members of the parliament from both the ruling and opposition parties. These members of the parliament pledged to advance FP as a socio-economic development tool, engage in policy on fund disbursement and supply chain management, and improve the quality of health services as steps toward reaching the national target of a CPR of 60 percent by 2015. In addition, several FP champions have been identified and recruited to bring change. Since 2010, 300 champions have been identified and recruited,[9] including parliamentarians, district executive directors, regional commissioners, religious leaders, journalists, and celebrities.

The MOHSW has made good advancement in engaging the private sector. TDHS results revealed that between 2004/2005 and 2015, the percentage of women who accessed FP services from non-government facilities rose from 32 percent to 39 percent. Stakeholders interviewed

agreed it was a good advancement to see private-sector players as part of the NFPTWG. Private-sector players were involved in the development and implementation of the NFPCIP. During implementation, the players contributed to procuring and distributing commodities, equipping private facilities, and training their service providers.

In summary, multi-sectoral coordination was observed, although mostly within the health sector. Stakeholders interviewed agreed that going beyond the health sector should be a priority under the NFPCIP II, but so should strengthening collaboration within the health sector by involving other ministries or directorates. Stakeholders also agreed that public-private partnerships still need to be strengthened in many areas, including commodities and regulations in the private sector that may be barriers to access (e.g., limitations in advertising). In addition, collaboration needs to be strengthened. Although private NGOs that are doing social marketing are part of the TWG, there are many other private partners that are offering FP services but not reporting them.

Intermediate Result 3

IR3: Policies that improve equitable and affordable access to high-quality FP services and information adopted and put into place	• Existence of national or subnational policies or strategic plans that promote access to FP services and information • Existence of national or subnational policies or strategic plans that promote access to FP services and information for underserved populations • Documentation of instances in which a formal implementation or operational directive or plan is issued to accompany a national or subnational FP policy • Evidence that policy barriers to accessing FP services and information have been identified or removed

This IR includes indicators related to existing policies, but it also measures the essential steps from developing a policy to putting it into practice.

With the aim of increasing equitable and affordable access, several key policies, guidelines, and strategies were developed or amended during NFPCIP implementation (Figure 34). The development of others is planned.

Figure 34. Key Policies, Guidelines, and Strategies

- In 2010, the National Package of Essential FP Interventions for CCHPs was developed to help CHMTs better plan and budget for FP services.
- In 2013, the National Operational Guidelines for Integration of Maternal, Newborn, Child Health, and HIV/AIDS Services (NOGI) were developed to improve coordination between the MOHSW's RCHS and the National AIDS Control Programme.
- The National Community-based Health Program Guidelines aim to improve coordination, harmony, and cohesion among a range of stakeholders, including implementing community-based organizations supporting health care programs (FP included).
- The National Costed Operational Plan for Strengthening Community-based Family Planning Services at Scale 2014–2020 provides a more comprehensive plan for addressing community-based FP service key issues and challenges.
- In 2013, the National Family Planning Guidelines and Standards were revised to provide explicit directives on operations, rules, regulations, and administrative norms governing FP services and programs in Tanzania. The document reflects the principles and policy guidelines outlined in the National Policy Guidelines for RCHS (2003), and the priorities and targets identified in the NFPCIP.
- Operational tools for some integration modalities were developed and evaluated during the NFPCIP. These included tools for the integration of FP with care and treatment clinics, voluntary counselling and testing, home-based care, prevention of mother-to-child transmission, comprehensive post-abortion care, and prenatal and antenatal care.
- Plans were made to further develop operational guidelines for integration and referral of FP with immunizations, breast cancer, cervical cancer, and the community-based FP operational plan.

With the aim of increasing access to FP, the integration of FP/HIV and FP/MNCH was identified as a priority area under the NFPCIP (both the first version and the amended version). SR1 of SAA III under the amended NFPCIP called for integration of FP within HIV and MNCH services (i.e., post-abortion care, prenatal care, antenatal care, provider-initiated counseling and testing) for men, women, and youth to be implemented at scale. During the first years of the NFPCIP, several models for integrating FP into HIV were found feasible, which led to changes in the national HIV reporting tools. For example, FP codes and data on FP use among people living with HIV were incorporated into national HIV reporting tools and databases, and in 2013 the NOGI were developed. Although strategic activities within SAA III called for developing and implementing operational guidelines for FP/HIV and FP/MNCH integration, the context shifted and the decision was made to remain aligned with the NOGI.

Stakeholders interviewed for this assessment recommended that integration still be part of the NFPCIP II. This should include strengthening the involvement of national- and council-level key decision makers from relevant programs and units in service-level FP/RCH/HIV integration (e.g., the National AIDS Control Program, the RCHS with the FP Unit, Safe Motherhood Unit, and Immunization Unit).

Evidence-based advocacy is the foundation for policy and programmatic change in all areas, including FP. Strategic area 1a under SAA II (Capacity Building) is implementing task shifting at all levels of the health system. To help achieve this, three studies were conducted during NFPCIP implementation to generate evidence on task shifting of FP services that will inform advocacy efforts and eventually policy change. These studies looked at the potential of ADDOs to provide expanded FP services in Tanzania, the potential of community-based distributers to administer injectable contraceptives, and a feasibility analysis to examine clinical officers' abilities to safely and effectively perform tubal ligations. Although the studies demonstrated the feasibility of task shifting, the barriers that prevent task shifting have not been removed. Stakeholders interviewed suggested that in order to move from evidence to policy change and implementation, it is important to have the right people and relevant bodies on board. The NFPCIP II should consider moving the available evidence to action.

Findings of the study conducted by Mzumbe University on behalf of the RCHS[10] revealed that the 2013 Tanzania Public Procurement Regulations and the related law, the 2011 Public Procurement Act, contribute to stockouts and inadequacy in access to commodities, including FP commodities. Guided by this evidence and the analysis of the procurement act in relationship to Tanzania's ambition to improve maternal and newborn mortality, the Human Development Trust's (HDT's) recommendation passed and the 2016 Public Procurement Act also passed with a special provision to fast track life-saving health commodities, including contraceptives.

In summary, encouraging advances focusing on creating an enabling environment in accessing services have been observed, measured by the available national policies, plans, and guidelines. However, there is a need to examine whether these documents have been helpful and whether there is a need to translate some of them into operational plans. In addition, different stakeholders interviewed expressed a need for clear policies that promote access to FP and information to youth. Stakeholders also suggested that task shifting should still be included in the NFPCIP II, with a focus on advocating for policy change and implementation based on the available evidence.

Intermediate Result 4

IR4: Evidence-based data or information used to inform advocacy, policy dialogue, policy development, planning, resource allocation, budgeting, program design, guidelines, regulations, and program improvement and management	• Evidence of data or information used to support repositioning FP efforts • Evidence of international FP best practices incorporated into national health standards • Evidence of a defined and funded FP research agenda • Evidence of in-country organizational technical capacity for the collection, analysis, and communication of FP information

This IR assesses the extent to which polices and programs are grounded in data and information to ensure a sound rationale. Achievement of this indicator includes actual use of information for program improvement.

Guided by the NFPCIP, in 2010 The National Package of Essential FP Interventions for the CCHPs was developed to help CHMTs better plan and budget for FP services. In fiscal year 2010/2011, the GOT revised the CCHPs to include financing guidelines, which led to an increase in resources allocated to FP in district budgets.

In 2013, the NFPCIP was revised to accommodate a description of activities that will help fulfill implementation of the global partnership and FP2020 country commitments made by Hon Kikwete while attending the high-profile London Summit on FP in July 2012.

During 2013, the MOHSW in collaboration with implementing partners of the NFPTWG organized a three-day national FP conference in Dar es Salam. The conference provided a platform for sharing locally generated evidence from research and programmatic experiences to inform at-scale implementation of effective strategies to reposition FP in Tanzania. The theme for the research forum was “Local Solutions to Local Problems: Advancing the Evidence Base for Repositioning FP in Tanzania.” As an outcome of the FP conference, the Tanzania National FP Research Agenda 2013–2018 was developed.

In summary, the FP program has been able to use data and information to support repositioning activities. The national FP research agenda was also developed during the NFPCIP period, although it still needs to be funded and implemented. NFPCIP monitoring data were collected and analyzed on an annual basis to identify gaps and recommendations for moving forward. Although monitoring of the NFPCIP has been successful, during the interviews stakeholders from the MOHSW expressed a need for capacity building during the NFPCIP II to analyze monitoring data and generate reports, rather than depend on the implementing partners to do the analysis.

Intermediate Result 5

IR5: Individual or institutional capacity strengthened in the public sector, civil society, and private sector to assume leadership and/or support the FP agenda	•Evidence of entities provided with donor assistance that demonstrate capacity to independently implement activities to reposition FP •Evidence of government departments or other entities established or strengthened to support the FP agenda •Evidence of targeted public- and private-sector officials, faith-based organizations, or community leaders publicly demonstrating new or increased commitment for FP •Evidence of regional/national centers or collaboratives for shared education and research in FP

Strengthening the existing NFPTWG was done after the launch of the NFPCIP by formulating task forces to steer the process of moving from planning to action of the NFPCIP. Four task forces were formed based on the identified four priority areas for implementation of the NFPCIP. Each task force was composed of a leader from the MOHSW, along with a co-leader designated from a lead partner agency and other members from a list of FP implementers. These task forces were 1) Resource Mobilization Plan and Implementation, co-led by Pathfinder; 2) Advocacy Coordination and Implementation, co-led by JHU and Futures; 3) Monitoring Resource Mobilization, Activity Implementation, and Results, co-led by FHI 360; and 4) Engaging the Media to Advance the NFPCIP Agenda, co-led by JHU and Futures.

Several religious leaders have been trained on FP. As a result, two booklets were developed, printed, and disseminated: one on Christianity and FP and one on Islam and FP.

4.5.3 Analysis of Gaps

- The NFPCIP lacked specific activities geared toward engaging multiple sectors (e.g., education, agriculture, environment) in FP policy making and implementation.

- One of the goals of the NFPCIP was to promote involvement of the private sector to increase resources for FP. However, direct activities that could demonstrate government engagement and support for the private sector were missing.

- Development and rolling out of the new and existing guidelines was not prioritized. For example, operational guidelines for the integration of FP with HIV and maternal, newborn, and child health have not been developed and implemented due to a shift in context and the decisions made to remain with NOGI. In addition, efforts were invested in developing the national community-based FP operational plans, but the MOHSW decided not to validate and disseminate the plan because it was incorporated into the National Community-based Health Care Strategy.

- Implementing task shifting was among the SRs under Capacity Building, and it included conducting studies to examine the feasibility for task shifting and to generate recommendations. Although studies were conducted and evidence generated, the

available evidence was not used effectively to advocate for a policy change on task shifting.

- Through the NFPCIP, a substantial number of FP champions were identified at various levels. However, a mechanism to monitor and track FP champions was neither established nor implemented.

4.5.4 Key Recommendations

1. ***Sustain advocacy efforts at the government and district levels to increase FP resources and avoid fluctuations.***

   Advocacy should be continued to ensure sustained, adequate funding allocation and to avoid fluctuations in both the amounts allocated and the amounts disbursed in budget commitment. In addition, the NFPCIP II should include efforts to advocate for government funding to go beyond commodity funding to different program areas.

2. ***Clear transparencies are needed so that funding contributions can be accessed by everyone from one common source.***

   For example, trends on budget allocations from the government's own sources need to be easily accessible and, if possible, need to be reflected in two tables separating the FP planning resource allocations for the central government from those for LGAs. Also, the GOT's known budgets are only for commodities and supplies. No figure is available for running the whole program, which should be made clear during the NFPCIP II.

3. ***Strengthen public-private partnerships.***

   The NFPCIP II should include activities that focus on improving coordination, collaboration, and engagement between the government and the private sector. In addition, there is a need to advocate for more FP resources from public-private partnerships, such as convincing private health facilities to waive all charges associated with the provision of FP services and focus on making these services part of the basic health insurance package.

4. ***Include activities that focus on demonstrating good governance, leadership, and accountability.***

   Continue to raise awareness and involve policy makers, members of the parliament, LGAs, and CSOs to ensure leadership and accountability on FP matters. To increase accountability, consider engaging community groups or NGOs that focus on community voices (e.g., SIKIKA, TWAWEZA). In addition, include activities that focus on strengthening and increasing multi-sectoral coordination in moving the FP agenda forward (e.g., engaging ministries focused on economic development, youth, labor, and agriculture).

The NFPCIP II should also include activities that focus on strengthening the RCHS to analyze monitoring data to inform decision making. There is also a need to advocate and agree on institutionalizing sources of harmonized data to get rid of multiple sources of data, so that misinterpretation of the actual situation can be avoided.

5. ***Task shifting should still be given priority in the NFPCIP II.***

   Advocacy on task shifting should be based not only on available evidence but also on other relevant efforts in the communities to convince policy makers of this agenda. In addition, professional bodies (e.g., MAT, AGOTA, PRINMAT, TPHA, WRA, Tanzania Nursing Midwives Council) need to be actively involved to move the task shifting agenda forward.

6. ***Strengthen the monitoring and implementation of the NFPCIP.***

   Data availability has made it difficult to gauge the performance in NFPCIP implementation. Much has been done on the ground, but very little data have been reported. This accounts for the observed discrepancies and gaps in implementation. There is a need to examine the reporting period and improve the indicators to be reported under the NFPCIP II, to enable us to track progress (e.g., focusing on outcome indicators, rather than process indicators, to measure progress).

7. ***Advocacy partners should have access to the HMIS so that it can be used for advocacy and planning purposes.***

8. ***The GOT's monitoring framework should include more indicators for the FP program (e.g., CPR, met need, total fertility rate, age-specific fertility rate, number of FP service delivery points).***

9. ***Government and development partners should fund and implement the existing FP research agenda.***

10. ***Making a cost-effective development agenda for FP should be a priority (demographic dividend).***

4.6 Area of Measurement 5: Impact on Contraceptive Prevalence

Definition

Modern contraceptive prevalence is the proportion of adults ages 15–49 who are currently using a modern contraceptive method including OCPs, injectables, implants, IUDs, male and female condoms, male and female sterilization, emergency contraception, diaphragms, foams/spermicides, the lactational amenorrhea method (LAM), and the Standard Days Method. The mCPR can be calculated among all women; married women; or unmarried, sexually active women ages 15–49 years.

Key Insights

- Increases in knowledge of longer-acting methods (e.g., IUDs, implants) in parallel with increases in use of these methods
- Stagnant urban mCPR of concern because of high rate of population growth in urban areas
- Increased momentum in the growth of rural mCPR. The factors behind this are complex and interrelated, but the activities to strengthen FP delivery through ADDOs may have increased access to methods, especially in hard-to-reach areas.
- Lack of momentum for translating task sharing policies into action, particularly with regards to ADDOs and CHWs. Addressing this issue may help propel the gains seen in rural areas even further.

Recommendations

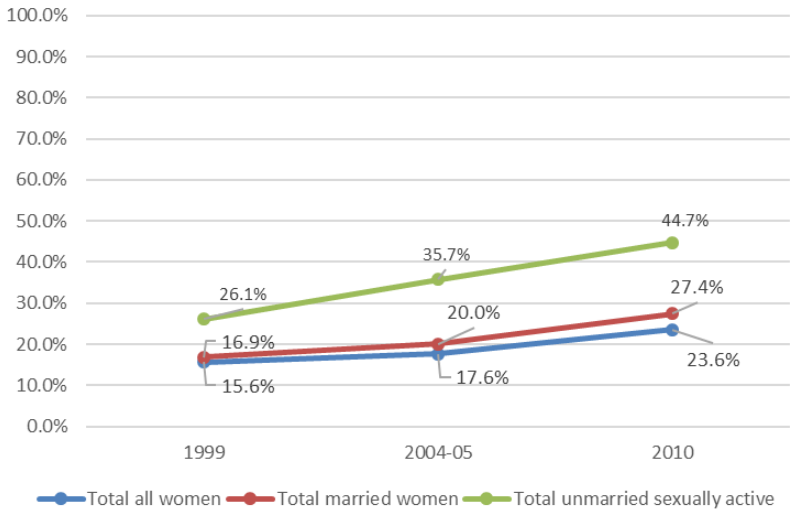
- Support the delivery of FP at the community level by ensuring that support is in place at all levels. This means having up-to-date training curricula and job aids, as well as efforts to implement the task sharing guidelines for CHWs.
- Determine the reason behind the stalled urban mCPR so that efforts can be made to address it.
- Do not neglect adolescents in the NFPCIP II, as they will be very important in increasing the national mCPR.

Modern contraceptive prevalence is the proportion of adults ages 15–49 who are currently using a modern contraceptive method, including oral OCPs, injectable hormonal contraceptives, contraceptive implants, IUDs, male and female condoms, male and female sterilization (i.e., vasectomy and bilateral tubal ligation [BTL], respectively), emergency contraception, diaphragms, foams/spermicides, the LAM, and the Standard Days Method. Most typically, current contraceptive use is calculated only among women, and includes women who state that their male sexual partners are using male condoms or vasectomy. The mCPR is calculated among varied populations that can include all women ages 15–49 years; married women ages 15–49 years; or unmarried, sexually active women ages 15–49 years.

4.6.1 Status and Key Issues Prior to the NFPCIP

The rate of modern contraceptive use among women in Tanzania slowly, but steadily, increased in the decade before implementation of the NFPCIP. According to TDHS data, the mCPR among all women ages 15–49 years increased from 15.6 percent in 1999 to 23.6 percent in 2010.[56, 5] The mCPR among unmarried, sexually active women remained substantially higher than among married women at all time points (Figure 35).

Figure 35. Modern Contraceptive Prevalence, 1999–2010

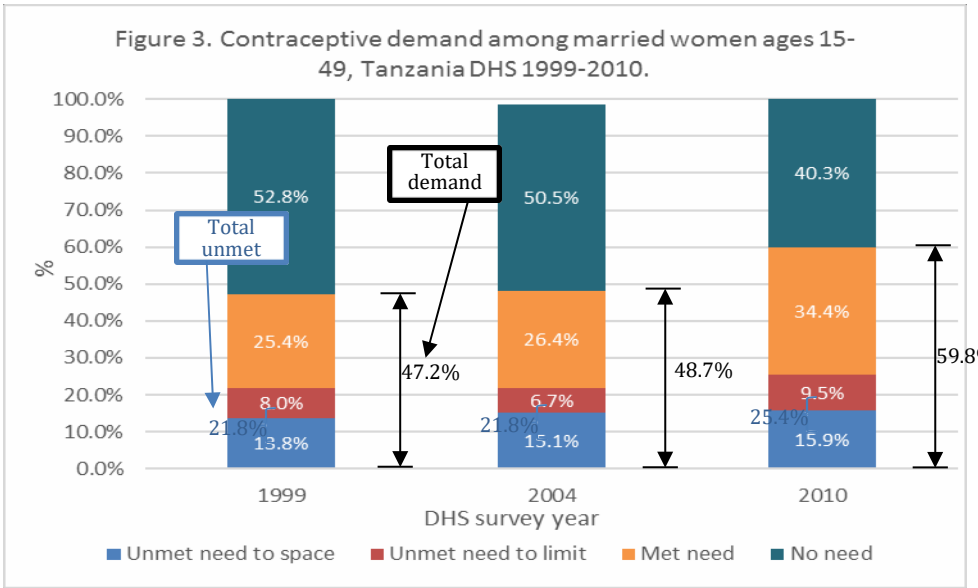


Contraceptive Need and Demand

To understand the potential mCPR, demand for FP methods must be examined. According to the DHS, unmet need for contraception is calculated among married women ages 15–49 years as the proportion who 1) are not pregnant, are not postpartum amenorrhoeic, are fecund, and want to postpone their next birth for at least two years or stop childbearing, but are not using a contraceptive method; 2) have a current pregnancy that is mistimed or unwanted; or 3) are postpartum amenorrhoeic and had a birth in the past two years that was mistimed or unwanted.[57] Demand, as measured by the DHS, is the combined total of modern contraceptive users plus the

total of those who have an unmet need for contraception (i.e., the combination of met and unmet need).[13] As shown in Figure 36, until 2010, demand for contraception was increasing, as was the proportion of that demand that was being met (black arrows to the right of each bar); however, inroads had yet to be made into substantially reducing unmet contraceptive need among married women in Tanzania.

Figure 36. Contraceptive Demand among Married Women Ages 15–49, 1999–2010



Factors Influencing Contraceptive Prevalence

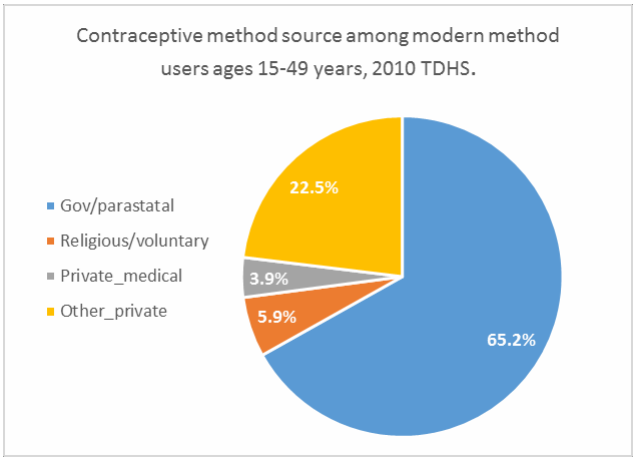
At the levels of the individual and the couple, knowledge of contraceptive methods and beliefs about their use, effectiveness, and side effects can influence contraceptive prevalence, as can fertility desires. Extensive evidence has demonstrated that contraceptive use to space or limit pregnancies is also strongly tied to educational attainment and wealth status. Social, cultural, and religious norms can also shape individual perceptions and behaviors around contraception. Within the context of the health system, affordable, reliable, and convenient access to a wide range of contraceptive methods that can adequately meet the specific needs of individuals and couples is essential. Properly trained health care providers who can help individuals make fully informed decisions about which method may be best for their circumstances are also critical.

Looking at some of the factors that can be associated with contraceptive use, knowledge of modern contraceptive methods was high among married women ages 15–49 in 2010 (Table 4). Nearly all women had heard of most short-acting methods, such as pills, injectables, and male condoms. LARCs such as implants and IUDs were also widely known. Male sterilization was reported by fewer than half of the women, as were emergency contraception and LAM. Among those women who were currently using a modern contraceptive method in 2010, the majority obtained their methods from governmental or parastatal sources (Figure 37). Other private sources, including pharmacies, shops/kiosks, and friends/neighbors, made up the second largest source at that time.

Table 4. Percent of Married Women Ages 15–49 Reporting Knowledge of Modern Contraceptive Methods, by Method, 2010

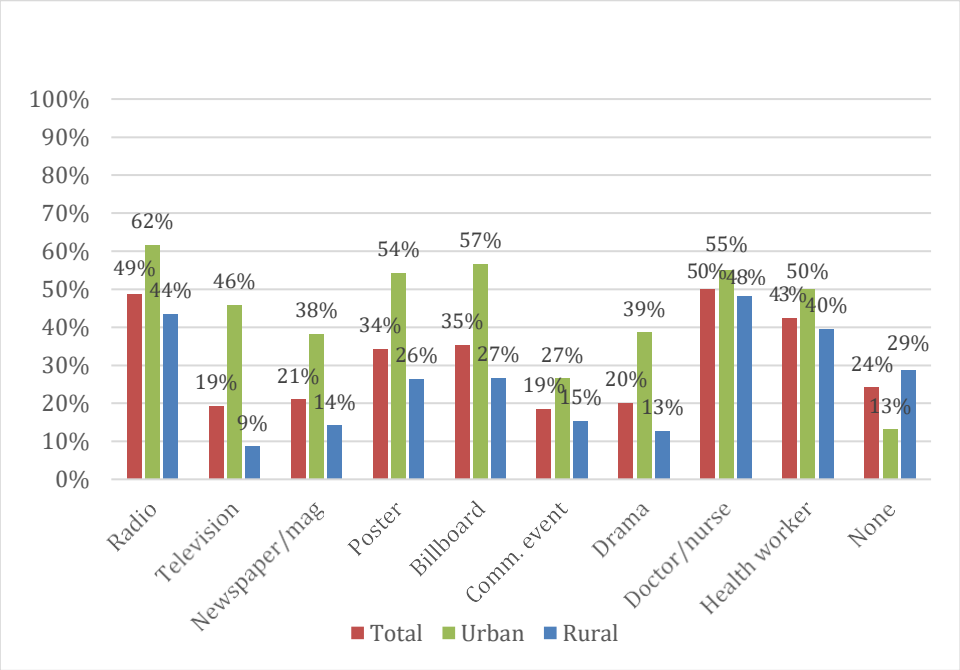
Method	%
Any modern method	98.9
Female sterilization	87.5
Male sterilization	40.3
Pills	98.0
IUDs	79.3
Injectables	97.5
Implants	88.0
Male condoms	95.6
Female condoms	74.6
Emergency contraception	12.3
LAM	37.2

Figure 37. Contraceptive Method Source among Modern Method Users Ages 15–49, 2010



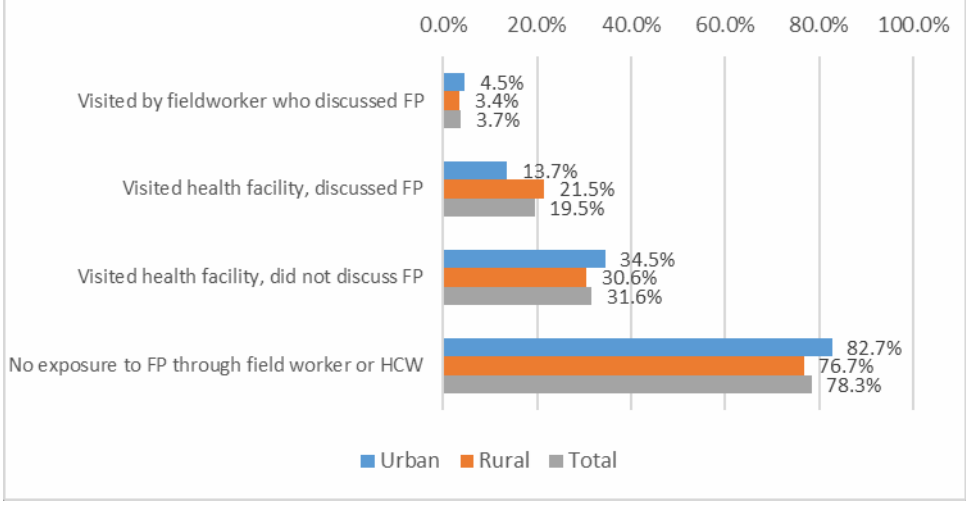
Exposure to FP messages was relatively high in 2010. Only about one in four women reported not hearing any FP messages in the six months preceding the TDHS (Figure 38). Among those who did hear such messages, radio was the most common source among urban residents, with other common sources being health care staff, posters, and billboards. About half of rural residents reported hearing FP messages from doctors/nurses and radio.

Figure 38. Percentage of Women Ages 15–49 Who Had Heard a Family Planning Message in the Past Six Months, by Source, 2010



Among the women who were not using a contraceptive method at the time of the 2010 TDHS, the vast majority reported not having had contact with either a health care worker who discussed FP with them at a health facility or a field workers who discussed FP with them during a home visit (Figure 39). In fact, fewer than 5 percent of women in urban or rural settings reported exposure to a field worker who discussed FP, and only one in five urban residents and less than one in seven rural residents who visited a health facility in the prior 12 months discussed FP with a health care worker.

Figure 39. Percent of Non-users Who Had Contact with a Health Facility Worker or Field Worker Who Discussed Family Planning, 2010



4.6.2 How the NFPCIP Addressed Impact on Contraceptive Prevalence

The 1990s were known as the "golden age" of FP in Tanzania. During this time, modern contraceptive method use more than doubled among married women, increasing from 6.6 percent in 1992 to 15.5 percent in 1999.[40, 56] Since 1999, growth in mCPR has slowed considerably. The GOT, through the One Plan, set a goal to increase the mCPR to 60 percent by 2015, while FP2020 commitments seek to reach 5.2 million new users by 2020.

Although the goal of increasing mCPR is inherent to all of the NFPCIP's SAAs, specific activities directly addressed health system factors contributing to contraceptive method use. In particular, activities that fell under SAA I (Contraceptive Security), SAA II (Capacity Building), and SAA III (Service Delivery) emphasized low-performing regions and were specifically designed to address known health system barriers to modern contraceptive method use.

4.6.3 Results of the NFPCIP

SAA I: Contraceptive Security

One key contributor to modern contraceptive method use is a reliable supply of a broad range of contraceptive methods that are affordable to the public. The activities under SAA I (Contraceptive Security) were integral to affecting contraceptive utilization. Please refer to section 4.3 of the report for a full description of that area of measurement.

SAA II: Capacity Building

This SAA refers to capacity building of those who deliver and support the safe, effective use of FP methods and services. Capacity building considerations include the numbers, categories, attitudes, skills, supervision, and remuneration of service personnel at all levels, including those working at the community level.

The following selected SAA II indicators were achieved:

- An assessment was conducted to compare the performance of trained clinical officers and assistant medical officers in conducting BTL for women through outreach services, meeting 100 percent of this target. A follow-on study is being conducted for comparison purposes.
- A pre-service IUD core competencies curriculum was developed, and three nursing schools integrated the curriculum into their teaching curricula.
- A literature review was conducted to understand evidence supporting task shifting of FP service provision to other cadres of health workers and to generate recommendations for adopting this strategy in Tanzania.
- One workshop was conducted to develop operational guidelines, a training curriculum, and job aids, meeting 25 percent of this target.

SAA III: Service Delivery

Under SAA III, efforts were made to strengthen service delivery systems and increase options for the delivery of high-quality, affordable, and sustainable FP services. Specific activities under this SAA included expansion of community-based services, outreach activities, and sale of certain modern methods through pharmacies and ADDOs.

The following selected SAA III indicators were achieved:

- Access to FP services in remote sites/low-CPR regions increased through implementation of outreach services. Outreach services included trained nurses and surgeons traveling to facilities in hard-to-reach or otherwise underserved areas and providing periodic FP services.
- Guidelines for FP outreach were developed and launched (100 percent of the target met). A TWG focused on outreach was established to facilitate coordination and information sharing. This TWG also developed the guidelines for outreach activities nationwide, which were used by stakeholders to implement outreach efforts according to national standards.
- 7,768 outreach events were carried out in low-CPR districts and hard-to-reach areas (381 percent of target met). Through outreach services 744,385 people were served with FP services.
- An FP refresher training curriculum was developed for CHWs, and job aids for CHWs were updated, meeting 100 percent of this target.
- A total of 2,400 CHWs received two-week trainings, meeting 60 percent of this target.
- Projects provided material support (e.g., methods) and remuneration to 1,786 CHWs, meeting 44 percent of this target.
- Sixty-nine districts that employ the use of CHWs in their FP activities received supportive supervision visits for community-based FP, meeting 99 percent of this target.
- Community outreach events reached 6,350 men, meeting 156 percent of this target.
- In all, 3,765 ADDOs stocked OCPs and condoms to sell as part of the effort to expand the mix of methods available through socially marketed products sold through private settings, meeting 3,586 percent of this target.
- IUDs, implants, OCPs, injectables, and emergency contraceptives were stocked by 418 pharmacies for direct sale to the public, meeting 398 percent of this target.
- A total of 695 dispensers at ADDOs and pharmacies were trained on the efficacy and side effects of the contraceptive methods available to be sold through these outlets, meeting 199 percent of this target.

SAA IV: Advocacy and Strategic Communication

The NFPCIP emphasized communication efforts that addressed knowledge and belief-related barriers to FP use, including limited understanding of return to fecundity in the postpartum period for women, and myths and misconceptions with regard to FP methods through SBCC campaigns. For further details on communication as part of demand generation activities, please refer to section 4.4 of this report.

Change in mCPR. The NFPCIP set a highly ambitious goal for the nation, aiming to achieve a mCPR of 60 percent by 2015. Unfortunately, total mCPR among married women ages 15–49 only grew by 4.6 percentage points, increasing to 32.0 percent in 2015 (Figure 40). This increase was driven largely by the mCPR in rural areas, which saw an increase of 5.4 percentage points from 2010 to 2015, as compared with urban areas, which saw an increase of less than 1 percentage point during the same period.

Contraceptive need and demand. The period from 2010 to 2015 also saw a slight decrease in unmet contraceptive need among married women. Although total contraceptive demand remained essentially stagnant between 2010 and 2015, the proportion of demand that was currently being met did increase.

Method source. According to TDHS data, the source of contraceptive methods for users also did not change substantially over the five-year period from 2010 to 2015. The most common sources for modern FP methods remained public health facilities, followed by pharmacies, ADDOs (2015 data only), and shops/kiosks (Table 5). Expanding access to contraceptives through ADDOs may have played some role in the continued increase in mCPR in rural areas, with 10.3 percent of women citing ADDOs as their source of methods.

Figure 40. Total, Urban, and Rural Modern Contraceptive Prevalence among Married Women Ages 15–49, 1999–2015

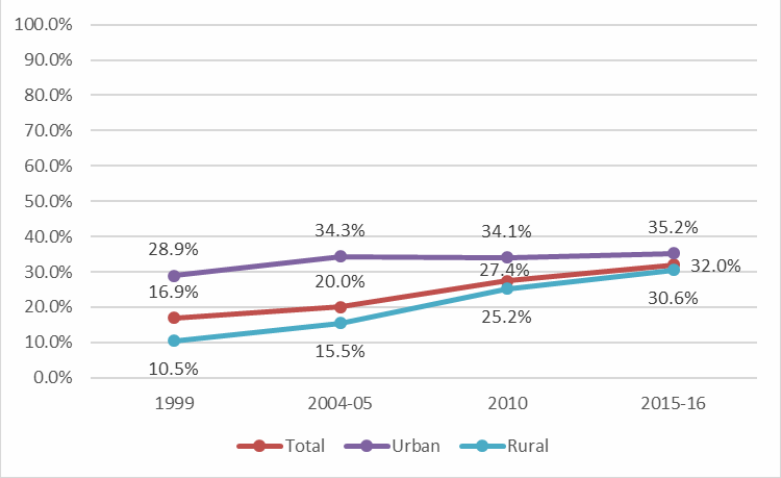


Table 5. Source of Contraceptive Methods among Modern Method Users Ages 15–49, 2010–2015

Source	2010	2015
National/regional/specialty hospital	4.2%	3.4%
Public district hospital	8.3%	7.3%
Public health center	15.7%	13.7%
Public dispensary/clinic or village health post	36.3%	36.3%
CHW	0.5%	0.2%
Religious/voluntary managed facilities	5.9%	10.5%
Private clinic	3.9%	1.6%
Pharmacy	9.7%	11%
ADDO	NA*	10.3%
Shop/kiosk	11.1%	3.6%
Other	2.6%	2.0%

*ADDOs were not assessed as a method source in the 2010 TDHS.

Knowledge of modern contraceptive methods remained high in 2015, but with some increase in the proportion of married women ages 15–49 who were aware of LARCs such as IUDs and implants (Table 6).

Table 6. Knowledge of Modern Contraceptive Methods among Married Women Ages 15–49, 2010–2015 TDHS

Method	2010	2015
Any modern method	98.9%	99.1%
BTL	87.5%	87.9%
Vasectomy	40.3%	46.9%
Pills	98.0%	98.1%
IUDs	79.3%	88.9%
Injectables	97.5%	98.1%
Implants	88.0%	95.2%
Male condoms	95.6%	95.8%
Female condoms	74.6%	80.8%
Emergency contraception	12.3%	20.7%
LAM	37.2%	37.9%
Standard Days Method	NA	11.5%

Although the goal of increasing mCPR is inherent in all of the NFPCIP's SAAs, SAA II (Capacity Building) and SAA III (Service Delivery) both emphasized making quality FP services more accessible in hard-to-reach areas.

4.6.4 Analysis of Gaps

SAA II: Capacity Building

The primary gap in SAA II implementation was in the area of developing guidelines, training curricula, and job aids for task sharing of FP. Because only one workshop was held toward this aim (out of a target of four), several subsequent activities that relied on the existence of such materials could not happen. For example, trainings of trainers and provider trainings could not occur without guidelines and curricula. In addition, because of the limited momentum on demonstration projects and lack of coordinated advocacy efforts to influence policy changes on task shifting, no policy decisions were made on task sharing (activity 1b). Not surprisingly, spending on SAA II activities was low, with all but one activity (the demonstration project, activity II.1.a, at 12.8 percent of the target) reaching just 1.3 percent or less of their targets.

SAA III: Service Delivery

In April 2014, the MOHSW released policy guidelines for its community-based health program in an effort to support measures to establish community-based health services offered by a formalized cadre of CHWs nationwide. The most notable success of SAA III occurred in the area of ADDOs, where a number of activity targets were exceeded. Expanding the method mix available at ADDOs and ensuring ADDO operators are trained to counsel and provide such methods is an important component of community-based FP, as these outlets are often the first and most convenient location for people in rural areas to obtain health supplies.

4.6.5 Key Recommendations

1. ***Ensure that support for the delivery of FP at the community level is in place at all levels.***

   This means having up-to-date training curricula and job aids, as well as efforts to implement the task sharing guidelines for CHWs.

2. ***Determine what is behind the stalled urban mCPR.***

   The reason for this trend is undoubtedly complicated, and it needs to be understood so that it can be appropriately addressed.

3. ***Do not neglect adolescents.***

   There is such a large population of youth who will be entering their reproductive years during the next NFPCIP. These adolescents (who are greatly underserved) must not be overlooked, as they will be very important in increasing the national mCPR.

4. A more targeted approach is needed to address regional variation and urban versus rural variation in different segments of the population.

With NFPCIP II development, a more targeted approach will help address the different needs of the different segments of the population.

4.7 Area of Measurement 6: Method Mix

Definition

Method mix—the percent distribution of contraceptive users by method—is one measure that reflects the availability of a range of contraceptive methods. Patterns of method mix are complex and reflect preferences affected by societal and cultural norms, as well as by issues affecting availability and accessibility, including policies, cost, infrastructure, and provider training. A broad method mix means that a population has access to a range of contraceptive methods, and an ideal method mix means the population has a range of methods to meet the varying needs of women and couples over their reproductive lives.

Key Insights

- Increase in implants possibly filling latent need previously filled by short-acting methods
- Underutilization of the highly effective IUD
- Underutilization of female sterilization and near non-existence of vasectomy
- Low rates of condom use that are concerning, particularly because of remaining concerns about the prevalence of HIV and other sexually transmitted infections

Recommendations

- More efforts are needed to promote vasectomy and BTL as safe and effective methods for men and women who do not wish to have additional children.
- For women who do not wish to undergo BTL but do not want more children, the IUD should also be promoted as a highly effective method for those women who wish to use it.
- In terms of LARCs, the IUD remains underutilized (although use of contraceptive implants has increased), particularly for women who do not wish to have any more pregnancies but do not want to undergo sterilization. The IUD can also be particularly useful for young women who wish to delay a first pregnancy by several years.
- Dual method use should be promoted given the low rates of condom use.
- To support a broad contraceptive method mix, ensure that providers are adequately trained on a full range of methods, method selection by women and couples is informed, and all offered methods are readily available.
- Outreach efforts to bring a broader array of methods to women and couples who are not being reached by health facilities can also help expand the method mix.
- Monitoring and implementation of the NFPCIP II needs to be improved to include realistic targets/indicators, budget estimates, and timing of reports.

According to Measure Evaluation,[58] the contraceptive method mix refers to the "percent distribution of contraceptive users (or alternatively, acceptors) by method." This provides a description of the relative use of different contraceptive methods in the country. Access to methods influences the method mix and can fluctuate depending on the introduction of new methods or stockouts of existing methods. Other factors such as costs, user preferences, and provider biases can also affect the mix.

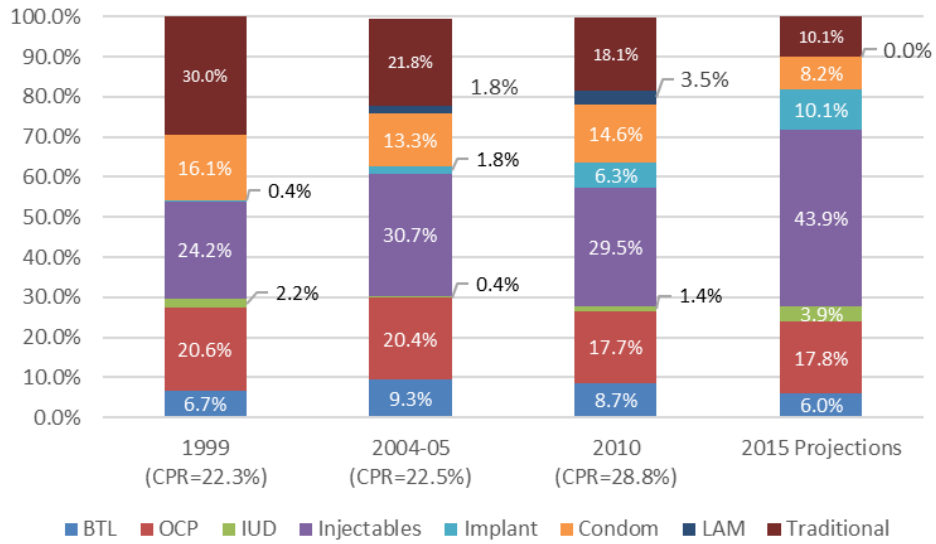
Ideally, the method mix should include a range of methods to meet the varying needs of women and couples over the course of their reproductive lives.[58] Short-acting methods such as condoms, OCPs, and injectables (e.g., DMPA) are often preferred by women and couples who wish to delay a first pregnancy or space pregnancies, whereas longer-acting methods (e.g., IUDs, implants) or permanent methods (i.e., vasectomy, BTL) are often preferred by those who wish to limit pregnancies.

Examining a country's method mix can indicate needed changes in terms of method distribution, contraceptive security, provider training needs, or other issues related to achieving a broad method mix that is accessible to all potential users.

4.7.1 Status and Key Issues Prior to the NFPCIP

The CPR in Tanzania has been steadily increasing since the first DHS was conducted in 1991/1992. Prior to the implementation of the NFPCIP in 2010, the mix of contraceptive methods was skewed largely toward short-acting methods such as OCPs, injectables, and condoms (Figure 41).

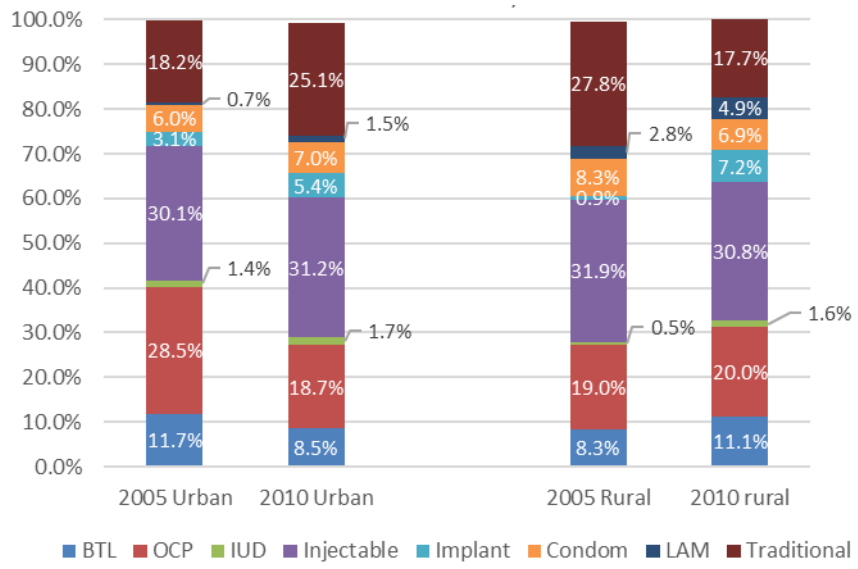
Figure 41. Contraceptive Method Mix, 1999–2010 with 2015 Projections



This pattern held over the 11-year period from 1999 to 2010, although the mix of short-acting methods changed somewhat, as injectable use increased over time with a corresponding small decrease in OCP use. Traditional methods continued to make up a substantial, though decreasing, proportion of users during the same period.

Looking at 2010 TDHS data, prior to the implementation of the NFPCIP, traditional contraceptive use was higher in urban areas than rural areas (25.1 percent versus 17.7 percent) (Figure 42). LAM use, although low overall, was greater in rural areas (4.9 percent) than in urban areas (1.5 percent). BTL and implants also made up slightly larger proportions of the method mix in rural areas than in urban areas. There were no other notable differences between urban and rural settings at the time.

Figure 42. Contraceptive Method Mix by Urban/Rural Status, 2005–2010



In addition to supporting the DHS, Measure Evaluation supports the implementation of a national SPA in many countries. The most recent Tanzania SPAs were conducted in 2006[30] and 2015.[36] Therefore, any service provision characteristics that changed during NFPCIP implementation between 2006 and 2010 may not have been fully captured. However, comparing 2006 SPA findings with 2015 SPA findings can help shed light on why some of the observed changes in CPR and method mix may have occurred.

In 2006, approximately 76 percent of all health facilities offered at least one modern method, including 97 percent of government facilities, 50 percent of parastatal facilities, 39 percent of faith-based facilities, and 32 percent of private, for-profit facilities (data not shown). Also in 2006, among facilities that offered specific methods of FP, only a minority had all methods that they offered available on the day of the SPA. Availability of most short-acting methods was

high, but availability of LARCs (e.g., IUDs, implants) and certain short-acting methods (i.e., female condoms, combined hormonal injectable contraceptives) was less than optimal.

4.7.2 How the NFPCIP Addressed Method Mix

In 2012, during the London Summit on FP, the Tanzania FP program galvanized its priority to establish a broad method mix to cater to different user needs by including the following as part of its six FP2020 commitments: commitment # 3 to strengthen contraceptive commodity security and logistic systems to ensure the continuous availability of quality contraceptives with a desired method mix.[59]

Through the NFPCIP, the GOT aimed to broaden its contraceptive method mix by addressing several key issues that were presumed to influence the method mix, as outlined below. Key strategies that addressed method mix in the NFPCIP included:

- Increasing access to LAPMs, as well as injectables, and reducing the rural-urban gap for these methods by expanding the number of service delivery points capable of providing them.
    - SAA II (SR 1): Task shifting implemented at all levels of the health system
    - SAA II (SR 2): Provider capacity to deliver quality FP services improved
    - SAA III (SR 6): Access to FP services in remote sites/low-CPR regions through implementation of outreach services increased
    - SAA III (SR 8): Availability, accessibility, and quality of socially marketed contraceptive products expanded and strengthened
    - SAA IV (SR 3): Demand for FP services increased and sustained

- Expanding procurement of implant brands to include Jadelle, which was lower in cost than Implanon.
    - SAA I (SR 1): Adequate contraceptive commodities and supplies procured to meet country needs

- Introducing and promoting use of the Standard Days Methods and LAM.
    - SAA I (SR 3): Contraceptive method mix broadened by the introduction of new methods

- Exploring the potential expansion of injectables through non-clinical provider platforms.
    - SAA III (SR 3): Availability of integrated community-based services strengthened and increased
    - SAA III (SR 8): Availability, accessibility, and quality of socially marketed contraceptive products expanded and strengthened

4.7.3 Results of the NFPCIP

From 2010 to 2015, total CPR modestly increased from 28.8 percent to 32.4 percent among all women ages 15–49 years. The mCPR also increased, from 23.6 percent to 27.1 percent during this same period, although the gain was far from the targeted 60 percent set at the beginning of the NFPCIP.

In terms of method mix, the five years of the NFPCIP saw an increase in the use of contraceptive implants, which corresponded with an increase in availability of the method through efforts supported by the Clinton Health Access Initiative (CHAI) Volume Pricing Partnership and social marketing of the products. This substantial increase in the long-acting contraceptive implant likely tapped into a latent need for such a method—one that was previously filled by short-acting methods such as OCPs.

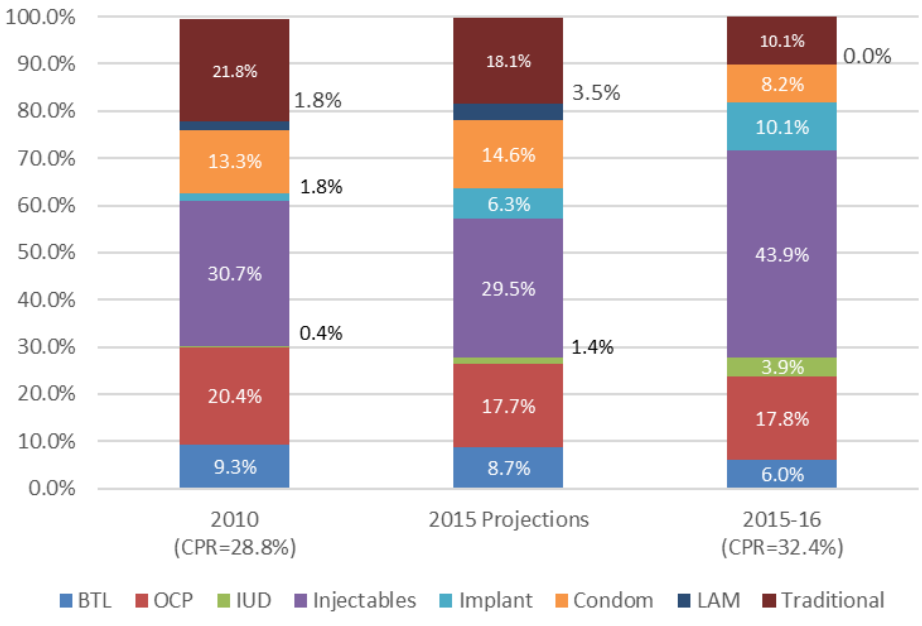
Traditional methods, which are not as effective as modern contraceptive methods, saw an overall decrease in terms of the proportion of contraceptive users who rely on them. This was observed in both rural and, to a lesser extent, urban settings. Patterns of changes in method mix by zones differed, although it is not clear to what extent these differences were driven by supply-side factors (e.g., service provision, product availability) and demand-side factors (e.g., patient preference, social norms).

The proportion of health care facilities offering FP methods, and the proportion of those facilities that had individual methods available improved from the 2006 SPA to the 2015 SPA, particularly for methods such as IUDs and implants. Training providers on FP methods remained an important challenge, as did adequately equipping facilities to be able to offer a full range of FP methods. Below are selected results, categorized by source of data.

Findings from the 2015/2016 Demographic and Health Survey

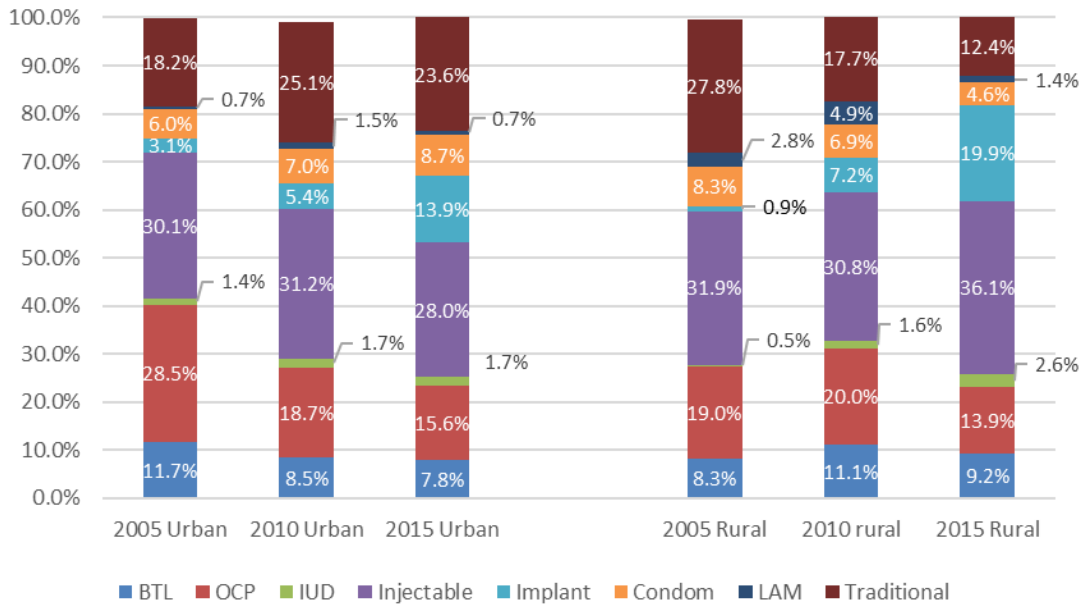
Shifts in method mix. After five years of NFPCIP implementation, data from the 2015/2016 TDHS revealed that overall CPR increased to 32.4 percent and the method mix shifted slightly for some methods. The most notable changes were observed for OCPs and contraceptive implants. The proportion of contraceptive users who reported using OCPs dropped from 18 percent in 2010 to 13 percent in 2015, which corresponded to an 11 percentage point increase in implant use (6 percent to 17 percent). Injectable and condom use remained largely unchanged, as did the use of traditional contraceptive methods (Figure 43).

Figure 43. Contraceptive Method Mix, 2000–2015 with 2015 Projections



Between 2010 and 2015, use of any method, including traditional methods (45.9 percent in 2010 and 46.1 percent in 2015), and use of modern methods (34.1 percent in 2010 and 35.2 percent in 2015) held steady in urban areas; any method use (30.5 percent to 34.6 percent) and modern method use (25.2 percent to 30.6 percent) increased slightly in rural areas (data not shown). From 2010 to 2015, both urban and rural areas experienced a decline in the proportion of current contraceptive method users who chose traditional methods, although the decline in rural areas (17.7 percent to 12.4 percent) was greater than that in urban areas (25.1 percent to 23.6 percent). Both urban and rural areas also experienced declines in the proportion of women selecting female sterilization and OCPs, and both experienced substantial increases in the proportion of contraceptive method users who reported using contraceptive implants. Two notable differences between urban and rural areas involved the use of condoms and injectable contraceptives. In urban areas, condom use increased slightly (7.0 percent to 8.7 percent) and injectable contraceptive use declined (36.2 percent to 28.0 percent) from 2010 to 2015; the opposite occurred in rural areas, where condom use declined (6.9 percent to 4.6 percent) and injectable use increased (30.8 percent to 36.1 percent) (Figure 44).[5,13]

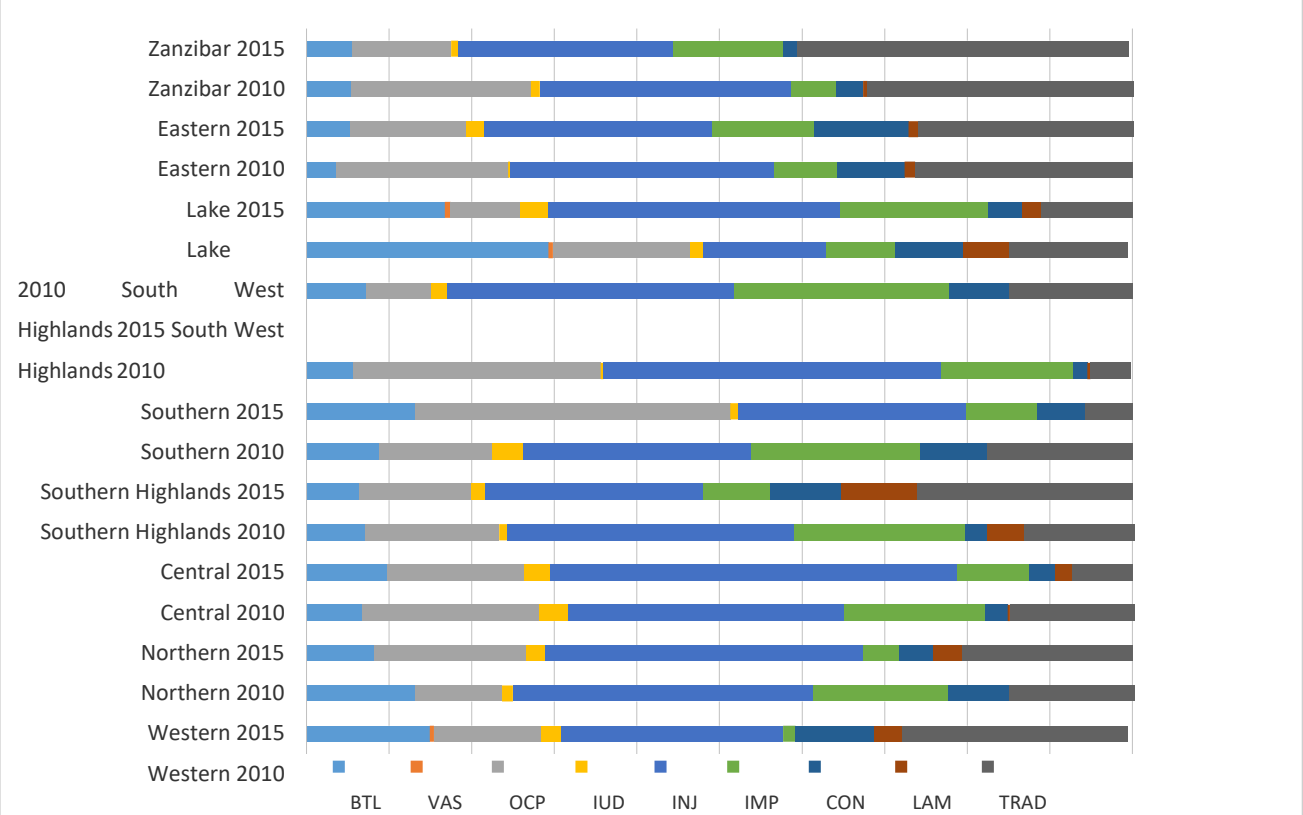
Figure 44. Contraceptive Method Mix by Urban/Rural Status, 2005–2015



<u>Zonal changes</u>. Review of method mix shifts across zones also provided some useful insights (Figure 45):

- Traditional methods made up various portions of the method mix across zones but decreased overall from 2010 to 2015, except in Zanzibar, where traditional method use increased from 32.6 percent to 40.2 percent, and in the Central Zone, where it increased from 7.3 percent to 13.3 percent.
- OCP use decreased across zones from 2010 to 2015 but still made up nearly one-third of the method mix in the Southern Zone, which was substantially more than in any other zone.

Figure 45. Contraceptive Method Mix by Zone among Current Users, 2010–2015



Findings from the 2014/2015 Service Provision Assessment

The 2006 and 2015 SPAs measured provider training on FP at different intervals. In 2006, only about 16 percent of FP providers had any FP-related training in the 36 months prior to the survey.[30] In 2015, only 18 percent of FP providers had any such training in the 24 months preceeding the survey. In 2015, only about 10 percent of providers had received recent in-service training on IUD insertion and removal, implant insertion and removal, FP for clients living with HIV, or postpartum FP.

The SPAs also provided data on the percentage of facilities offering FP services that had specific contraceptive methods available on the day they were surveyed (Table 7).

Table 7. Percentage of Facilities with Specific Methods Available on the Day of the SPA, 2006 and 2015

Method	2006			2015			
	Hospital	Health Center	Dispensary	Hospital	Health Center	Dispensary	Clinic*
Combined OCPs	93	100	89	89	86	87	100
Progestin-only pills	84	86	74	76	77	74	96
Progestin-only injectables	84	87	81	94	87	91	91
Combined injectables	35	100	0	62	77	72	100
Male condoms	84	86	79	86	85	89	83
Female condoms	11	0	7	86	70	79	65
IUDs	62	39	2	95	89	79	100
Implants	60	27	2	95	91	90	97
CycleBeads**	NA	NA	NA	50	69	44	60
All offered methods available on day of survey	36	38	30	60	55	61	71

*The health facility classification "clinic" was not included in the 2006 SPA.
**CycleBeads were not included in the 2006 SPA.

Findings from NFPCIP Implementation

<u>Increasing access to LAPMs, as well as injectables, with the purpose of expanding service delivery points and reducing the rural-urban gap for these methods</u>

SAA II (SR 1): Task shifting implemented at all levels of the health system

To accelerate the availability of skilled providers in the provision of LAPMs, efforts were made to integrate FP core competency training into the teaching curricula for clinical staff. Specifically, an IUD core competency curriculum was integrated into the pre-service training curricula at three nursing schools and later into the national curriculum that is used for all nursing certificate and diploma programs that follow the MOHSW/National Council for Technical Education system. Further, instructional content for the provision of LAPMs was integrated into the pre-service curriculum for assistant medical officers and nurse midwives. This content included training on FP counseling and method provision.

SAA II (SR2): Provider capacity to deliver quality FP services improved

A newly updated national FP guidelines manual and training curriculum were released in 2010 at the beginning of the NFPCIP. During NFPCIP implementation, activities focused on disseminating the tools at national, zonal, regional, and districts levels. By the end of the

NFPCIP, 1,408 FP trainers had received initial training or refresher training on the FP procedures manual and the FP training modules.

During NFPCIP implementation, 200 tutors (i.e., trainers of trainers) received an initial orientation on FP, and 88 percent of these trainings included information on LAPMs. Efforts were also directed to increase the pool of zonal FP trainers, but only 38 zonal trainers (30 percent of the target) were trained. Additionally, 50 tutors received a contraceptive technology update training (4 percent of the target).

Considerable in-service training of providers was also undertaken. In particular, 95 percent of the pool of trainers during Years 3–6 received training on LAPMs.

SAA III (SR 6): Access to FP services in remote sites/low-CPR regions through implementation of outreach services increased

Outreach services were given high priority in the NFPCIP because of challenges in providing access to LAPMs in rural areas, remote sites, and low-CPR regions. A TWG was formed to focus on outreach services and oversee coordination of such activities. This TWG was tasked with developing guidelines for outreach activities nationwide. Outreach guidelines were developed and used by stakeholders to implement outreach efforts according to national standards. Development began in 2013, and the guidelines were officially approved in 2015.

Further, various implementing partners came together to deliver coordinated outreach activities that reached 744,385 people with FP services (information, referrals for complicated cases, and provision of methods not available at lower-level facilities or not available in hard-to-reach areas). The services were provided through a mix of community provision, mobile clinics, and static facilities.

SAAIII (SR 8): Availability, accessibility, and quality of socially marketed contraceptive products expanded and strengthened

Prior to the NFPCIP, contraceptive products delivered through social marketing strategies were limited to short-acting methods (primarily condoms and pills). Efforts were made to expand long-acting methods, injectables, and emergency contraception in 418 pharmacies reached by medical retailers. All of the socially marketed products, except for IUDs and emergency contraception, were branded Familia. IUDs and implants were the main long-acting methods that pharmacies could sell, and they were mostly sold directly to private health facilities. If clients themselves came in for the long-acting methods, they could buy them at the pharmacies but had to go to a health facility for insertion. The aim of expanding social marketing was to increase the range of outlets where methods could be accessed, rather than to necessarily attract new users.

Expanding procurement of implant brands to include Jadelle, which was lower in cost than Implanon

SAA I (SR 1): Adequate contraceptive commodities and supplies procured to meet country needs

The Volume Guarantee Partnership, led by CHAI, negotiated a 50 percent price reduction of implants, resulting in procurement savings and making implants one of the most cost-effective methods on a couple-years of protection basis.[60] In 2012, Bayer reduced the price of Jadelle from US$18 to US$8.50, and in 2013, Merck reduced the price of Implanon from US$16.50 to US$8.50.[60] The reduction in the price of implants, together with volume-guarantee discounts, allowed the government to procure more implants.

During the NFPCIP, 3,523,068 contraceptive implants were procured. In 2012, the Tanzania Food and Drug Authority approved the lower-cost Jadelle implant for use.

Introducing and promoting use of the Standard Days Method by introducing CycleBeads

SAA I (SR 3): Contraceptive method mix broadened by the introduction of new methods

During the NFPCIP, 784,381 CycleBeads were procured (34 percent of the target). However, distribution of the beads was limited to only one region (Shinyanga) as a pilot test for the method.

Exploring the potential expansion of injectables through non-clinical provider platforms

SAAIII (SR 3): Availability of integrated community-based services strengthened and increased

Given the popularity of injectable contraceptives, combined with substantial evidence on the safety and feasibility of their community-based distribution in other countries, the GOT commissioned a pilot in Morogoro Region 2014 to examine the feasibility of such an approach in Tanzania. Results from the study, which concluded in 2015, were disseminated to FP stakeholders and senior MOHCDGEC staff. Findings demonstrated that CHWs can safely distribute and administer injectable contraceptives within the community. However, despite findings from the pilot test and evidence from other countries, policy makers chose not to change existing policy to permit the community-based distribution of injectable contraceptives by CHWs.

4.7.3. Analysis of Gaps

- Despite considerable efforts to improve training during the NFPCIP, only a minority of health care providers responsible for FP services have received any recent training on FP. What factors contributed to this and how can the GOT ensure that all FP providers receive adequate FP training and regular updates? What strategies may improve the reach of the training to all relevant health staff (e.g., online training courses, requiring continuing education to remain licensed, periodic recertification examinations for health staff)?
- To what extent do provider biases limit uptake of methods that are more time-consuming to administer, such as sterilization and IUDs? To what extent is facility infrastructure the limiting factor to these methods? What are ways in which these barriers can be overcome?

- How can social norms be addressed to improve the uptake of vasectomy among men who no longer wish to have children?
- Can FP services be integrated into other routine primary health care services in such a way that informed choice and a full range of contraceptive options remain feasible? Will integration perpetuate an inclination toward short-acting methods?
- Can immediate postpartum IUD insertion and BTL be ways to better meet the unmet demand to limit pregnancies? What barriers persist to the routine offer of these services?
- Who is using socially marketed LARCs and why?

4.7.4 Key Recommendations

1. ***More efforts are needed to promote vasectomy and BTL as safe and effective methods for men and women who do not wish to have additional children, as these methods are underutilized.***

2. ***The IUD should also be promoted as a highly effective method for women who do not wish to undergo BTL.***

   In terms of LARCs, although contraceptive implant use increased, the IUD also remains underutilized, particularly for those women who do not wish to have any further pregnancies but do not wish to undergo sterilization. IUDs can also be particularly useful for young women who wish to delay a first pregnancy by several years.

3. ***Promote monthly injectables as an alternative to OCPs or three-month injectables like DMPA.***

   A decline in the use of short-acting contraceptive pills, which are among the most prone to user error, was not surprising. The adoption of the monthly combined hormonal injectable may be an alternative for those who no longer wish to use OCPs but also do not want a three-month injectable.

4. ***The promotion of dual method use should be a main focus moving forward since low rates of condom use are concerning, particularly in a country where HIV prevalence and the prevalence of other sexually transmitted infections remain important concerns.***

5. ***Broader efforts are needed to improve access to and uptake of contraceptive methods for the healthy timing and spacing of pregnancies.***

6. ***Support the fundamentals of a broad method mix by ensuring that:***

   - Health care providers are adequately trained on a full range of contraceptive methods. Training of health workers should be done strategically to inform the method mix as per the FP needs of different segments of the population.
   - Method selection by women and couples is guided by informed choice (which requires that fertility preferences be considered).

- All offered methods are readily available.
- Outreach efforts to bring a broader array of methods to women and couples who are not being reached by health facilities are considered to expand the method mix.

7. ***Improve collaboration and synergy between the public and private sectors to promote method mix.***

8. ***Perform an in-depth analysis on method mix per different segments of the population (e.g., young people by age, urban young versus rural).***

   Also, in-depth segmentation analysis of current FP users by region, urban versus rural, and other characteristics will better inform a needed shift in method mix for the NFPCIP II.

9. ***The promotion of methods should be informed by segmentation analysis. For example, LARCs can be ideal for regions with high fertility rates, such as Tabora, as compared with regions with low fertility rates.***

10. ***Determine why OCP use is dropping, including finding out who used OCPs in the past and who is using them now.***

4.8 Zonal Analysis (2005-2015): Central Zone

KEY INDICATOR HIGHLIGHTS FOR THE CENTRAL ZONE, 2005-2015

- **Adolescent pregnancy increased** over 9 percentage points (from approx. 23 to 32 percent)
- **CPR remained the same for young women ages 15-19** from 2005 to 2015, at roughly 16 percent
- **Implant use increased substantially** from 2005 to 2015**,** from less than 1 percent to over 26 percent

Image 1. 2015 zonal distribution of Tanzania

BACKGROUND

TABLE 1. Central Zone population demographic characteristics, 2012 Census data

Population	% Male	% Female	% Rural	% Urban
4,879,356	49.5	50.5	13.7	86.3

The geographical boundaries and regions included in the Central Zone shifted from 2005 to 2015. Until 2015, regions in the Central Zone included only Dodoma and Singida. In 2015, the Central Zone expanded to include the Manyara region.[1] The Central Zone is located near the center of Tanzania (see **Image 1**) and is mostly rural. Per the 2012 Census, there are approximately 4.9 million people in the Central Zone (see **Table 1**). Indicators presented in this report were selected based on available data from the 2005, 2010, and 2015 DHS reports.[2]

ADOLESCENT PREGNANCY

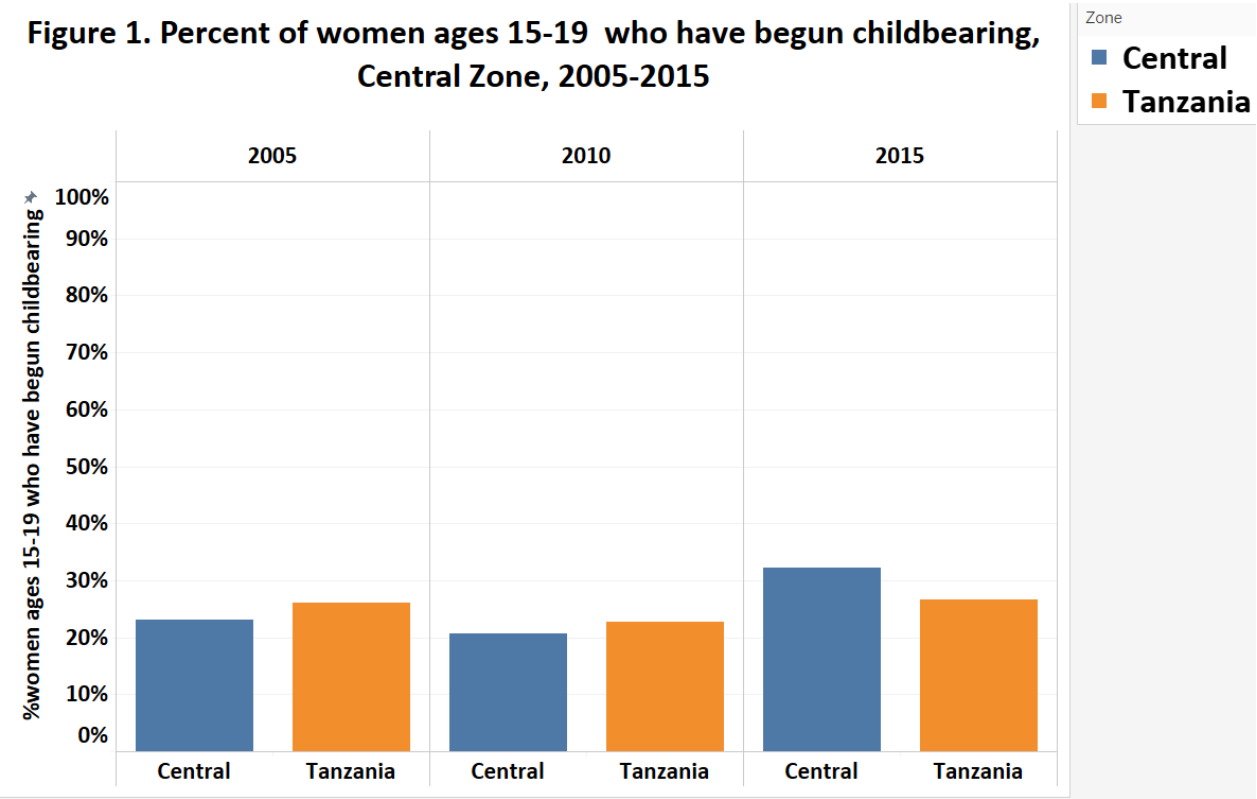
In the Central Zone, the proportion of women ages 15-19 who had begun childbearing increased from approximately 23 percent in 2005 to 32 percent in 2015. Most notably, there was a small decrease in

[1] For this report, to ensure that the areas evaluated remained the same across each year, zonal data for each DHS year reflect the geographic distribution of the zone in 2015. Re-mapping was conducted prior to analyzing the zonal data to ensure the data in each zone was equally weighted and comparable across the three DHS years

[2] Indicators presented in this report were selected based on adequate sample size

adolescent pregnancy from 2005 to 2010, but the rate increased over 10 percentage points from 2010 to 2015. Also, for 2005 and 2010 the Central Zone had a lower adolescent pregnancy rate than the country, but this situation reversed in 2015 when the rate in the Central Zone surpassed that of Tanzania (see **Figure 1**).

Figure 1. Percent of women ages 15-19 who have begun childbearing, Central Zone, 2005-2015



Age of first sex, first birth, and first marriage did not vary much from 2005 to 2015 among all women ages 20-49[3] in the Central Zone, and remained below the national average by 1-2 years across all three categories (see **Table 2**).

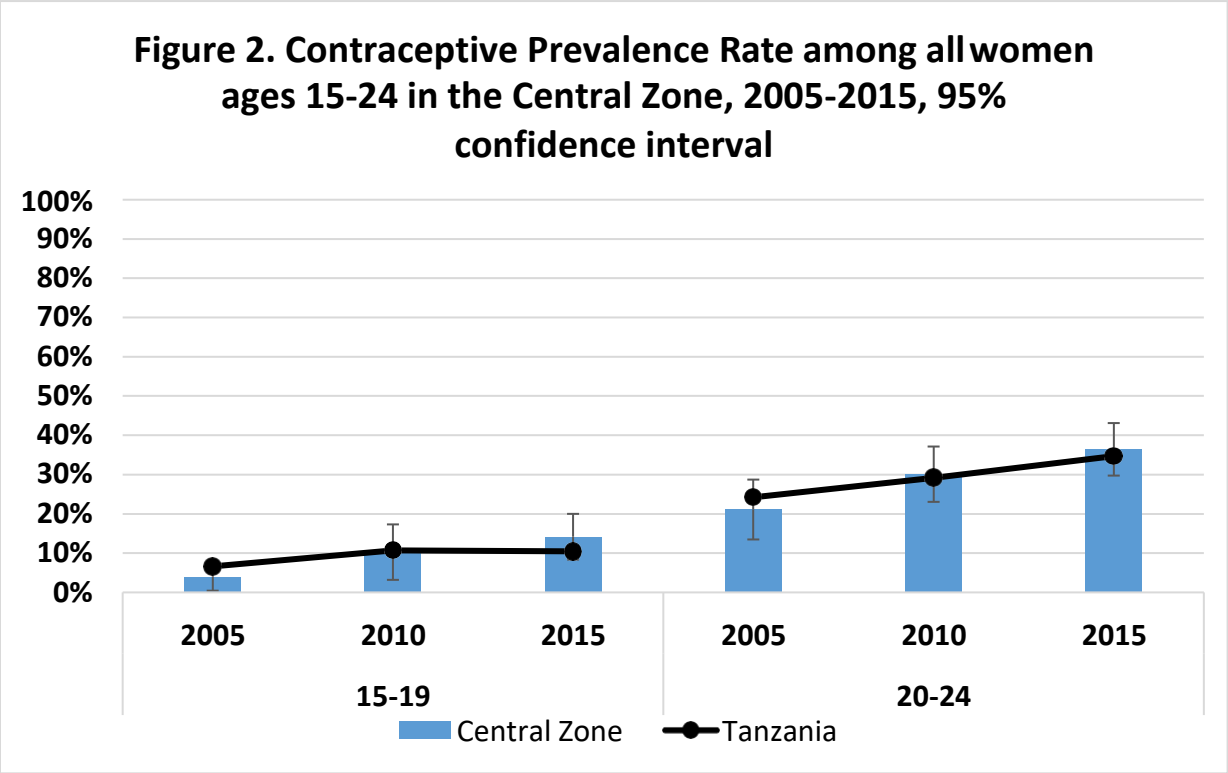
Table 2. Age at first intercourse, birth, and marriage, all women ages 20-49, Central Zone, 2005-2015

	Intercourse			Birth			Marriage		
Zone	2005	2010	2015	2005	2010	2015	2005	2010	2015
Central	15.0	15.9	15.7	18.0	18.4	18.4	17.2	17.3	17.6
Tanzania	17.0	17.4	17.3	19.4	19.5	19.8	18.6	18.9	19.3

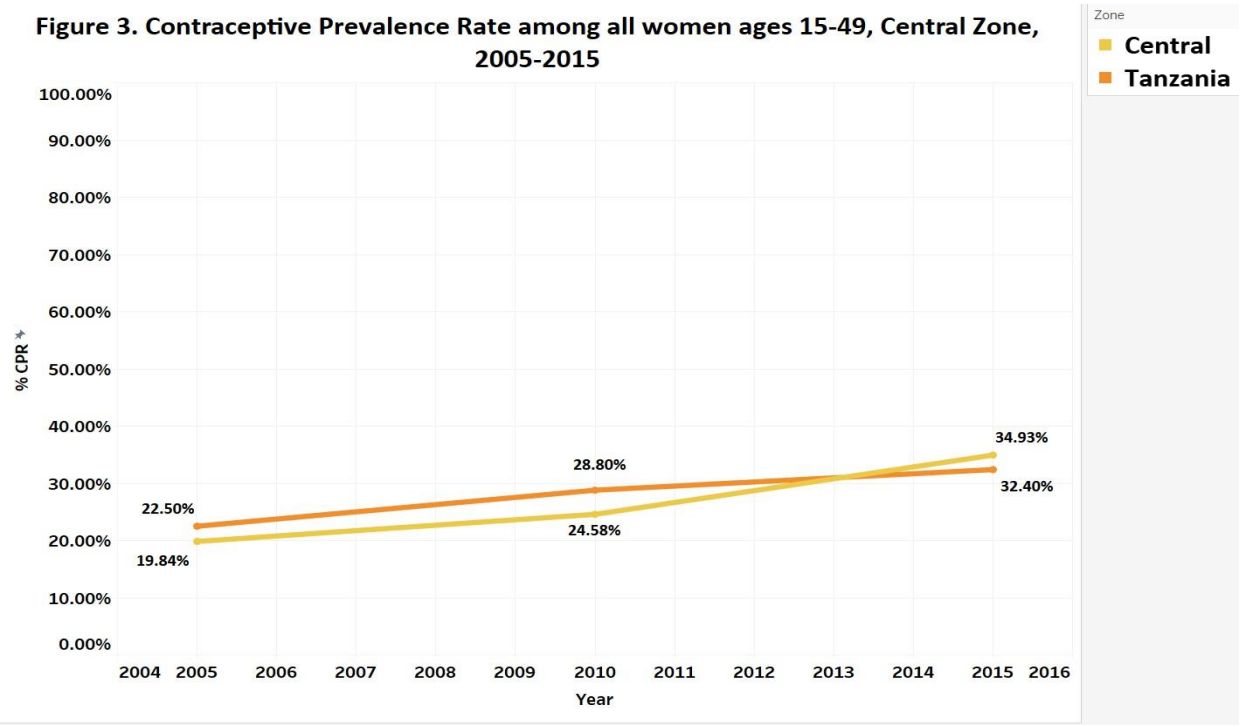
CPR

Figure 2 shows the contraceptive prevalence rate (CPR) among young women, ages 15-19 and 20-24 in the Central Zone with confidence intervals and compared to national data. CPR among women ages 15- 19 increased by about 10 percentage points, from 4 percent to roughly 14 percent. For women ages 20- 24, CPR increased over 15 percentage points from 2005 to 2015, and in 2015 the CPR in this age group were nearly the same in the Central Zone and in Tanzania, at roughly 35-36 percent.

[3] In this section of the DHS, women ages 20-49 were surveyed, unlike many other sections of the DHS where women ages 15-49 were surveyed

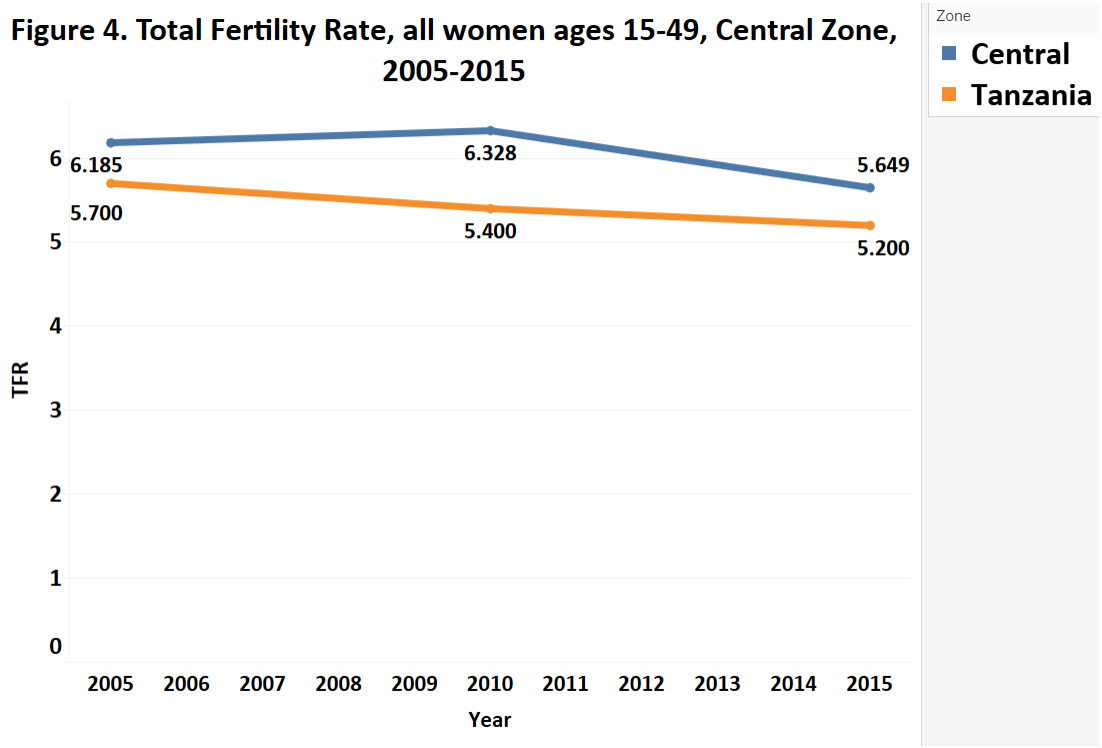


CPR for all women ages 15-49 in the Central Zone increased from roughly 20 percent to nearly 35 percent for all women ages 15-49 from 2005-2015 (see **Figure 3**). In 2015, CPR in the Central Zone surpassed CPR for Tanzania just slightly.

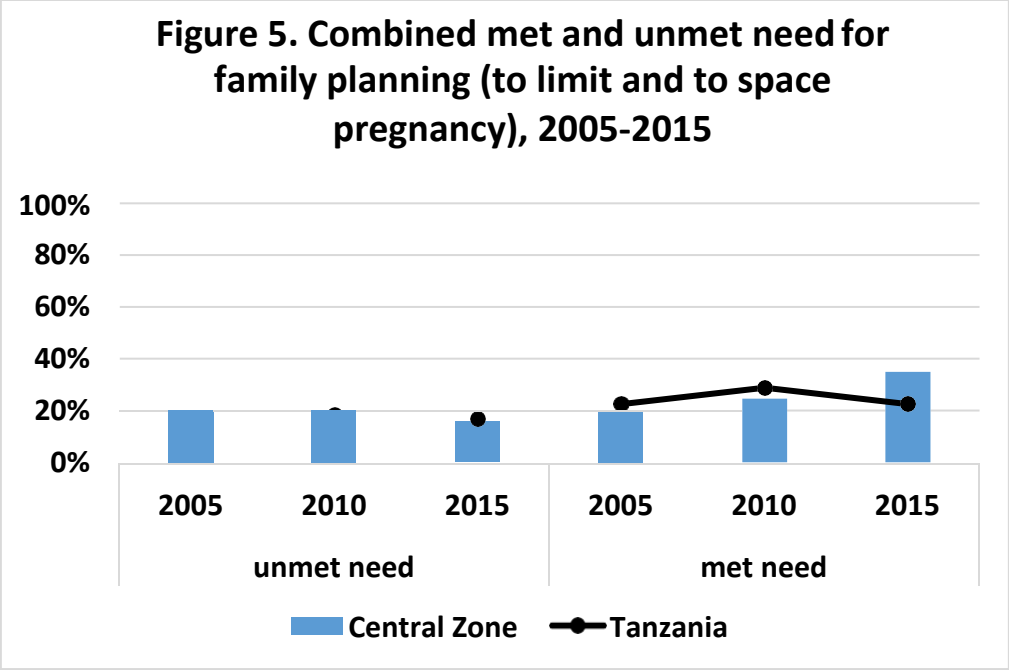


NEED AND DEMAND FOR FAMILY PLANNING

Total fertility rate (TFR) for all women ages 15-49 in the Central Zone decreased slightly, by about 0.5 children per woman, and remained slightly above the average TFR for Tanzania for the entire period of 2005-2015 (see **Figure 4**).

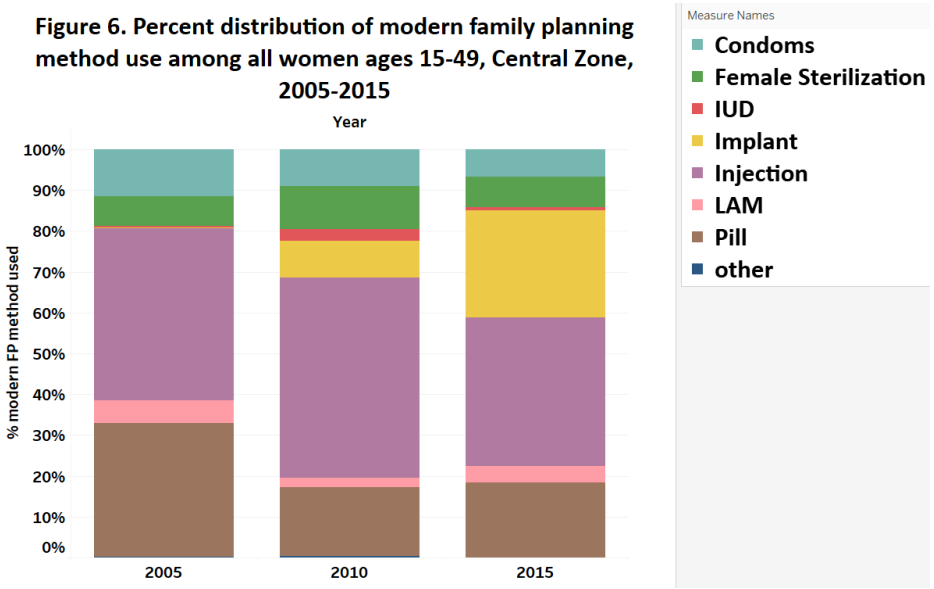


Combined contraceptive need and unmet need (for limiting and for spacing pregnancy) among all women ages 15-49 in the Central Zone is depicted in **Figure 5**. Most notably, total met need increased roughly 15 percentage points (from approximately 20 to 35 percent) from 2005 to 2015, while unmet changed only slightly from 2005 to 2015, and was nearly the same as the national average in 2015 at about 16 percent.



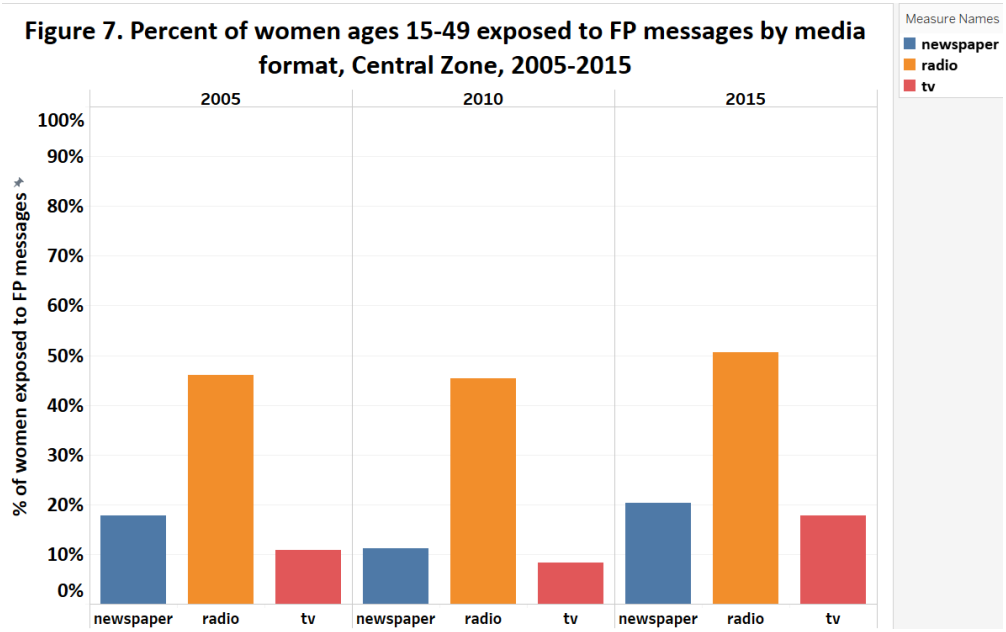
METHOD MIX

Figure 6 presents all modern contraceptive methods used by women ages 15-49 currently using any method of family planning in the Central Zone, where "other" includes minimally (<1 percent) used modern methods.[4] Most notably, oral contraceptive pill use (progestin-only and combined) decreased 14 percentage points, from 32 percent in 2005 to 18 percent in 2015. Contraceptive implant use increased substantially from 2010 to 2015 from approximately 9 percent to over 26 percent.



[4] Minimally used methods include emergency contraceptives, diaphragm, male sterilization, and female condoms

Figure 7 shows the distribution of family planning messaging, by format. It is worth noting that sources of family planning messages changed from 2005 to 2010, and this report only shows data for the sources that were consistent throughout the 10-year period.[5] In the Central Zone, radio remained the most prevalent media format for FP messaging at near 50 percent across all three DHS years followed by TV, which saw an uptick from 2010 to 2015 from 8 to 18 percent.



[5] Mobile phone messages were reported as a source only in the 2015 DHS. In the Central Zone, approximately 2.5 percent of women reported they received family planning messages from a mobile phone

Zonal Analysis (2005-2015): Eastern Zone

KEY INDICATOR HIGHLIGHTS FOR THE EASTERN ZONE, 2005-2015

- **Adolescent pregnancy remained nearly the same** at 18-20 percent from 2005-2015
- **CPR increased for young women ages 20-24**, from roughly 29 percent to over 46 percent from 2005-2015
- **Implant use increased substantially** from approximately 9 percent to over 26 percent from 2005-2015

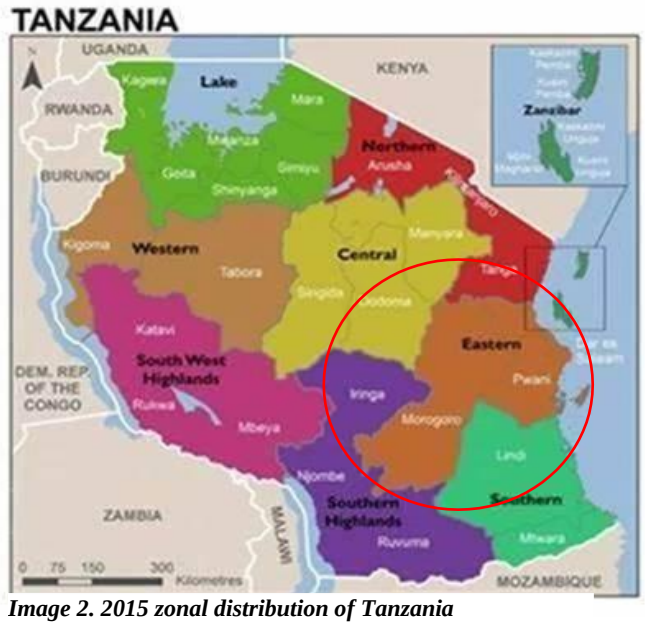


Image 2. 2015 zonal distribution of Tanzania

BACKGROUND

Table 1. Eastern Zone population demographic characteristics, 2012 Census data

Population	% Male	% Female	% Rural	% Urban
7,681,701	49	51	46	54

The geographical regions included in the Eastern Zone are Dar es Salaam, Pwani, and Morogoro.[6] The Eastern Zone is located on the east coast of Tanzania, and is nearly half rural and half urban (see **Table 1**). Per 2012 Census data, there are approximately 7.7 million people in the Eastern Zone with slightly more women than men. Indicators presented in this report were selected based on available data from the 2005, 2010, and 2015 DHS reports.[7]

ADOLESCENT PREGNANCY

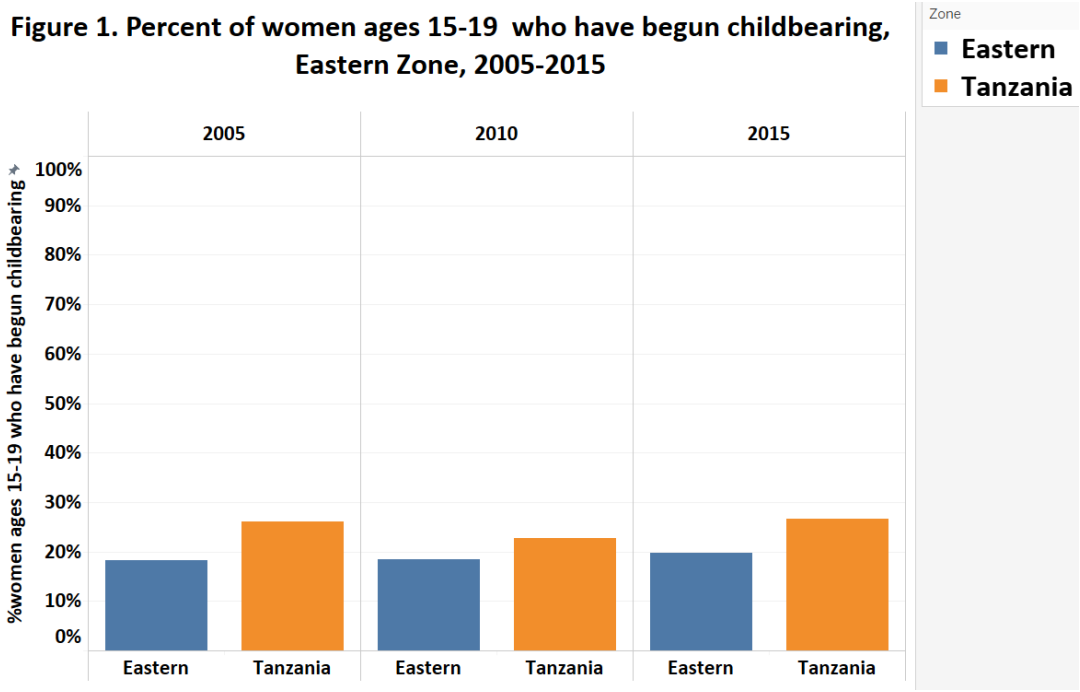
In the Eastern Zone, age distribution is relatively young, and nearly 11 percent of the entire population is young women ages 15-24. Women ages 15-19 who had begun childbearing changed minimally from 2005 to 2015 (from approximately 18 to 20 percent, respectively). Also, the

[6] For this report, to ensure that the areas evaluated remained the same across each year, zonal data for each DHS year reflect the geographic distribution of the zone in 2015. Re-mapping was conducted prior to analyzing the zonal data to ensure the data in each zone was equally weighted and comparable across the three years

[7] Indicators presented in this report were selected based on adequate sample size

Eastern Zone maintained a slightly lower adolescent pregnancy rate than the average for Tanzania across all three DHS years (see **Figure 1**).

Figure 1. Percent of women ages 15-19 who have begun childbearing, Eastern Zone, 2005-2015



Age of first intercourse and first birth among all women ages 20-49[8] in the Eastern Zone remained lower than the national average and did not vary much from 2005 to 2015, but age of marriage increased by nearly one year across the 10-year period (see **Table 2**).

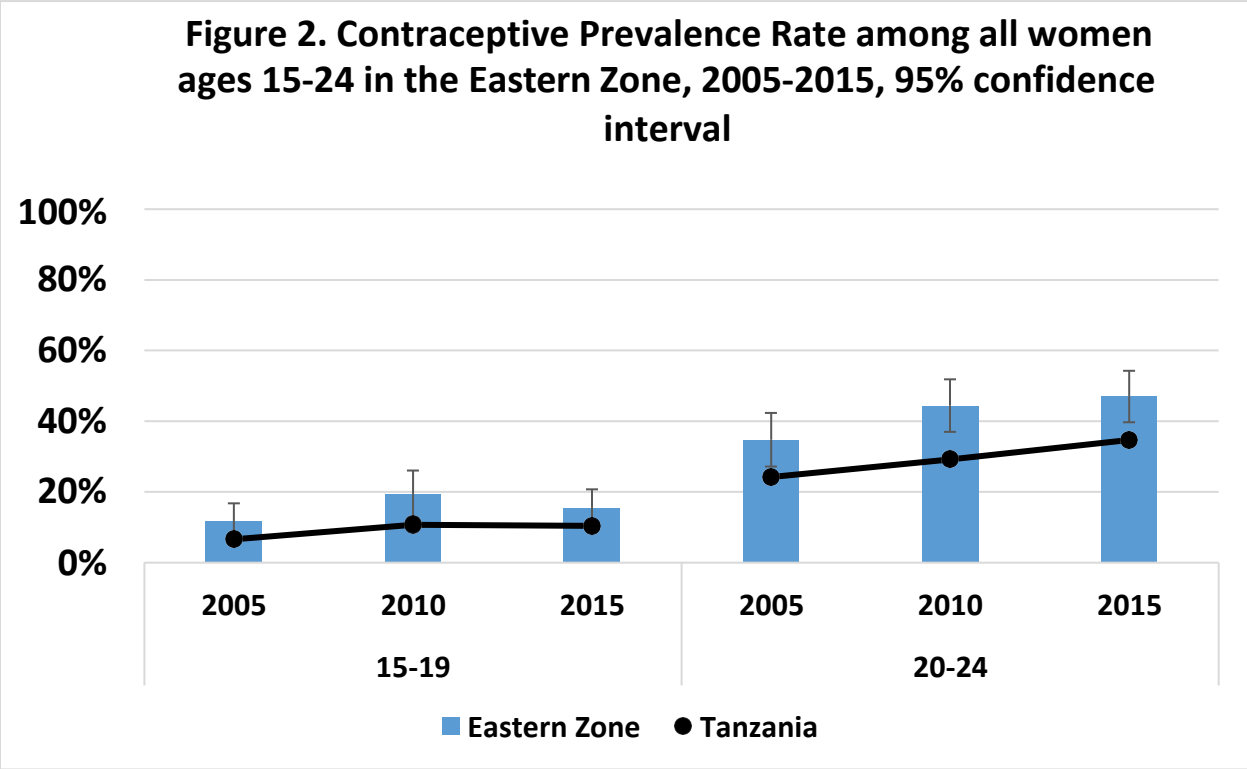
Table 2. Age at first intercourse, birth, and marriage, all women ages 20-49, Eastern Zone, 2005-2015

	Intercourse			Birth			Marriage		
Zone	2005	2010	2015	2005	2010	2015	2005	2010	2015
Eastern	15.7	15.8	15.9	18.0	18.1	18.6	17.5	17.9	18.4
Tanzania	17.0	17.4	17.3	19.4	19.5	19.8	18.6	18.9	19.3

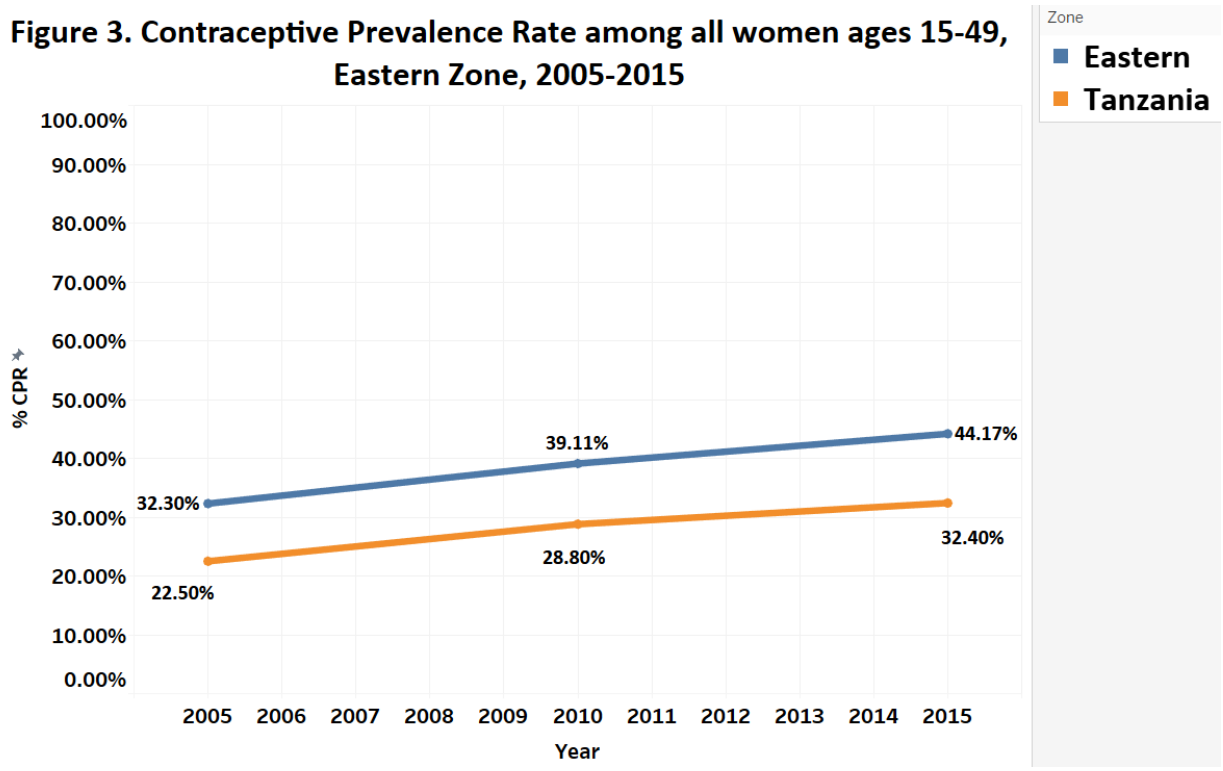
CPR

As shown in **Figure 2**, the contraceptive prevalence rate (CPR) among young women (ages 15-19 and 20-
24) in the Eastern Zone varied only slightly 2005 to 2015, and stayed only slightly above the national average. For women ages 20-24, CPR increased from roughly 35 percent to 47 percent from 2005-2015 and stayed above the national average across the 10-year period.

[8] In this section of the DHS, women ages 20-49 were surveyed, unlike many other sections of the DHS where women ages 15-49 were surveyed

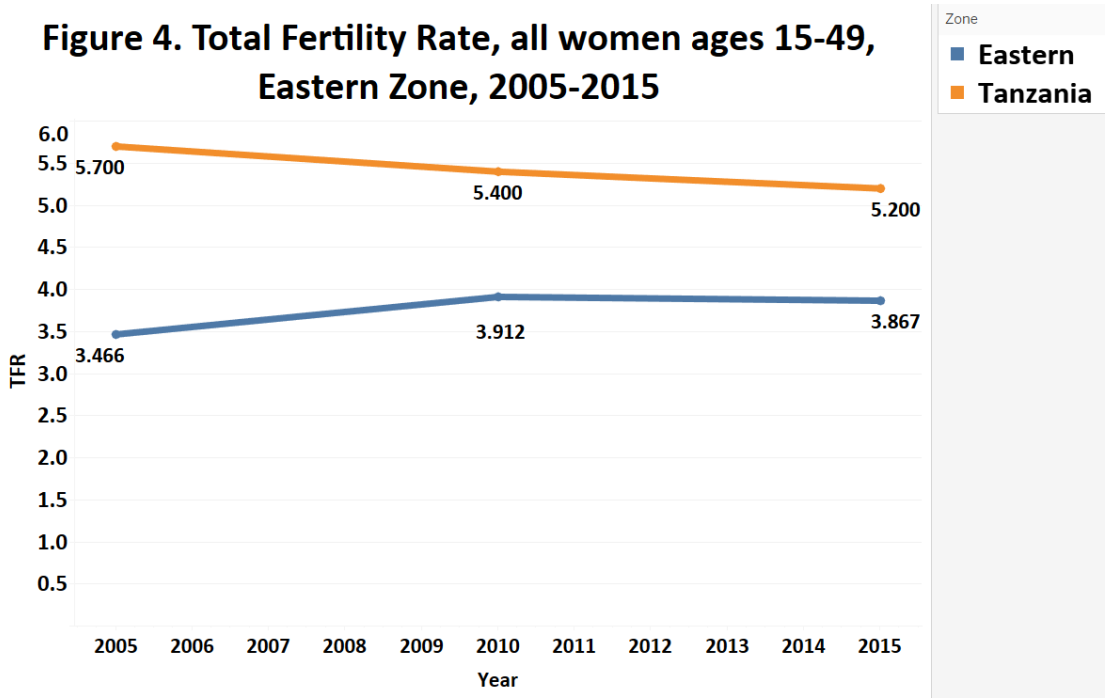


CPR among all women ages 15-49 in the Eastern Zone (shown in **Figure 3**) increased roughly 12 percentage points from 2005-2015 and was over 10 percentage points above the national average from 2005 to 2015.

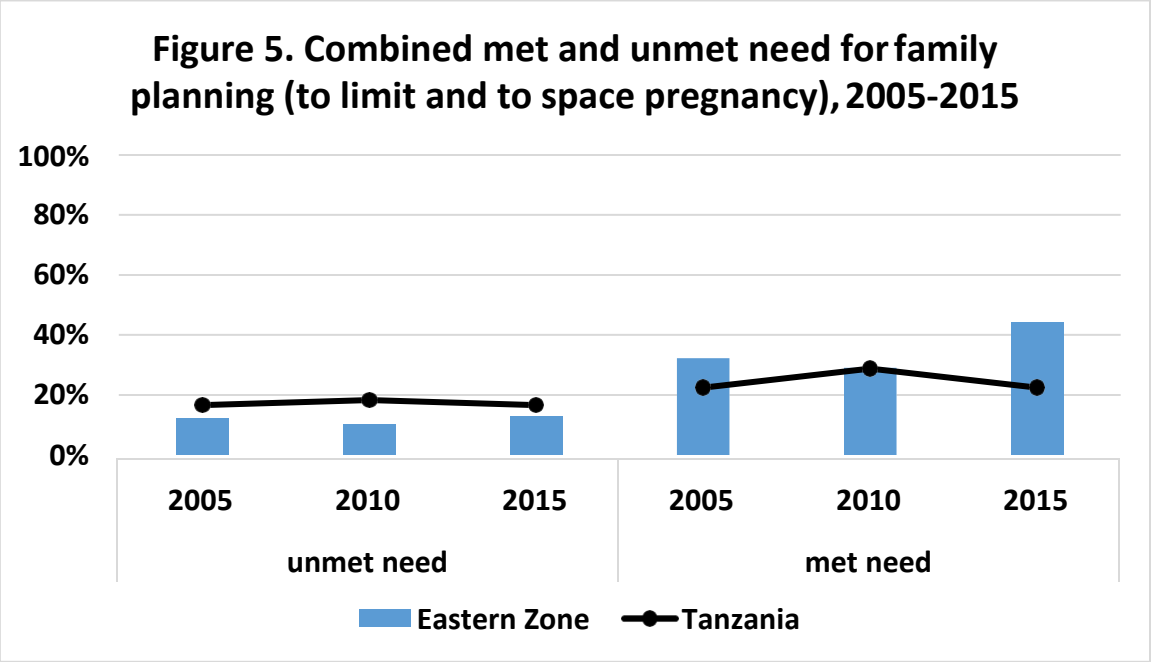


NEED AND DEMAND FOR FAMILY PLANNING

Total fertility rate (TFR) among all women ages 15-49 in the Eastern Zone varied only slightly from 2005 to 2015, at under 4 children per woman, and remained below the national average by over one child per woman across all three DHS years (see **Figure 4**).



Combined contraceptive need and unmet need (for limiting and for spacing pregnancy) among all women ages 15-49 in the Eastern Zone is depicted in **Figure 5**. Most notably, total met need increased by nearly 12 percentage points between 2005 and 2015 (from approx. 32 to 44 percent), while unmet need remained nearly unchanged at roughly 12 percent across all three DHS years.



METHOD MIX

Figure 6 presents all modern contraceptive methods used by women ages 15-49 currently using any method of family planning in the Eastern Zone, where "other" includes minimally (<1 percent) used methods.[9] From 2005 to 2015, implant use increased approximately 13 percentage points (from about 3 percent to over 16 percent). Further, use of oral contraceptive pills (progestin-only and combined) decreased by approximately 11 percentage points from 2005 to 2015.

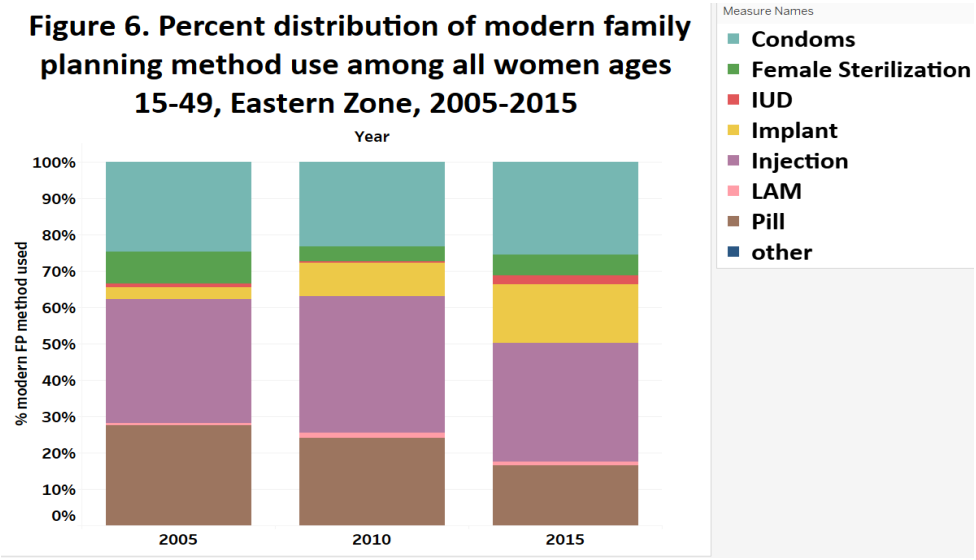
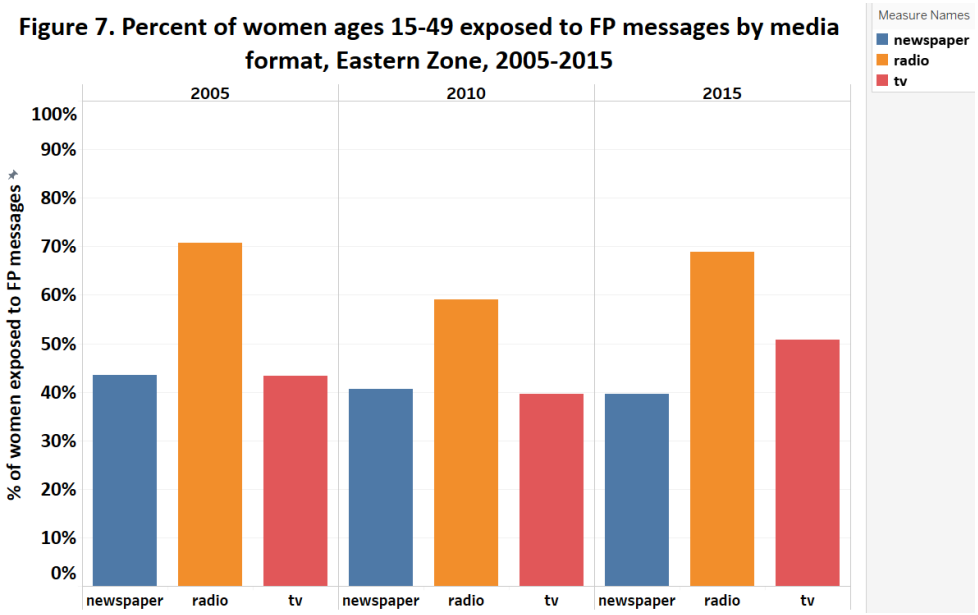


Figure 7 shows the distribution of family planning messaging, by format. It is worth noting that sources of family planning messages changed from 2005 to 2010, and this report only shows data for the sources

[9] Minimally used methods include emergency contraceptives, diaphragm, male sterilization, and female condoms

that were consistent throughout the 10-year period.[10] In the Eastern Zone, approximately 70 percent of men and women ages 15-49 were exposed to family planning messages in 2015, and TV as a source of family planning messaging increased 11 percent from 2010 to 2015.

Figure 7. Percent of women ages 15-49 exposed to FP messages by media format, Eastern Zone, 2005-2015



[10] Mobile phone messages were reported as a source only in the 2015 DHS. In the Eastern Zone, approximately 11 percent of women reported they received family planning messages from a mobile phone

Zonal Analysis (2005-2015): Lake Zone

KEY INDICATOR HIGHLIGHTS FOR THE LAKE ZONE, 2005-2015

- **CPR for young women in the Lake Zone ages 15-19 increased slightly** from 2005 to 2015, but remained below the national average
- **CPR increased among all women ages 15-49 from 2005-2015**, but was still 11 percent below the national average in 2015
- **Implant use increased substantially** from less than 2 percent to over 20 percent from 2005 to 2015

Image 3. 2015 zonal distribution of Tanzania

BACKGROUND

TABLE 1. Lake Zone population demographic characteristics, 2012 Census data

Population	% Male	% Female	% Rural	% Urban
11,832,857	48.8	51.2	83.5	16.5

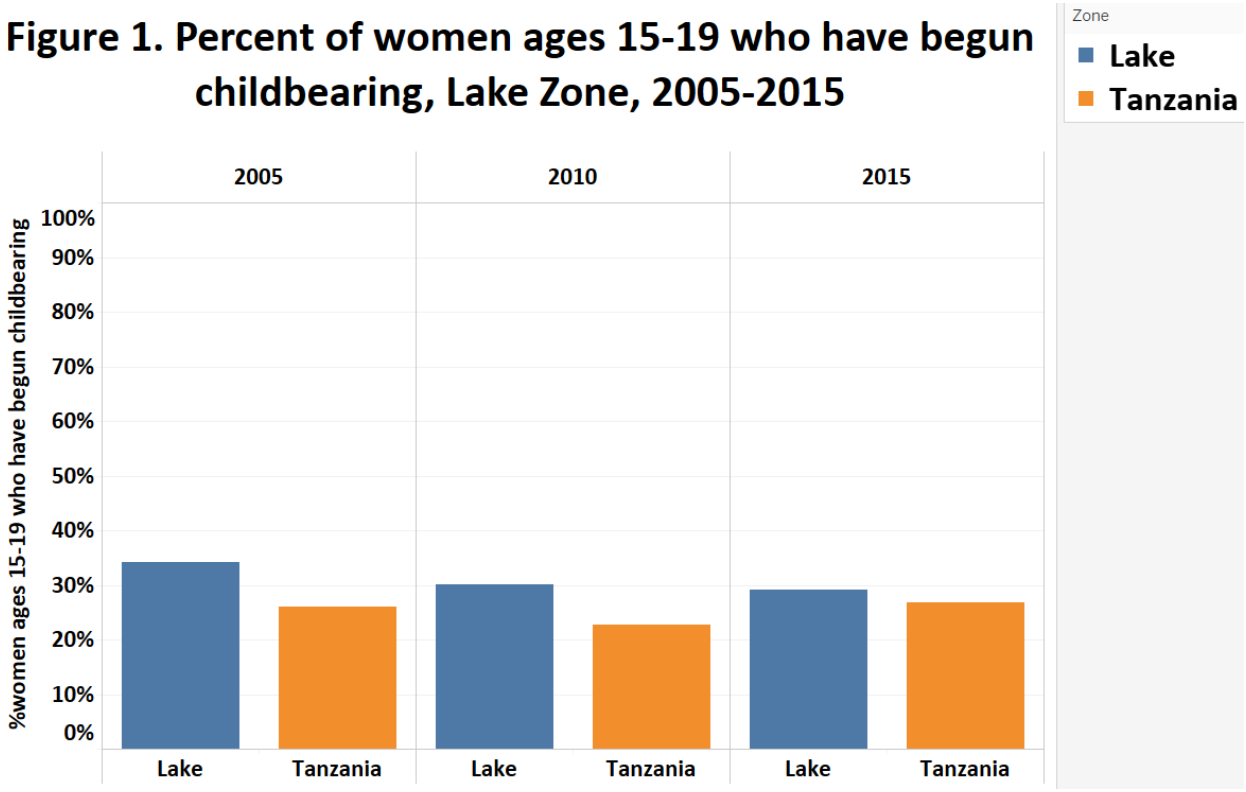
The number of geographical regions within the Lake Zone increased from 2010 to 2015. Until 2010, regions in the Lake Zone included only Kagera, Mwanza, and Mara. In 2015, the Lake Zone expanded to include Geita, Simiyu, and Shinyanga.[11] The Lake Zone is located on the northern border of Tanzania (see **Image 1**), with mostly rural regions. Per 2012 Census data, there are approximately 11.8 million people in the Lake Zone with slightly more women than men (see **Table 1**).
Indicators presented in this report were selected based on available data from the 2005, 2010, and 2015 DHS reports.[12]

[11] For this report, to ensure that the areas evaluated remained the same across each year, zonal data for each DHS year reflect the geographic distribution of the zone in 2015. Re-mapping was conducted prior to analyzing the zonal data to ensure the data in each zone was equally weighted and comparable across the three years
[12] Indicators presented in this report were selected based on adequate sample size

ADOLESCENT PREGNANCY

Nearly 10 percent of the total population in the Lake Zone is young women ages 15-24. The percentage of women ages 15-19 who had begun childbearing decreased slightly between 2005-2015. As of 2015, adolescent pregnancy rates in the Lake Zone were slightly higher than national rates (see **Figure 1**).

Figure 1. Percent of women ages 15-19 who have begun childbearing, Lake Zone, 2005-2015



Age of first intercourse, first birth, and first marriage did not vary much from 2005 to 2015 among all women ages 20-49[13] in the Lake Zone, and was below the national average across the three DHS years (see **Table 2**).

Table 2. Age at first intercourse, birth, and marriage, all women ages 20-49, Lake Zone, 2005-2015

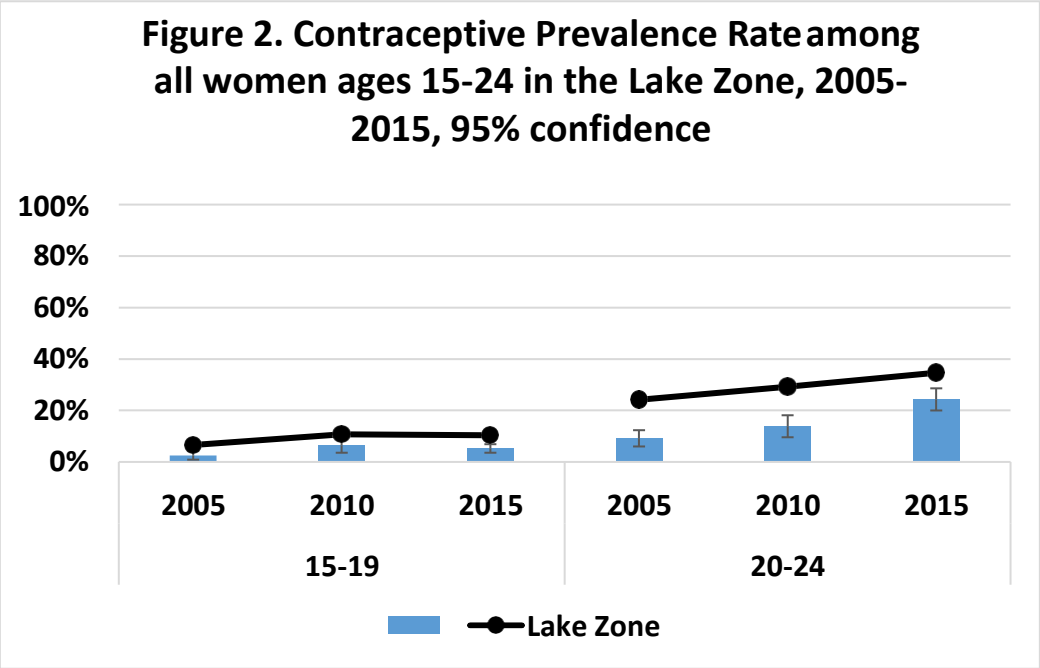
	Intercourse			Birth			Marriage		
Zone	2005	2010	2015	2005	2010	2015	2005	2010	2015
Lake	15.3	15.3	15.1	17.7	17.7	17.8	16.6	16.8	17.0
Tanzania	17.0	17.4	17.3	19.4	19.5	19.8	18.6	18.9	19.3

CPR

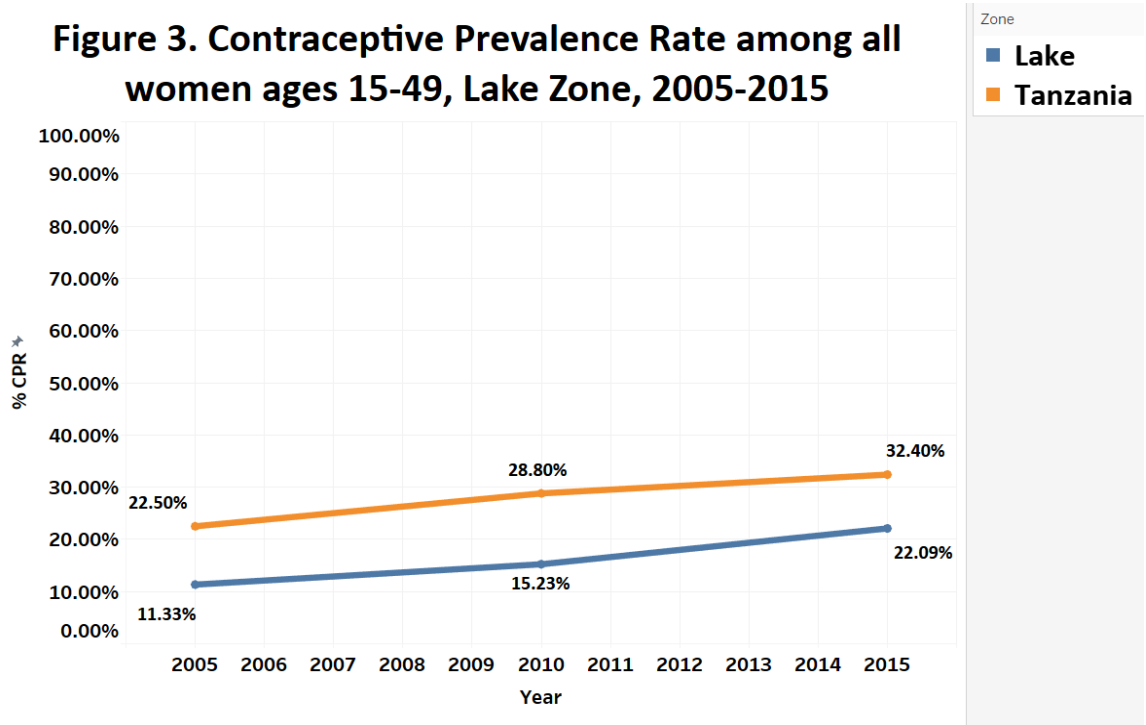
Figure 2 shows the contraceptive prevalence (CPR) among young women in the Lake Zone with confidence intervals and compared to national data. The CPR for young women in the Lake Zone ages 15-19 increased slightly from 2005 to 2015, but remained below the national average. CPR among

[13] In this section of the DHS, women ages 20-49 were surveyed, unlike many other sections of the DHS where women ages 15-49 were surveyed

women ages 20-24 also remained well below the national average, although it increased about 15 percentage points, from 9 percent to 24 percent, from 2005 to 2015.

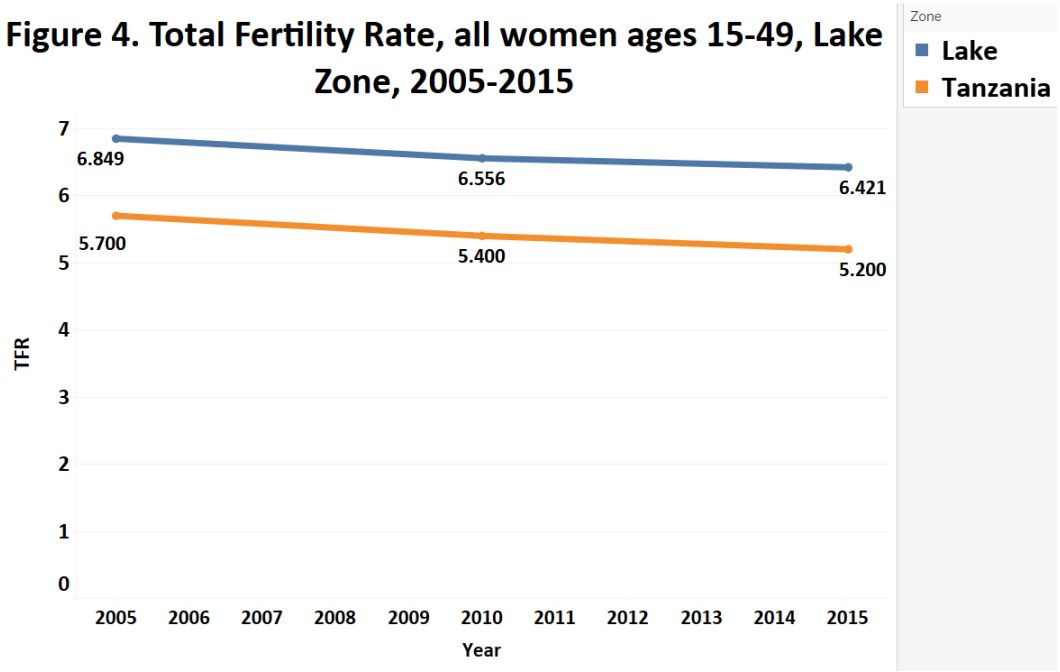


The CPR among all women ages 15-49 (shown in **Figure 3**) doubled from 2005 to 2015, (from roughly 11 percent to 22 percent). Throughout the three DHS years, CPR in the Lake Zone remained 10 or more percentage points below the average CPR for Tanzania.

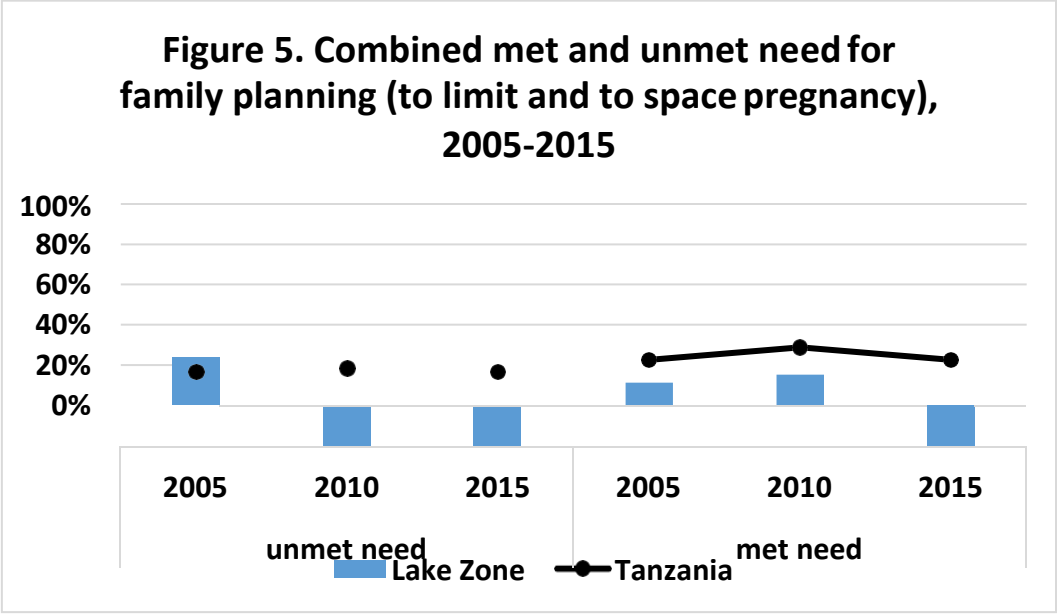


NEED AND DEMAND FOR FAMILY PLANNING

Total fertility rate (TFR) among all women ages 15-19 in the Lake Zone decreased by only slightly from 2005 to 2015, and remained above the national average by just over 1 child per woman across the three DHS years (see **Figure 4**).



Combined contraceptive need and unmet need (for limiting and for spacing pregnancy) among all women ages 15-49 in the Lake Zone is depicted in **Figure 5**. From 2005 to 2015, unmet need decreased roughly 10 percentage points (from about 20 percent to 10 percent), while total percent met need increased by 22 percentage points (from approximately 27 percent to 49 percent).



METHOD MIX

Figure 6 presents all modern contraceptive methods used by women ages 15-49 currently using any method of family planning in the Lake Zone, where "other" includes minimally (<1 percent) used methods.[14] Contraceptive implant use increased considerably between 2005 and 2015 from less than 2 percent to over 20 percent, respectively. Use of contraceptive pills (progestin-only and combined) decreased approximately 10 percentage points from 2005 to 2015 (from nearly 18 percent to just over 8 percent).

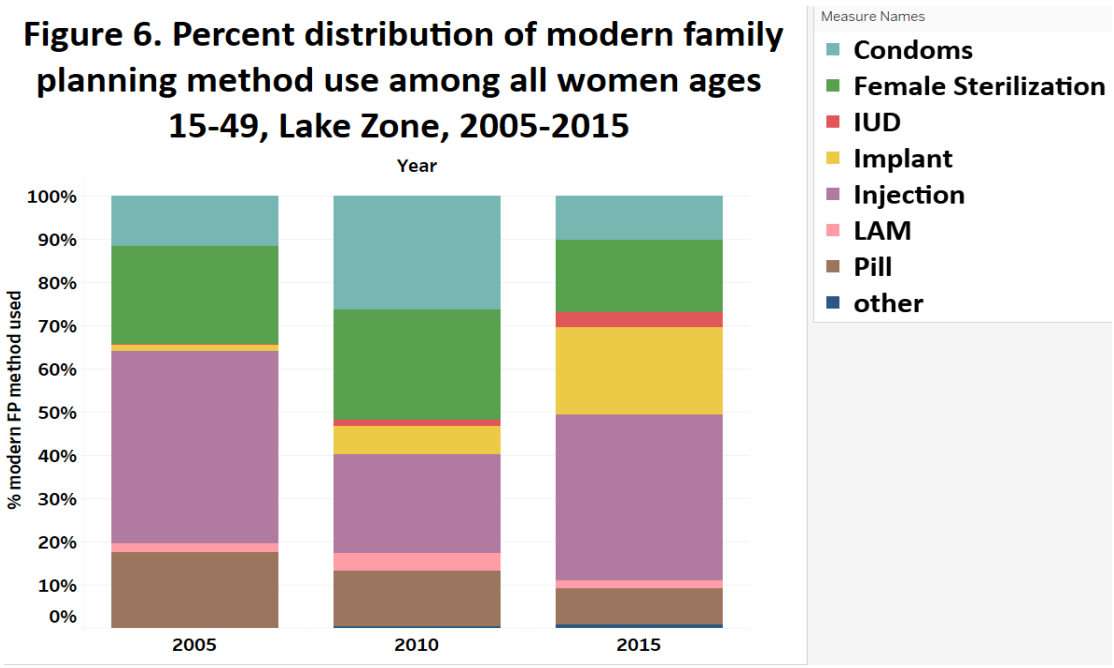
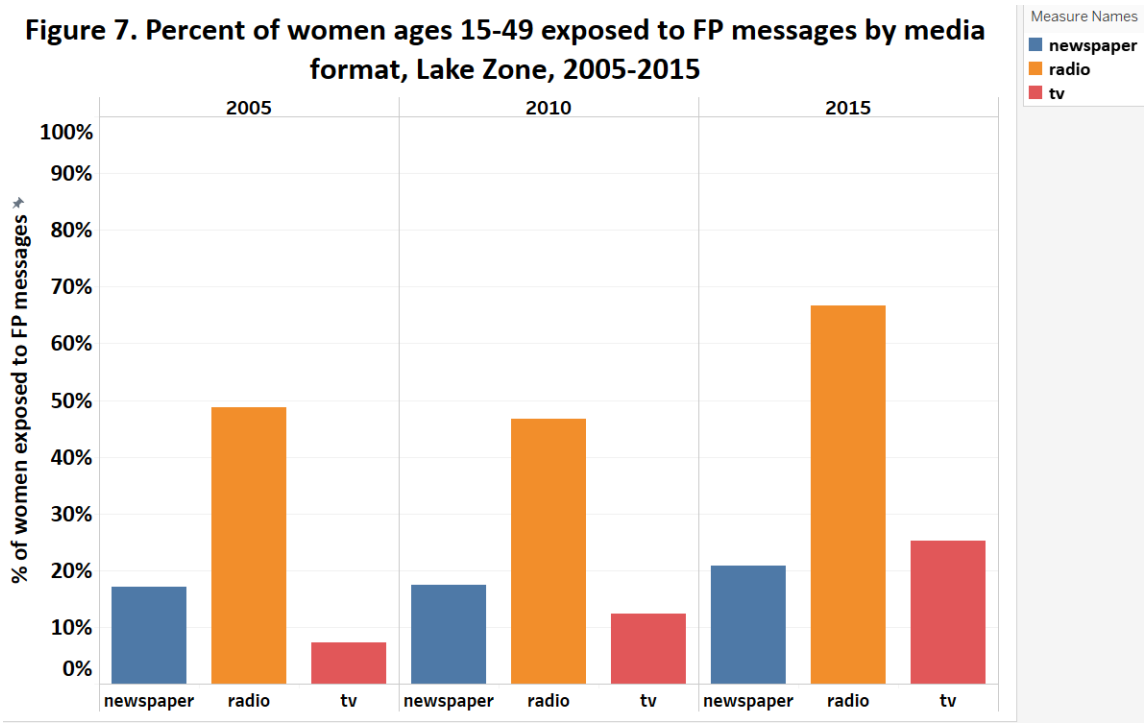


Figure 7 shows the distribution of family planning messaging, by format. It is worth noting that sources of family planning messages changed from 2005 to 2010, and this report only shows data for the sources that were consistent throughout the 10-year period.[15] In the Lake Zone, the most common source of FP messaging was the radio, which increased by 18 percentage points from 2005 to 2015.

[14] Minimally used methods include emergency contraceptives, diaphragm, male sterilization, and female condoms

[15] Mobile phone messages were reported as a source only in the 2015 DHS. In the Lake Zone, approximately 3 percent of women reported they received family planning messages from a mobile phone

Figure 7. Percent of women ages 15-49 exposed to FP messages by media format, Lake Zone, 2005-2015



Zonal Analysis (2005-2015): Northern Zone

KEY INDICATOR HIGHLIGHTS FOR THE NORTHERN ZONE, 2005-2015

- **Adolescent pregnancy rates remained nearly the same** from 2005-2015
- **CPR decreased for young women ages 15-19,** from approximately nine percent to 4 percent from 2005-2015
- **Implant use increased substantially** from approximately 3 percent to over 20 percent from 2005-2015

Image 4. 2015 zonal distribution of Tanzania

BACKGROUND

TABLE 1. Northern Zone population demographic characteristics, 2012 Census data

Population	% Male	% Female	% Rural	% Urban
5,379,602	48.5	51.5	74	26

The number of geographical regions within the Northern Zone decreased from 2010 to 2015. Until 2015, regions in the Northern Zone included Kilimanjaro, Tanga, Arusha, and Manyara. In 2015, the Manyara region moved to the Central Zone, leaving the Northern Zone with the remaining three.[16] The Northern Zone is located in the northeast portion of Tanzania and is mostly rural (see **Image 1**). Per the 2012 Census, there are approximately 5.4 million people in the Northern Zone with slightly more women than men (see **Table 1**). Indicators presented in this report were selected based on available data from the 2005, 2010, and 2015 DHS reports.[17]

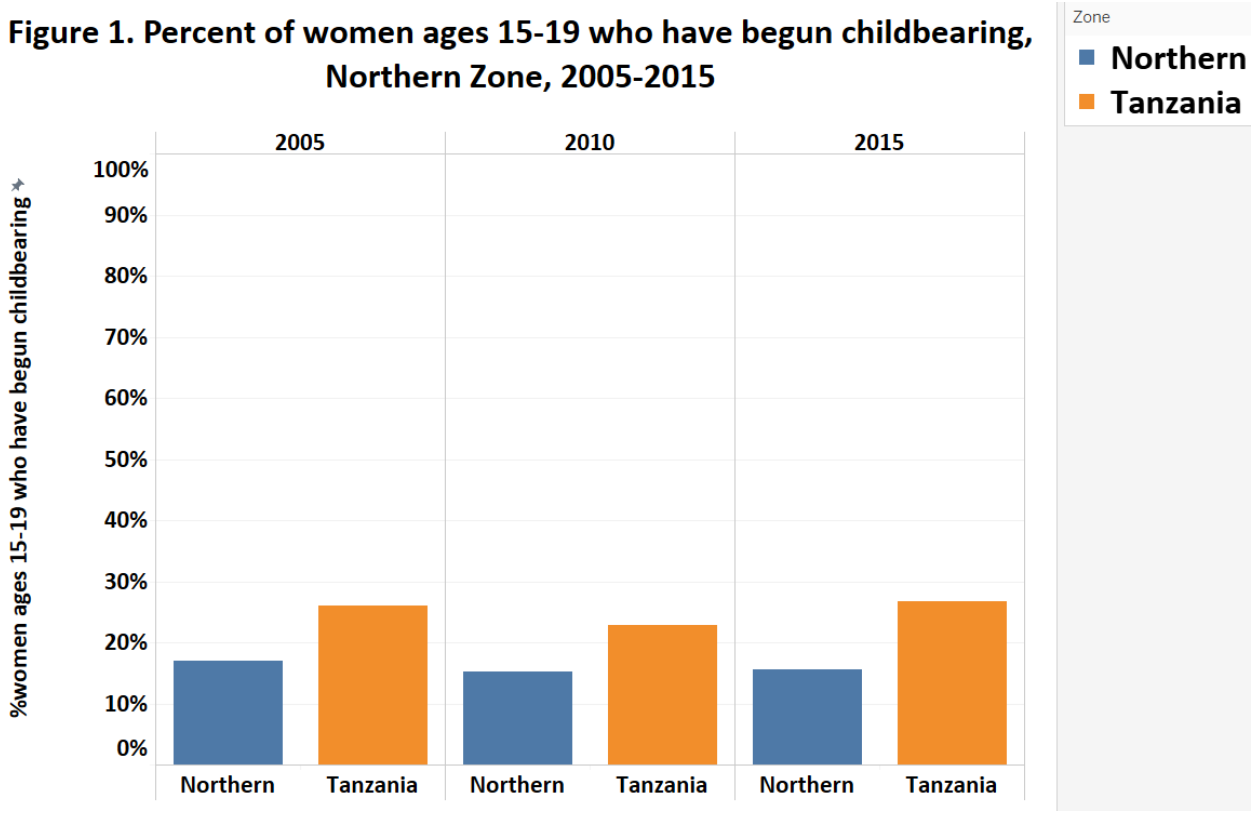
[16] For this report, to ensure that the areas evaluated remained the same across each year, zonal data for each DHS year reflect the geographic distribution of the zone in 2015. Re-mapping was conducted prior to analyzing the zonal data to ensure the data in each zone was equally weighted and comparable across the three DHS years

[17] Indicators presented in this report were selected based on adequate sample size

ADOLESCENT PREGNANCY

In the Northern Zone, 10 percent of the entire population is young women ages 15-24. The proportion of women ages 15-19 who had begun childbearing remained nearly the same, at about 15-17 percent, from 2005 to 2015 and was below the national average across all three DHS years (see **Figure 1**).

Figure 1. Percent of women ages 15-19 who have begun childbearing, Northern Zone, 2005-2015



Age of first sex, first birth, and first marriage did not vary much from 2005 to 2015 among all women ages 20-49[18] in the Northern Zone, and remained steadily below the national average (see **Table 2**).

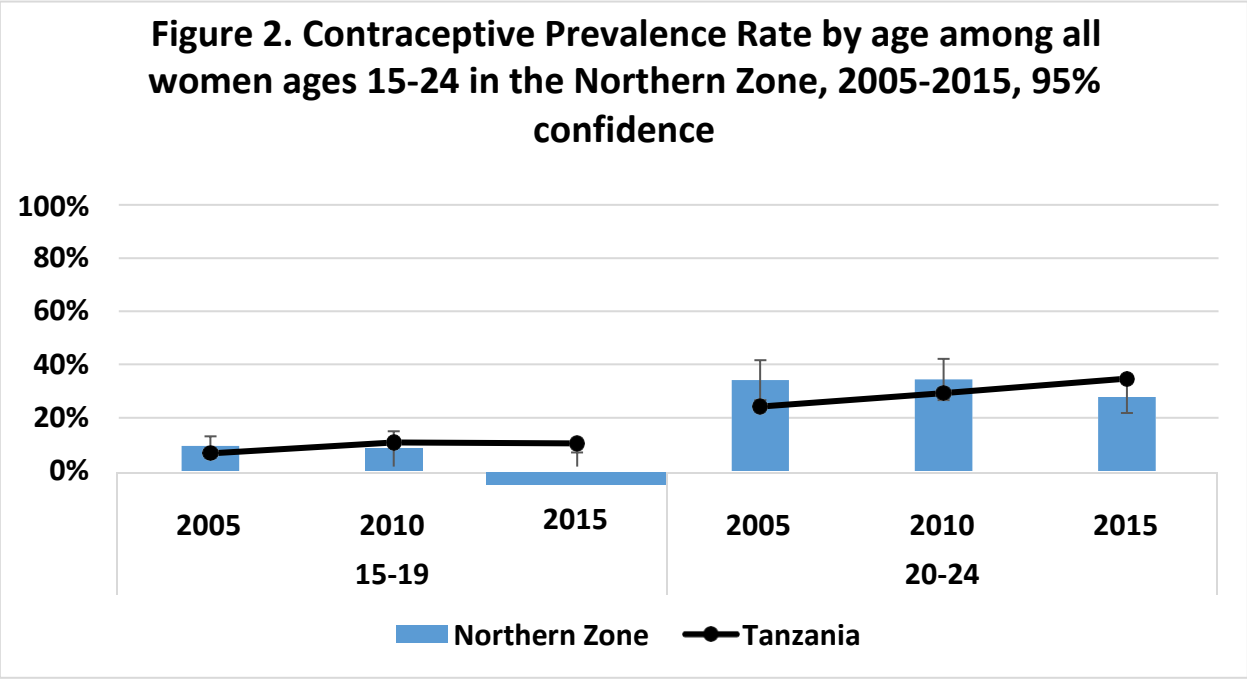
Table 2. Age at first intercourse, birth, and marriage, all women ages 20-49, Northern Zone, 2005-2015

	Intercourse			Birth			Marriage		
Zone	2005	2010	2015	2005	2010	2015	2005	2010	2015
Northern	16.2	16.4	16.1	18.7	18.7	19.0	18.1	18.2	18.5
Tanzania	17.0	17.4	17.3	19.4	19.5	19.8	18.6	18.9	19.3

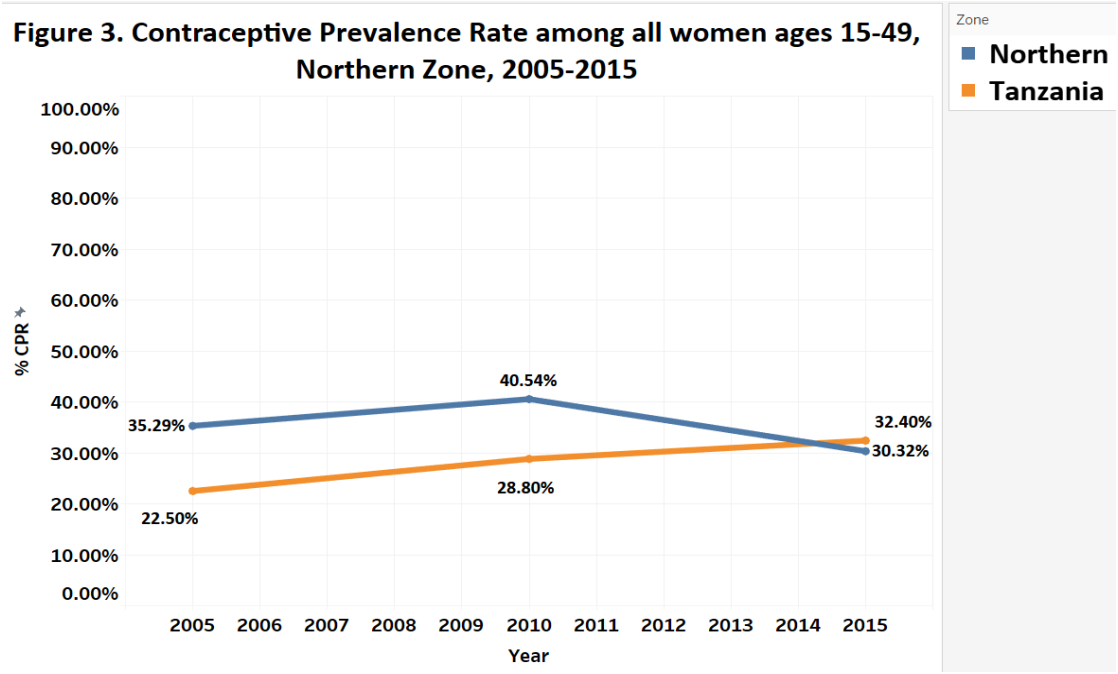
CPR

Figure 2 shows the contraceptive prevalence rate (CPR) among young women, ages 15-19 and 20-24 in the Northern Zone with confidence intervals and compared to national data. The CPR for young women ages 15-19 decreased by about 5 percentage points from 2005 to 2015 and was about 6 percentage points below the national average in 2015. For women ages 20-24, CPR decreased from roughly 34 percent to 27 percent from 2005-2015 and was about 7 percentage points below the national average in 2015.

[18] In this section of the DHS, women ages 20-49 were surveyed, unlike many other sections of the DHS where women ages 15-49 were surveyed

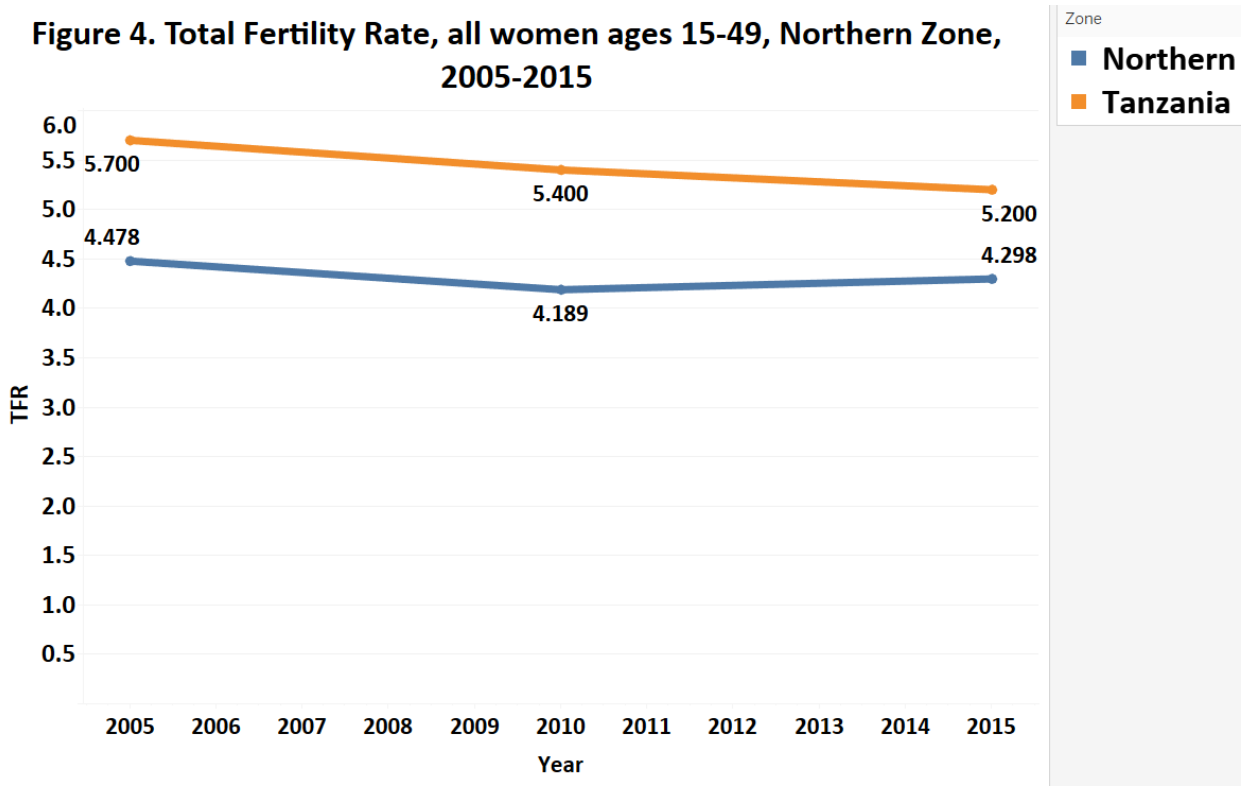


CPR for all women ages 15-49 in the Northern Zone decreased nearly 5 percentage points from 2005- 2015, from roughly 35 to 30 percent (see **Figure 3**). Although CPR in the Northern Zone was above the national average in 2005, it sunk 2 percentage points below CPR in Tanzania in 2015.

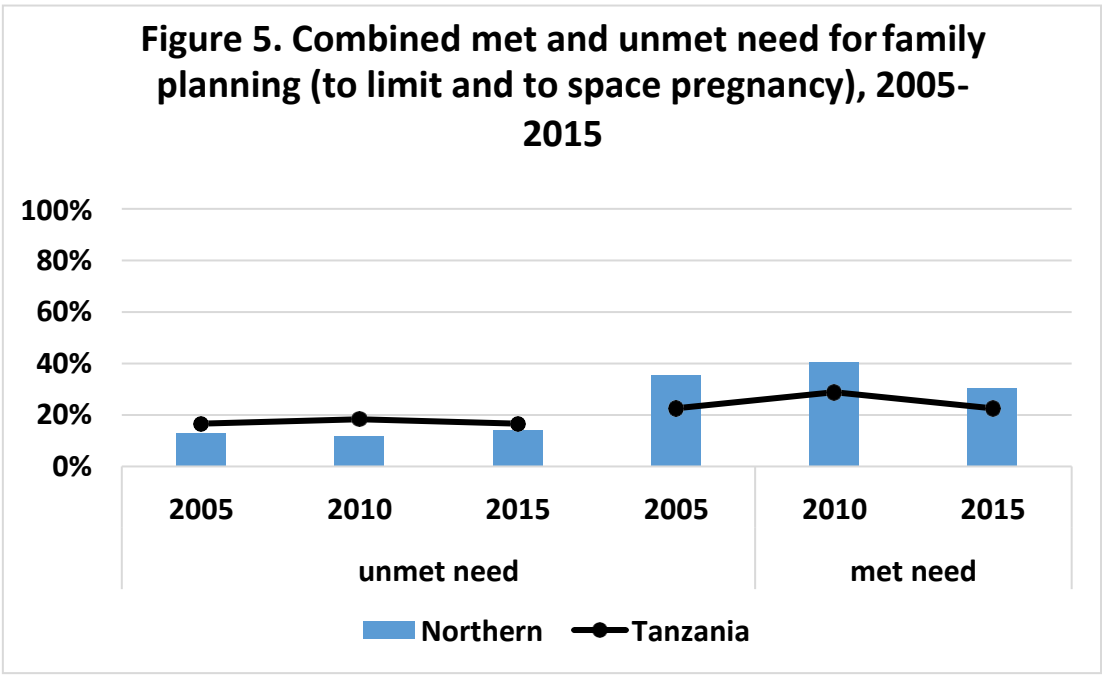


NEED AND DEMAND FOR FAMILY PLANNING

Total fertility rate (TFR) in the Northern Zone decreased slightly and remained below the average TFR for Tanzania by over 1 child per woman for the entire period of 2005-2015 (see **Figure 4**).



Combined contraceptive need and unmet need (for limiting and for spacing pregnancy) among all women ages 15-49 in the Northern Zone is depicted in **Figure 5**. Most notably, total met need decreased roughly 10 percentage points (from approx. 40 to 30 percent) from 2010 to 2015, while unmet remained below the national average across all three DHS years.



METHOD MIX

Figure 6 presents all modern contraceptive methods used by women ages 15-49 currently using any method of family planning in the Northern Zone, where "other" includes minimally (<1 percent) used modern methods.[19] Most notably, contraceptive implant use increased considerably between 2005 and 2015 from around 3 percent to over 20 percent, and use of injectables decreased about 9 percentage points (from 46.5 to 37.3 percent) from 2010 to 2015.

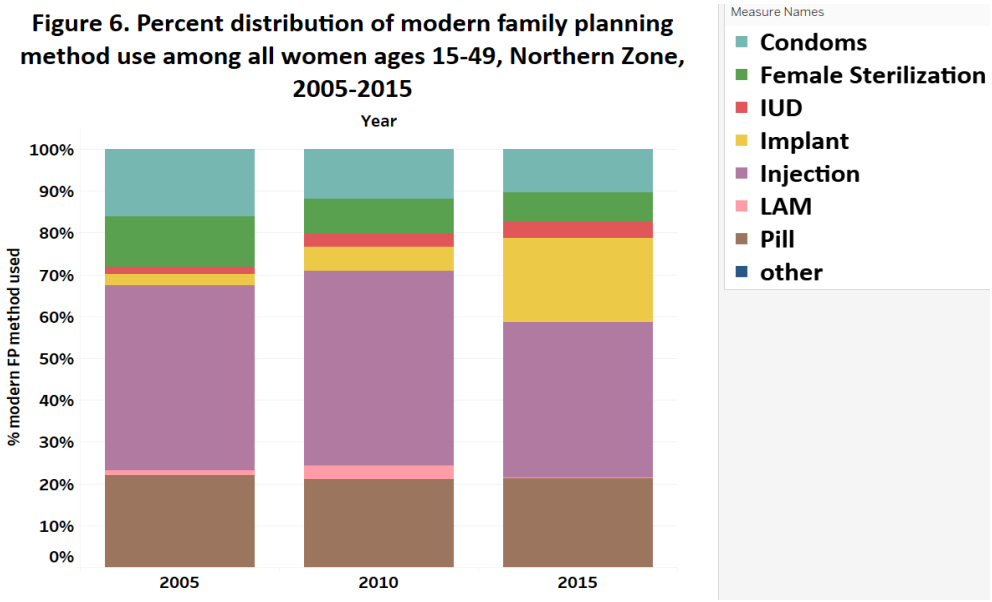
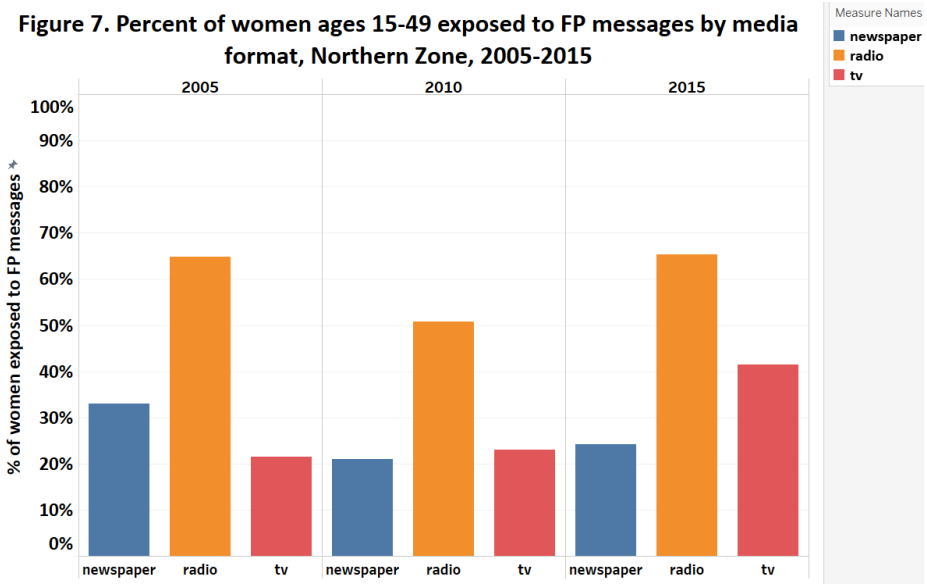


Figure 7 shows the distribution of family planning messaging, by format. It is worth noting that sources of family planning messages changed from 2005 to 2010, and this report only shows data for the sources that were consistent throughout the 10-year period.[20] In the Northern Zone, radio remained the most popular media format for FP messaging across all three DHS years, followed by TV, which saw an uptick from 2010 to 2015 from 23 to 41 percent.

[19] Minimally used methods include emergency contraceptives, diaphragm, male sterilization, and female condoms

[20] Mobile phone messages were reported as a source of family planning messaging only in the 2015 DHS. In the Northern Zone, approximately 5.4 percent of women reported they received family planning messages from a mobile phone

Figure 7. Percent of women ages 15-49 exposed to FP messages by media format, Northern Zone, 2005-2015



Zonal Analysis (2005-2015): Southern Zone

KEY INDICATOR HIGHLIGHTS FOR THE SOUTHERN ZONE, 2005-2015

- **CPR for young women ages 15-19 increased** by about 13 percentage points from 2005-2015
- **CPR for all women ages 15-49 increased** 13 percentage points from 2005-2015, and was 17 percentage points above the national average in 2015
- **Use of injectables greatly increased**, from about 27 percent in 2010 to nearly 42 percent in 2015

Image 5. 2015 zonal distribution of Tanzania

BACKGROUND

TABLE 1. Southern Zone population demographic characteristics, 2012 Census data

Population	% Male	% Female	% Rural	% Urban
2,135,506	47.5	52.5	79	21

The number of geographical regions within the Southern Zone decreased from 2010 to 2015. Until 2010, regions in the Southern Zone included Lindi, Mtwara, and Rumuva. In 2015, the Rumuva region moved to the Southern Highlands Zone, leaving the Southern Zone with the remaining two.[21] The Southern Zone is in the south of Tanzania (see **Image 1**), and is mostly rural. Per 2012 Census data, there are approximately 2.1 million people in the Southern Zone with slightly more women than men (see **Table 1**). Indicators presented in this report were selected based on available data from the 2005, 2010, and 2015 DHS reports. [22]

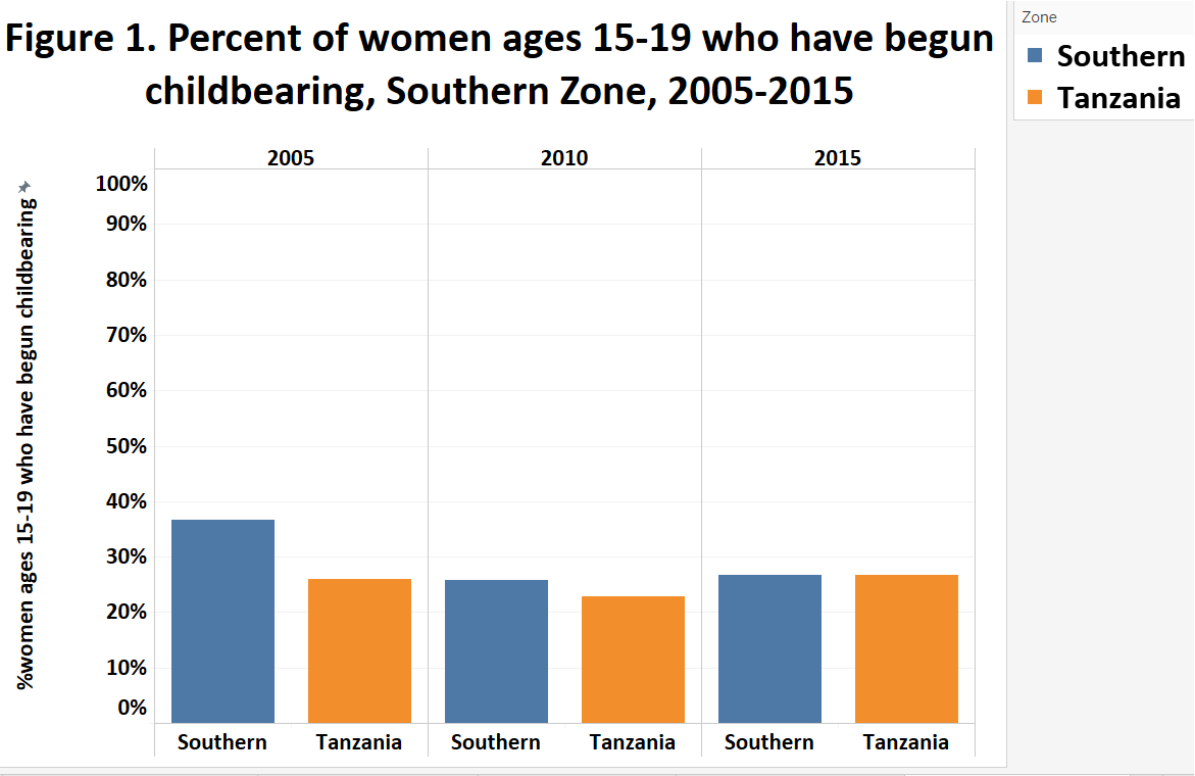
[21] For this report, to ensure that the areas evaluated remained the same across each year, zonal data for each DHS year reflect the geographic distribution of the zone in 2015. Re-mapping was conducted prior to analyzing the zonal data to ensure the data in each zone was equally weighted and comparable across the three years

[22] Indicators presented in this report were selected based on adequate sample size

ADOLESCENT PREGNANCY

In the Southern Zone, 8.5 percent of the entire population is young women ages 15-24. The percentage of women ages 15-19 who had begun childbearing decreased by 10 percentage points from 2005 to 2015 and the national average for adolescent pregnancy was nearly the same as that of the Southern Zone in 2015 (see **Figure 1**).

Figure 1. Percent of women ages 15-19 who have begun childbearing, Southern Zone, 2005-2015



Age of first sex, first birth, and first marriage did not vary much from 2005 to 2015 among all women ages 20-49[23] in the Southern Zone, and remained below the national average across the three DHS years (see **Table 2**).

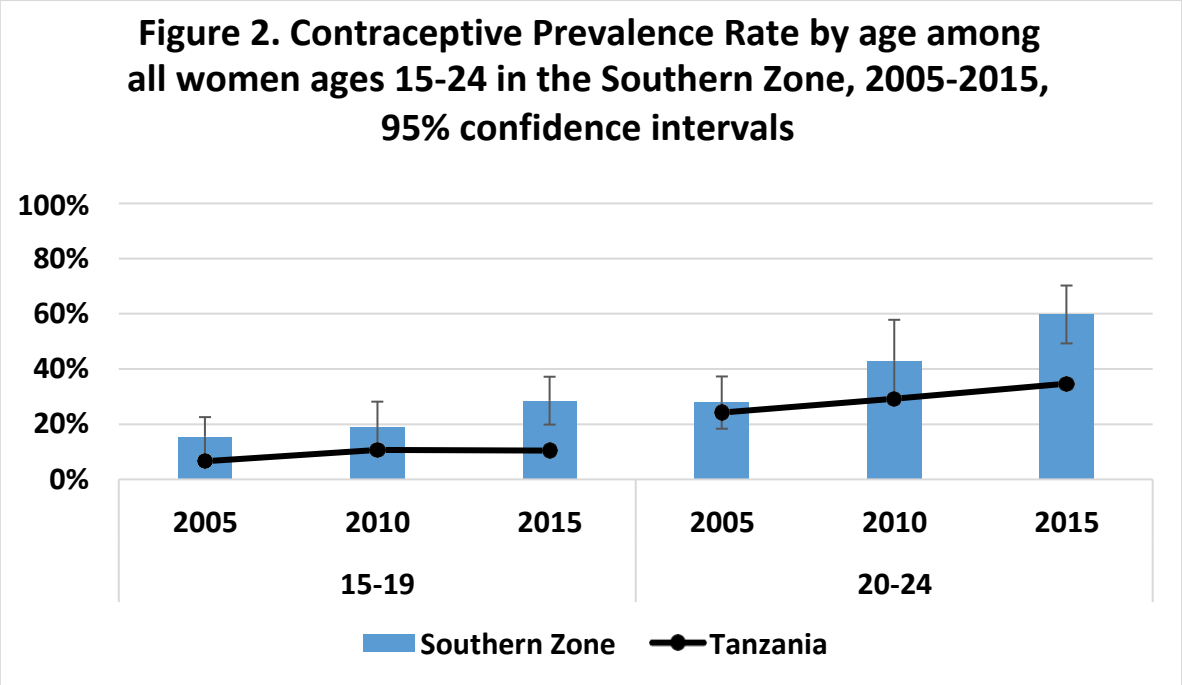
Table 2. Age at first intercourse, birth, and marriage, all women ages 20-49, Southern Zone, 2005-2015

	Intercourse			Birth			Marriage		
Zone	2005	2010	2015	2005	2010	2015	2005	2010	2015
Southern	14.9	14.6	15.1	17.5	17.7	17.6	16.9	17.3	16.9
Tanzania	17.0	17.4	17.3	19.4	19.5	19.8	18.6	18.9	19.3

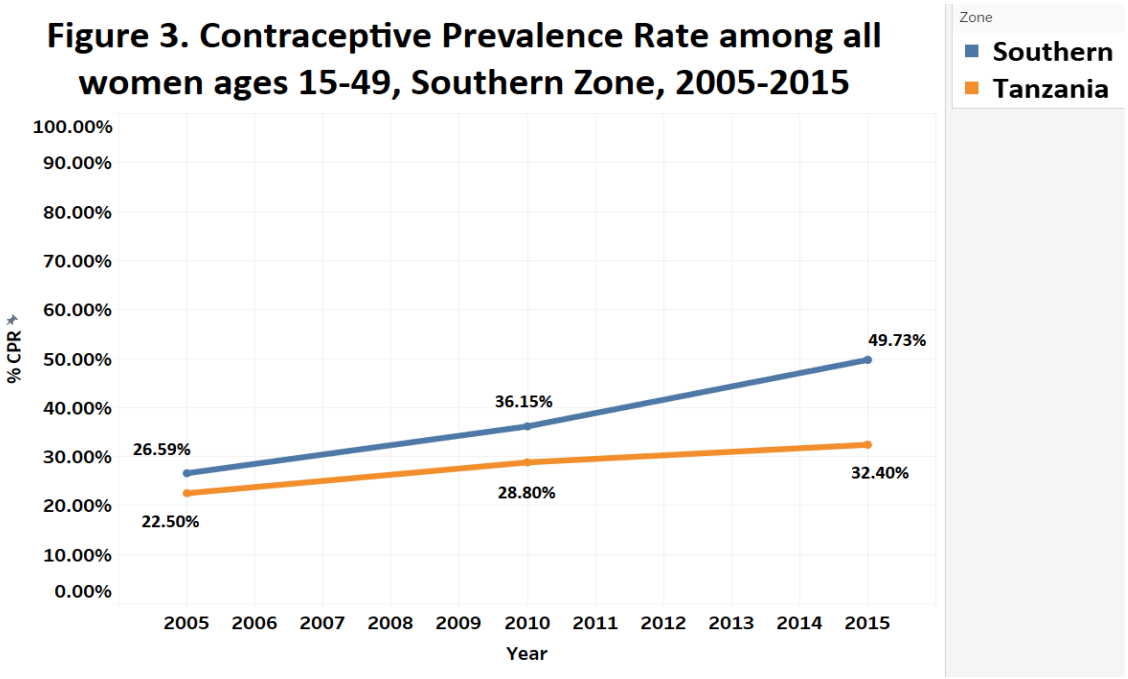
[23] In this section of the DHS, women ages 20-49 were surveyed, unlike many other sections of the DHS where women ages 15-49 were surveyed

CPR

The CPR for young women in the Southern Zone ages 15-19 remained well above the national average, and increased by about 13 percentage points from 2005 to 2015 (see **Figure 2**). For women ages 20-24, CPR increased from roughly 27 percent to 59 percent from 2005-2015 and CPR in this age group was about 25 percentage points above the national average in 2015.

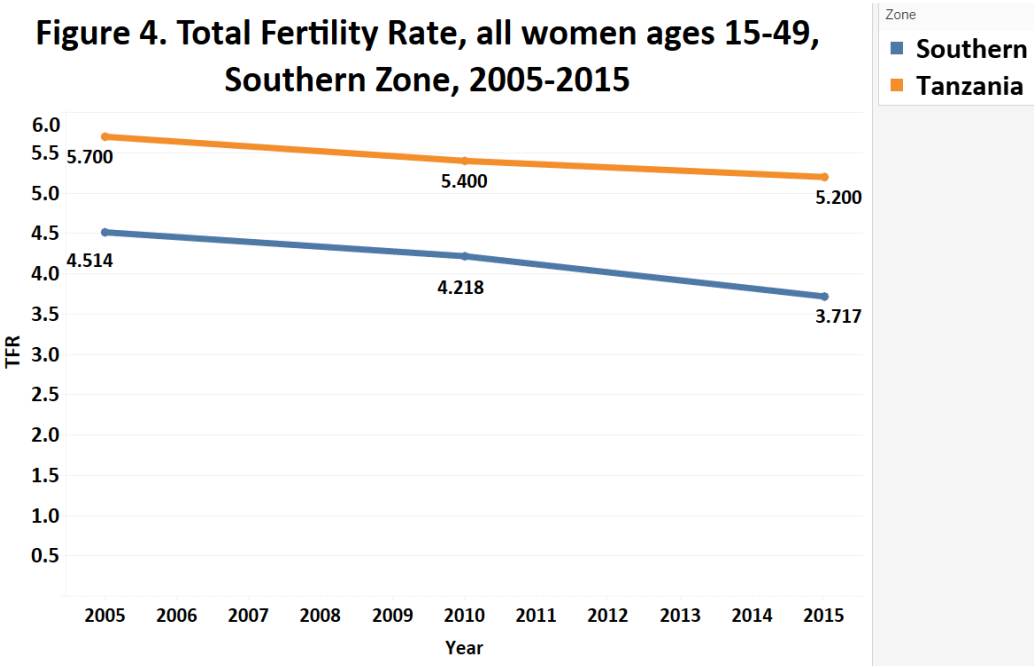


CPR in the Southern Zone increased significantly—from roughly 27 percent to 50 percent—for all women ages 15-49 from 2005-2015. As shown in **Figure 3**, CPR in the Southern Zone was more than 17 percentage points above the national average by 2015.



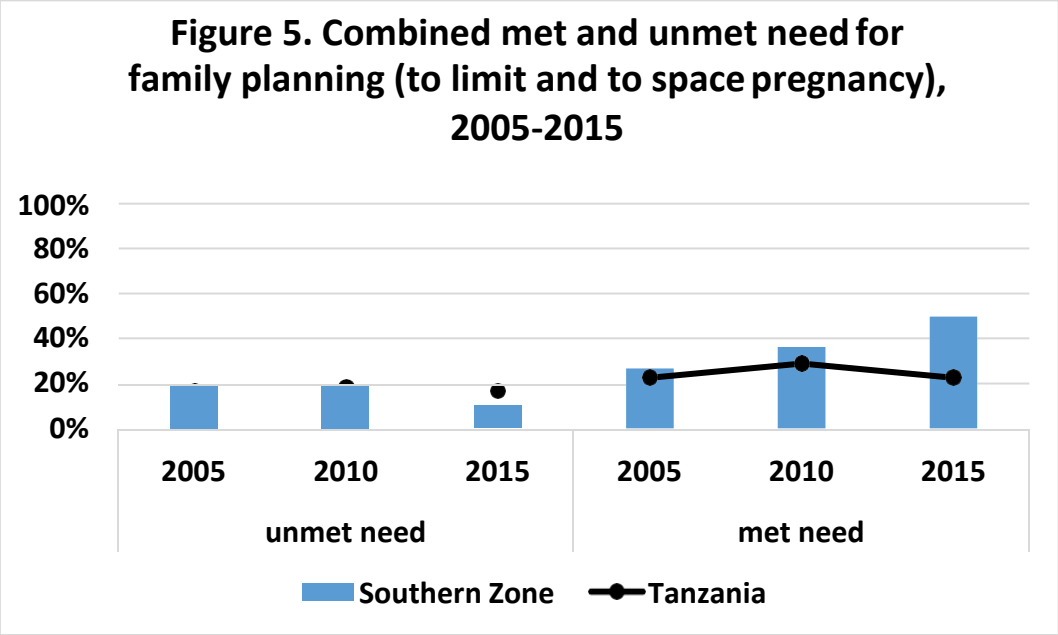
NEED AND DEMAND FOR FAMILY PLANNING

Total fertility rate (TFR) among all women ages 15-49 in the Southern Zone decreased substantially from 2005 to 2015, from 4.5 to 3.7 children per woman. By 2015, TFR in the Southern Zone was 1.5 children per woman below the national TFR (see **Figure 4**).



Combined contraceptive need and unmet need (for limiting and for spacing pregnancy) among all women ages 15-49 in the Southern Zone is depicted in **Figure 5**. Most notably, total met need increased

by over 23 percentage points (from approximately 27 to 50 percent), while unmet decreased nearly 10 percentage points from 2005 to 2015 (from about 20 percent to 10 percent).



METHOD MIX

Figure 6 presents all modern contraceptive methods used by women ages 15-49 currently using any method of family planning in the Southern Zone, where "other" includes minimally (<1 percent) used methods.[24] In the Southern Zone, oral contraceptive use (progestin-only and combined) decreased from about 51 percent in 2010, to 27 percent in 2015. Also, use of injectables greatly increased roughly 15 percentage point from 2005 to 2015 (from about 27 percent to 42 percent in 2015). Finally, implant use increased from just over 1 percent in 2005 to over 16 percent in 2015.

[24] Minimally used methods include emergency contraceptives, diaphragm, male sterilization, and female condoms

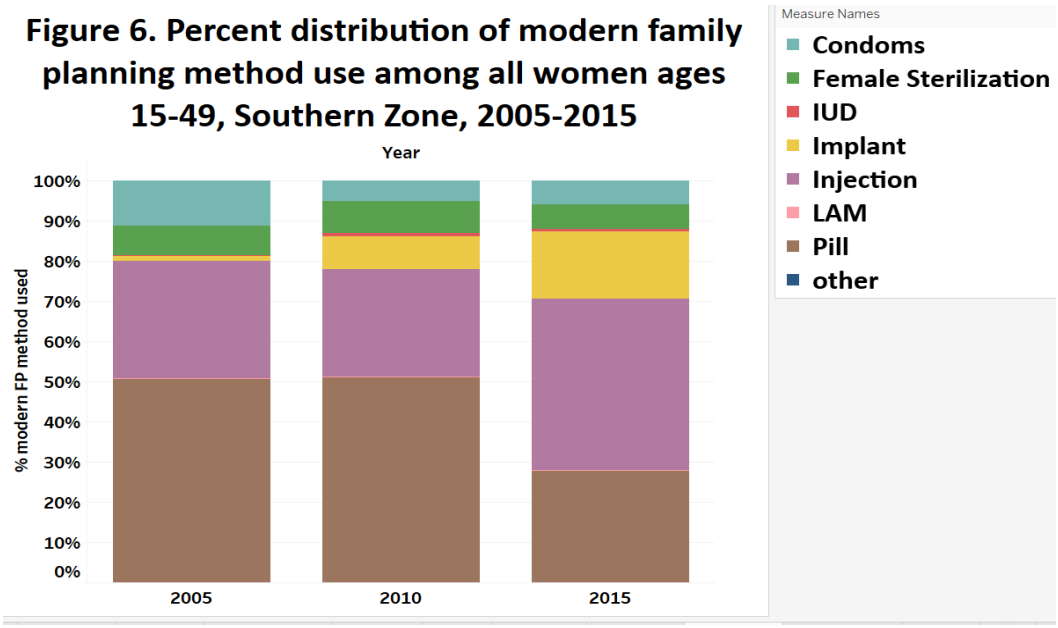
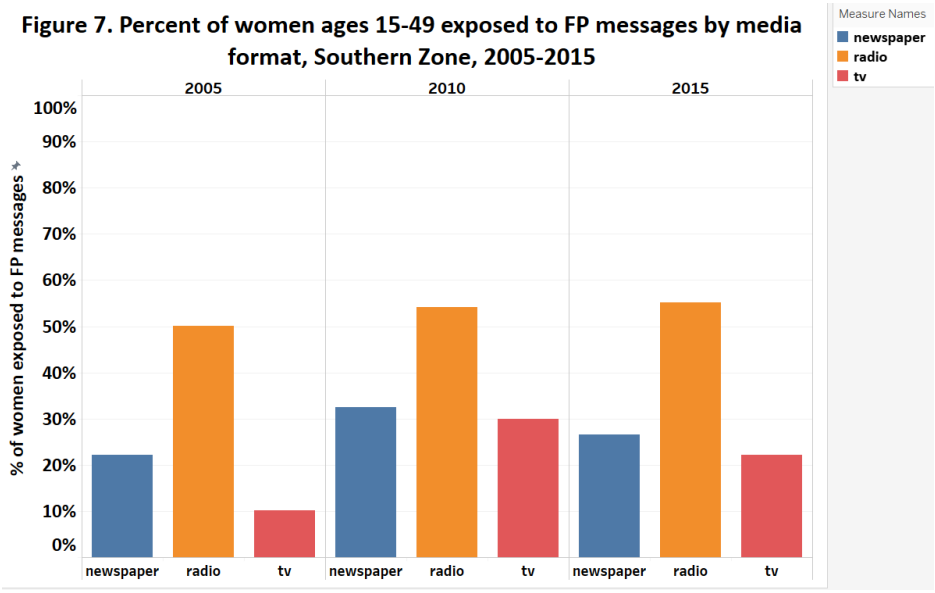


Figure 7 shows the distribution of family planning messaging, by format. It is worth noting that sources of family planning messages changed from 2005 to 2010, and this report only shows data for the sources that were consistent throughout the 10-year period.[25] In the Southern Zone, over 50 percent of all women were exposed to FP message via radio across all three DHS years and, unlike many other zones in Tanzania, TV as a source of FP messaging decreased from 2010 to 2015 (by 8 percentage points).



[25] Mobile phone messages were reported as a source only in the 2015 DHS. In the Southern Zone, approximately 5.9 percent of women reported they received family planning messages from a mobile phone

Zonal Analysis (2005-2015): Southern Highlands Zone

KEY INDICATOR HIGHLIGHTS FOR THE SOUTHERN HIGHLANDS ZONE, 2005-2015

- **CPR among young women ages 20-24 increased** about 14 percentage points from 2005-2015 and was roughly 17 percentage points above the national average in 2015
- **Adolescent pregnancy increased** nearly 10 percentage points from 2010 to 2015
- **Use of implants substantially increased**, from just over 1 percent in 2005 to over 23 percent in 2015

Image 6. 2015 zonal distribution of Tanzania

BACKGROUND

TABLE 1. Southern Highlands Zone population demographic characteristics, 2012 Census data

Population	% Male	% Female	% Rural	% Urban
3,020,226	48%	52%	75%	25%

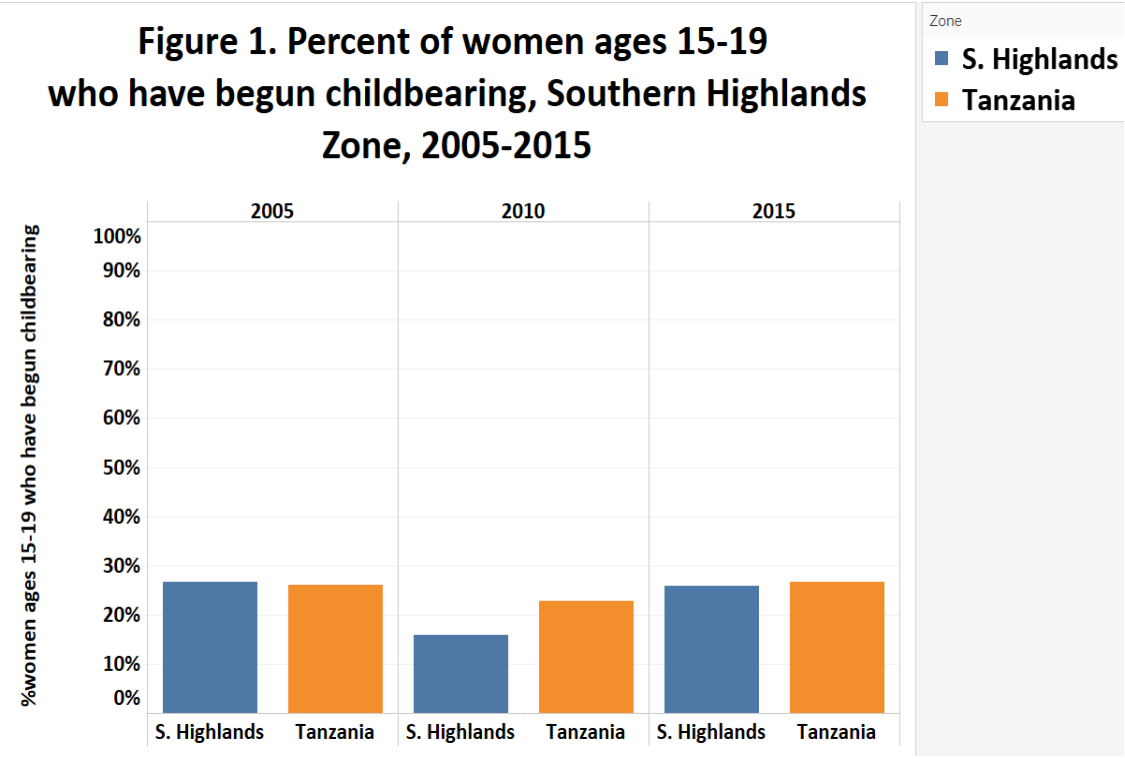
The geographical regions in the Southern Highlands Zone changed from 2010 to 2015. In 2005 and 2010, regions in the Southern Highlands Zone included Mbeya, Iringa, and Rukwa. In 2015, regions in the Southern Highlands Zone became Iringa, Njombe, and Ruvuma.[26] The Southern Highlands Zone is in the south of Tanzania (see **Image 1**), and is mostly rural. Per the 2012 Census, there are about 3 million people in the Southern Highlands Zone with roughly 4 percent more women than men (see **Table 1**). Indicators presented in this report were selected based on available data from the 2005, 2010, and 2015 DHS reports.[27]

[26] For this report, to ensure that the areas evaluated remained the same across each year, zonal data for each DHS year reflect the geographic distribution of the zone in 2015. Re-mapping was conducted prior to analyzing the zonal data to ensure the data in each zone was equally weighted and comparable across the three years

[27] Indicators presented in this report were selected based on adequate sample size

ADOLESCENT PREGNANCY

In the Southern Highlands Zone, nearly 10 percent of the population is young women ages 15-24. Women ages 15-19 who had begun childbearing increased approximately 10 percentage points from 2010 to 2015, and was nearly the same as Tanzania's average adolescent pregnancy rate in 2015 (see **Figure 1**).



Age of first sex, first birth, and first marriage did not vary much from 2005 to 2015 among all women ages 20-49[28] in the Southern Highlands Zone, and remained one year (or more) below the national average in all categories across the three DHS years (see **Table 2**).

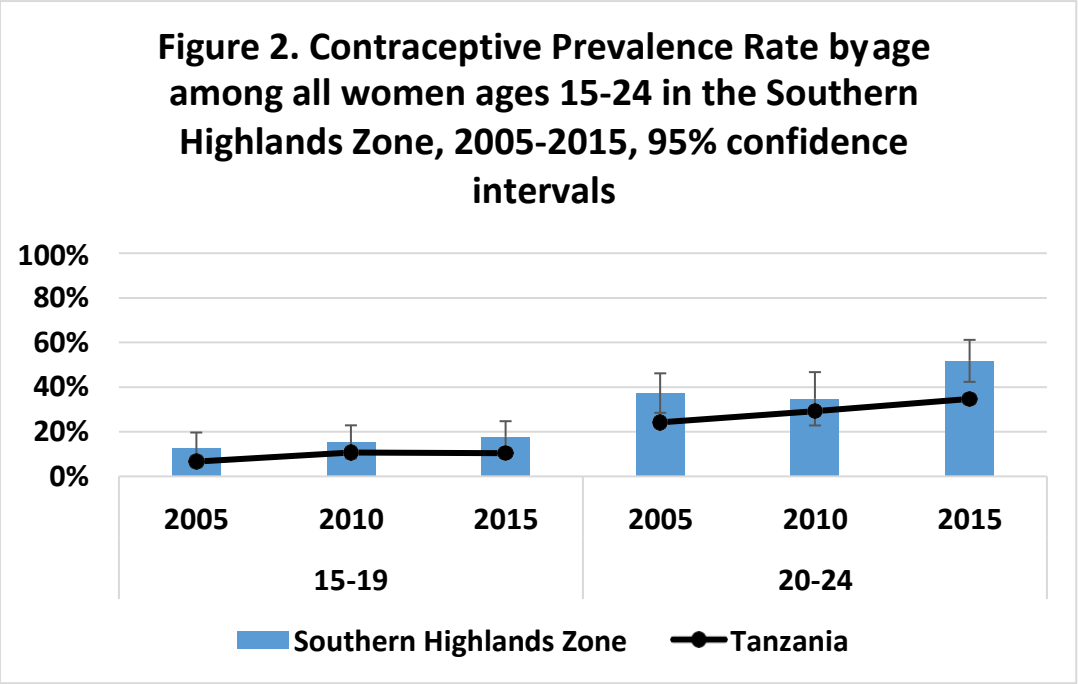
Table 2. Age at first intercourse, birth, and marriage, all women ages 20-49, Southern Highlands Zone, 2005-2015

	Avg. age at first intercourse			Avg. age at first birth			Avg. age at first marriage		
Zone	2005	2010	2015	2005	2010	2015	2005	2010	2015
S. Highlands	15.7	16.0	16.1	18.2	18.3	18.4	18.1	17.9	18.3
Tanzania	17.0	17.4	17.3	19.4	19.5	19.8	18.6	18.9	19.3

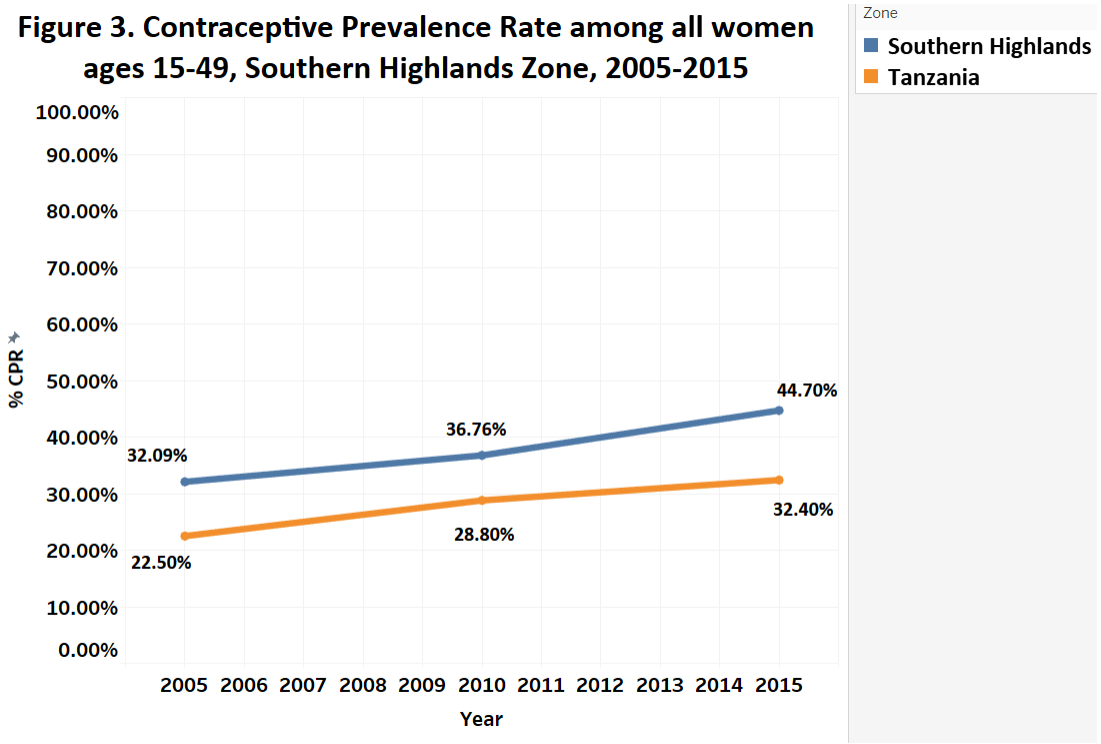
CPR

As shown in **Figure 2**, the contraceptive prevalence rate (CPR) among young women (ages 15-19 and 20-24) was higher in the Southern Highlands Zone than in Tanzania, and increased in both age groups from 2005 to 2015.

[28] In this section of the DHS, women ages 20-49 were surveyed, unlike many other sections of the DHS where women ages 15-49 were surveyed

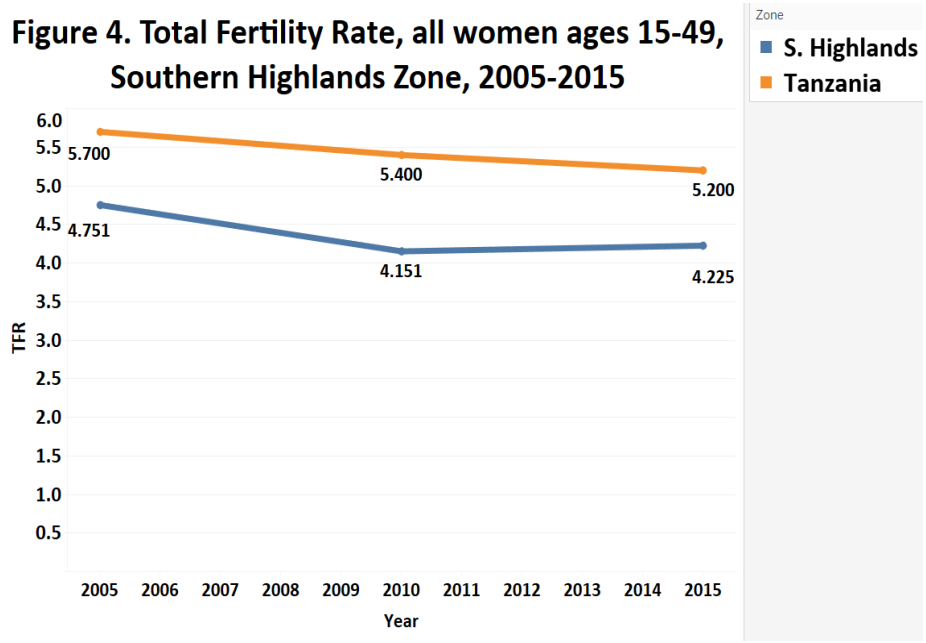


The CPR among all women ages 15-49 (shown in **Figure 3**) increased over 12 percentage points from 2005-2015 and was more than 12 percentage points above the national average in 2015.

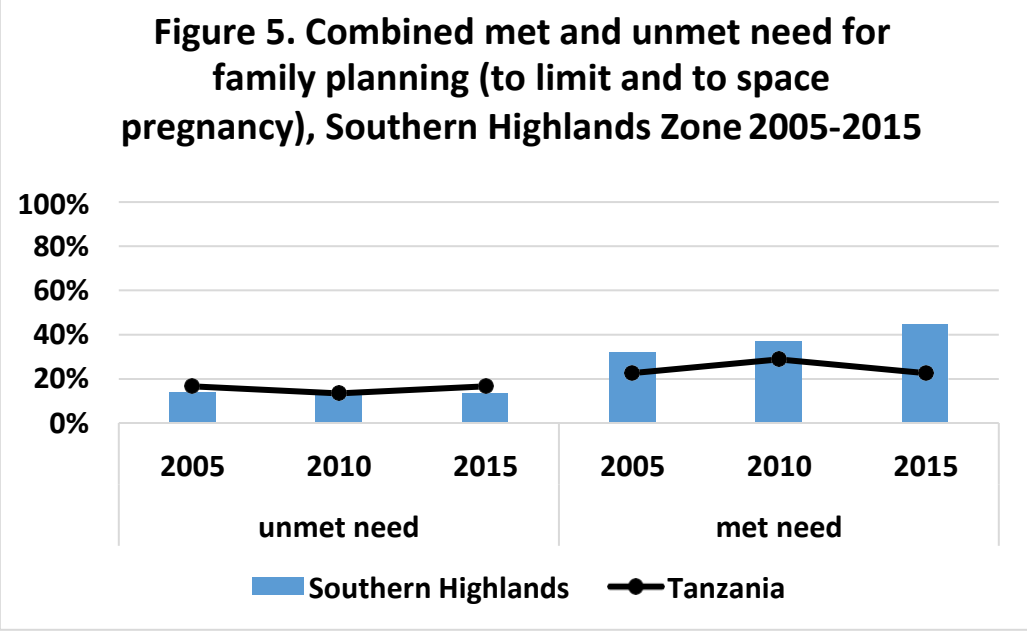


NEED AND DEMAND FOR FAMILY PLANNING

Total fertility rate (TFR) among all women ages 15-19 in the Southern Highlands Zone decreased by approximately 0.5 children per woman from 2005 to 2015 and was nearly 1 child per woman below the national average in 2015 (see **Figure 4**).



Combined contraceptive need and unmet need (for limiting and for spacing pregnancy) among all women ages 15-49 in the Southern Highlands Zone is depicted in **Figure 5**. While unmet need in the Southern Highlands Zone remained at around 13 percent across the three DHS years, met need increased nearly 12 percentage points from 2005 to 2015, and was over 22 percentage points above the national average for combined met need in 2015.



METHOD MIX

Figure 6 presents all modern contraceptive methods used by women ages 15-49 currently using any method of family planning in the Southern Highlands Zone, where "other" includes minimally (<1 percent) used methods.[29] In the Southern Highlands Zone, oral contraceptive pill use (progestin-only and combined) decreased from roughly 21 percent to 13 percent from 2005 to 2015. Contraceptive implant use increased substantially from about 2 percent to roughly 23 percent between 2005 and 2015.

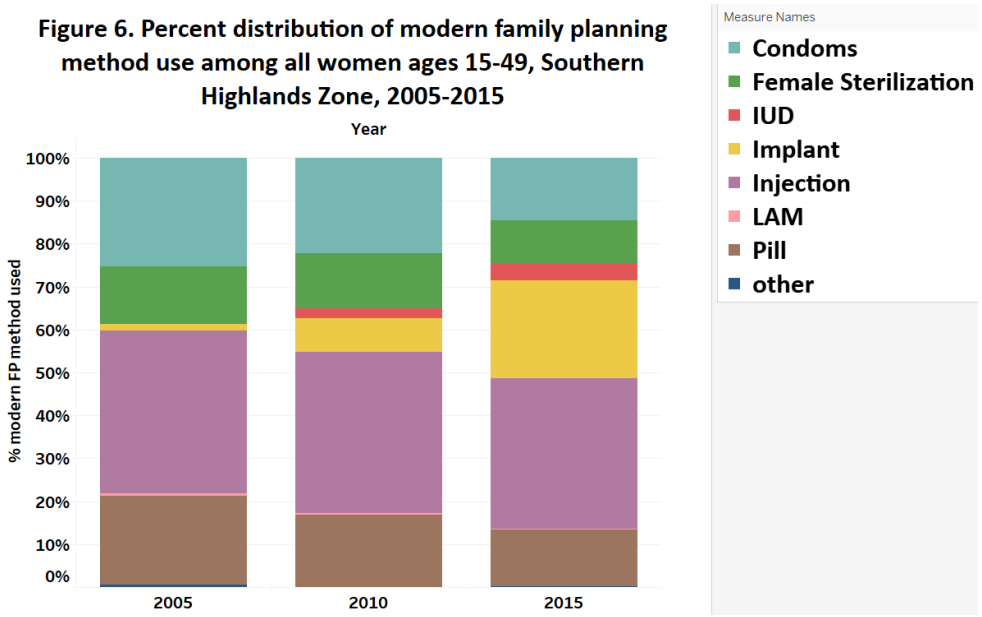


Figure 7 shows the distribution of family planning messaging, by format. It is worth noting that sources of family planning messages changed from 2005 to 2010, and this report only shows data for the sources that were consistent throughout the 10-year period.[30] In the Southern Highlands Zone, radio was by far the most common source of messaging across all three DHS years and exposure to family planning messages via TV increased from 9 percent to 35 percent from 2005 to 2015.

[29] Minimally used methods include emergency contraceptives, diaphragm, male sterilization, and female condoms

[30] Mobile phone messages were reported as a source only in the 2015 DHS. In the Southern Highlands Zone, 8 percent of women reported they received family planning messages from a mobile phone

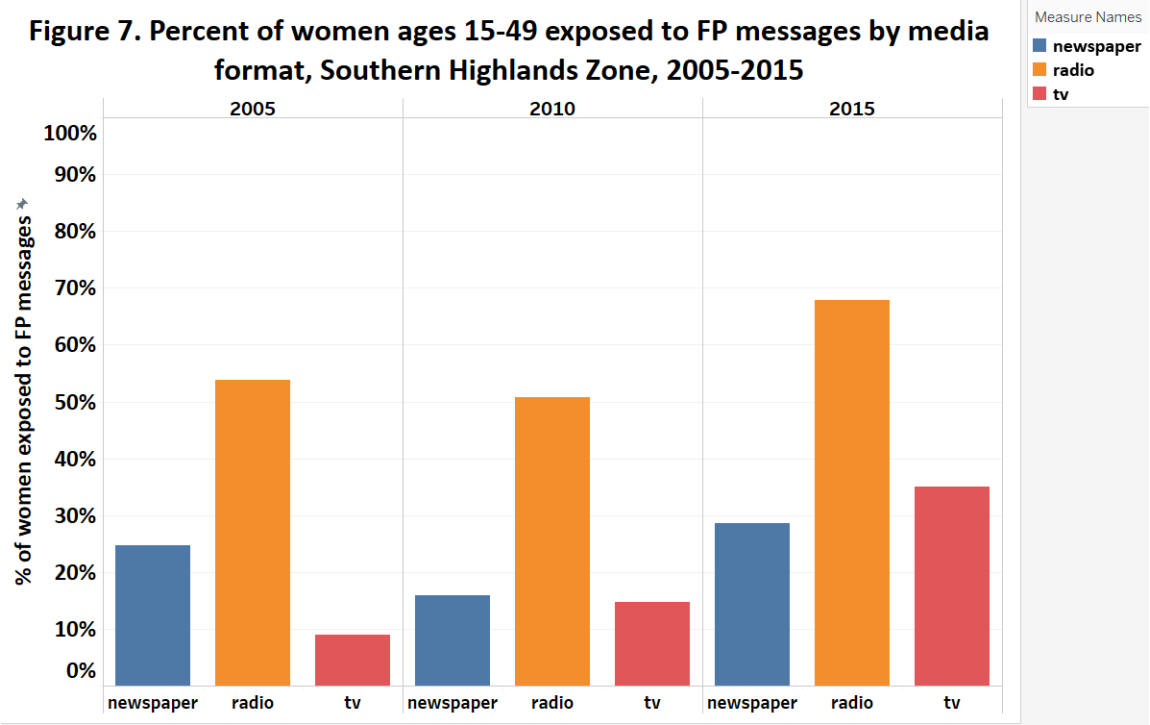


Figure 7. Percent of women ages 15-49 exposed to FP messages by media format, Southern Highlands Zone, 2005-2015
Measure Names
newspaper
radio
tv
2005
2010
2015
% of women exposed to FP messages
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
newspaper
radio
tv

Zonal Analysis (2005-2015): Southwest Highlands Zone

KEY INDICATOR HIGHLIGHTS FOR THE SOUTHWEST HIGHLANDS ZONE, 2005-2015

- **Adolescent pregnancy remained nearly the same** at 18-20 percent from 2005-2015
- **CPR increased for young women ages 20-24** by roughly 17 percentage points from 2005-2015
- **Implant use increased** from approximately 9 percent to over 26 percent from 2005-2015

Image 7. 2015 zonal distribution of Tanzania

BACKGROUND

TABLE 1. Southwest Highlands Zone population demographic characteristics, 2012 Census data

Population	% Male	% Female	% Rural	% Urban
4,276,553	48.6	51.4	72	28

The Southwest Highlands did not exist until 2015, when the Mbeya, Rukwa, and Katavi regions were re-zoned to comprise the Southwest Highlands Zone.[31] The Southwest Highlands Zone is located in southwest Tanzania (see **Image 1**), and is mostly rural. Per the 2012 Census, there are over 4 million people in the Southwest Highlands Zone and just slightly more women than men (see **Table 1**). Indicators presented in this report were selected based on available data from the 2005, 2010, and 2015 DHS reports.[32]

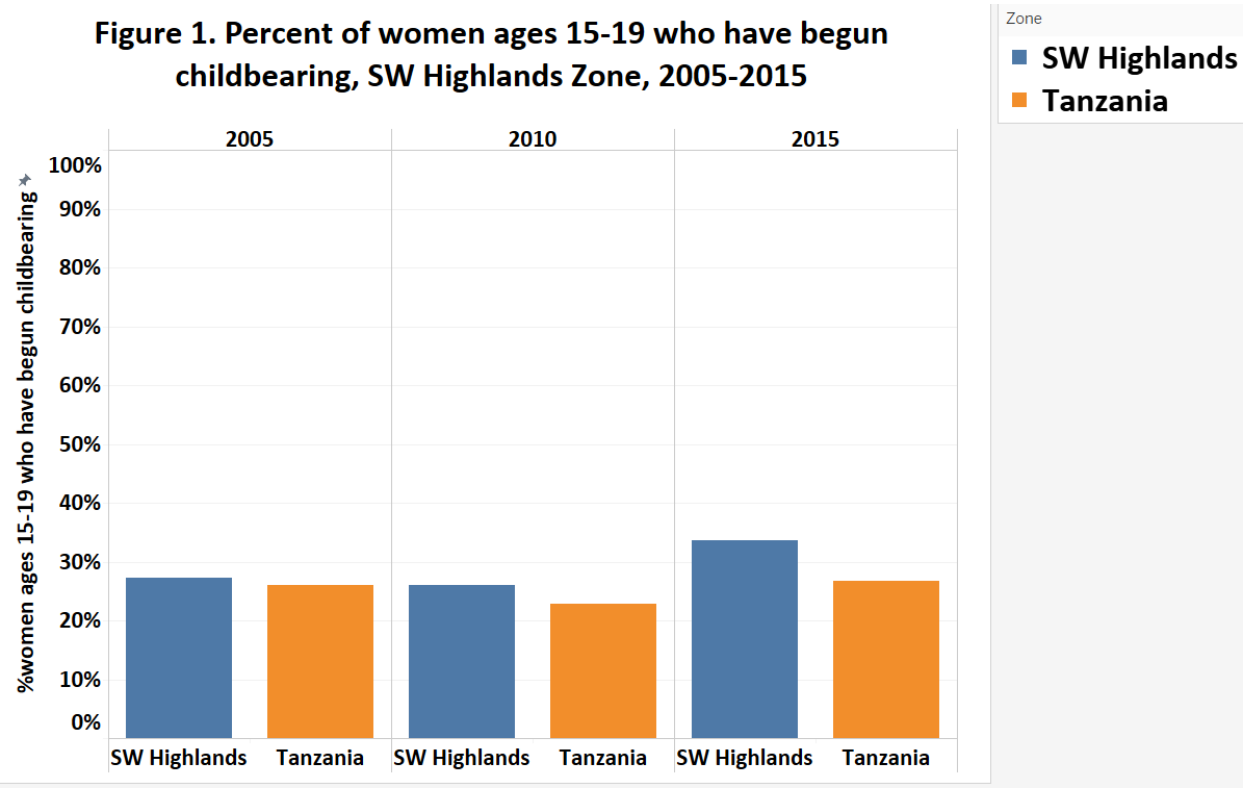
[31] For this report, to ensure that the areas evaluated remained the same across each year, zonal data for each DHS year reflect the geographic distribution of the zone in 2015. Re-mapping was conducted prior to analyzing the zonal data to ensure the data in each zone was equally weighted and comparable across the three years

[32] Indicators presented in this report were selected based on adequate sample size

ADOLESCENT PREGNANCY

More than 10 percent of the population in the Southwest Highlands Zone is young women ages 15-24. Adolescent pregnancy rates increased by about 7 percentage points from 2005 to 2015 (from approximately 27 to 34 percent, respectively), and remained relatively close to average adolescent pregnancy rates for Tanzania until 2015, when the rate in the Southwest Highlands surpassed that of Tanzania by 7 percentage points (see **Figure 1**).

Figure 1. Percent of women ages 15-19 who have begun childbearing, SW Highlands Zone, 2005-2015



Age of first sex, first birth, and first marriage did not vary much from 2005 to 2015 among all women ages 20-49[33] in the Southwest Highlands Zone, and remained below the national average in all categories across the three DHS years (see **Table 2**).

Table 2. Age at first intercourse, birth, and marriage, all women ages 20-49, Southwest Highlands Zone, 2005-2015

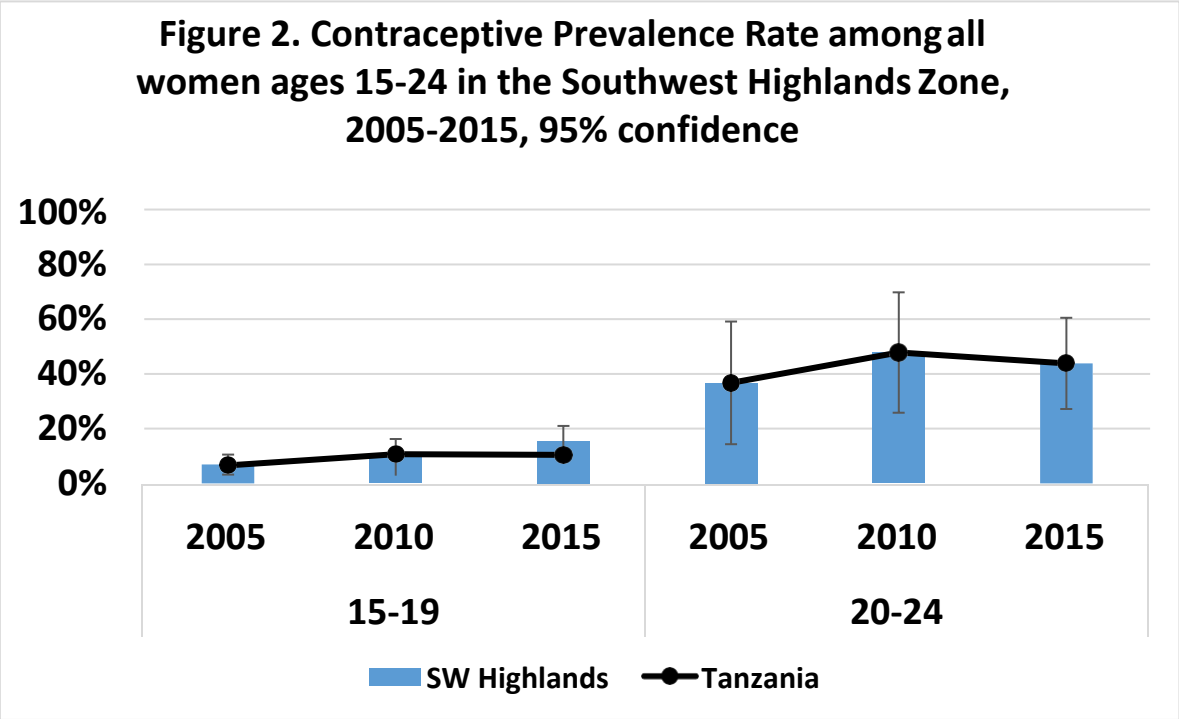
	Intercourse			Birth			Marriage		
Zone	2005	2010	2015	2005	2010	2015	2005	2010	2015
SW Highlands	15.6	15.9	15.5	17.7	17.8	18.1	16.5	16.9	17.3
Tanzania	17.0	17.4	17.3	19.4	19.5	19.8	18.6	18.9	19.3

CPR

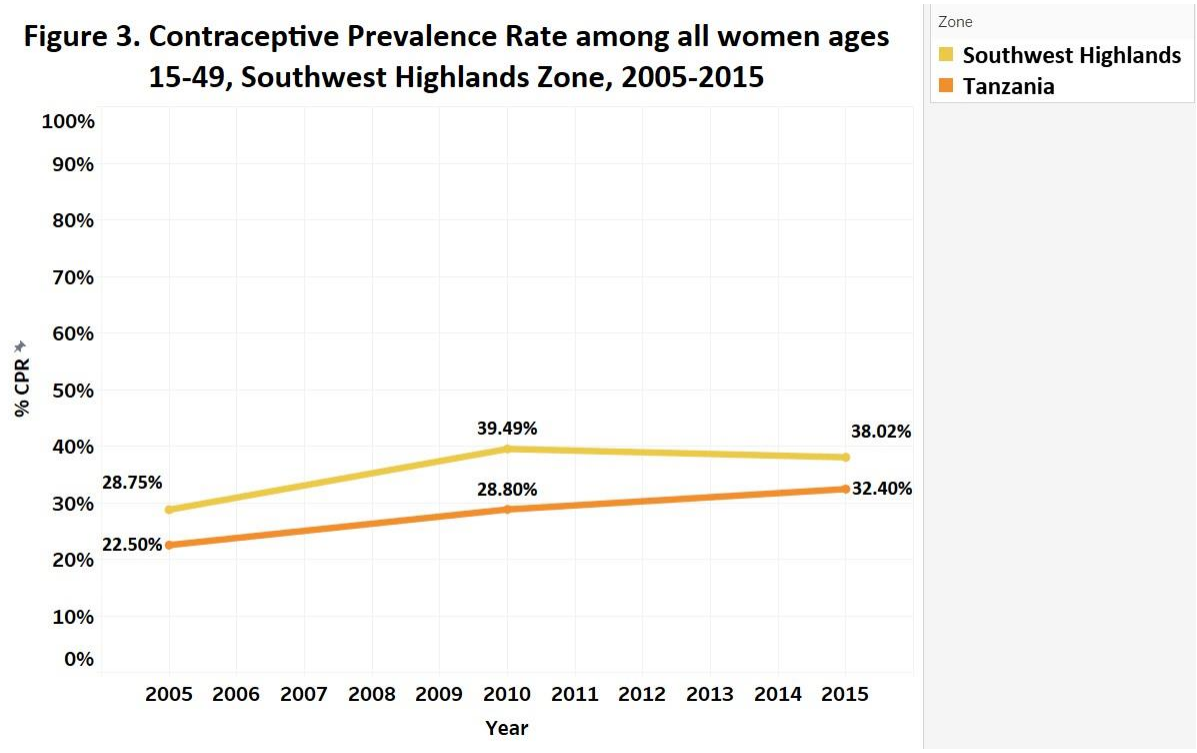
As shown in **Figure 2**, the CPR for women ages 15-19 in the Southwest Highlands Zone increased slightly from 2005 to 2015, and stayed only nearly the same as the national average CPR for this same age

[33] In this section of the DHS, women ages 20-49 were surveyed, unlike many other sections of the DHS where women ages 15-49 were surveyed

group. For women ages 20-24, CPR increased from roughly 37 percent to 44 percent from 2005-2015 and stayed above the national average across the 10-year period.

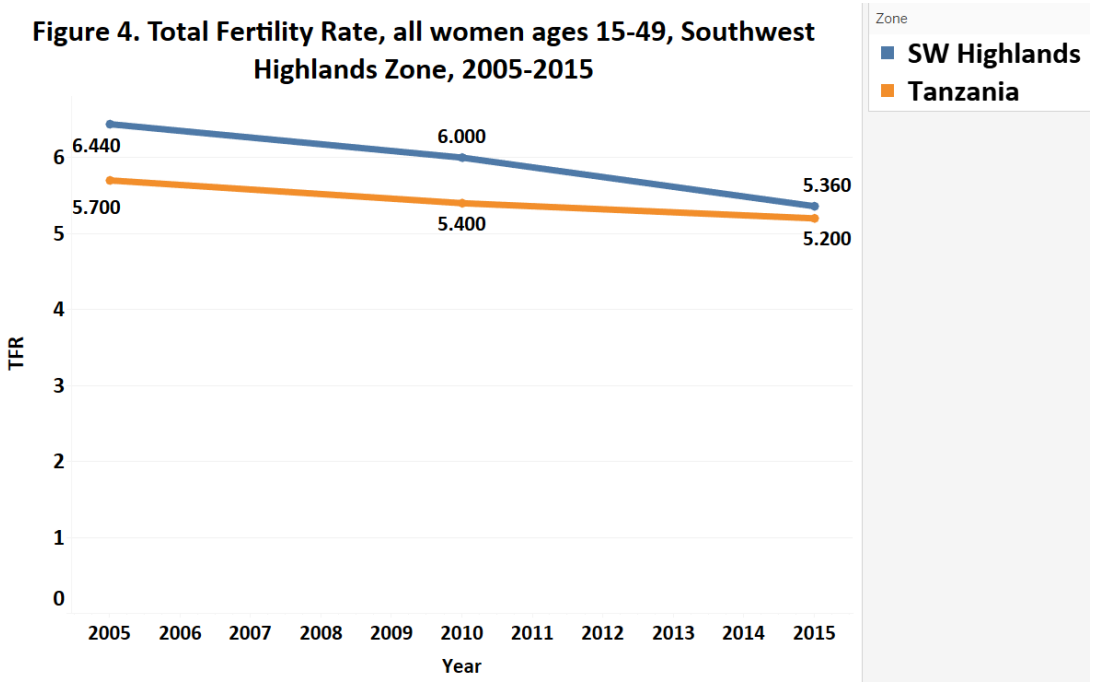


For all women ages 15-49 in the Southwest Highlands Zone, CPR increased nearly 10 percentage points, from over 28 percent to about 38 percent from 2005-2015 (see **Figure 3**). CPR in the Southwest Highlands Zone also remained above the average CPR in Tanzania by over 6 percentage points from 2005-2015.

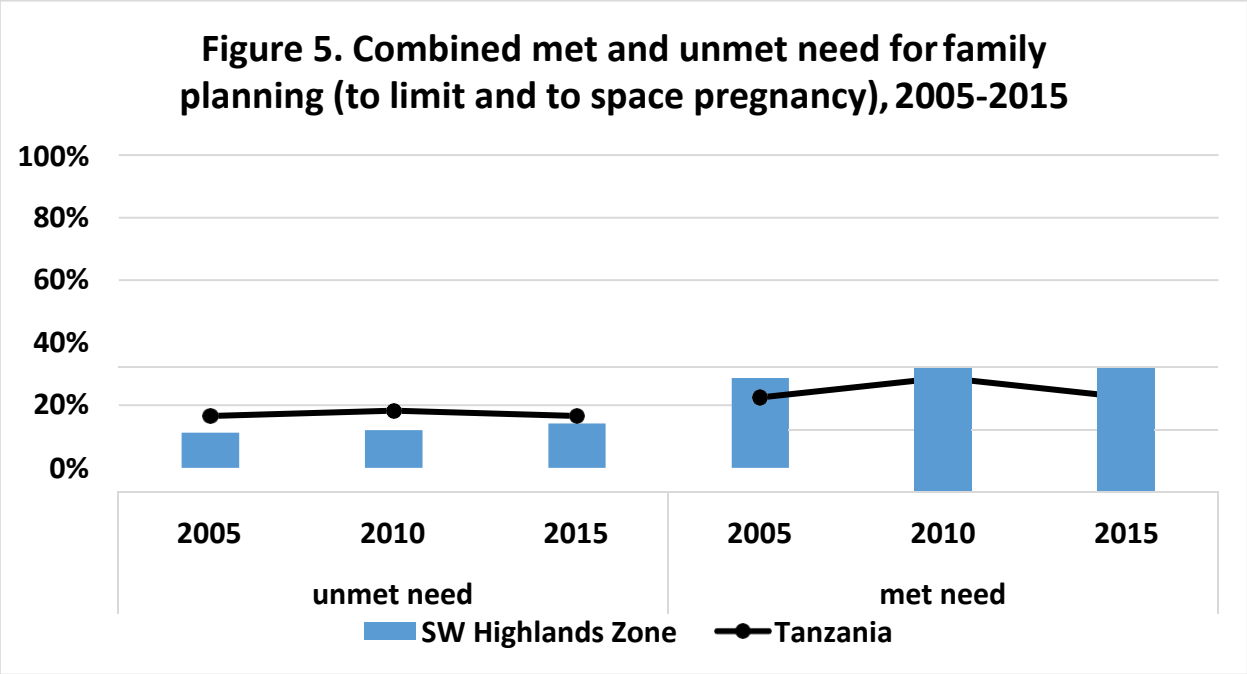


NEED AND DEMAND FOR FAMILY PLANNING

Total fertility rate (TFR) among all women ages 15-49 in the Southwest Highlands Zone decreased from 2005 to 2015 by nearly 1 child per woman. In 2015, TFR for the Southwest Highlands Zone and the average TFR for Tanzania were nearly the same (see **Figure 4**).



Combined contraceptive need and unmet need (for limiting and for spacing pregnancy) among all women ages 15-49 in the Southwest Highlands Zone is depicted in **Figure 5**. While unmet need in the Southwest Highlands Zone increased only slightly and remained below the national average across the three DHS years, met need increased nearly 10 percentage points from 2005 to 2015, and was over 16 percentage points above the national average for combined met need in 2015.



METHOD MIX

Figure 6 presents all modern contraceptive methods used by women ages 15-49 currently using any method of family planning in the Southwest Highlands Zone, where "other" includes minimally (<1 percent) used methods.[34] Most notably, implant use increased over 23 percentage points from 2005 to 2015, while use of contraceptive pills (combined and progestin-only) decreased nearly 20 percentage points. Also, long-acting methods decreased from 17 percent in 2010 to less than 1 percent in 2015.

[34] Minimally used methods include emergency contraceptives, diaphragm, male sterilization, and female condoms

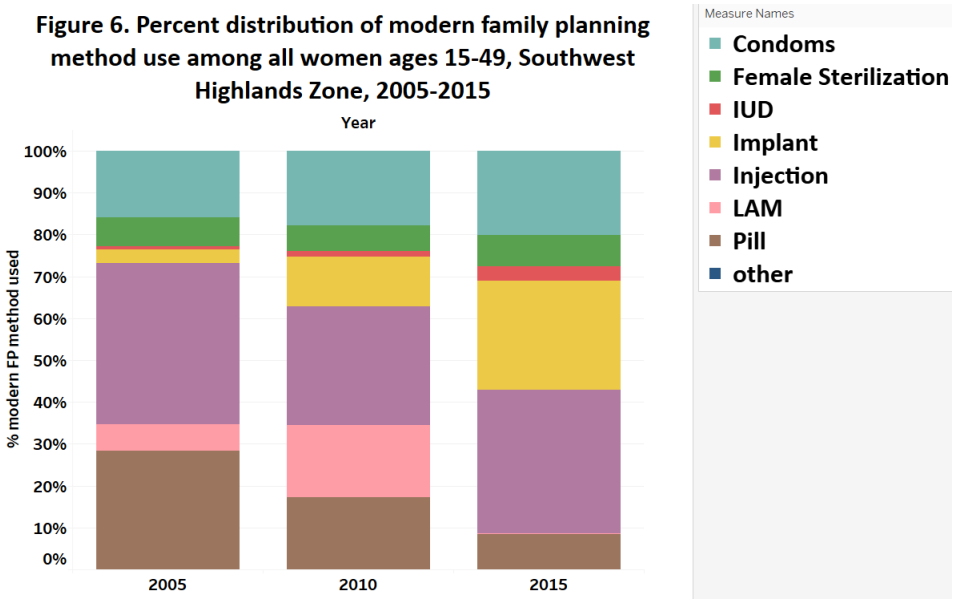
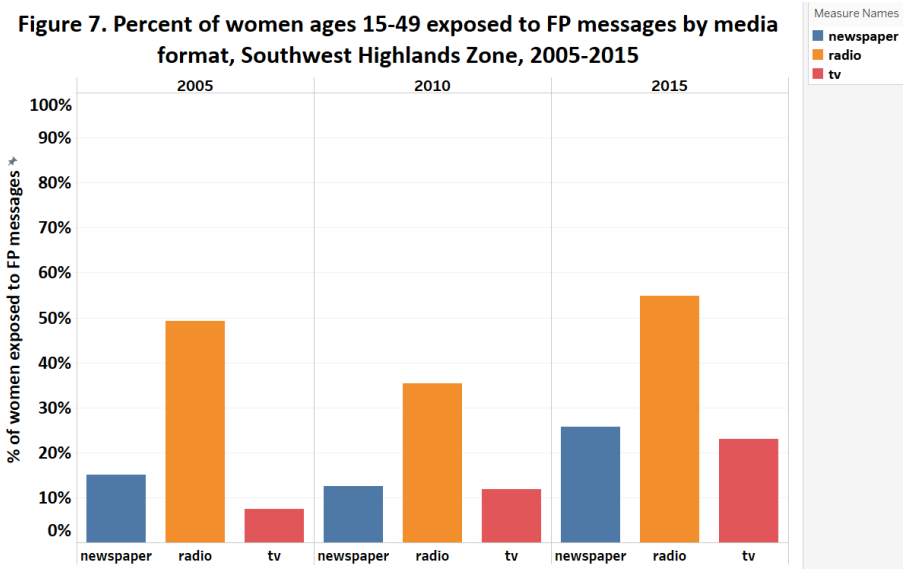


Figure 7 shows the distribution of family planning messaging, by format. It is worth noting that sources of family planning messages changed from 2005 to 2010, and this report only shows data for the sources that were consistent throughout the 10-year period.[35] In the Southwest Highlands Zone radio was the most popular media format for exposure to FP messages across the three DHS years, and increased nearly 20 percentage points from 2010 to 2015.



[35] Mobile phone messages were reported as a source only in the 2015 DHS. In the Southwest Highlands Zone, 3 percent of women reported they received family planning messages from a mobile phone

Zonal Analysis (2005-2015): Western Zone

KEY INDICATOR HIGHLIGHTS FOR THE WESTERN ZONE, 2005-2015

- **Adolescent pregnancy remained nearly the same**, at 18-20 percent from 2005-2015
- **CPR increased for young women ages 20-24**, from roughly 29 percent to over 46 percent from 2005-2015
- **Implant use increased** from approximately 9 percent to over 26 percent from 2005-2015

Image 8. 2015 zonal distribution of Tanzania

BACKGROUND

Table 1. Western Zone population demographic characteristics, 2012 Census data

Population	% Male	% Female	% Rural	% Urban
4,419,553	49	51	85	15

The geographical regions in the Western Zone decreased in 2015. Until 2015, regions in the Western Zone included Tabora, Kigoma, and Shinyanga. In 2015, the Shinyanga region moved to the Lake Zone, leaving the Western Zone with the remaining two.[36] The Western Zone is in northeast Tanzania (see **Image 1**), and is mostly rural. Per 2012 Census data, there are approximately 4.4 million people in the Western Zone with slightly more women than men (see **Table 1**). Indicators presented in this report were selected based on available data from the 2005, 2010, and 2015 DHS reports.[37]

ADOLESCENT PREGNANCY

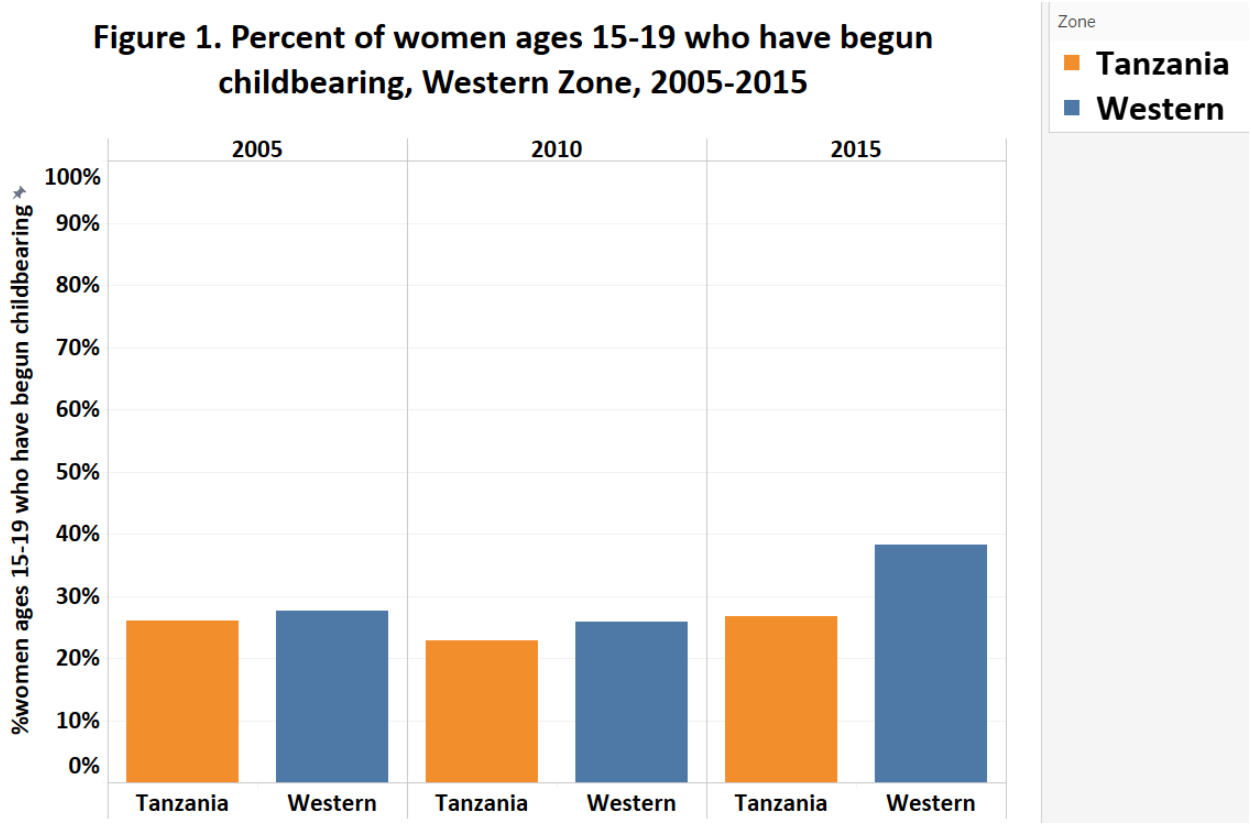
Nearly 10 percent of the total population in the Western Zone is young women ages 15-24. The number of women ages 15-19 who had begun childbearing increased by roughly 10 percentage points, from 28 to 38

[36] For this report, to ensure that the areas evaluated remained the same across each year, zonal data for each DHS year reflect the geographic distribution of the zone in 2015. Re-mapping was conducted prior to analyzing the zonal data to ensure the data in each zone was equally weighted and comparable across the three years

[37] Indicators presented in this report were selected based on adequate sample size

percent, from 2005 to 2015. In 2015, adolescent pregnancy rates in the Western Zone were 10 percentage points higher than national rates (see **Figure 1**).

Figure 1. Percent of women ages 15-19 who have begun childbearing, Western Zone, 2005-2015



Age of first intercourse and first birth among all women ages 20-49[38] in the Western Zone did not vary much from 2005 to 2015, and remained below the national average in all three categories across all three DHS years (see **Table 2**).

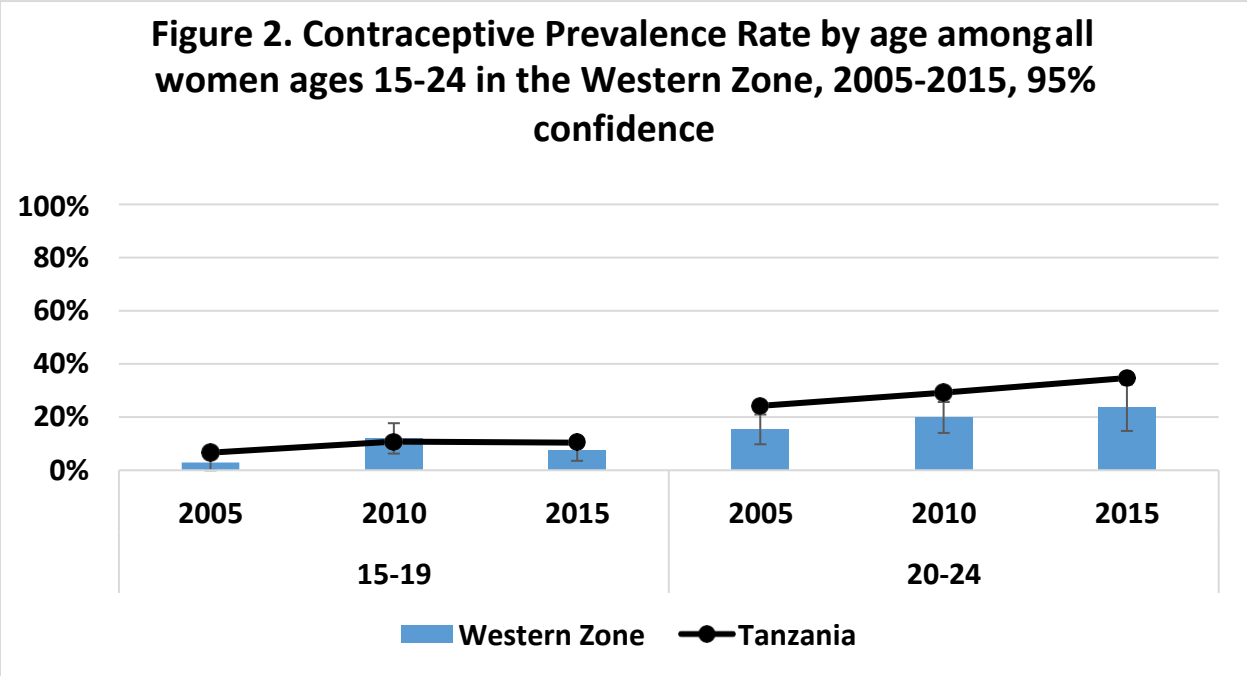
Table 2. Age at first intercourse, birth, and marriage, all women ages 20-49, Western Zone, 2005-2015

	Intercourse			Birth			Marriage		
Zone	2005	2010	2015	2005	2010	2015	2005	2010	2015
Western	15.0	15.4	15.2	17.9	17.9	17.9	16.7	17.0	16.8
Tanzania	17.0	17.4	17.3	19.4	19.5	19.8	18.6	18.9	19.3

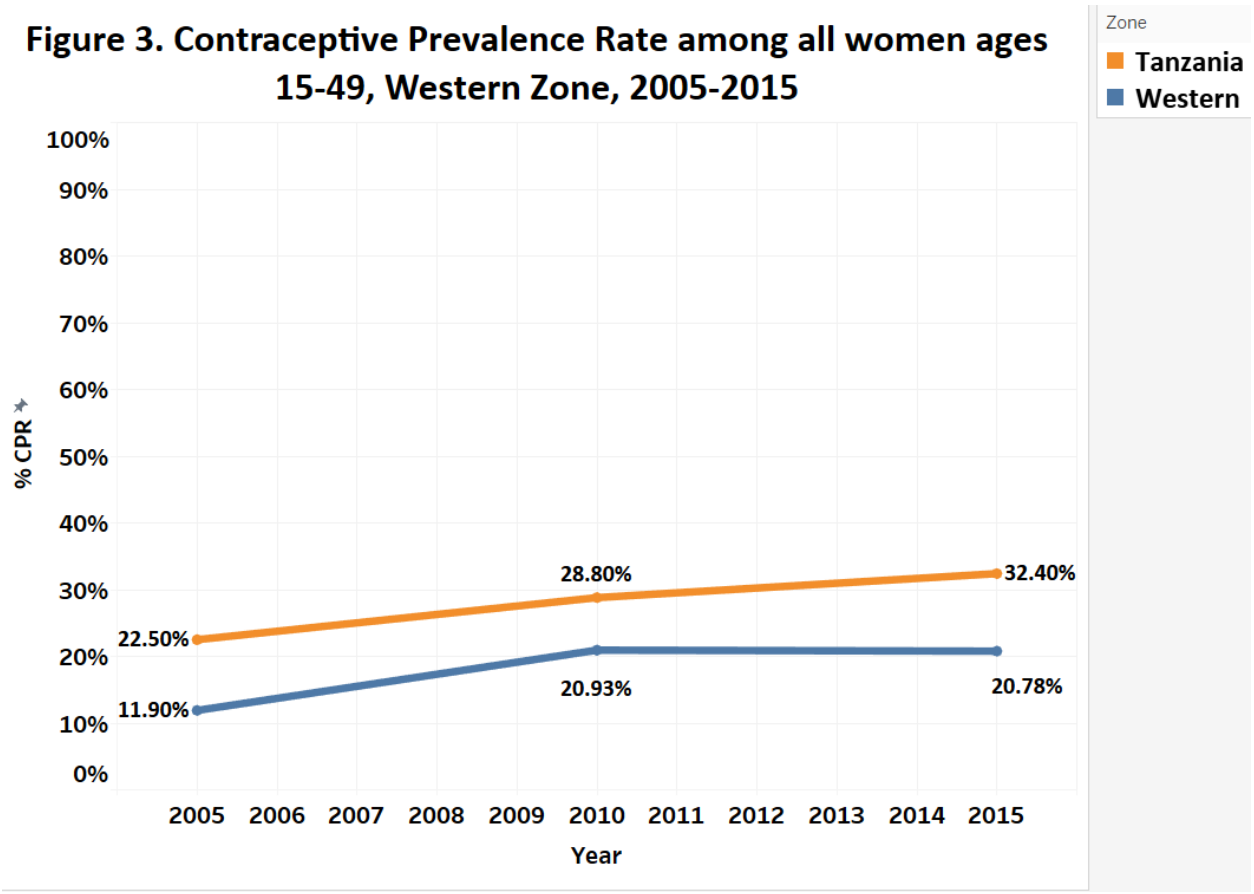
CPR

As shown in **Figure 2**, the contraceptive prevalence rate (CPR) among young women (ages 15-19 and 20-
24) in the Western Zone increased slightly from 2005 to 2015, but remained low and below the national average during the entire 10-year period. For women ages 20-24, CPR was also well below the national average, although it did increase from about 15 to 24 percent from 2005-2015.

[38] In this section of the DHS, women ages 20-49 were surveyed, unlike many other sections of the DHS where women ages 15-49 were surveyed

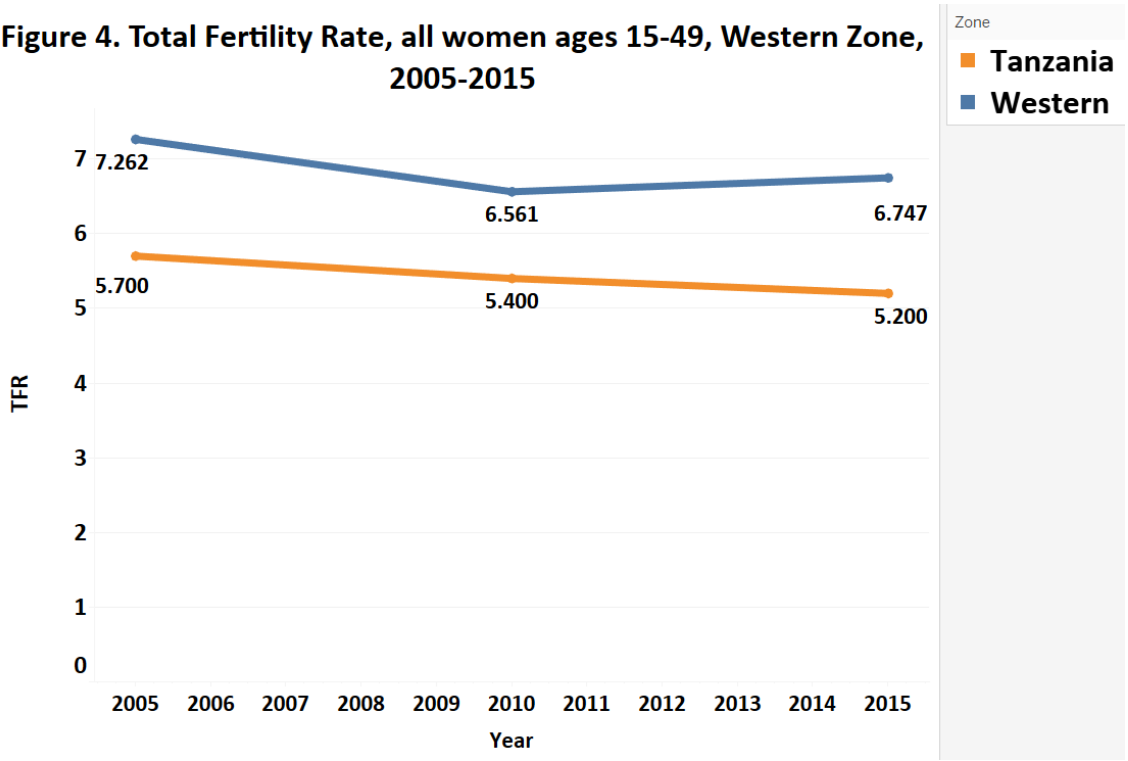


As shown in **Figure 3**, CPR among all women ages 15-49 in the Western Zone increased by about 9 percentage points from 2005 to 2015, (from roughly 11.9 percent to 20.8 percent). Throughout the three DHS years, CPR in the Western Zone remained below the average CPR for Tanzania.

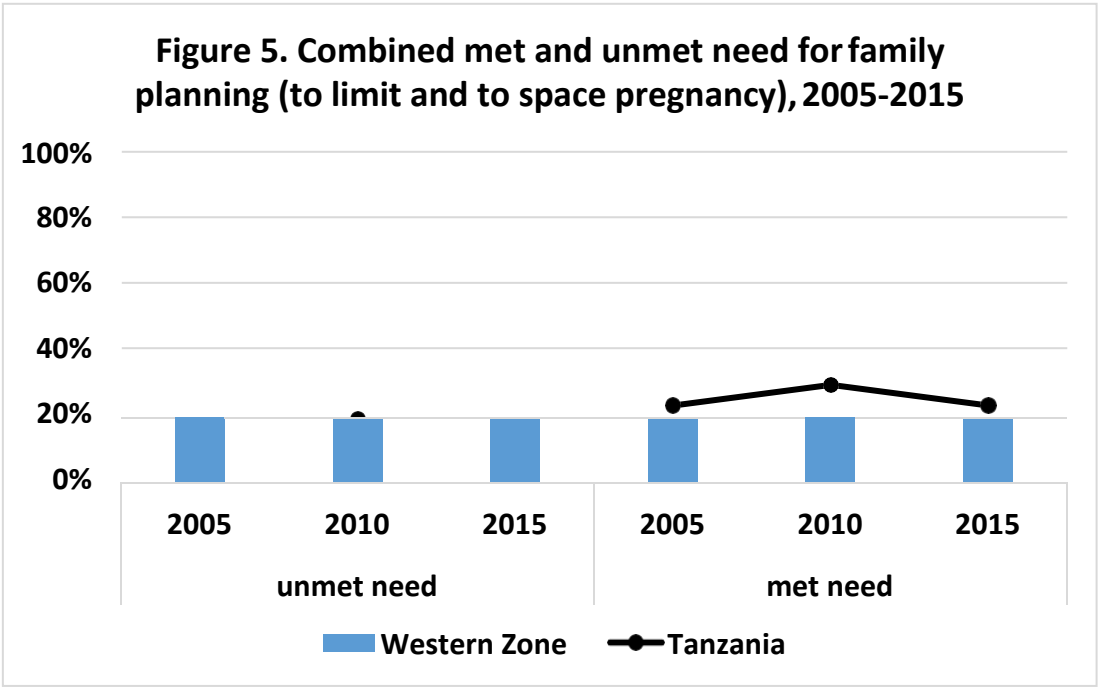


NEED AND DEMAND FOR FAMILY PLANNING

Total fertility rate (TFR) among all women ages 15-49 in the Western Zone decreased slightly from 2005 to 2015, by about .5 children per woman. TFR remained above the national average by more than 1.5 children per woman throughout the three DHS years (see **Figure 4**).



Combined contraceptive need and unmet need (for limiting and for spacing pregnancy) among all women ages 15-49 in the Western Zone is depicted in **Figure 5**. Both met and unmet need for FP varied only slightly across all three DHS years, and remained close to national averages, at around 20 percent for both met and unmet need.



METHOD MIX

Figure 6 presents all modern contraceptive methods used by women ages 15-49 currently using any method of family planning in the Western Zone, where "other" includes minimally (<1 percent) used methods.[39] Most notably, implant use increased from about 1 percent to nearly 19 percent from 2005 to 2015, and use of injectables decreased, from 53 to 41 percent.

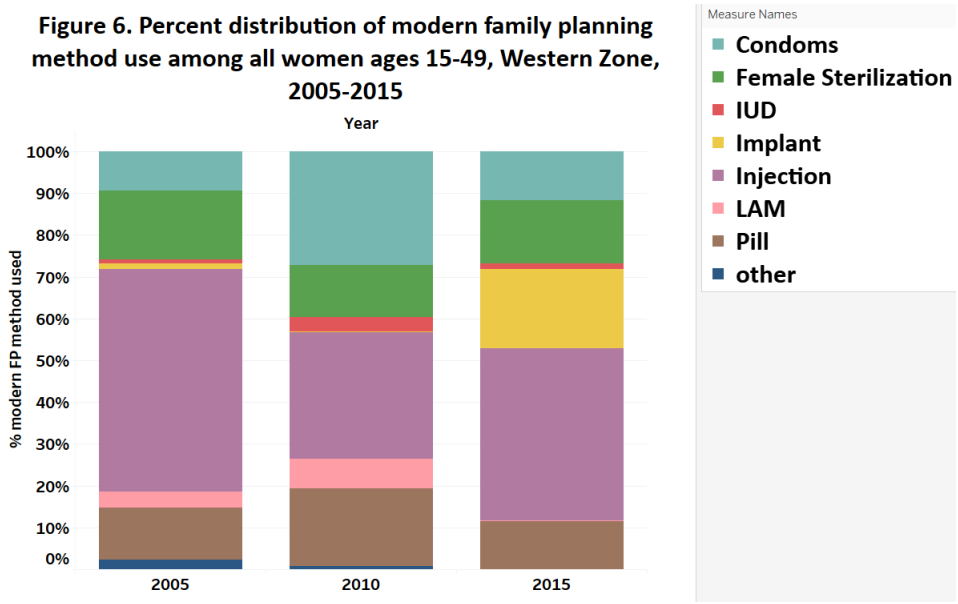


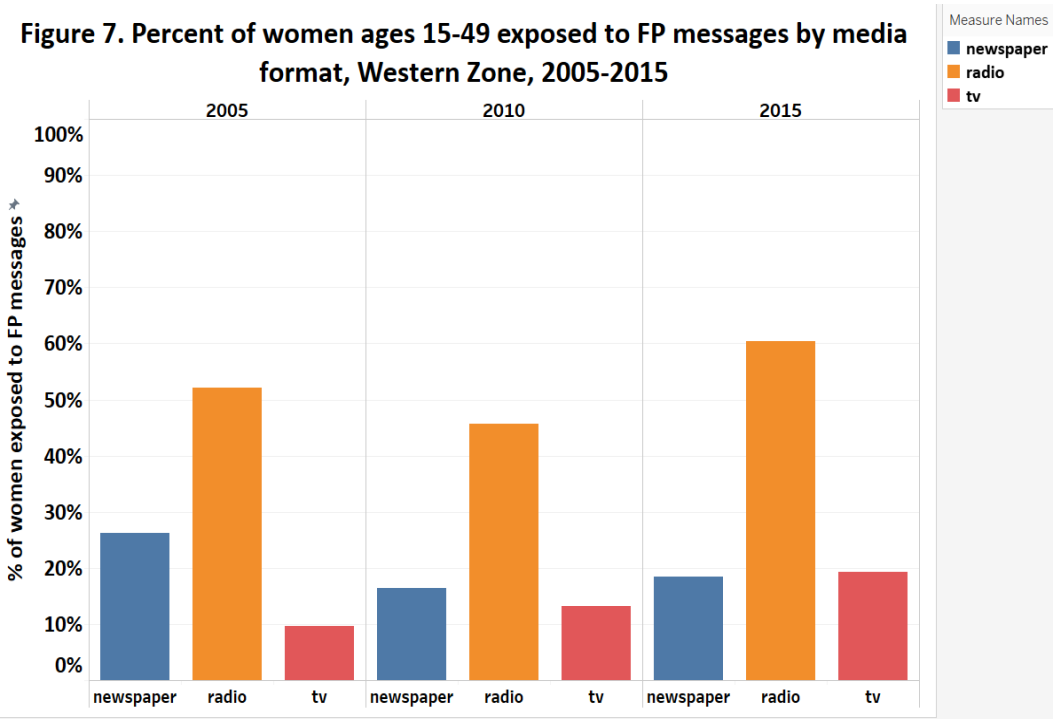
Figure 7 shows the distribution of family planning messaging, by format. It is worth noting that sources

of family planning messages changed from 2005 to 2010, and this report only shows data for the sources that were consistent throughout the 10-year period.[40] In the Western Zone, the radio was consistently the most prevalent source of FP messages, and increased about 14 percentage points from 2010 to2015, whereas newspaper declined 8 percentage points from 2005 to 2015.

[39] Minimally used methods include emergency contraceptives, diaphragm, male sterilization, and female condoms

[40] Mobile phone messages were reported as a source only in the 2015 DHS. In the Western Zone, approximately 5.8 percent of women reported they received family planning messages from a mobile phone

Figure 7. Percent of women ages 15-49 exposed to FP messages by media format, Western Zone, 2005-2015



4.9 Regional Analysis (2005-2015): Dar es Salaam Region

KEY INDICATOR HIGHLIGHTS FOR THE DAR ES SALAAM REGION, 2005-2015

- **Adolescent pregnancy slightly decreased** from 2005 to 2015, from approximately 15 to 12 percent
- **Combined unmet need for family planning increased slightly** among all women ages 15-49, by about 8 percentage points
- **CPR among young women ages 15-19 stayed nearly the same** from 2005-2015, at around 13-14 percent

Image 9. 2015 regional and zonal distribution of Tanzania

BACKGROUND

TABLE 1. Dar es Salaam Region population demographic characteristics, 2012 Census data

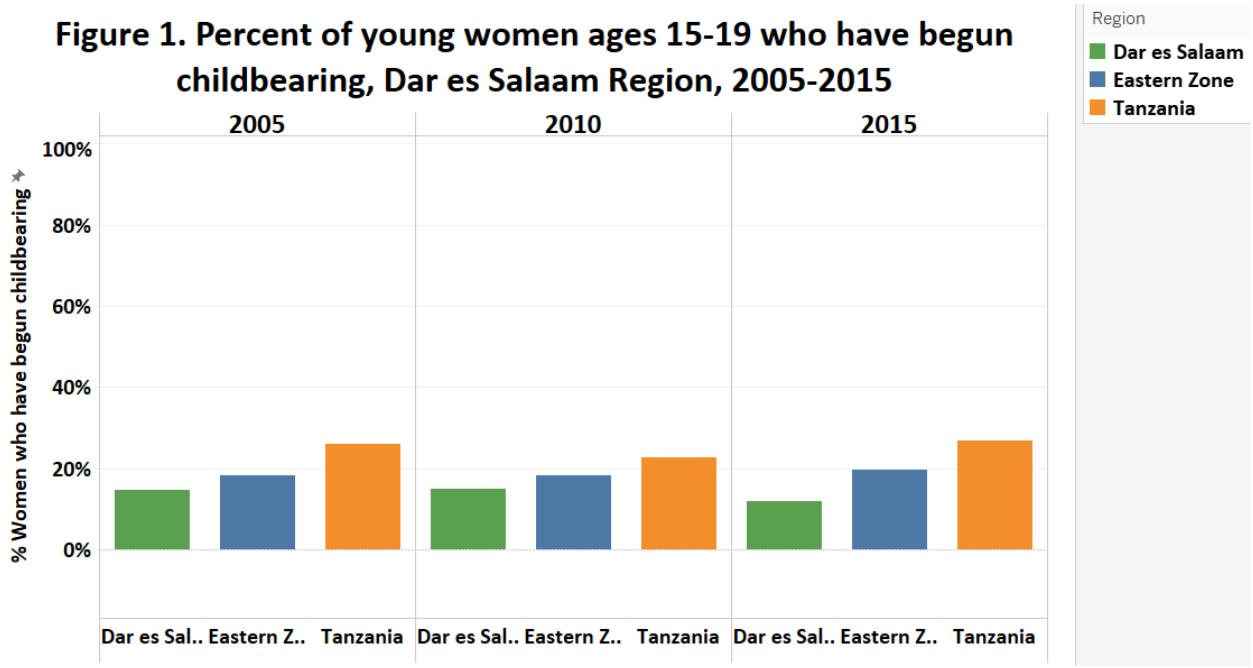
Population	% Male	% Female	% Rural	% Urban
4,364,541	49	51	0	100

Part of the Eastern Zone, the Dar es Salaam Region is in southeastern Tanzania (see **Image 1**). Per 2012 Census data, about 4.3 million people live in the Dar es Salaam Region, with slightly more female than male inhabitants (see **Table 1**). The entire Dar es Salaam Region is urban, and age distribution is more equal than most other regions in Tanzania. Indicators presented in this report were selected based on available data from the 2005, 2010, and 2015 DHS reports.[41]

ADOLESCENT PREGNANCY

In the Dar es Salaam Region, adolescent pregnancy decreased slightly (from 15 to 12 percent) and was 8 or more percentage points below the national average and slightly below the average for the Eastern Zone across the three DHS years (see **Figure 1**).

[41] Indicators presented in this report were selected based on adequate sample size



Age of first sex, first birth, and first marriage increased from 2005 to 2015 among all women ages 20-49.[42] Average ages across all three categories higher than the Eastern Zone, and nearly the same as the national average across the three DHS years (see **Table 2**).

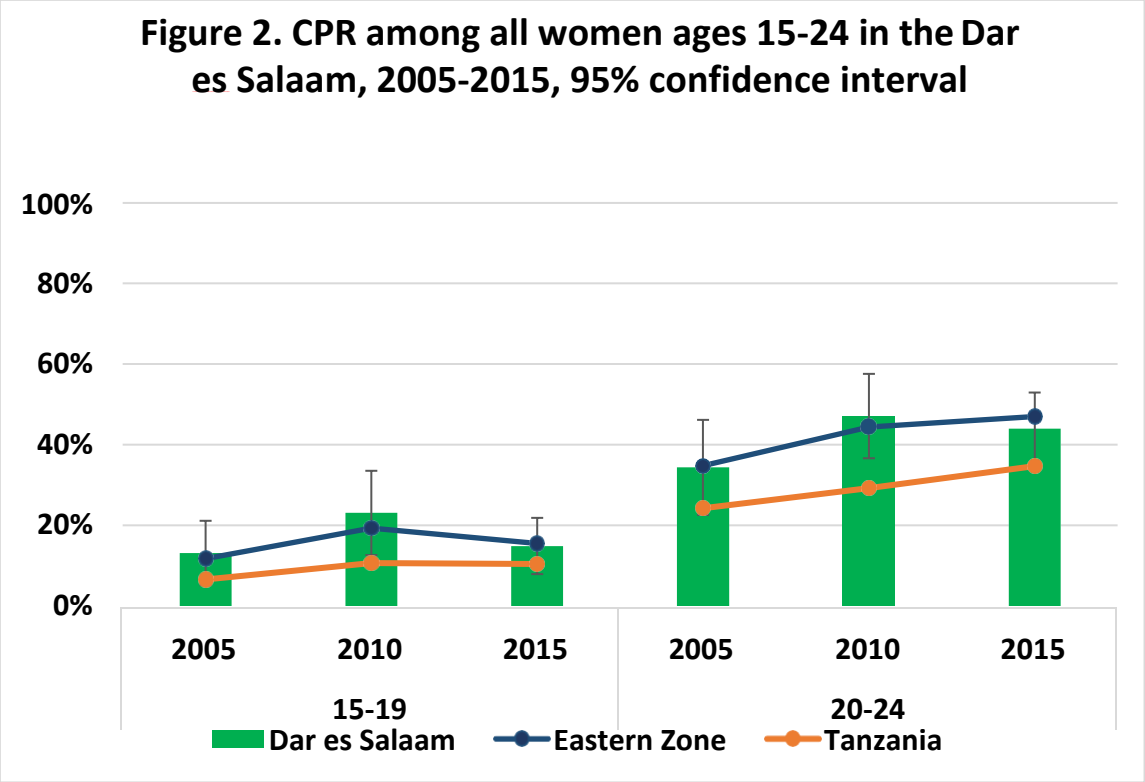
Table 2. Age at first birth, intercourse, and marriage, women ages 20-49, Dar es Salaam Region, 2005-2015

	Birth			Intercourse			Marriage		
Region	2005	2010	2015	2005	2010	2015	2005	2010	2015
Dar es Salaam	18.5	18.6	19.4	15.7	16.0	16.4	18.1	18.8	19.4
Eastern Zone	18.0	18.1	18.6	15.7	15.8	15.9	17.5	17.9	18.4
Tanzania	19.4	19.5	19.8	17.0	17.4	17.3	18.6	18.9	19.3

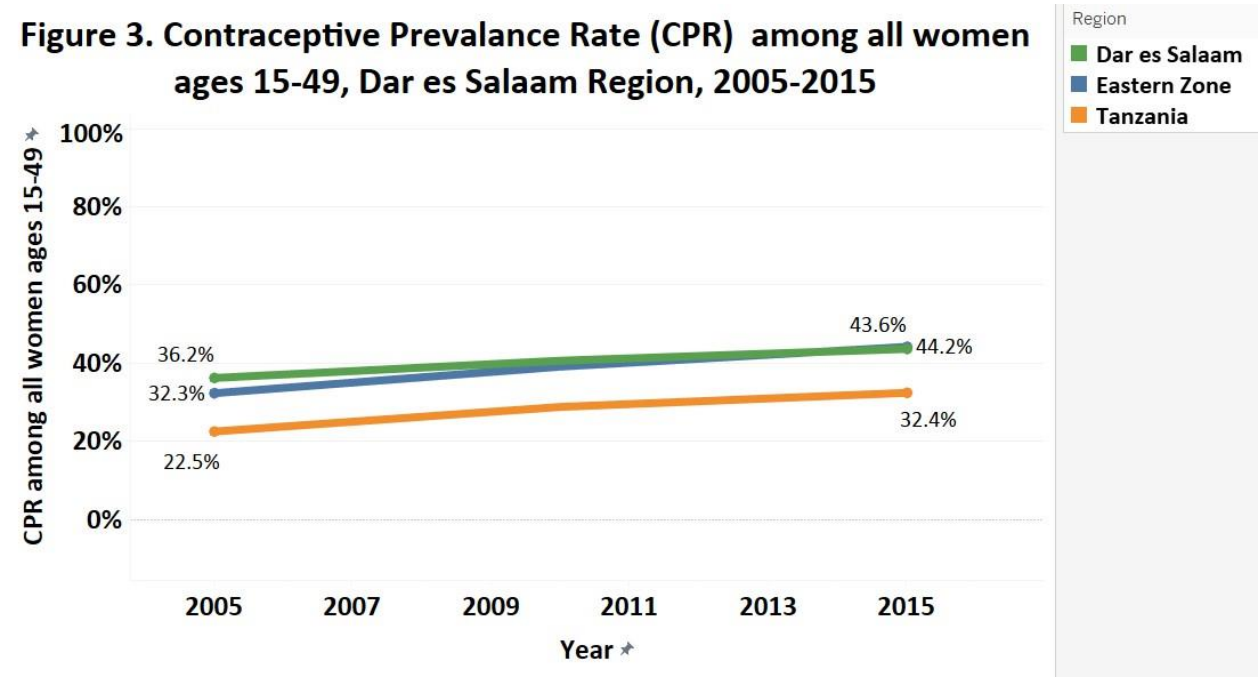
CPR

Figure 2 shows the contraceptive prevalence rate (CPR) among young women, ages 15-19 and 20-24 in the Dar es Salaam Region with confidence intervals and compared to zonal and national data. Although there was a slight increase in CPR in both age groups from 2005 to 2010 and across the 10-year period, CPR decreased from 2010 to 2015. Overall, CPR among young women in both age groups in Dar es Salaam remained above the national average and nearly the Eastern Zone throughout the three DHS years.

[42] In this section of the DHS, women ages 20-49 were surveyed, unlike many other sections of the DHS where women ages 15-49 were surveyed



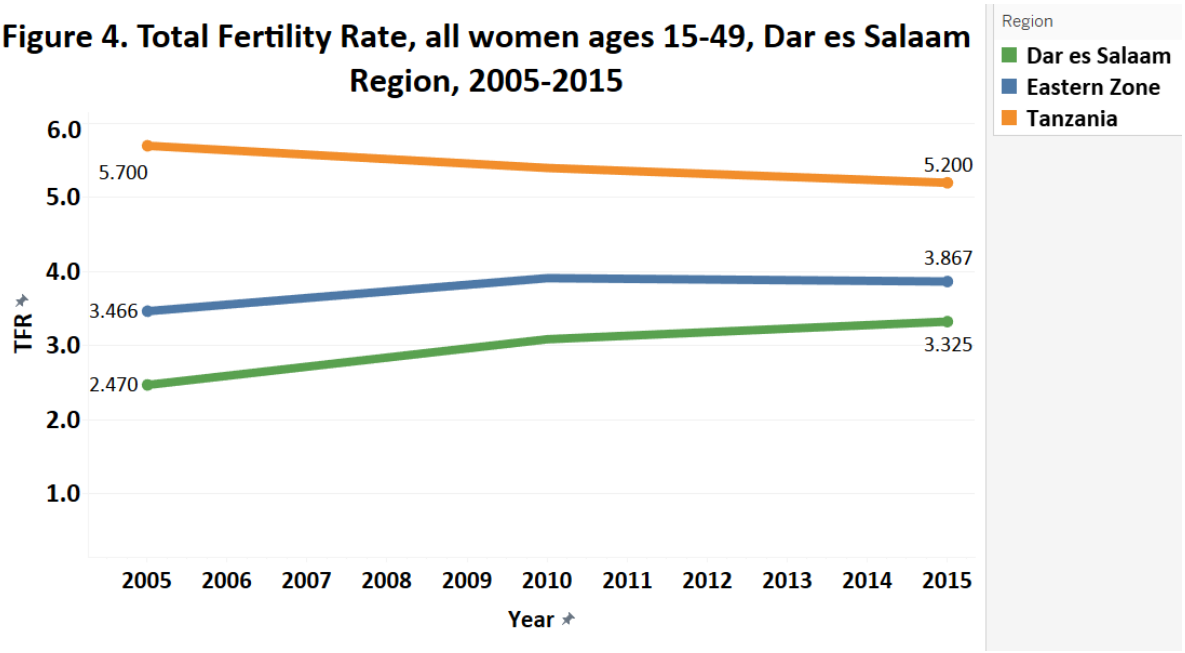
CPR among all women ages 15-49[43] in the Dar es Salaam Region increased only slightly, by about 7 percentage points from 2005 to 2015 and remained above national CPR, by about 11 percentage points in 2015 (see **Figure 3**).



[43] Regional CPR data in this report were calculated for all women (married and unmarried) ages 15-49 and are therefore slightly different than regional CPR data in the DHS, which only calculated CPR among married women ages 15-49

NEED AND DEMAND FOR FAMILY PLANNING

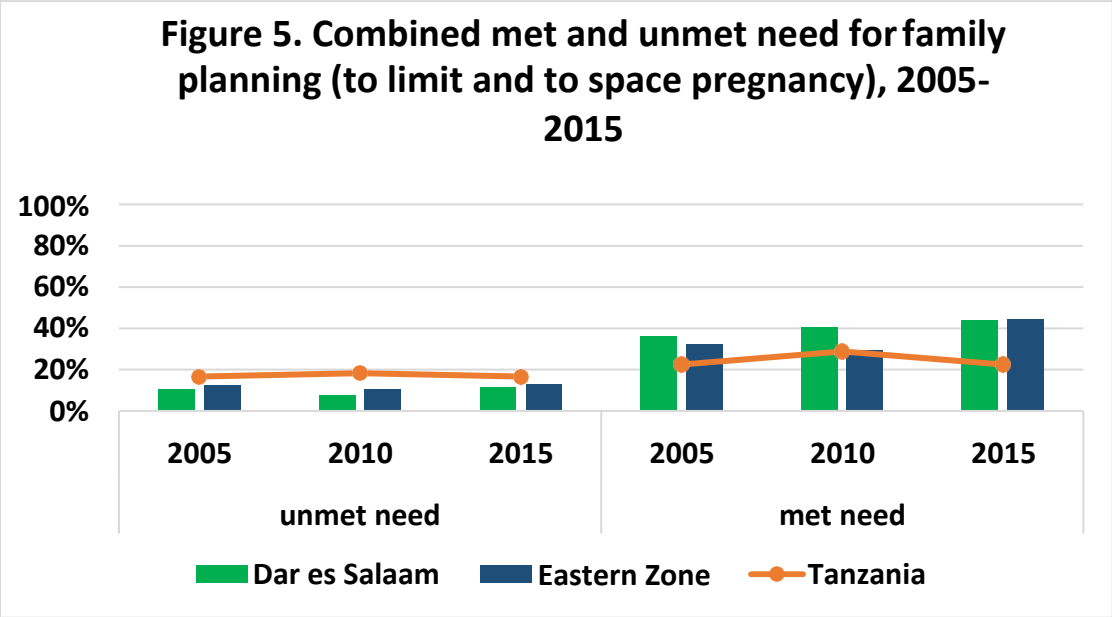
Total fertility rate (TFR) in the Dar es Salaam Region increased by over about 0.8 children per woman from 2005 to 2015, remained below the average for Tanzania by almost 2 children per woman, and was slightly below the TFR for the Eastern Zone across the three DHS years (see **Figure 4**).



Combined met[44] and unmet contraceptive need (for limiting and for spacing pregnancy) among all women ages 15-49[45] in the Dar es Salaam Region is depicted in **Figure 5**. Changes in unmet need remained nearly the same, and combined met need increased roughly 8 percentage points. Compared to zonal and national data, unmet need for planning was slightly lower in Dar es Salaam, and met need was the same or slightly higher in Dar es Salaam than in the Eastern Zone and much higher than met need in all of Tanzania, by over 20 percentage points in 2015.

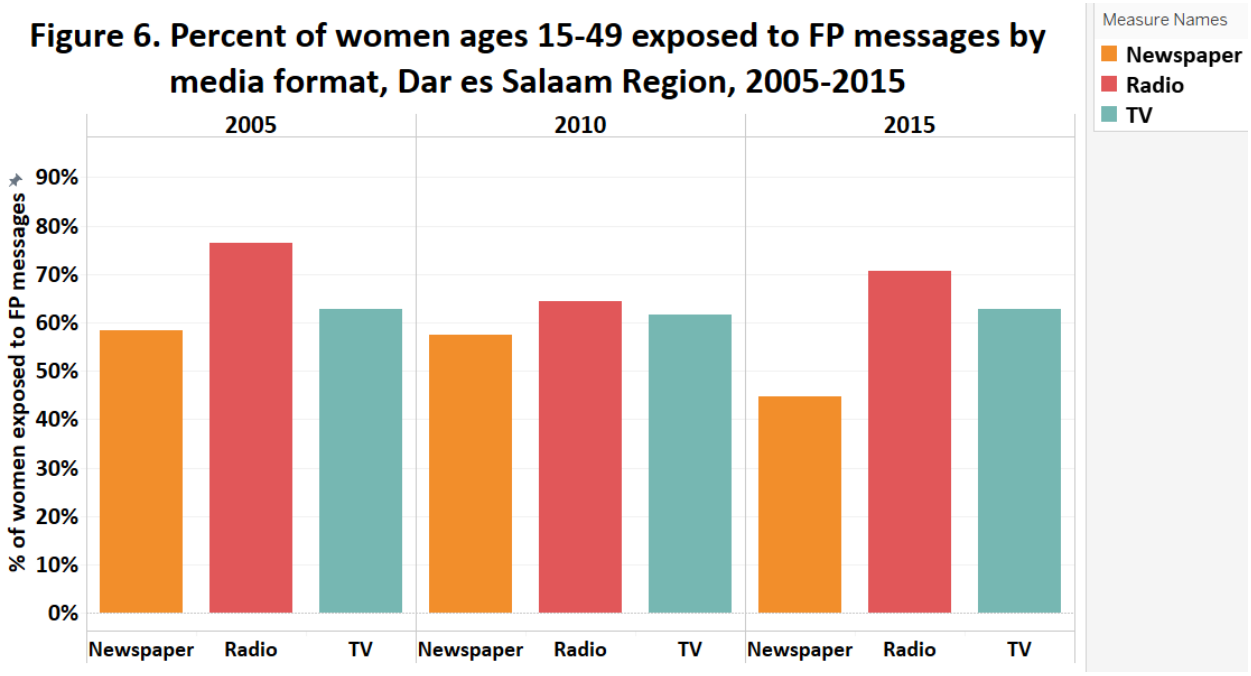
[44] Regional data on met need in this report were calculated for all women (married and unmarried) ages 15-49 and are therefore slightly different than regional data on met need in the DHS, which only calculated need for FP among married women ages 15-49

[45] Data for met and unmet need shown this report are for all women (married and unmarried) ages 15-49 with sampling weights applied, and therefore do not match data on met and unmet need in the DHS



SOURCES OF FAMILY PLANNING MESSAGING

Figure 6 shows the distribution of family planning messaging, by format. It is worth noting that sources of family planning messaging changed from 2005 to 2010, and this report only shows data for the sources that were consistent throughout the 10-year period.[46] Although radio was the most common source of FP messaging across all three DHS years, TV was a close second. Also, overall rates of FP messaging were much higher than the national average in every category across all three DHS years.



[46] Mobile phone messages were reported as a source of family planning messaging only in the 2015 DHS. In the Dar es Salaam Region, approximately 16 percent of women reported they received family planning messages from a mobile phone

Regional Analysis (2005-2015): Dodoma Region

KEY INDICATOR HIGHLIGHTS FOR THE DODOMA REGION, 2005-2015

- **Adolescent pregnancy increased** by roughly 12 percentage points (from 27 to 39 percent) from 2005 to 2015
- **Combined met need for family planning increased** among all women ages 15-49 by nearly 22 percentage points (from 19 to 41 percent) from 2005 to 2015
- **CPR for young women ages 15-19 increased** roughly 20 percentage points (from 6.5 to 24.5 percent) from 2005 to 2015

Image 10. 2015 regional and zonal distribution of Tanzania

BACKGROUND

TABLE 1. Dodoma Region population demographic characteristics, 2012 Census data

Population	% Male	% Female	% Rural	% Urban
2,083,588	48.7	51.3	85	15

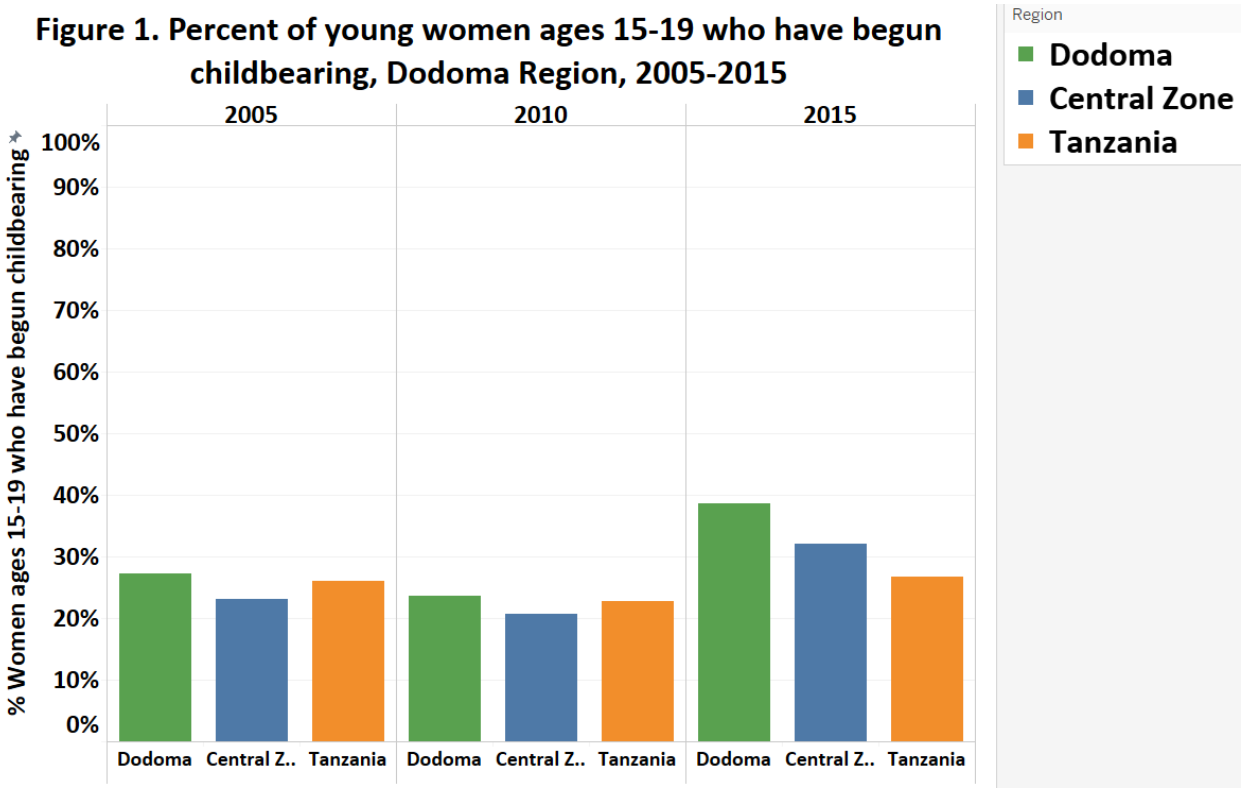
Part of the Central Zone, the Dodoma Region is located near the center of Tanzania (see **Image 1**). Per 2012 Census data, just over 2 million people live in the Dodoma Region, with slightly more female than male inhabitants (see **Table 1**). Age distribution is relatively young, with over half of the population 19 years old or younger. Indicators presented in this report were selected based on available data from the 2005, 2010, and 2015 DHS reports.[47]

ADOLESCENT PREGNANCY

From 2005-2015, adolescent pregnancy increased by nearly 12 percentage points (from 27 to 39 percent, respectively) in the Dodoma Region and stayed above rates for both the Central Zone and Tanzania across all three years (see **Figure 1**).

[47] Indicators presented in this report were selected based on adequate sample size

Figure 1. Percent of young women ages 15-19 who have begun childbearing, Dodoma Region, 2005-2015



Age of first birth, and first marriage did not vary much from 2005 to 2015 among all women ages 20-49[48] in the Dodoma Region, were similar to the average in the Central Zone in these categories, and remained below the national average across all three DHS years (see **Table 2**). Age of first sex increased by nearly one year from 2005 to 2015 in the Dodoma Region, but was still almost two years below age of first sex in Tanzania in 2015.

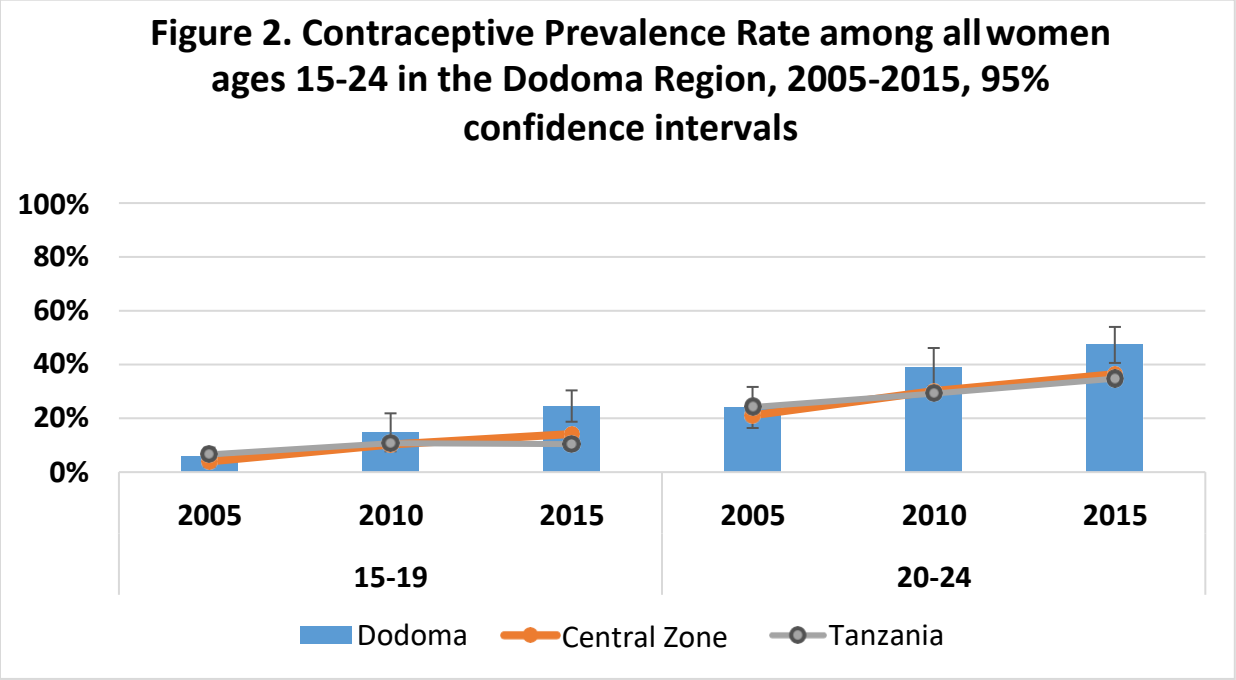
Table 2. Age at first birth, intercourse, and marriage, women ages 20-49, Dodoma Region, 2005-2015

	Birth			Intercourse			Marriage		
Region	2005	2010	2015	2005	2010	2015	2005	2010	2015
Dodoma	17.7	18.0	18.1	14.5	15.6	15.4	16.9	16.8	17.0
Central Zone	18.0	18.4	18.4	15.0	15.9	15.7	17.2	17.3	17.6
Tanzania	19.4	19.5	19.8	17.0	17.4	17.3	18.6	18.9	19.3

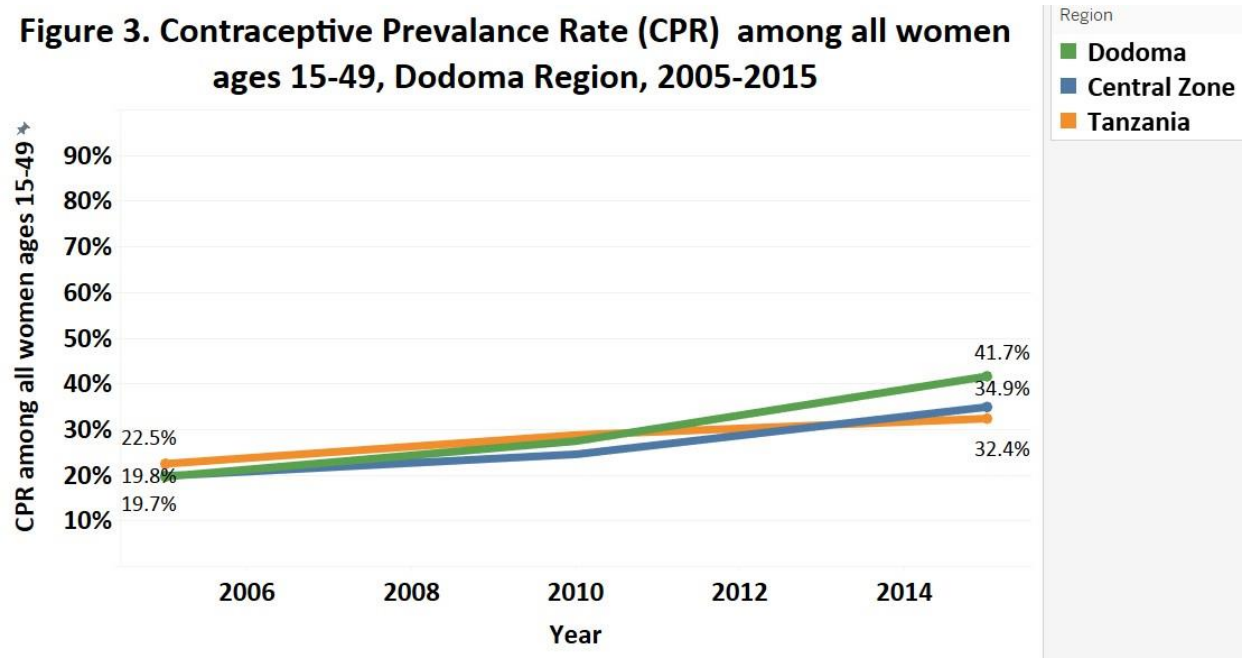
CPR

Figure 2 shows the contraceptive prevalence rate (CPR) among young women, ages 15-19 and 20-24 in the Dodoma Region with confidence intervals and compared to zonal and national data. The CPR for young women ages 15-19 increased over 19 percentage points from 2005 to 2015, and surpassed the national and zonal average CPR for this same age group by approximately 10 percentage points in 2015. For women ages 20-24, CPR steadily increased to over 23 percent in 2015 and surpassed both zonal and national average CPRs by over 13 percentage points.

[48] In this section of the DHS, women ages 20-49 were surveyed, unlike many other sections of the DHS where women ages 15-49 were surveyed



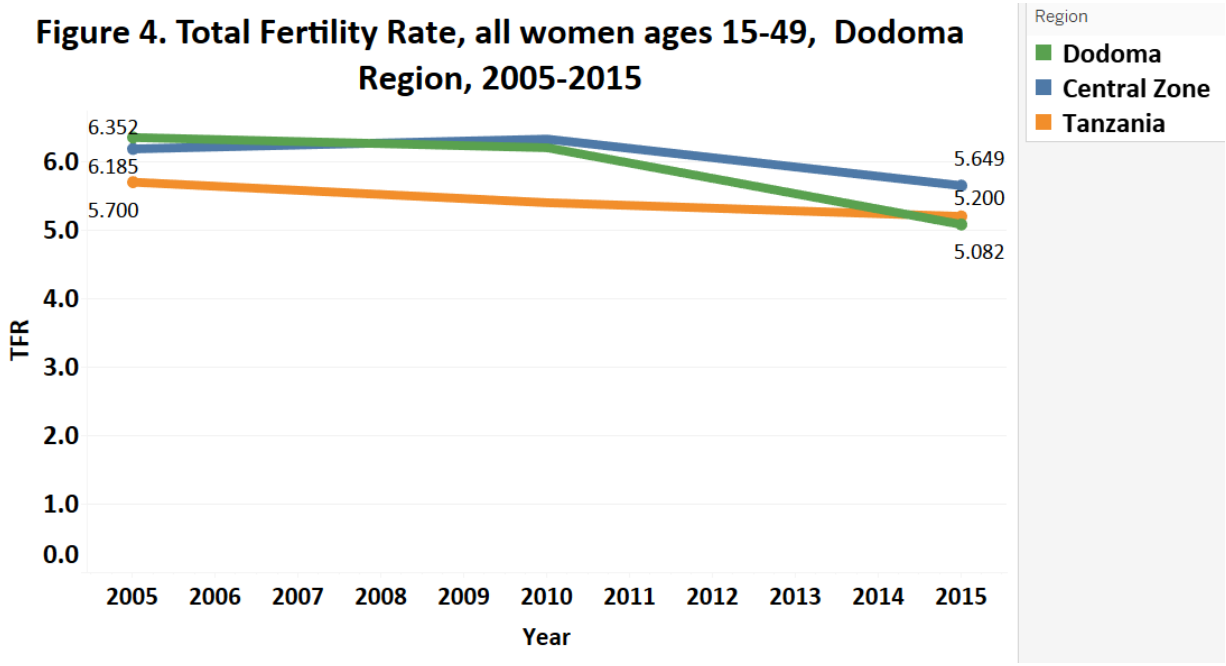
CPR for all women ages 15-49[49] in the Dodoma Region more than doubled from 2005 to 2015 (see **Figure 3**). Notably, although CPR in the Dodoma Region was below the overall CPR for Tanzania in 2005, it surpassed national rates by 10 percentage points and was 7 percentage points higher than the Central Zone in 2015.



[49] Regional CPR data in this report were calculated for all women (married and unmarried) ages 15-49 and are therefore slightly different than regional CPR data in the DHS, which only calculated CPR among married women ages 15-49

NEED AND DEMAND FOR FAMILY PLANNING

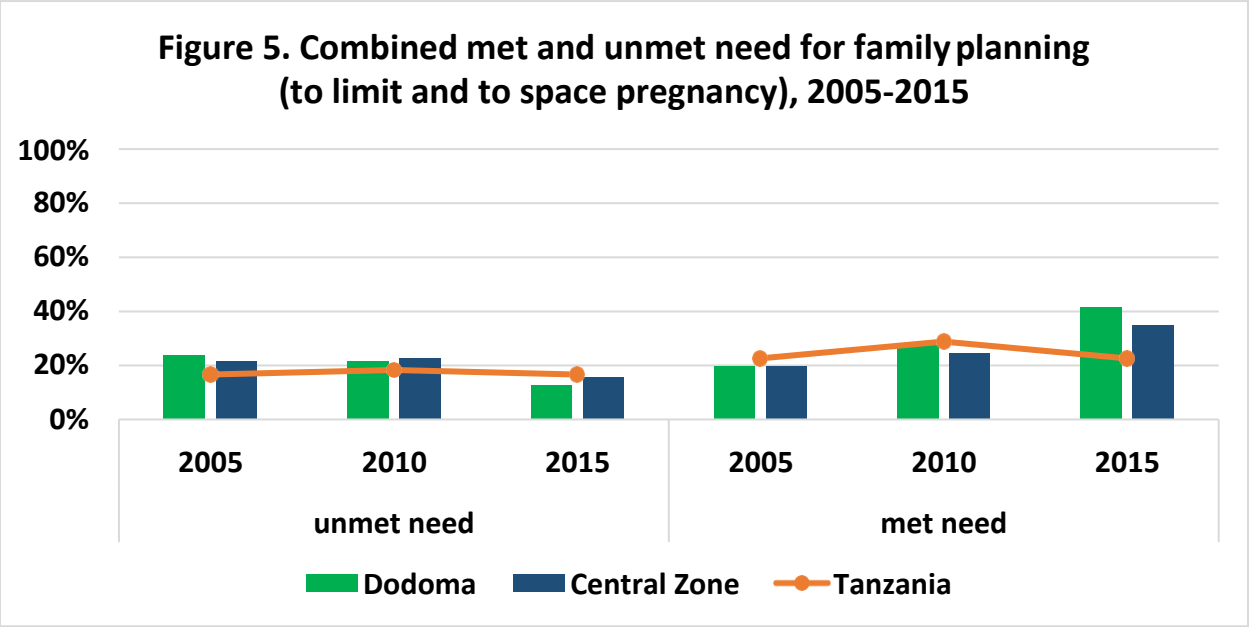
Total fertility rate (TFR) in the Dodoma Region decreased by over 1 child per woman from 2005 to 2015, was similar to the average TFR in Tanzania and slightly lower than TFR in the Central Zone in 2015 (see **Figure 4**).



Combined met[50] and unmet contraceptive need (for limiting and for spacing pregnancy) among all women ages 15-49[51] in the Dodoma region is depicted in **Figure 5**. While combined unmet need declined approximately 10 percentage points, combined met need increased over 20 percentage points. Although unmet need in the Dodoma region remained nearly the same as both Tanzania and the Central zone, met need was much higher in Dodoma than Tanzania and slightly higher than met need in the Central Zone in 2015.

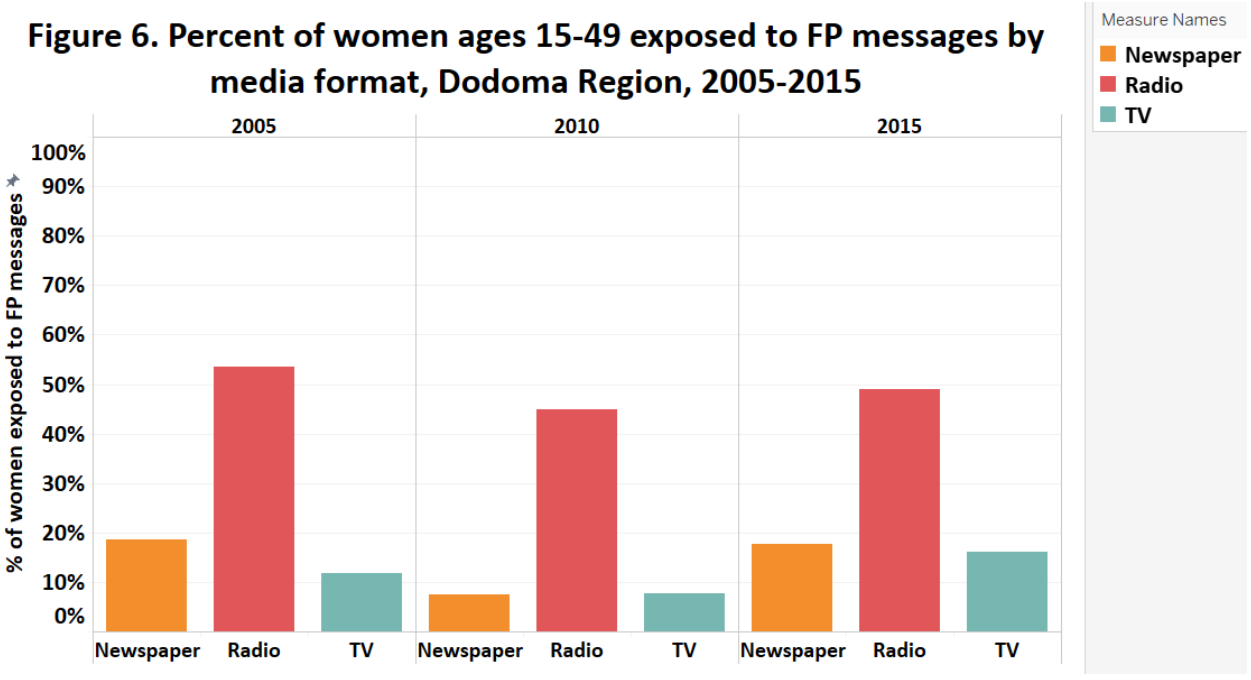
[50] Regional data on met need in this report were calculated for all women (married and unmarried) ages 15-49 and are therefore slightly different than regional data on met need in the DHS, which only calculated need for FP among married women ages 15-49

[51] Data for met and unmet need shown this report are for all women (married and unmarried) ages 15-49 with sampling weights applied, and therefore do not match data on met and unmet need in the DHS



SOURCES OF FAMILY PLANNING MESSAGING

Figure 6 shows the distribution of family planning messaging, by format. It is worth noting that sources of family planning messages changed from 2005 to 2010, and this report only shows data for the sources that were consistent throughout the 10-year period.[52] Compared to countrywide FP message distribution, the Dodoma region was slightly lower than Tanzania across all three sources of FP messaging, although in 2015, sources of FP messages for Dodoma and Tanzania were close to the same.



[52] Mobile phone messages were reported as a source of family planning messaging only in the 2015 DHS. In the Dodoma Region, approximately 2.5 percent of women reported they received family planning messages from a mobile phone

Regional Analysis (2005-2015): Geita Region

KEY INDICATOR HIGHLIGHTS FOR THE GEITA REGION, 2005-2015

- **CPR among all women ages 15-49 was much lower than the national average in 2015,** at around 12 percent
- **CPR among young women was low in 2015**, at around 1.5 percent for ages 15-19, and just over 10 percent for ages 20-24
- **Combined met need for family planning was only about 12 percent,** while unmet need was at 27 percent in 2015

Image 11. 2015 regional and zonal distribution of Tanzania

BACKGROUND

TABLE 1. Geita Region population demographic characteristics, 2012 Census data

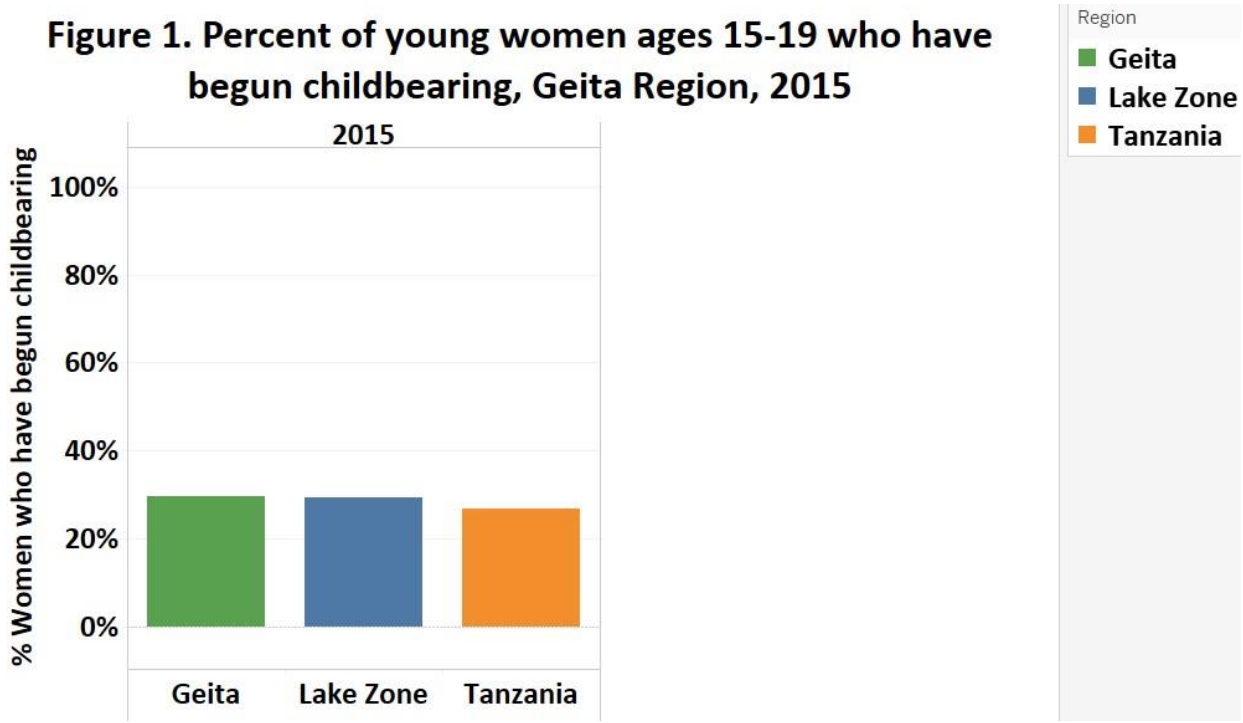
Population	% Male	% Female	% Rural	% Urban
1,739,530	50	50	84	16

Because it is a relatively new geographical region, data on the Geita Region was only available in the 2015 DHS report. Part of the Lake Zone, the Geita Region is located in northern Tanzania (see **Image 1**). Per 2012 Census data, about 1.7 million people live in the Geita Region, with slightly more female than male inhabitants (see **Table 1**). The Geita Region is mostly rural, and age distribution is relatively young.
Indicators presented in this report were selected based on available data from the 2015 DHS report.[53]

ADOLESCENT PREGNANCY

With a 30 percent adolescent pregnancy rate, the Geita Region was similar the Lake Zone in 2015, and about 3 percentage points above overall rates for Tanzania (see **Figure 1**).

[53] Indicators presented in this report were selected based on adequate sample size



Ages of first birth, first sex, and first marriage in the Geita Region in 2015 among all women ages 20-49[54] were nearly the same as the Lake Zone, but 2-3 years below the national average in all three categories (see **Table 2**).

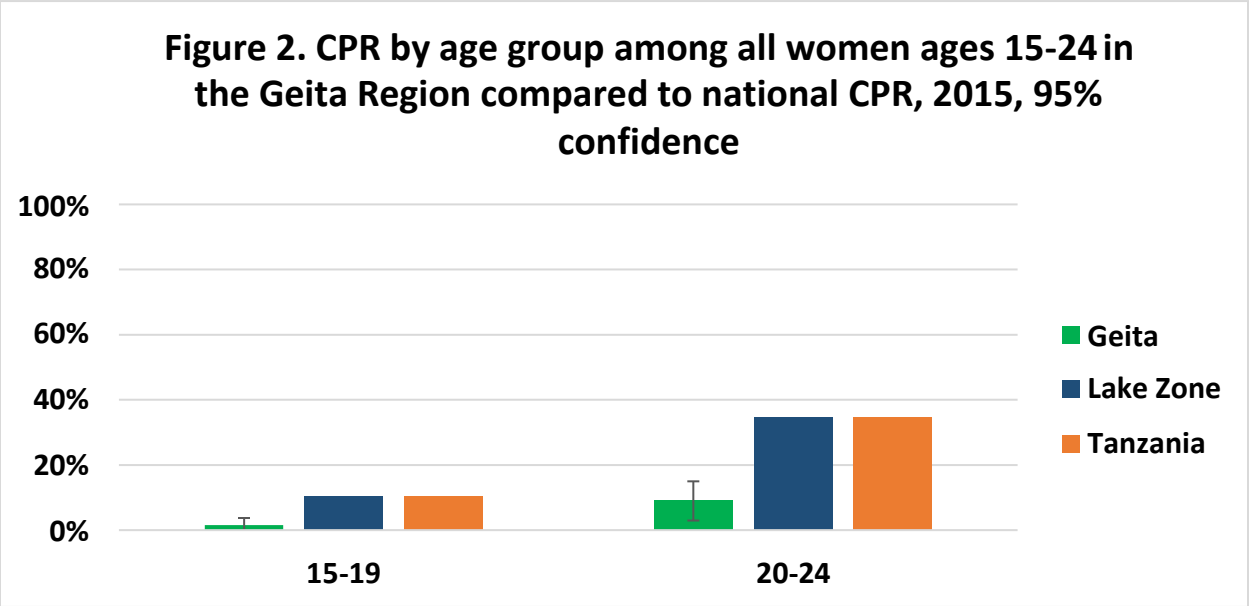
Table 2. Age at first birth, intercourse, and marriage, women ages 20-49, Geita Region, 2015

Region	Birth 2015	Intercourse 2015	Marriage 2015
Geita	17.5	14.9	16.6
Lake Zone	17.8	15.1	17.0
Tanzania	19.8	17.3	19.3

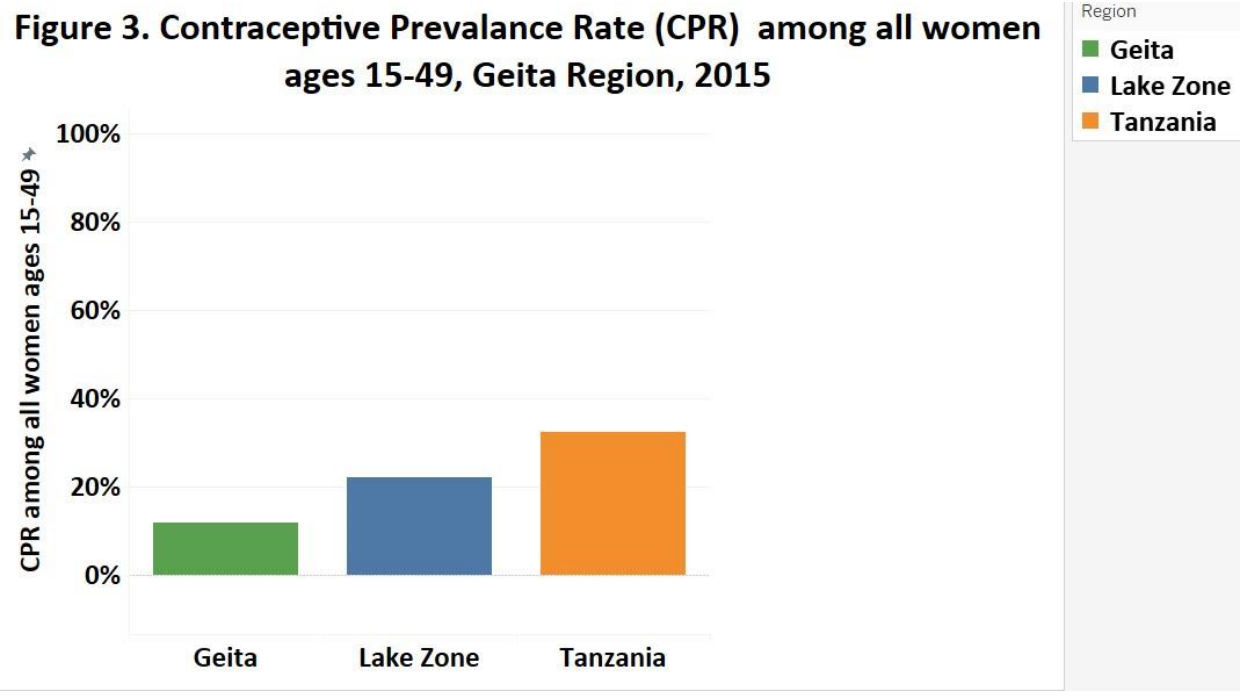
CPR

Figure 2 shows the contraceptive prevalence rate (CPR) among young women ages 15-19 and 20-24 in the Geita Region with confidence intervals and compared to zonal and national data. CPR in both age groups was well below both the zonal and national averages, by nearly 9 percentage points for ages 15- 19 (at approximately 1.5 percent compared to 9 percent), and by about 16 percentage points for ages 20-24 (at about 10 percent versus almost 35 percent).

[54] In this section of the DHS, women ages 20-49 were surveyed, unlike many other sections of the DHS where women ages 15-49 were surveyed



CPR among all women ages 15-49[55] in the Geita Region was 20 percentage points below national CPR, and 10 percentage points below CPR in the Lake Zone and Tanzania CPRs in 2015, at approximately 12 percent (see **Figure 3**).



[55] Regional CPR data in this report were calculated for all women (married and unmarried) ages 15-49 and are therefore slightly different than regional CPR data in the DHS, which only calculated CPR among married women ages 15-49

NEED AND DEMAND FOR FAMILY PLANNING

Total fertility rate (TFR) for all women ages 15-49 in the Geita Region was above the Lake Zone by about 0.5 children per woman, and above the national TFR in 2015 by nearly 2 children per woman (see **Figure 4**).

Figure 4. Total Fertility Rate, all women ages 15-49, Geita Region, 2015

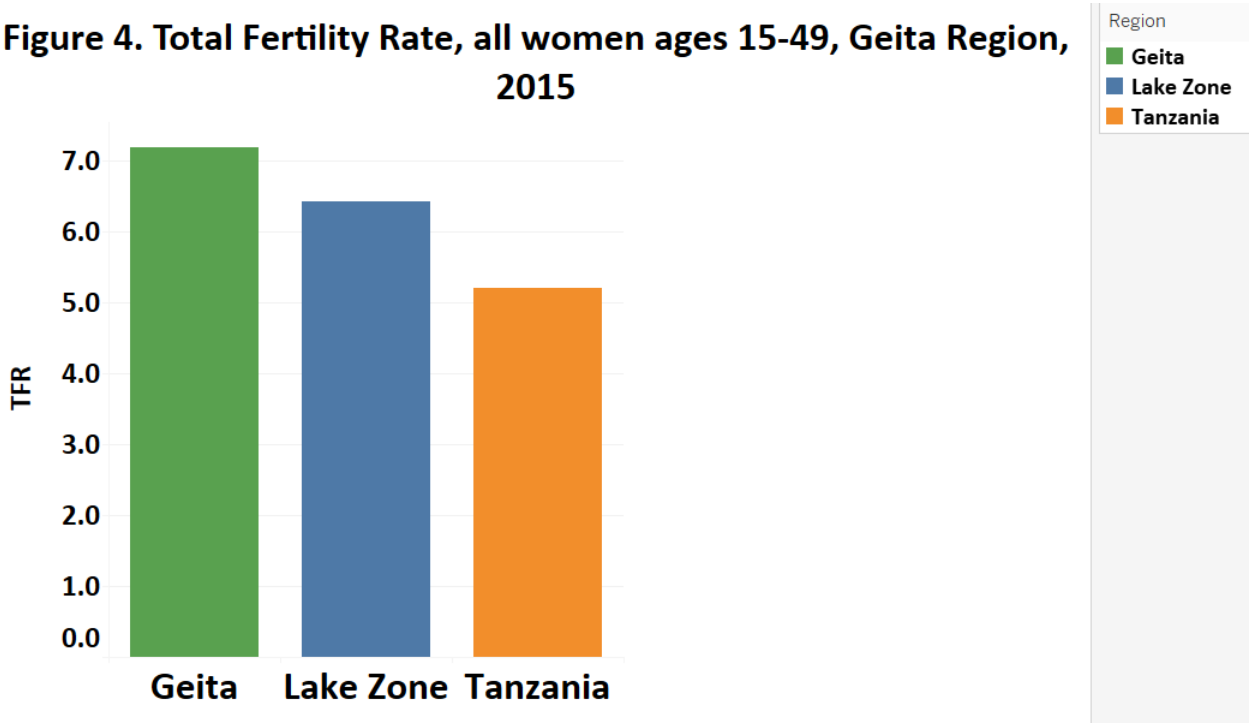
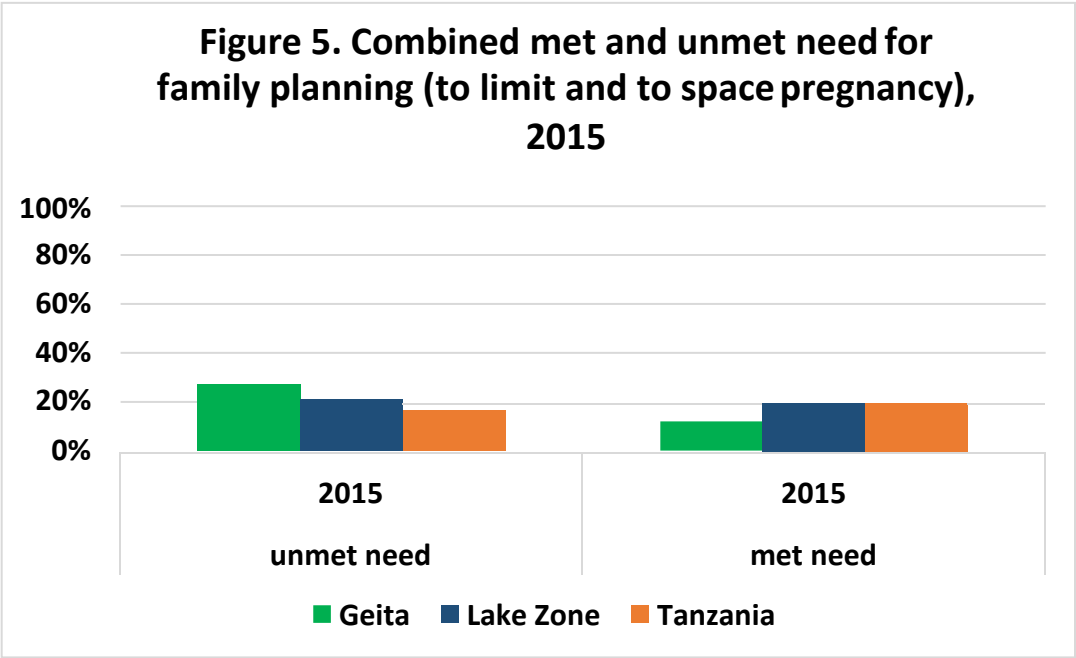


Figure 5 shows combined met[56] and unmet contraceptive need (for limiting and for spacing pregnancy) among all women ages 15-49[57] in the Geita Region. Combined unmet need was roughly 27 percent in the Geita Region, while met need was about 12 percent in 2015. Unmet need in Geita was nearly 9 percentage points higher than unmet need in Tanzania, and 6 percentage points higher than unmet need in the Lake Zone. Similarly, met need in Geita was much lower than met need in both the Lake Zone and in Tanzania, by approximately 10 percentage points.

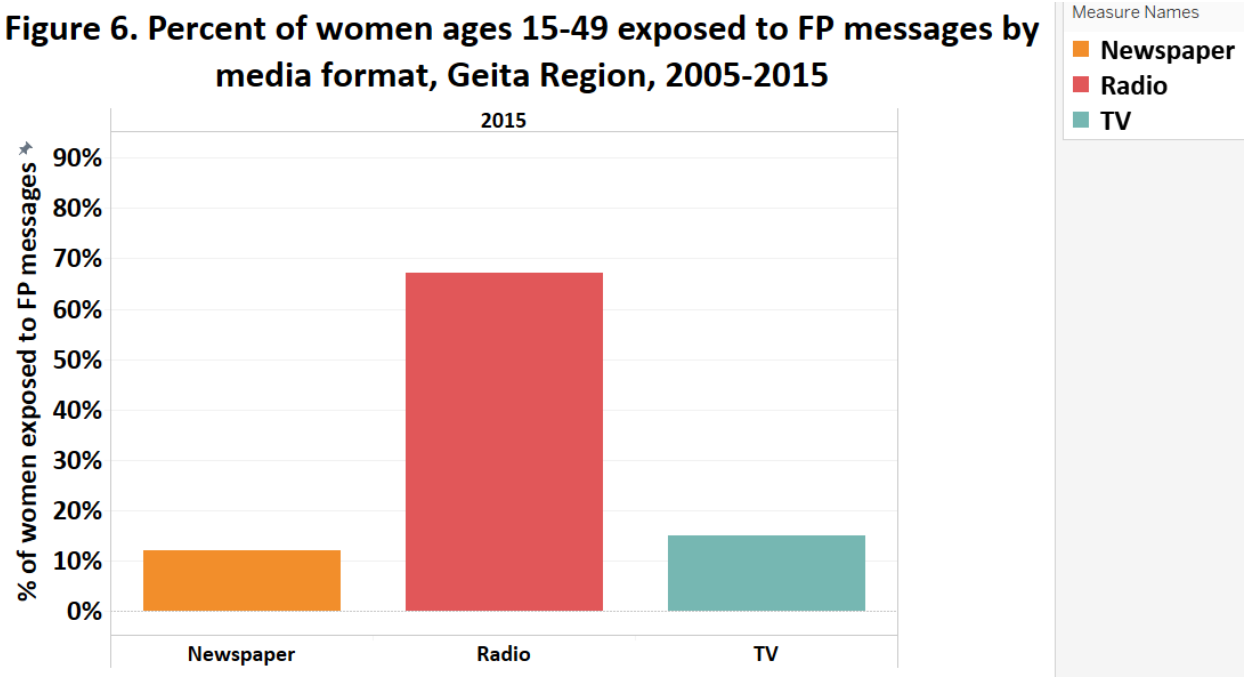
[56] Regional data on met need in this report were calculated for all women (married and unmarried) ages 15-49 and are therefore slightly different than regional data on met need in the DHS, which only calculated need for FP among married women ages 15-49

[57] Data for met and unmet need shown this report are for all women (married and unmarried) ages 15-49 with sampling weights applied, and therefore do not match data on met and unmet need in the DHS



SOURCES OF FAMILY PLANNING MESSAGING

Figure 6 shows the distribution of family planning messaging, by format. It is worth noting that sources of family planning messaging changed from 2005 to 2015, and this report only shows data for the sources that were consistent throughout the 10-year period.[58] At 67 percent, radio was by far the most prevalent source of FP messaging, followed by TV at 15 percent and newspaper at 12 percent.



[58] Mobile phone messages were reported as a source of family planning messaging only in the 2015 DHS. In the Geita Region, approximately 2.8 percent of women reported they received family planning messages from a mobile phone

Regional Analysis (2005-2015): Mara Region

KEY INDICATOR HIGHLIGHTS FOR THE MARA REGION, 2005-2015

- **Total fertility remained high from 2005-2015**, at approximately 7 children per woman (1.6 children per woman above the national TFR in 2015)
- **Adolescent pregnancy remained high from 2005-2015,** at around 37 percent **(**at least 15 percent above the national average)
- **Combined unmet need for family planning was 22-26** percent from 2005 to 2015

Image 12. 2015 regional and zonal distribution of Tanzania

BACKGROUND

TABLE 1. Mara Region population demographic characteristics, 2012 Census data

Population	% Male	% Female	% Rural	% Urban
1,743,830	48	52	83	17

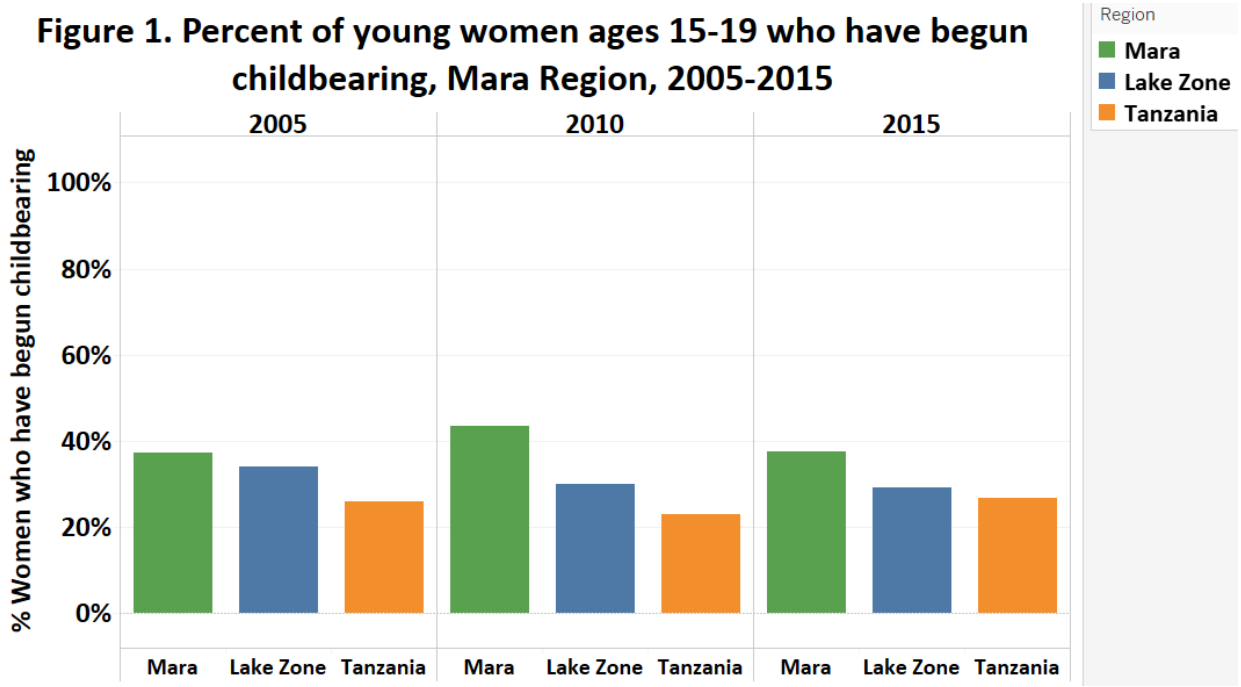
Part of the Lake Zone, the Mara Region is located in the northern region of Tanzania (see **Image 1**). Per 2012 Census data, about 1.7 million people live in the Mara Region, with slightly more female than male inhabitants (see **Table 1**). The Mara Region is mostly rural, and age distribution is relatively young. Indicators presented in this report were selected based on available data from the 2005, 2010, and 2015 DHS reports.[59]

ADOLESCENT PREGNANCY

In the Mara Region, adolescent pregnancy remained high at around 37 percent (with a slight uptick in 2010 at 43 percent), at least 15 percent above national adolescent pregnancy rates and slightly above rates for the Lake Zone (see **Figure 1**).

[59] Indicators presented in this report were selected based on adequate sample size

Figure 1. Percent of young women ages 15-19 who have begun childbearing, Mara Region, 2005-2015



There was little variance in age of first birth, first sex, and first marriage in the Mara Region from 2005 to 2015 among all women ages 20-49.[60] The Mara Region was nearly the same as the Lake Zone, but at least two years below the national average in all three categories across the three DHS years (see **Table 2**).

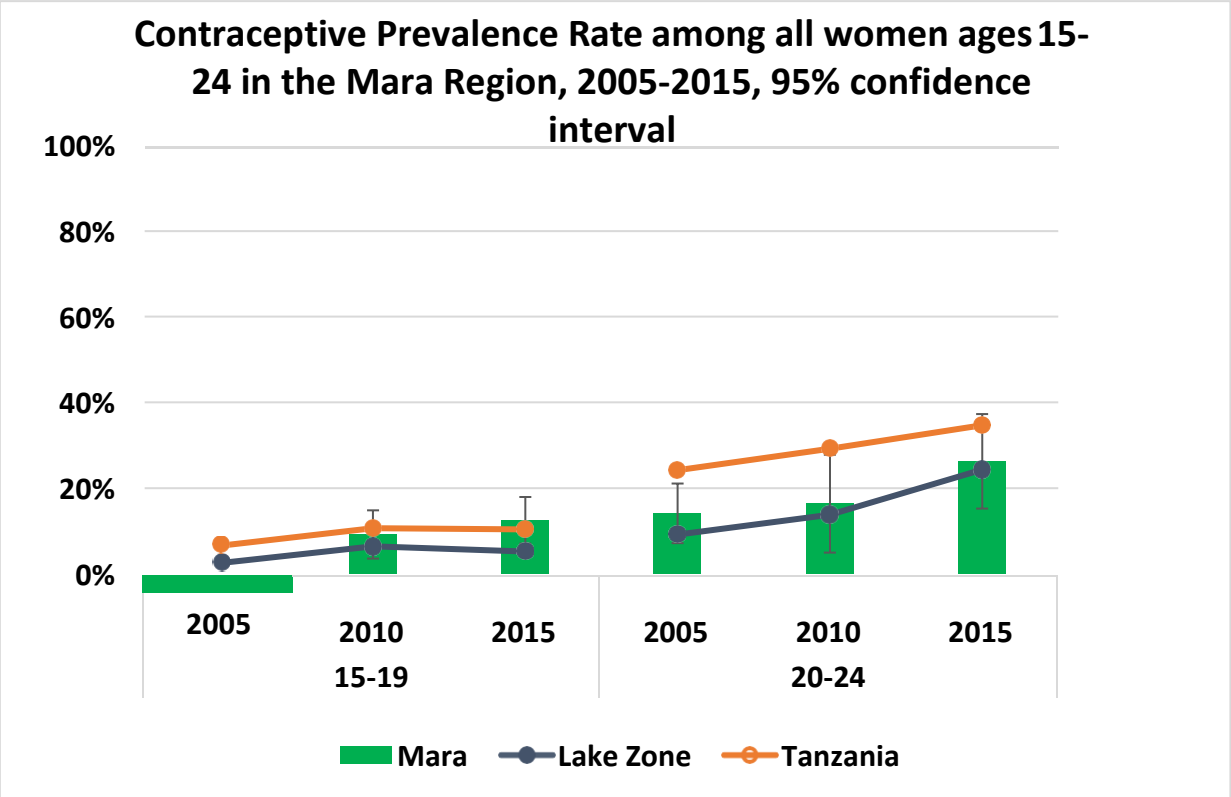
Table 2. Age at first birth, intercourse, and marriage, women ages 20-49, Mara Region, 2005-2015

	Birth			Intercourse			Marriage		
Region	2005	2010	2015	2005	2010	2015	2005	2010	2015
Mara	17.5	17.4	17.7	15.4	15.1	14.8	16.6	16.7	16.9
Lake Zone	17.7	17.7	17.8	15.3	15.3	15.1	16.6	16.8	17.0
Tanzania	19.4	19.5	19.8	17.0	17.4	17.3	18.6	18.9	19.3

CPR

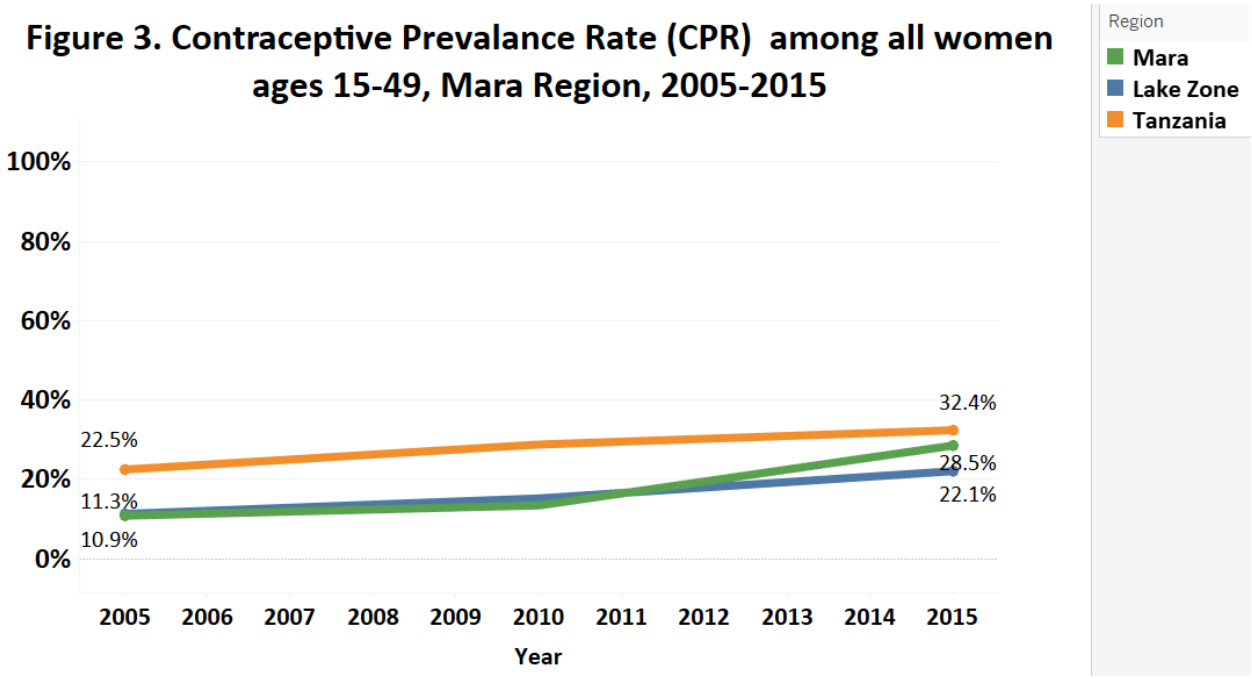
Figure 2 shows the contraceptive prevalence rate (CPR) among young women, ages 15-19 and 20-24 in the Mara Region with confidence intervals and compared to zonal and national data. There was an increase of about 9 percentage points in CPR among ages 15-19 and 12 percentage points for women ages 20-24. Overall, CPR among young women in the Mara Region remained below the national average throughout the 3 DHS years, and remained nearly the same as average CPR among women in both age groups in the Lake Zone.

[60] In this section of the DHS, women ages 20-49 were surveyed, unlike many other sections of the DHS where women ages 15-49 were surveyed



CPR among all women ages 15-49[61] in the Mara Region increased dramatically, by about 17 percentage points from 2005 to 2015. CPR in Mara was substantially below the national average in 2005, but rose above the zonal average to only 5 percentage points below the national average in 2015 (see **Figure 3**).

[61] Regional CPR data in this report were calculated for all women (married and unmarried) ages 15-49 and are therefore slightly different than regional CPR data in the DHS, which only calculated CPR among married women ages 15-49



NEED AND DEMAND FOR FAMILY PLANNING

Total fertility rate (TFR) for all women ages 15-49 in the Mara Region, remained high at nearly 7 children per woman from 2005 to 2015. TFR also remained well above TFR in the Lake Zone and about 1.6 children per woman above the national TFR in 2015 (see **Figure 4**).

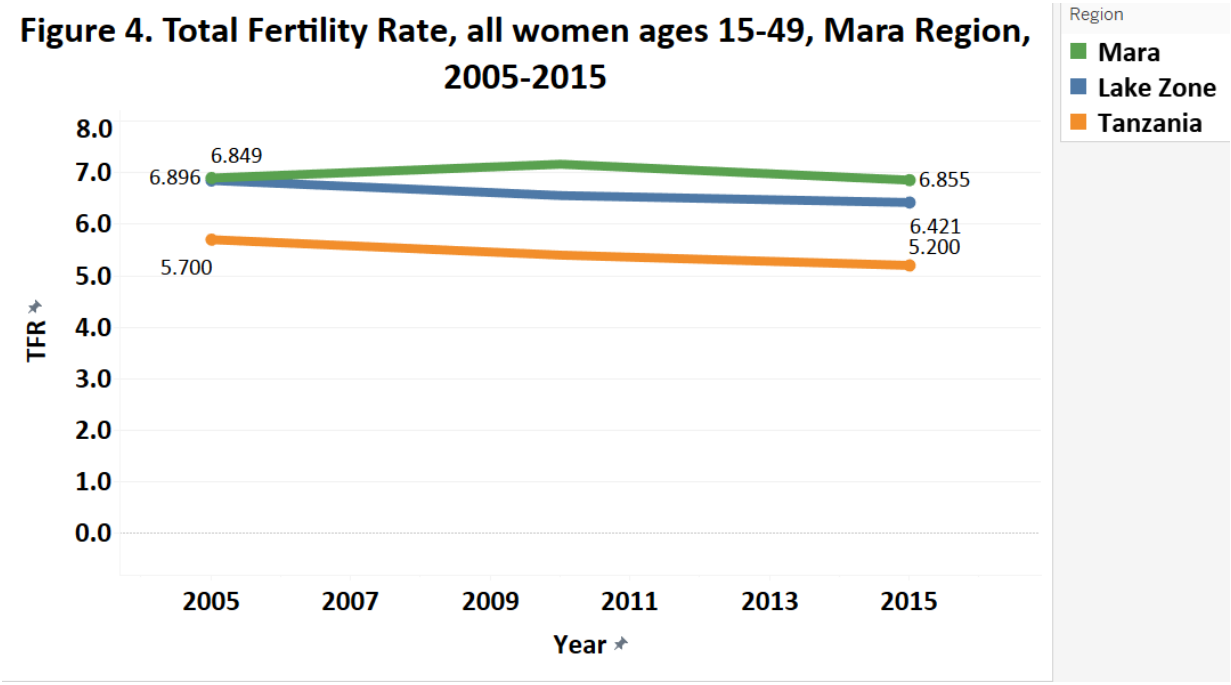
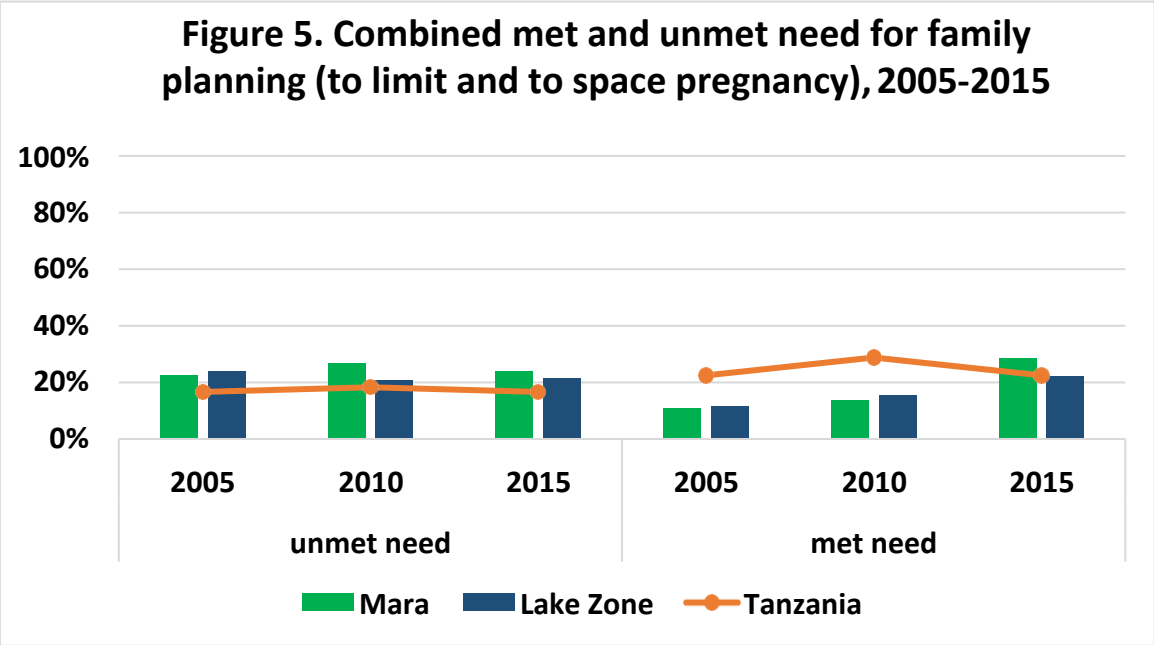


Figure 5 shows combined met[62] and unmet contraceptive need (for limiting and for spacing pregnancy) among all women ages 15-49[63] in the Mara Region. Unmet need remained high between 22 and 26 percent from 2005 to 2015, while met need drastically increased from 2010 to 2015, from roughly 11 percent to 26 percent. Unmet need in the Mara Region was nearly 7 percentage points above the national average in 2015, and met need was low in 2005 and 2010 compared to the national average, but surpassed both zonal and national averages in 2015.



SOURCES OF FAMILY PLANNING MESSAGING

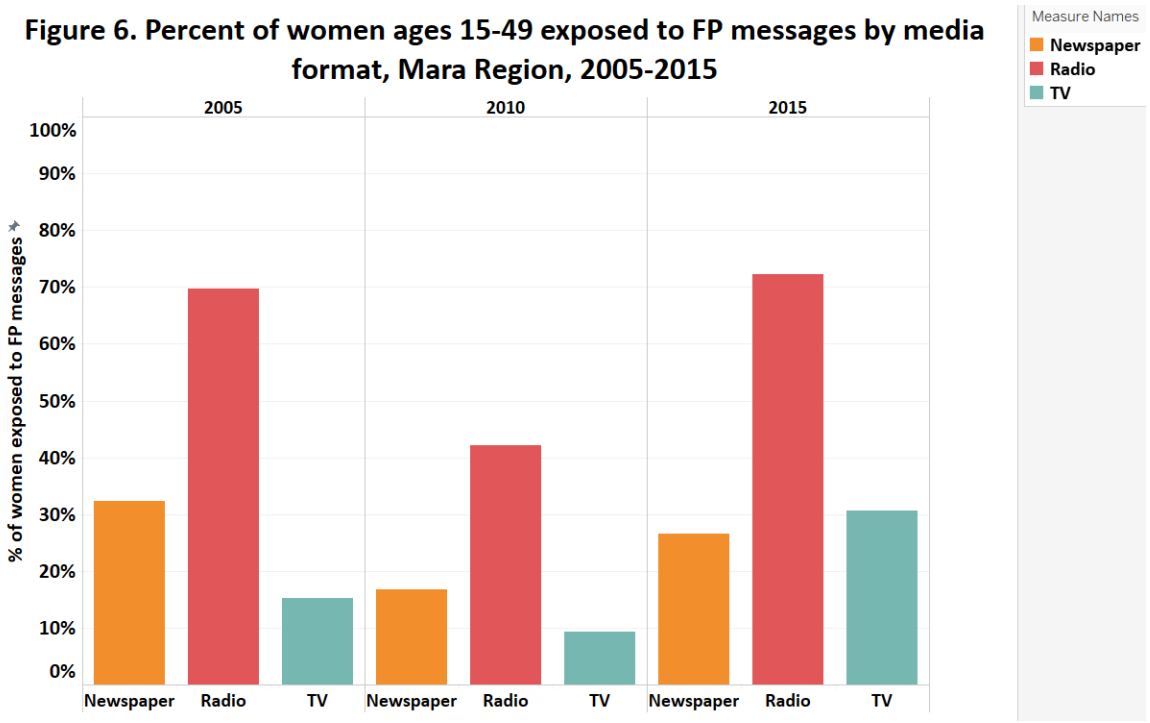
Figure 6 shows the distribution of family planning messaging, by format. It is worth noting that sources of family planning messaging changed from 2005 to 2015, and this report only shows data for the sources that were consistent throughout the 10-year period.[64] Television as a a source of FP messaging increased substantially from 2010 to 2015 (from roughly 15 percent to 31 percent) and radio was the most common source by far across all three DHS years.

[62] Regional data on met need in this report were calculated for all women (married and unmarried) ages 15-49 and are therefore slightly different than regional data on met need in the DHS, which only calculated need for FP among married women ages 15-49

[63] Data for met and unmet need shown this report are for all women (married and unmarried) ages 15-49 with sampling weights applied, and therefore do not match data on met and unmet need in the DHS

[64] Mobile phone messages were reported as a source of family planning messaging only in the 2015 DHS. In the Mara Region, approximately 3.1 percent of women reported they received family planning messages from a mobile phone

Figure 6. Percent of women ages 15-49 exposed to FP messages by media format, Mara Region, 2005-2015



Regional Analysis (2005-2015): Mbeya Region

KEY INDICATOR HIGHLIGHTS FOR THE MBEYA REGION, 2005-2015

- **Total fertility rate among all women ages 15-49 decreased drastically** 2005 to 2015, from about 6.4 to 4.6 children per woman
- **Adolescent pregnancy increased by 12 percent** and surpassed the national average by 6 percentage points from 2005-2015
- **Combined unmet need for family planning among all women ages 15-49 stayed the same** from 2005-2015, at about 10 percent

Image 13. 2015 regional and zonal distribution of Tanzania

BACKGROUND

TABLE 1. Mbeya Region population demographic characteristics, 2012 Census data

Population	% Male	% Female	% Rural	% Urban
2,707,410	48	52	67	33

Part of the Southwest Highlands Zone, the Mbeya Region in southwestern Tanzania (see **Image 1**). Per 2012 Census data, about 2.7 million people live in the Mbeya Region, with slightly more female than male inhabitants (see **Table 1**). The Mbeya Region is mostly rural, but has a higher urban population that many other regions in Tanzania, and age distribution is relatively young. Indicators presented in this report were selected based on available data from the 2005, 2010, and 2015 DHS reports.[65]

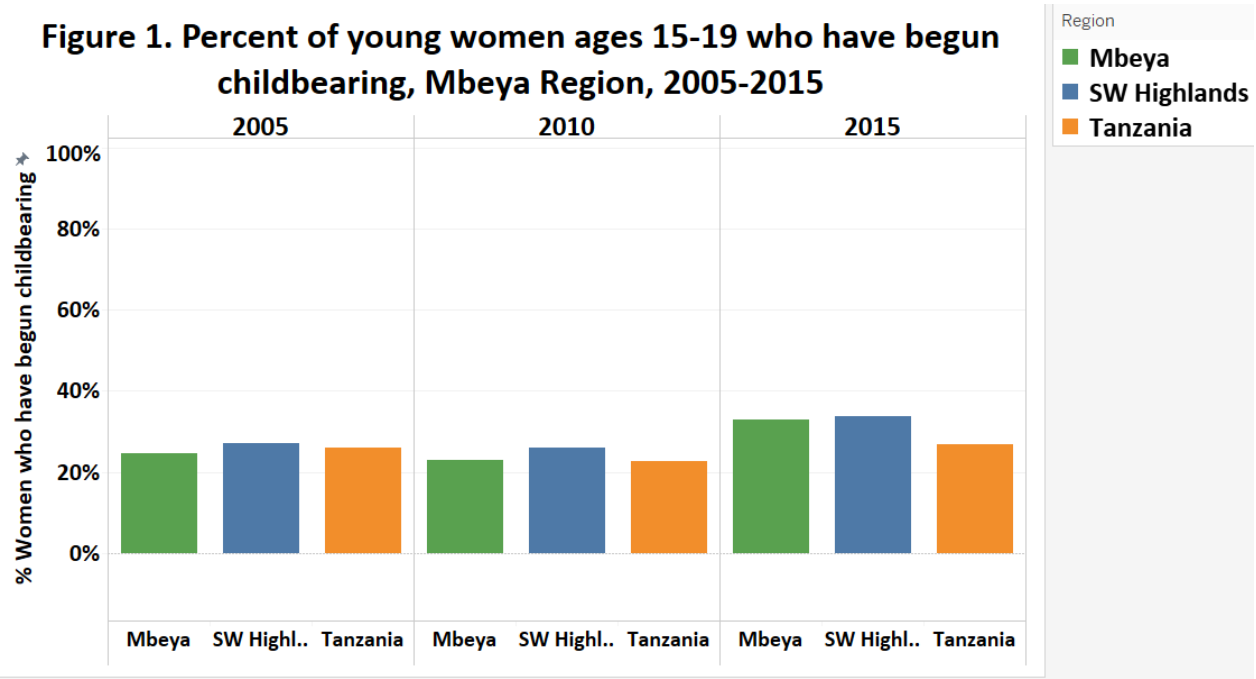
ADOLESCENT PREGNANCY

In the Mbeya Region, adolescent pregnancy rates increased by 12 percent and surpassed the national average by 6 percentage points.

The Southwest Highlands Zone and Mbeya Region had similar adolescent pregnancy rates across the 10-year period (see **Figure 1**).

[65] Indicators presented in this report were selected based on adequate sample size

Figure 1. Percent of young women ages 15-19 who have begun childbearing, Mbeya Region, 2005-2015



Age of first sex did not vary much in the Mbeya Region, but age of first birth, and first marriage increased slightly from 2005 to 2015 among all women ages 20-49.[66] The Mbeya Region was nearly the same as the Southwest Highlands Zone, but at least two years below the national average in all three categories across the three DHS years (see **Table 2**).

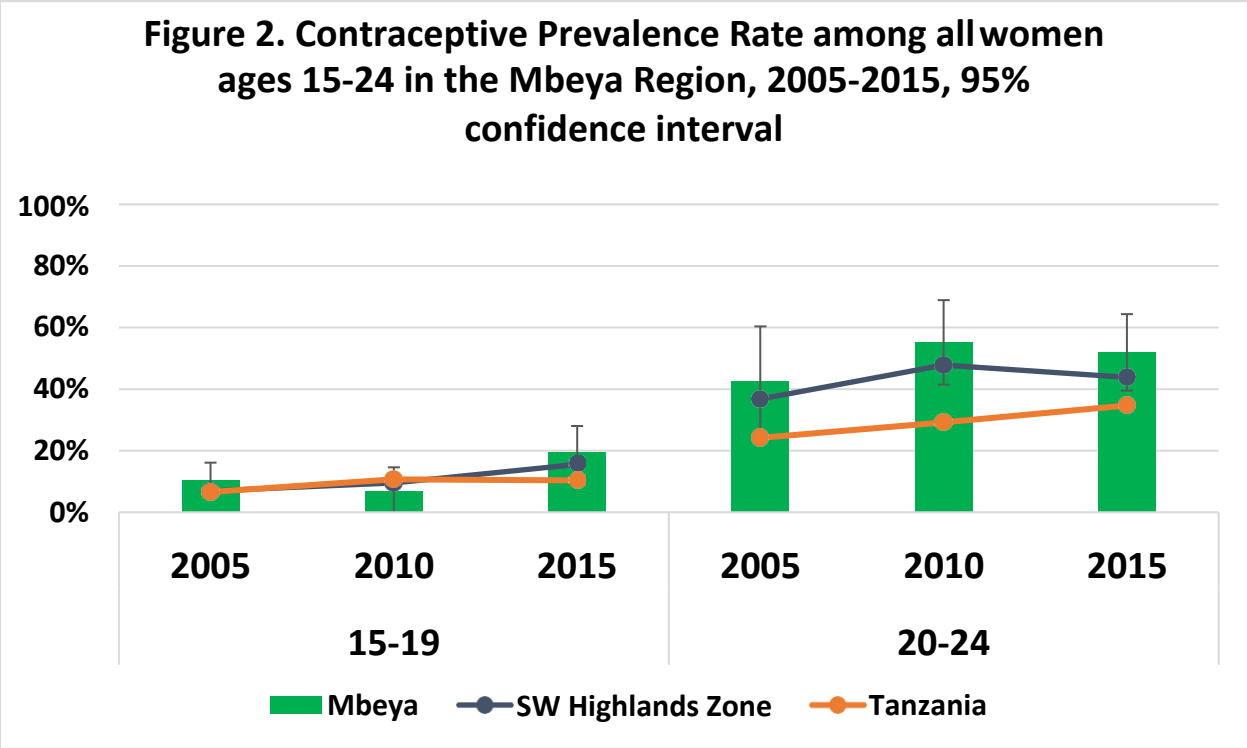
Table 2. Age at first birth, intercourse, and marriage, women ages 20-49, Mbeya Region, 2005-2015

	Birth			Intercourse			Marriage		
Region	2005	2010	2015	2005	2010	2015	2005	2010	2015
Mbeya	17.7	17.7	18.2	15.7	15.7	15.8	16.5	16.7	17.3
SW Highlands	17.7	17.8	18.1	15.6	15.9	15.5	16.5	16.9	17.3
Tanzania	19.4	19.5	19.8	17.0	17.4	17.3	18.6	18.9	19.3

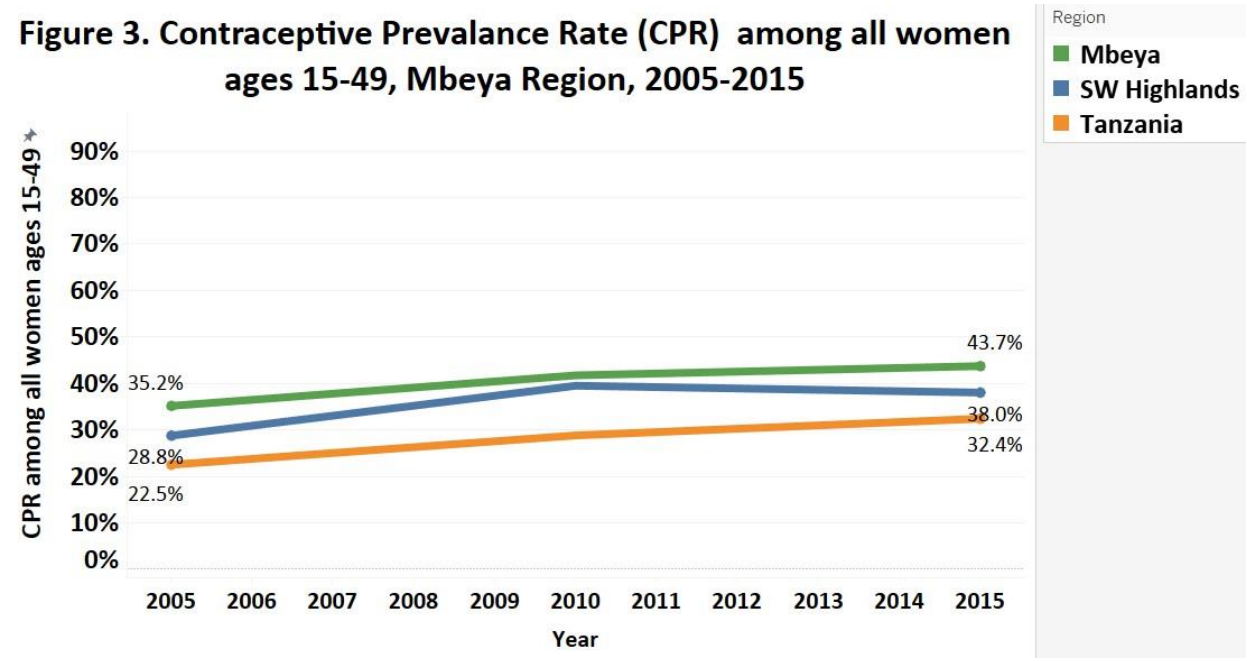
CPR

Figure 2 shows the contraceptive prevalence rate (CPR) among young women, ages 15-19 and 20-24 in the Mbeya Region with confidence intervals and compared to zonal and national data. There was an increase of about 10 percentage points in both age groups from 2005 to 2015. Overall, CPR among young women in the Mbeya Region remained above the national average throughout the 3 DHS years, and slightly above the zonal average across all 3 DHS years (with the exception of 2010) for women ages 15-19.

[66] In this section of the DHS, women ages 20-49 were surveyed, unlike many other sections of the DHS where women ages 15-49 were surveyed



CPR among all women ages 15-49[67] in the Mbeya Region increased by about 8 percentage points from 2005 to 2015. CPR in Mbeya remained above national CPR, by about 13 percentage points from 2005 to 2015 (see **Figure 3**).



[67] Regional CPR data in this report were calculated for all women (married and unmarried) ages 15-49 and are therefore slightly different than regional CPR data in the DHS, which only calculated CPR among married women ages 15-49

NEED AND DEMAND FOR FAMILY PLANNING

Total fertility rate (TFR) in the Mbeya Region decreased drastically from 2005 to 2015 in Mbeya, by about 1.6 children per woman. Although the TFR was above the national average in 2005 it was lower than national TFR by over 1.5 children per woman by 2015 (see **Figure 4**).

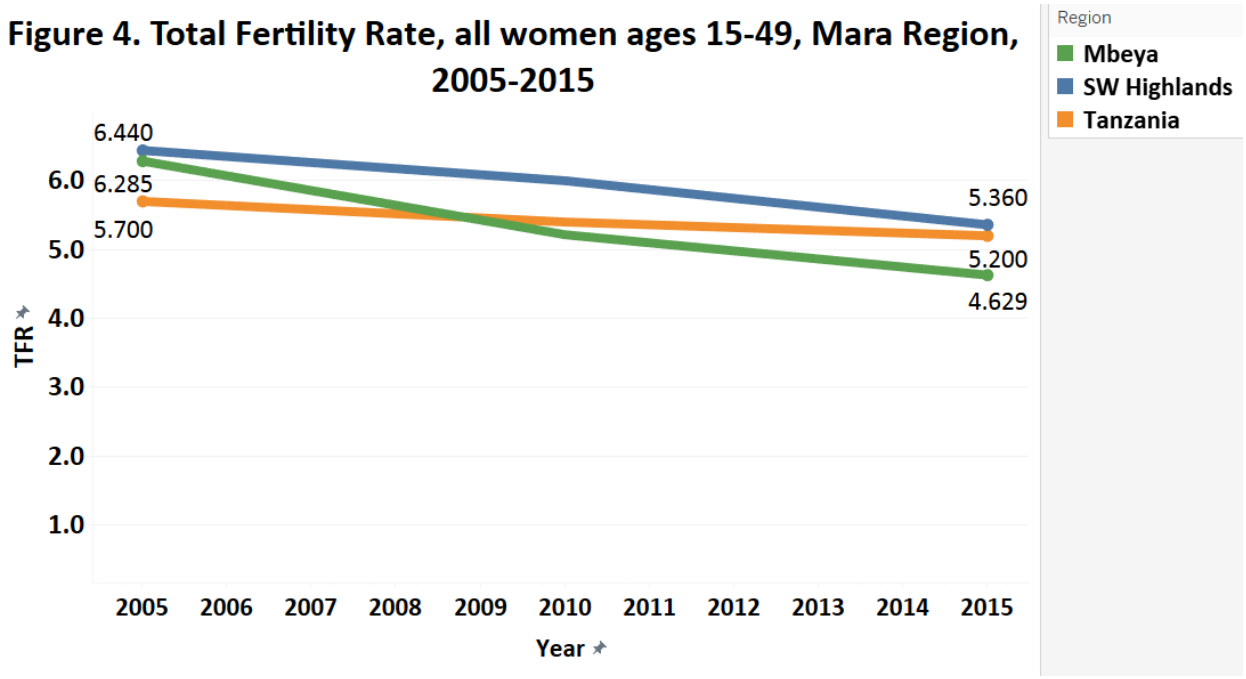
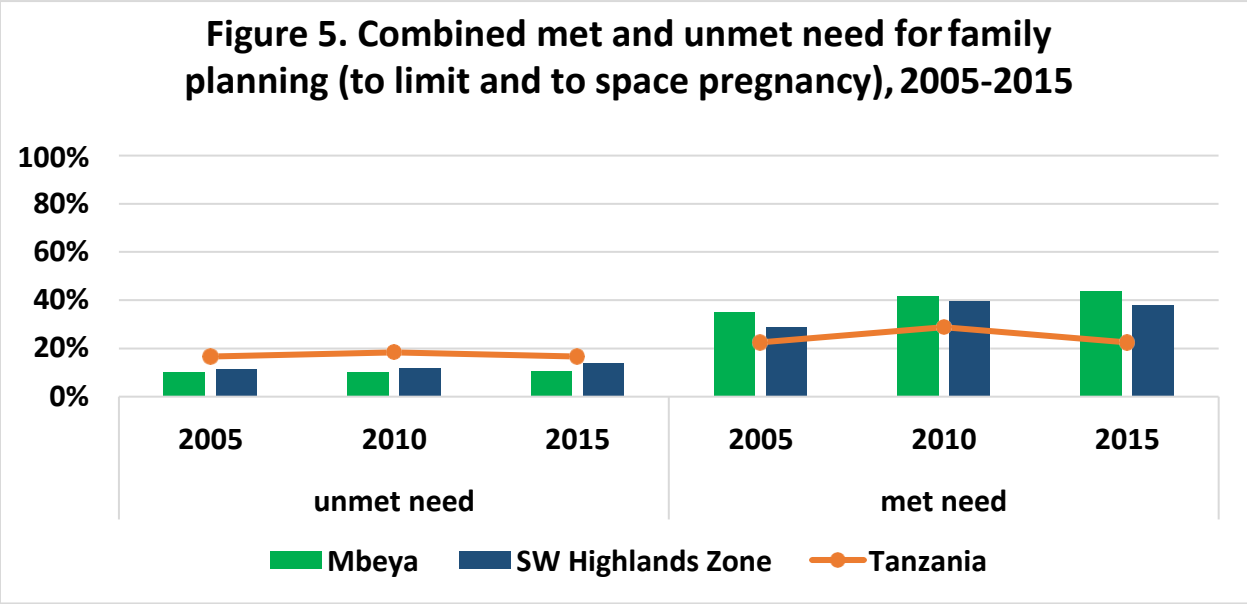


Figure 5 shows combined met[68] and unmet contraceptive need (for limiting and for spacing pregnancy) among all women ages 15-49[69] in the Mbeya Region. Unmet need remained nearly the same at around 10 percent, approximately 8 percentage points below the national average. Combined met need increased slightly, by about 8 percentage points from 2005 to 2015, and was much higher than the national average in 2015, by nearly 20 percentage points. Met and unmet need for family planning was nearly the same in Mbeya as it was for the Southwest Highlands Zone across all three DHS years.

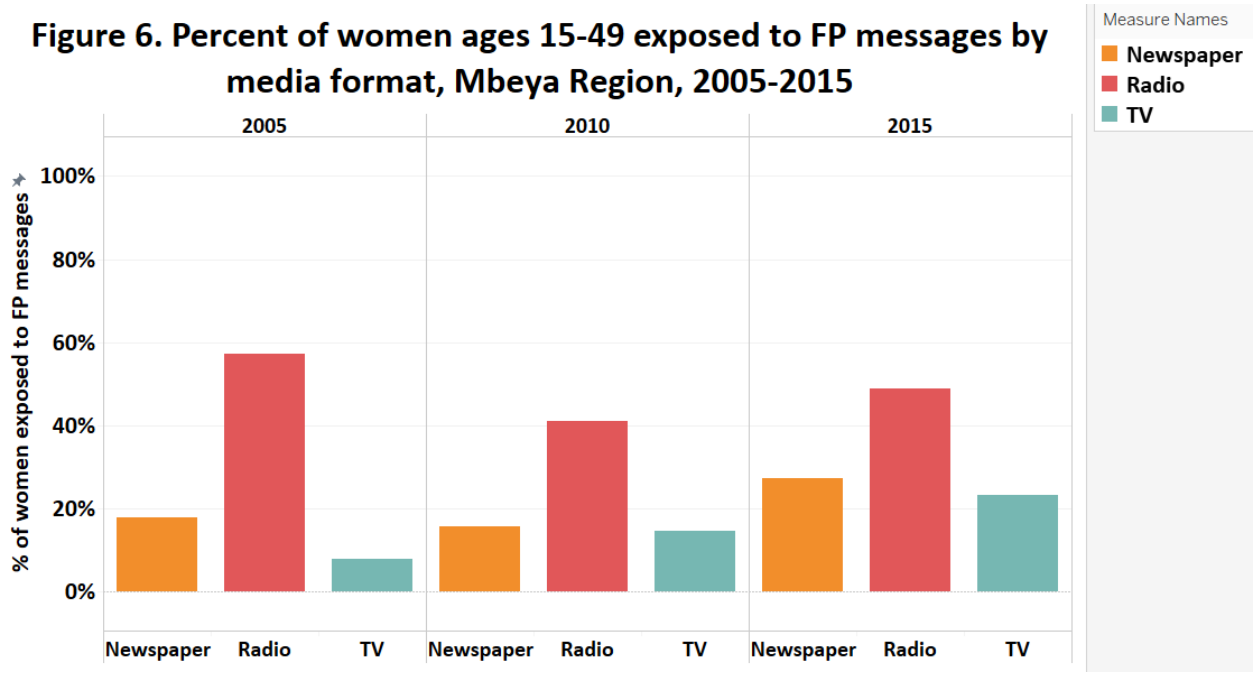
[68] Regional data on met need in this report were calculated for all women (married and unmarried) ages 15-49 and are therefore slightly different than regional data on met need in the DHS, which only calculated need for FP among married women ages 15-49

[69] Data for met and unmet need shown this report are for all women (married and unmarried) ages 15-49 with sampling weights applied, and therefore do not match data on met and unmet need in the DHS



SOURCES OF FAMILY PLANNING MESSAGING

Figure 6 shows the distribution of family planning messaging, by format. It is worth noting that sources of family planning messages changed from 2005 to 2010, and this report only shows data for the sources that were consistent throughout the 10-year period.[70] Television and newspaper both increased substantially from 2010 to 2015 (by 9 percent and 11 percent, respectively).



[70] Mobile phone messages were reported as a source of family planning messaging only in the 2015 DHS. In the Mbeya Region, approximately 5.6 percent of women reported they received family planning messages from a mobile phone

Regional Analysis (2005-2015): Tabora Region

KEY INDICATOR HIGHLIGHTS FOR THE TABORA REGION, 2005-2015

- **CPR among all women ages 15-49 increased by about 13 percentage points**, but stayed at least 10 percent below the national average from 2005-2015
- **Adolescent pregnancy rates remained above the national average from 2005-2015, at between 39-43 percent**
- **Combined met need for family planning increased** by 14 percentage points from 2005-2015

Image 14. 2015 regional and zonal distribution of Tanzania

BACKGROUND

TABLE 1. Tabora Region population demographic characteristics, 2012 Census data

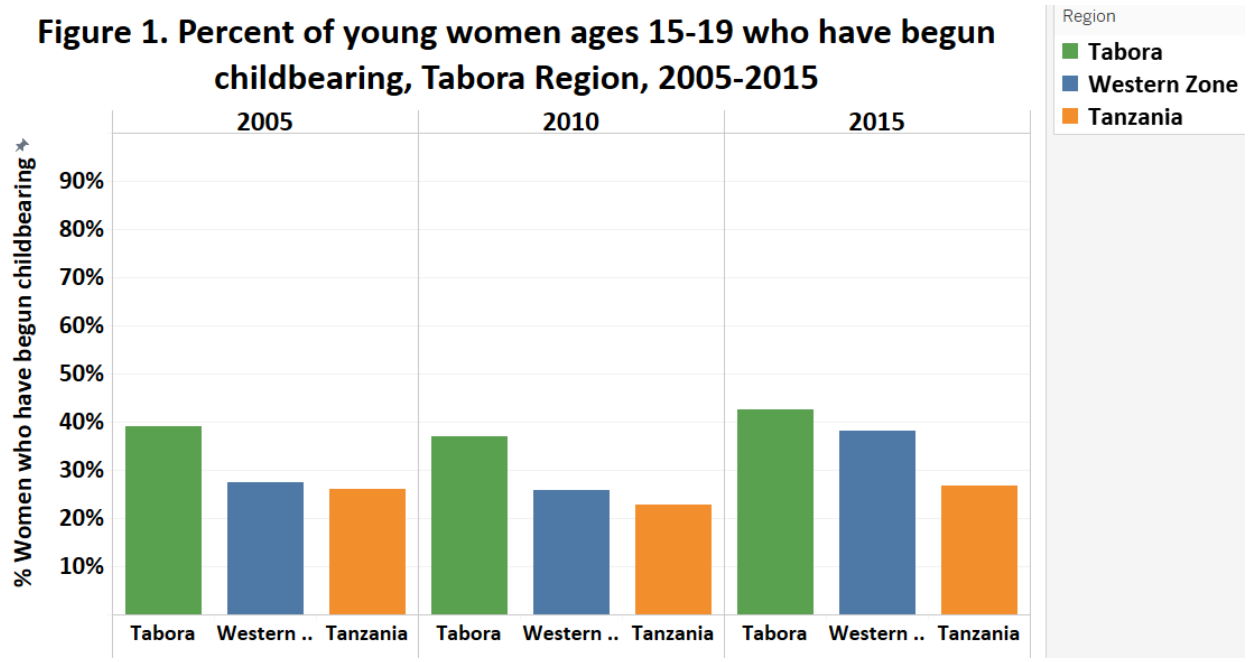
Population	% Male	% Female	% Rural	% Urban
2,291,623	49	51	87	13

Part of the Western Zone, the Tabora Region is located in the northwest region of Tanzania (see **Image 1**). Per 2012 Census data, about 2.3 million people live in the Tabora Region, with slightly more female than male inhabitants (see **Table 1**). The Tabora Region is mostly rural, and there is a relatively high proportion of the population under age 24. Indicators presented in this report were selected based on available data from the 2005, 2010, and 2015 DHS reports.[71]

ADOLESCENT PREGNANCY

In the Tabora Region, adolescent pregnancy increased from 2005 to 2015, but only slightly, from 39 percent to 43 percent. Adolescent pregnancy rates in the Tabora Region were slightly above rates for the Western Zone in 2015, and well above national rates across the 10-year period (see **Figure 1**).

[71] Indicators presented in this report were selected based on adequate sample size



Age of first birth, first sex, and first marriage did not vary much from 2005 to 2015 among all women ages 20-49[72] in the Tabora Region, were slightly lower than the Western Zone, and two or more years below the national average across all three DHS years (see **Table 2**).

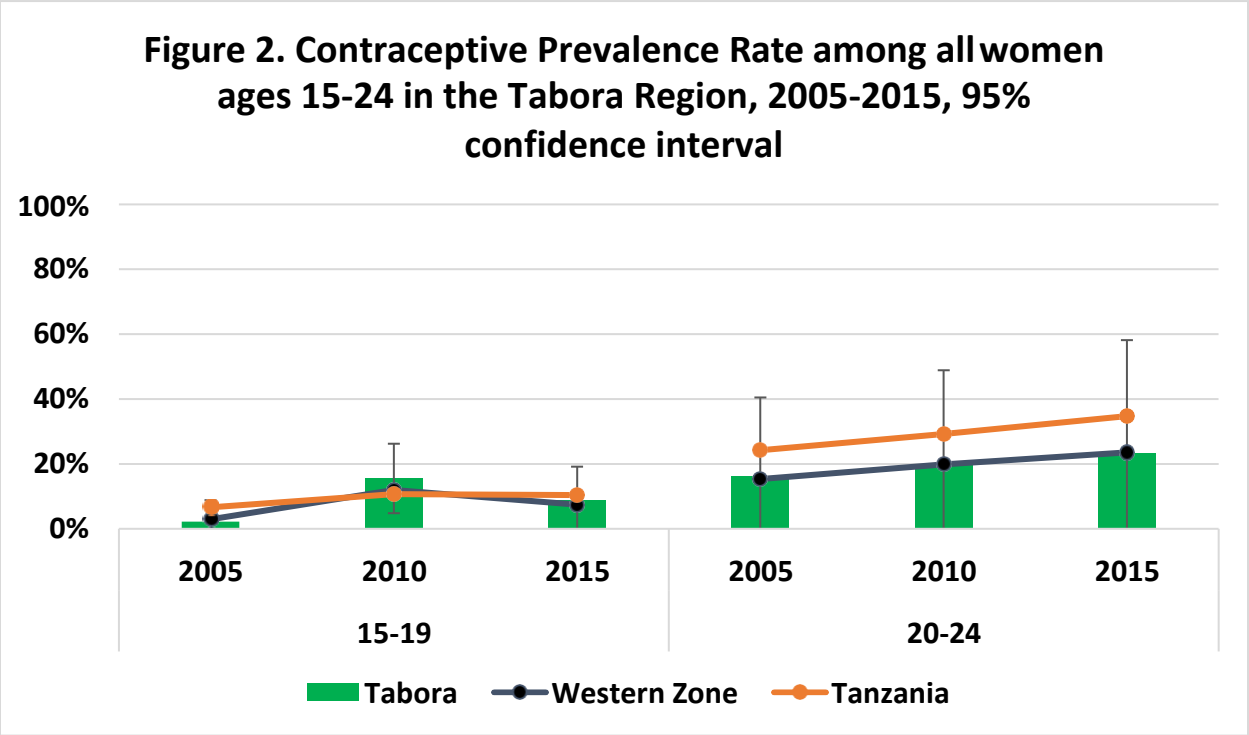
Table 2. Age at first birth, intercourse, and marriage, women ages 20-49, Tabora Region, 2005-2015

	Birth			Intercourse			Marriage		
Region	2005	2010	2015	2005	2010	2015	2005	2010	2015
Tabora	17.0	17.3	17.6	14.7	15.1	14.8	15.9	16.3	16.3
Western Zone	17.9	17.9	17.9	15.0	15.4	15.2	16.7	17.0	16.8
Tanzania	19.4	19.5	19.8	17.0	17.4	17.3	18.6	18.9	19.3

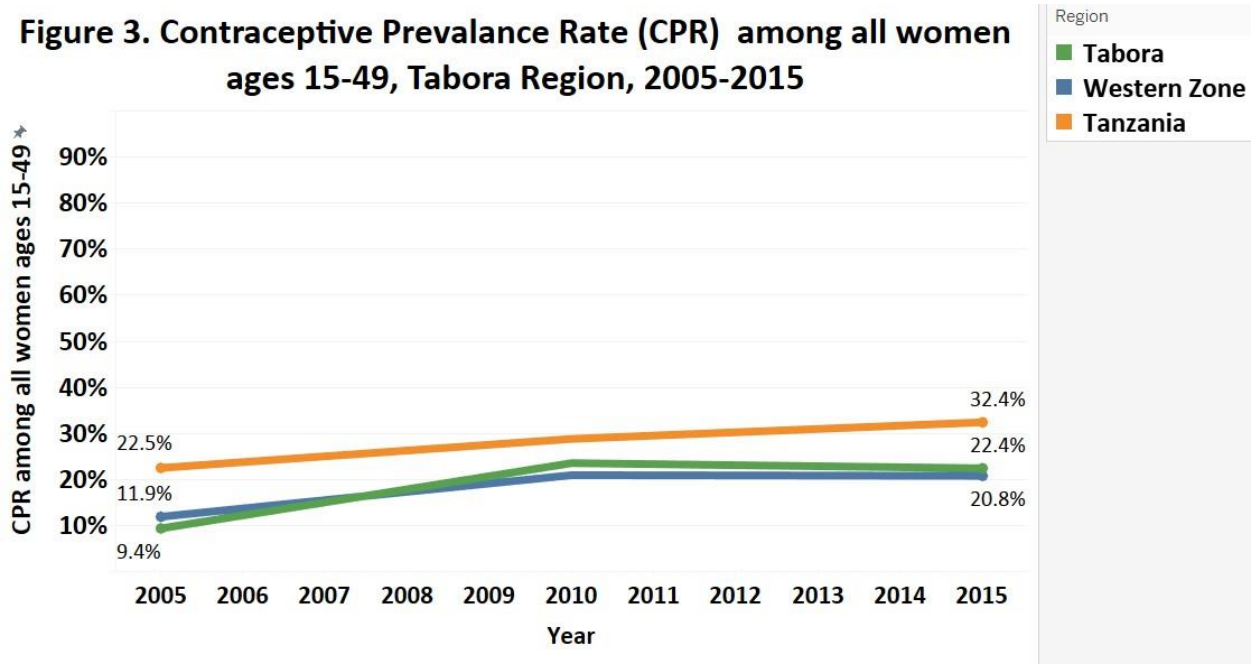
CPR

Figure 2 shows the contraceptive prevalence rate (CPR) among young women, ages 15-19 and 20-24 in the Tabora Region with confidence intervals and compared to zonal and national data. There was a slight increase in CPR in both age groups from 2005 to 2015 (at about 6 and 7 percentage points, respectively). Overall, CPR among young women in the Tabora Region remained below the national average (apart from 2010 for ages 15-19) and nearly the same as the Western Zone across all three DHS years for both age groups.

[72] In this section of the DHS, women ages 20-49 were surveyed, unlike many other sections of the DHS where women ages 15-49 were surveyed



CPR among all women ages 15-49[73] in the Tabora Region increased by about 13 percentage points from 2005 to 2015, but remained well below the national average by at least 10 percentage points during the 10-year period (see **Figure 3**).



[73] Regional CPR data in this report were calculated for all women (married and unmarried) ages 15-49 and are therefore slightly different than regional CPR data in the DHS, which only calculated CPR among married women ages 15-49

NEED AND DEMAND FOR FAMILY PLANNING

Total fertility rate (TFR) in the Tabora Region decreased by about 0.5 children per woman from 2005 to 2015. TFR in the Tabora Region and the Western Zone were similar from 2005 to 2015, and Tabora's TFR was about 1.4 children per woman above the national TFR in 2015 (see **Figure 4**).

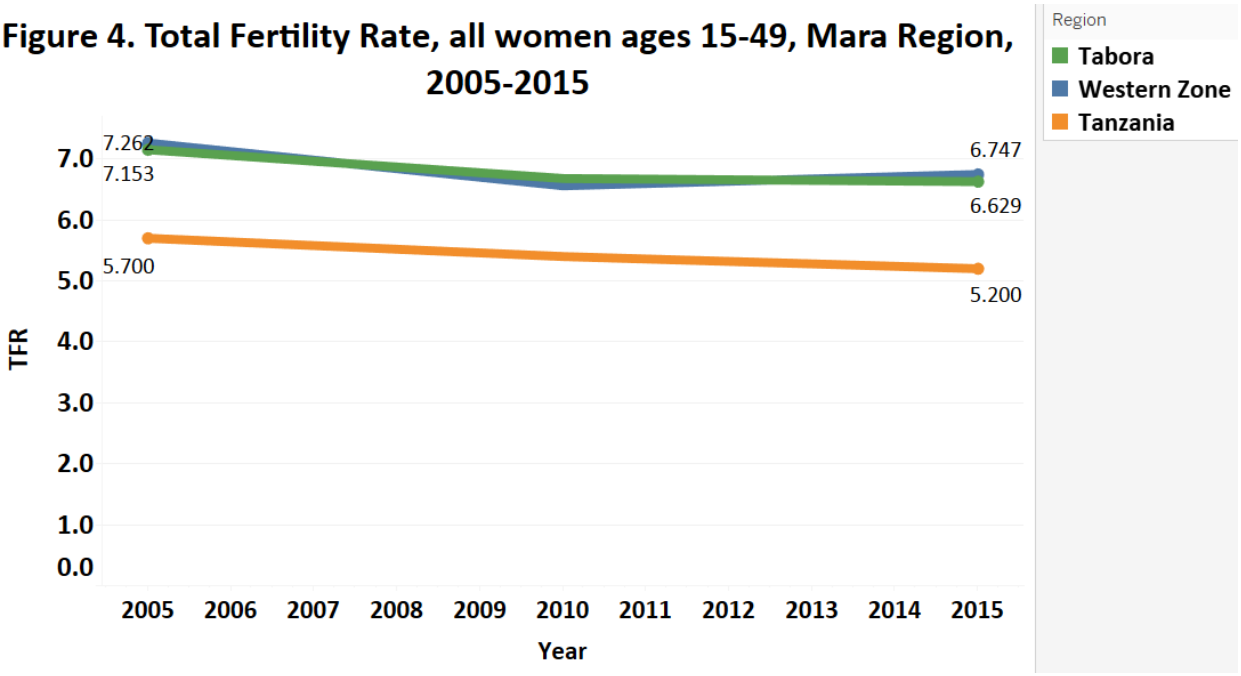
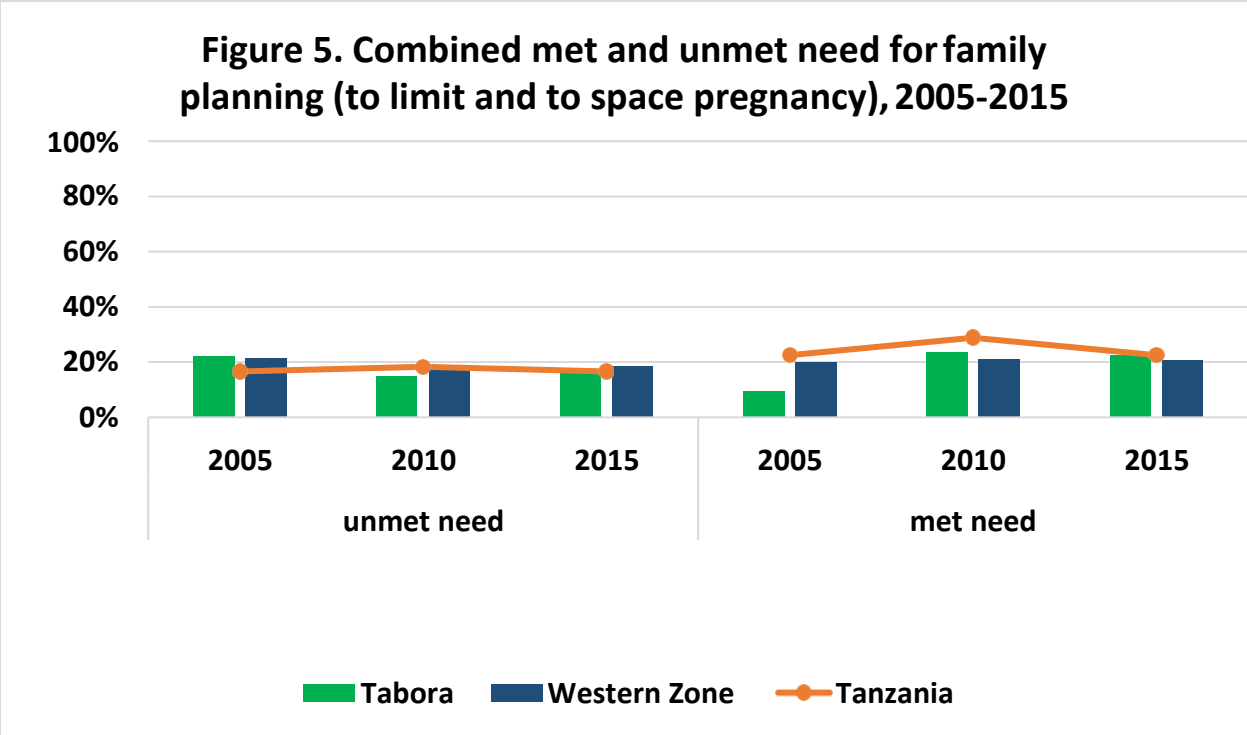


Figure 5 shows combined met[74] and unmet contraceptive need (for limiting and for spacing pregnancy) among all women ages 15-49[75] in the Tabora Region. While unmet need decreased about 5 percentage points from 2005 to 2015, combined met need increased 14 percentage points, from roughly 9 to 23 percent, respectively. The Tabora Region remained nearly the same as both the Western Zone and Tanzania from 2005 to 2015 for unmet need. Met need was slightly below the national average and nearly the same as the zonal average from 2010 to 2015, but was over 10 percentage points lower than zonal and national met need in 2005.

[74] Regional data on met need in this report were calculated for all women (married and unmarried) ages 15-49 and are therefore slightly different than regional data on met need in the DHS, which only calculated need for FP among married women ages 15-49

[75] Data for met and unmet need shown this report are for all women (married and unmarried) ages 15-49 with sampling weights applied, and therefore do not match data on met and unmet need in the DHS

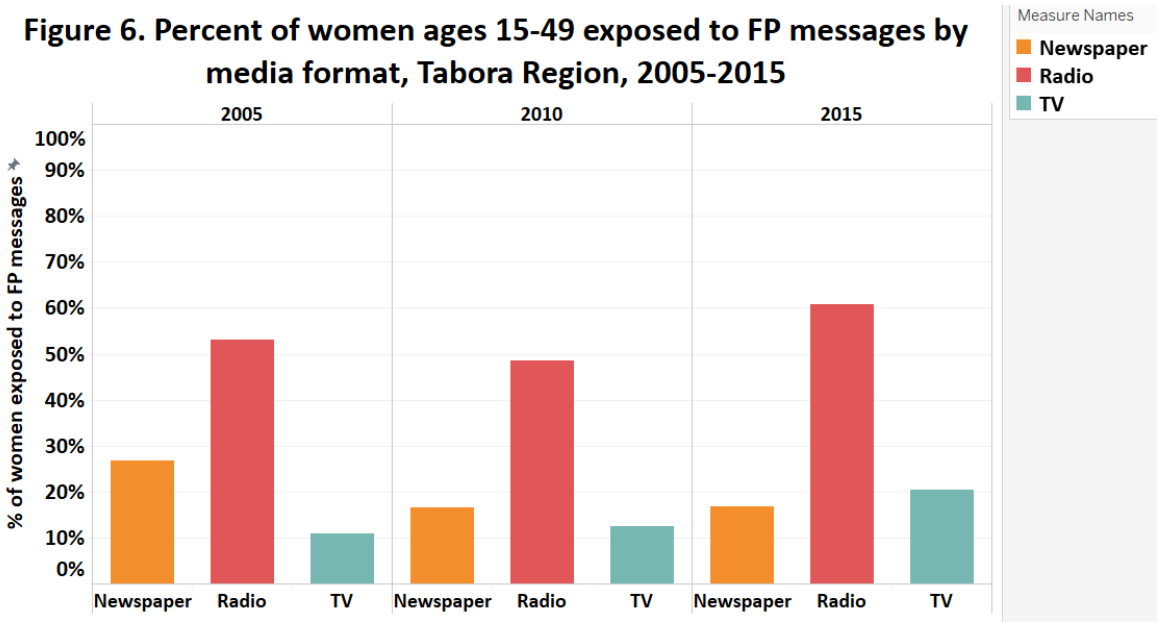


SOURCES OF FAMILY PLANNING MESSAGING

Figure 6 shows the distribution of family planning messaging, by format. It is worth noting that sources of family planning messaging changed from 2005 to 2010, and this report only shows data for the sources that were consistent throughout the 10-year period.[76] Compared to countrywide rates, sources of FP messaging in the Tabora Region were nearly the same, and varied only slightly from 2005 to 2015, with radio as by far the most prevalent form of family planning messaging across the three DHS years.

[76] Mobile phone messages were reported as a source of family planning messaging only in the 2015 DHS. In the Tabora Region, approximately 2.6 percent of women reported they received family planning messages from a mobile phone

Figure 6. Percent of women ages 15-49 exposed to FP messages by media format, Tabora Region, 2005-2015



5. References

1. Lasway C, Harber L, Musunga S. (2015). Gaining traction: Executing costed implementation plans. Experiences and lessons from Tanzania. Durham, NC: FHI 360. Available from: https://www.fhi360.org/sites/default/files/media/documents/tanzania-cip.pdf
2. National Family Planning Costed Implementation Program, 2010-2015 (Updated July 2013). Tanzania MOHSW. Available at http://www.rchs.go.tz/index.php/en/resources/family-planning/strategy-policy-8/131-national-family-planning-costed-implementation-program-2010-2015-updated-2013/file.html
3. United Nations. World Fertility Patterns 2015. Available from: http://www.un.org/en/development/desa/population/publications/pdf/fertility/world-fertility-patterns-2015.pdf
4. Lasway C, Harber L, Musunga S. (2015). Gaining traction: Executing costed implementation plans.
5. DHS 2010: National Bureau of Statistics (NBS) [Tanzania] and ICF Macro. 2011. Tanzania Demographic and Health Survey (DHS) 2010. Dar es Salaam, Tanzania: NBS and ICF Macro.
6. Jain A, Makawia A, Schlect J, et al. *Tanzania Baseline Survey Report 2004-2005: Technical Report.* E&R Study #4. New York: EngenderHealth/The ACQUIRE Project, 2006.
7. NFPCIP Annual Progress Report Year One, July 2010 to June 2011.
8. DHS 1996
9. DHS 2004/5
10. Keogh SC, Kimaro G, Muganyizi P, Philbin J, Kahwa A, Ngadaya E, et al. (2015) Incidence of Induced Abortion and Post-Abortion Care in Tanzania. PLoS ONE 10(9): e0133933.
11. Ministry of Finance (MoF) [Tanzania Mainland], Ministry of Finance(MoF) [Zanzibar], National Bureau of Statistics (NBS), Office of Chief Government Statistician (OCGS), Zanzibar, Presidents Office –Finance, Economy and Development Planning 2013. *Tanzania Population and Housing Census* (PHC) 2012. Dar es Salaam, Tanzania, 2013.
12. UNICEF (2011). Adolescence in Tanzania. United Nations Children's Fund, September 2011, Dar es Salaam, Tanzania.
13. 2015 DHS. Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) [Tanzania Mainland], Ministry of Health (MoH) [Zanzibar], National Bureau of Statistics (NBS), Office of 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: MoHCDGEC, MoH, NBS, OCGS, and ICF.
14. McCleary-Sills J, Douglas Z, Rwehumbiza A, Hamisi A, Mabala R. Gendered norms, sexual exploitation and adolescent pregnancy in rural Tanzania. Reprod Health Matters. 2013;21(41):97-105.
15. Exavery A, Kante AM, Njozi M, Tani K, Doctor HV, Hingora A, et al. Predictors of mistimed, and unwanted pregnancies among women of childbearing age in Rufiji, Kilombero, and Ulanga districts of Tanzania. Reprod Health. 2014;11:63.

16. Mbeba RM, Mkuye MS, Magembe GE, Yotham WL, Mellah AO, Mkuwa SB. Barriers to sexual reproductive health services and rights among young people in Mtwara district, Tanzania: a qualitative study. The Pan African medical journal. 2012;13 Suppl 1:13.
17. Dangat CM, Njau B. Knowledge, attitudes and practices on family planning services among adolescents in secondary schools in Hai District, northern Tanzania. Tanzania Journal of Health Research. 2013;15(1).
18. McHome Z, Richards E, Nnko S, Dusabe J, Mapella E, Obasi A. A 'mystery client' evaluation of adolescent sexual and reproductive health services in health facilities from two regions in Tanzania. PloS One. 2015;10(3):e0120822.
19. Dusabe J, McHome Z, Nnko S, Changalucha J, Obasi A. "There are bugs in condoms": Tanzanian close-to-community providers' ability to offer effective adolescent reproductive health services. The journal of family planning and reproductive health care. 2015;41(1):e2.
20. Rusibamayila A, Phillips J, Kalollela A, Jackson E, Baynes C. Factors influencing pregnancy intentions and contraceptive use: an exploration of the 'unmet need for family planning' in Tanzania. Culture, health & sexuality. 2017;19(1):1-16.
21. Stakeholder Consultations. Adolescent Sexual and Reproductive Health Technical Working Group, March 2017.
22. United Republic of Tanzania. MOHSW-RCHS, 2013. National Family Planning Guidelines and Standards 2013.
23. Nyakubega P. Factors associated with adolescent pregnancies among secondary school students. a study from Tanga-Tanzania. Dar Es Salaam Medical Students' Journal. 2010;16(1):31-4.
24. Pfeiffer, C et al. 2014. The use of social media among adolescents in Dar es Salaam and Mtwara, Tanzania. Reproductive Health Matters 22(43):178-186. June 2014 (file:///C:/Users/clasway/Downloads/SocialMediaReproductive%20Health%20matters%20(1).pdf)
25. Hare L, Hart C, Scribner S, Shepherd C, Pandit T. SPARHCS: Strategic Pathway to Reproductive Health Commodity Security. A tool for assessment planning and implementation. 2004.
26. USAID, Deliver Project. Contraceptive Security Indicators Washington, DC: USAID; 2013. Available from: https://www.k4health.org/toolkits/fpsuccess/contraceptive-security-indicators-2011.
27. USAID, Deliver Project. USAID/Deliver Project final country report: Tanzania. Arlington [VA]: USAID, Deliver Project; 2016.
28. Improving and sustaining contraceptive security in Tanzania. New York, New York, EngenderHealth, RESPOND Project, 2014 Jun; 2014.
29. John Snow D. Contraceptive Security and Decentralization: Lessons on Improving Reproductive Health Commodity Security in a Decentralized Setting. Arlington, Virginia, John Snow [JSI], DELIVER, 2012 Feb; 2012.
30. National Bureau of Statistics [Tanzania], Macro International I. Tanzania service provision assessment 2006. Dar es Salaam [Tanzania]: National Bureau of Statistics, Macro International I; 2007.
31. Wales J, Tobias J, Malangalila E, Swai G, Wild L. Stock-outs of essential medicines in Tanzania. London: ODI; 2014.

32. USAID, Deliver Project. The logistics handbook: a practical guide for the supply chain management of health commodities. Arlington, VA: USAID/Deliver Project; 2011.
33. Mzumbe University Directorate of External Linkage and Community Engagement. A comprehensive reproductive heatlh commodity security (RHCS) assessment in Tanzania mainland: a draft report. Mzumbe [Tanzania]: 2011.
34. Patykewich L, Tien M, Mielke E, Rosche T. Tanzania: contraceptive security assessment. Arlington [Virginia]: The Acquire Project; 2007.
35. Chimnani J, Kamunyori J, Bancroft E, Nazarewicz N, Kisoka N, Mahamba J. Tanzania: Review of the Health Facility Report and Request Formas at MSD Zonal Stores. Arlington [Virginia]: Project UD; 2010.
36. Tanzania Ministry of Health and Social Welfare, Zanzibar Ministry of Health, National Bureau of Statistics (NBS), Zanzibar Office of Chief Government Statistician (OGGS), ICF. International, DHS Program. Tanzania Service Provision Assessment Survey 2014-2015: Preliminary report. Dar es Salaam, Tanzania, and Rockville Maryland, USA: MoHSW, MoH, NBS, OCGS, and ICF International, 2015. Available: https://dhsprogram.com/pubs/pdf/SPA22/SPA22.pdf
37. USAID|Deliver Project. Tanzania Contraceptive Security Indicator Dashboard. 2014. Available from: http://www.familyplanning2020.org/resources/4610
38. DRCHCO representative. Contraceptive security interview, Tanzania CIP report. In: Musunga S, editor. Tanzania CIP. Ilala and Kinondoni [Tanzania]2017.
39. Health Communication Capacity Collaborative, JHU-CCP (2017). *Demand Generation I-Kit for underutilized, lifesaving commodities*. Available at: https://sbccimplementationkits.org/demandrmnch/power-of-demand-generation/ (Accessed 03-07-2017)
40. 1991-1992 DHS
41. Engender Health. 2011. *The SEED Assessment Guide for family Planning Programming*. New York.
42. National Health Insurance Fund (2017). Profile. Available at: http://www.nhif.or.tz/index.php/about-us/profile (Accessed 03-07-2017)
43. Hopwood, T and Merritt, R. (2011). Big Pocket Guide, to use social marketing for behaviour change. Available at: http://www.thensmc.com/sites/default/files/Big_pocket_guide_2011.pdf#page=1&zoom=auto,-25,601 (Accessed 03-07-2017).
44. J Orkis et al, Green Star Research Poster, Impact of the National Green Star FP Demand Creation Campaign in Tanzania.
45. David G (2013). *Reach, Recall and Impact of a National FP Campaign in Tanzania*, FP Poster presented at the International Conference for Family Planning, 2013.
46. Adamchak, S.E, Youth Net 2006. Youth Peer Education in Reproductive Health and HIV/AIDS: Progress, Process and Programing for Future.
47. Judice NR. Snyder E., 2013 *Measuring Progress on Repositioning FP in Tanzania*, Futures Group, HP Initiative.
48. A Repositioning FP Case Study, Dec 2006. Tanzania Case Study *"A Successful Program Losses Momentum."*
49. Information from the NFPCIP tracking tool, data collected from FP implementers
50. US Funding for International FP and RH, Issue Brief, April 2016
51. APF Rapid Assessment on Private Insurance Report, 2016

52. EngenderHealth Analysis of CCHP budgets
53. The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania, 2016-2020 (One Plan II)
54. NFPCIP Reports from Engender Health
55. Directorate of External Linkage and Community Engagement, Mzumbe University. A Comprehensive Reproductive Health Commodity Security (RHCS) Assessment in Tanzania Mainland [draft report] Nov, 2011. http://www.healthpromotiontanzania.org/index.php/en/library122/otherdocuments/nation al/doc_view/151-rhcs-report-november-2011.html.
56. 1999 DHS
57. United Nations, Department of Economic and Social Affairs, Population Division (2014).*World Contraceptive Use 2014* (POP/DB/CP/Rev2014). Available from: http://www.un.org/en/development/desa/population/publications/dataset/contraception/w cu2014/Metadata/WCU2014_UNMET_NEED_metadata.pdf
58. Measure Evaluation. Method Mix. Family Planning and Reproductive Health Indicators Database. Available from: https://www.measureevaluation.org/prh/rh_indicators/family- planning/fp/method-mix
59. 2016 FP2020 Annual Commitment Update Questionnaire Response. Available from: http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/10/FP2020_2016_Annual_Commitment_Update_Questionnaire- Tanzania_DLC.pdf
60. Clinton Health Access Initiative. Case Study: Expanding Global Access to Contraceptive Implants. Available from: http://www.clintonhealthaccess.org/content/uploads/2015/08/Case-Study_LARC.pdf