Barriers and Opportunities for Accelerating Contraceptive Choice in Tanzania

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Background

Evidence is clear that, the use of modern contraception increases when more methods become available, which supports the often undermined fact that no single method serves the needs of every subgroup in a population. However, for several decades, contraceptive choice in many Sub-Saharan African countries has remained limited to condoms, pills and injectables, leaving long-acting and permanent methods (LAPMs) less accessible and under-utilized despite their high effectiveness in preventing unwanted pregnancies. In line with the former statement, findings from one recent analysis of evidence that utilized representative national surveys of 113 countries (all from the developing region) showed that, the addition of one method available to at least half the population correlated with an increase of 4–8 percentage points in total use of the 6 modern contraceptive methods [1]. In practice, contraceptive choice means: 1) Individuals and couples are able to decide freely on the number and timing of their births; 2) have access to a choice of contraceptive options with which to realize their reproductive intentions and 3) they experience neither barriers nor coercion in putting their decisions and intentions into practice [2]. Access to a wide range of contraceptive options is a human right, yet it is still a dream for most women in Sub-Saharan countries.

Contraceptive choice as a human right

The right to informed choice in contraceptive use was first asserted at the International Conference on Human Rights in Teheran in 1968, and again by the 1994 International Conference on Population and Development (ICPD)[3]. The 1994 ICPD reaffirmed as human rights; 1) the right to voluntarily choose whether or not to marry and whether or not to establish a family, 2) the right to decide on the number, timing and spacing of children, 3) the right to have access to the information and means needed to exercise voluntary choices, and 4) the right to the highest attainable standard of health [3]. These are rights that women and young girls in particular are unable to access in most Sub-Saharan countries, including Tanzania, due to a number of policy and programs implementation barriers.

The Tanzanian context

Tanzania has a favorable policy environment for family planning (FP) and the country has made significant progress towards increasing access to quality FP services in the last decade. Between the two most recent Demographic and Health Surveys, Tanzania has observed a 30% increase in contraceptive prevalence rate (CPR), from 26 percent in 2004/2005 to 34 percent in 2010 [4], and the government has made a commitment to increase this rate to 60% by 2015 [5]. However, like many other Sub-Saharan African countries, there still exist huge variations in CPR in Tanzania, both geographically and among the various population sub-groups.

According to the most recent Demographic and Health Survey (2010 TDHS) some regions of Tanzanian like Kilimanjaro, Tanga and Dar es Salaam have CPRs much higher than the national average (64.8% for Kilimanjaro, 53.7% for Tanga and 50.4% for Dar es Salaam) while other regions e.g. Pemba, Mara and Mwanza have CPRs much lower than the national average i.e.

9.2%, 11.9% and 15.2% respectively. Much variation also exists among the various population subgroups in Tanzania; for example, the 2010 TDHS reported CPR to be 50.6% among women with secondary education or higher (compared to 13.4% among women with no education) and 45.2% among women in the highest wealth quantile (compared to only 15.6% among those in the lowest wealth quantile). Moreover, the use of any contraceptive method among all adolescents aged 15-19 in Tanzania was reported to be only 10.7 percent with 85.1 percent and 60.3 percent of currently married and sexually active unmarried adolescents aged 15-19 respectively not using any FP method currently [4]. Not surprisingly the 2010 TDHS also documented that 23 percent of all adolescents aged 15-19 had begun childbearing [4].

Various programs have been targeted at increasing contraceptive access and utilization among population sub-groups with the highest unmet need in Tanzania and table 1 below depicts the percentage increase in CPR among the various population sub-groups between the two most recent DHS (2004/05 and 2010).

Table 1. Percentage increase in CPR among the various population sub-groups in Tanzania between the two most recent DHS (2004/05 and 2010).

	CONTRACEPTIVE PREVALENCE RATE (CPR)					
	ANY METHOD			MODERN METHOD		
	DHS 2004/05	DHS 2010	% Increase	DHS 2004/05	DHS 2010	% Increase
National Average	**26.4**	**34.4**	**30.3%**	**20**	**27.4**	**37.0%**
RESIDENCE						
Urban	41.8	45.9	9.8%	34.3	34.1	-0.6%
Rural	21.6	30.5	41.2%	15.5	25.2	62.6%
REGIONS						
Kilimanjaro	49.5	64.8	30.9%	38.3	50.3	31.3%
Pemba	8.2	9.2	12.2%	6.9	8.1	17.4%
EDUCATION						
No education	13.4	22	64.2%	8.3	17.6	112.0%
Secondary or higher	50.6	51.8	2.4%	38.2	35.3	-7.6%
WEALTH QUANTILE						
Lowest	15.6	22.9	46.8%	10.7	19.2	79.4%
Highest	45.2	50.6	11.9%	36	37.7	4.7%
YOUTHS (15-19YRS)						
All youths	6.6	10.7	62.1%	5.5	9.4	70.9%
Currently Married	9.6	14.9	55.2%	6.9	12	73.9%
Sexually Active Unmarried	31.8	39.7	24.8%	30	34.5	15.0%

It is obvious from table 1, that such programs have been effective as demonstrated by the highest percentage increase in CPR in rural (41.2%) compared to urban areas (9.8%); among women with no education (64.2%) compared to those with secondary or higher education (2.4%); and among women in the lowest wealth quantile (46.8%) compared to those in the highest quantile (11.9%). Moreover, there has been a significant increase in CPR (> 50%) among currently married youths aged 15-19yrs, however, much less CPR increase is observed among sexually active unmarried youths (24.8%). On the other hand, the program needs to pay attention to the observed decrease, between the two surveys, of modern contraceptive use in urban areas (-0.6%) and among women with secondary education or higher (-7.6%).

Like many other Sub-Saharan countries, contraceptive use in Tanzania is limited to condoms, pills and injectables, with a very small proportion of women accessing and/or using long-acting and permanent methods (LAPMs). Table 2 below depicts the percentage increase in utilization of the various contraceptive methods between the two most recent DHS in Tanzania, both in urban and rural areas. Despite their low coverage, it is worth noting the significant increase in utilization of LAPMs, particularly among women in rural areas. This could be a result of the various effective programs targeting increasing utilization of LAPMs among women in hard to reach areas. Again, the program needs to pay attention to the observed decrease, between the two surveys, in use of pills (-27%) and female sterilization (-20.4%) among women in urban areas.

Another important observation from table 2 below is the significant increase, between the two surveys, in use of traditional methods among women in urban areas (>50%). This could be resulting from many factors, one being fear of side effects from modern methods. Tanzania may need to put more emphasis in supporting women preferring natural methods for them to use these methods effectively.

Table 2. Percentage increase in current use of the various contraceptive methods between two most recent DHS (2004/05 and 2010) in Tanzania.

	% OF CURRENTLY MARRIED WOMEN USING THE CONTRACEPTIVE					
	URBAN			RURAL		
TYPE OF CONTRACEPTIVE	2004/04	2010	% Increase	2004/05	2010	% Increase
Male condom	2.5	3.2	28.0%	1.8	2.1	16.7%
Pills	11.9	8.6	-27.7%	4.1	6.1	48.8%
Injectables	12.6	14.3	13.5%	6.9	9.4	36.2%
IUD	0.6	0.8	33.3%	0.1	0.5	400.0%
Implants	1.3	2.5	92.3%	0.2	2.2	1000.0%
Female Sterilization	4.9	3.9	-20.4%	1.8	3.4	88.9%
Lactational amenorrhea method (LAM)	0.3	0.7	133.3%	0.6	1.5	150.0%
Male sterilization	No data	0		No data	0.1	
Any modern method	34.3	34.1	-0.6%	15.5	25.2	62.6%
Any traditional method	7.6	11.9	56.6%	6	5.4	-10.0%

Factors affecting contraceptive choice in Tanzania: Key policy and implementation barriers

Tanzania is among countries that have made good progress towards securing commodity security at the national level, however, access to informed contraceptive choice is yet to be a reality due to many existing policy and programmatic barriers. In principal, four main factors affect contraceptive choice in any setting i.e. 1) funding, 2) procurement systems, 3) supply chain management (contraceptive distribution systems), and 4) service delivery. Interventions/programs aiming at improving contraceptive choice in any settings are primarily targeted at one or more of these four elements. On the other hand, any policy and/or programmatic factors negatively affecting any of the above mentioned four elements may affect the program functioning and prevent it from achieving optimal contraceptive choice. The following section discusses, under each of the four key elements above; key policy and implementation barriers towards achieving contraceptive choice in Tanzania, strategies for overcoming them, and further policy/implementation opportunities towards achieving contraceptive choice in Tanzanian. The information was gathered through a review of literature and program documents as well as conducting a few key informants' interviews.

1) Funding

Meagre allocation of funds for FP program is one among identified key barriers towards achieving contraceptive choice in Tanzania. Overall, evidence on financing for reproductive health commodities in Tanzania show that funding is generally low and shortfalls remains between funds committed and allocated and between funds allocated and spent [6]. Insufficient funds have been reported to often force the Tanzanian FP program to purchase less variety contraceptives than that forecasted; most often the program has opted for cheaper options e.g. short acting methods, instead of the expensive LAPMs, so as to suffice all regions of Tanzania. This has greatly contributed to reduced clients access to a wide contraceptive choice.

Key funding policy and implementation barriers

Except for family planning commodities, all other FP activities and services e.g. awareness raising, capacity building and even other FP equipment and supplies, are budgeted under the reproductive health services umbrella. This has resulted, in many cases, to low funding for such commodities and activities secondary to other competing priorities within the reproductive services umbrella e.g. safe delivery services, antenatal care, child immunization services etc. This was reported to have greatly contributed to scarcity of equipment and supplies for administration of LAPMs, which has in turn affected the provision of such methods even when these methods are available.

One recent analysis (2013) demonstrated that resources for FP have increased modestly in recent years in Tanzania; however, funds have essentially remained donor driven [7]. In that study, the large increase in reproductive health (RH) budget of the 8 districts surveyed had

predominantly came from development partners (donors) and basket funds with no contribution from districts' own sources [7]. Due this donor dependency on funding for FP services and supplies in Tanzania, there have been frequent delays in funds released by the government where commonly the government had released large sums of funds at the end of the financial year when services have already been delayed. Furthermore, the money allocated to the district level from donors and central government often have not been fully disbursed and district spending has often been directed towards donor/central Government priorities instead of needs identified at district level [8].

Strategies for improved funding for FP in Tanzania

There have been efforts by various FP stakeholders to accelerate funding for FP commodities and services in Tanzania, a notable achievement being the development of the National Family Planning Costed Implementation Program (NFPCIP) in 2009. Launched by the Ministry of Health and Social Welfare (MOHSW) in March 2010, the NFPCIP emphasizes five strategic areas with activities for implementation and which includes cost estimates, based on a forecasting approach, for each strategic area and each year between 2010 and 2015. The NFPCIP has been a very useful tool for FP resources mobilization in Tanzania where FHI 360 is supporting the MOHSW and partners to monitor program performance as a result of NFPCIP implementation. This innovative program has attracted attention outside of Tanzania, as it may hold promise as a model for planning and potentially implementing similar programs in other countries.

Since the launch of the NFPCIP, the government of Tanzania has established a budget line item for family planning (FP)/reproductive health (RH) in the Mid-Term Expenditure Framework (MTEF). This was made possible by intensive advocacy by the National Family Planning Technical Working Group (FP-TWG) comprising of members from the NGO's and implementing partners working in FP area and the Tanzanian ministry of health (RCHS – FP unit). Since the formation of the budget line item for contraceptive in 2011, there has been substantial increase in funding for contraceptives in Tanzania. The Government had increased "own" funding for FP commodities from 0.5bn TZ shillings in 2010/2011 to 1.2bn TZ shillings in 2013/14, and has announced its intention to raise own funding to 3bn TZ shillings in 2014/15.

Other gains resulting from Advocacy for increased funding for FP program and activities in Tanzania include; approval for inclusion of FP commodity request in Global Fund Round 10; inclusion of the FP in council health planning guidelines, which has resulted in an increase in FP resource allocations at the district level; and deployment of supplementary resources (off-basket) to fund commodities by traditional basket funders.

Potential opportunities and advocacy entry points towards increased funding for FP in Tanzania

- The program should advocate for stand-alone budget line for the FP program as whole to cover FP commodities as well as all the other FP activities and services e.g. awareness raising, capacity building, service delivery etc.

- More sensitization is needed for the Government officials and MoHSW managers to priorities and allocate sufficient funds for FP commodities and activities.
- Advocacy should also be directed to the local governments for the possibility of funding some of the FP activities at the district level, e.g. CBD programs, through districts' own sources of funds.

2) Procurement systems

Effective procurement systems are critical for ensuring access to reproductive health commodities and other essential health supplies. However, a report prepared by the United Nations Population Fund (UNFPA) and MoHSW in November 2011 cited the long procurement processes as one of the critical causes of contraceptive stock-outs in Tanzania [9]. On the other hand, data availability has been cited as the main challenge facing quantification and forecasting processes for commodities procurement in Tanzania.

Key policy and implementation barriers facing commodities procurement systems in Tanzania

Procurement of the commodities in Tanzania need to follow International Competitive Bidding (ICB) system and various procedures according to Public Procurement Act [9]. These are at times too long, taking up to a year, before the items are acquired. Moreover, the Medical Stores Department (MSD), being the sole agent for ordering medical supplies as well as distributing them, at times need to undergo a long consultative process with various stakeholders in getting the commodities purchased, especially when using the basket funds. The outcome of this is not only causing delays in the acquisition of commodities, but also delays in the release of funds that had already been committed for acquiring the items. The procurement process also takes long because the system requires time to prepare bidding documents, to advertise the tender, time to receive the applications and sort them, and then time to select the winner, a process that is full of back and forth course between the MSD, the MoHSW, and the development partners, particularly the World Bank, which is acting on behalf of development partners. This bureaucratic process has occasionally resulted in unused funds being released in huge amounts at the end of the year, lest it goes back to the funding source. Long and bureaucratic procedures have also been reported by MSD to be one of the major causes for some of the items reaching their expiry date within a short time after they are received or being received when they have already expired.

On the other hand, a study that carried out an in-depth assessment of the supply chain for reproductive and child health commodities in Tanzania (including logistics) reported that, the Report and Requisition (R&R) forms which are to feed the quantification data were not being filled properly, mostly due to lack of training [9]. Moreover , due to lack of responsible personnel to maintain data transfer, in some cases these forms never reached the zonal MSD and thereby MSD central, [9]. Hence, commodities procurement in Tanzania has in most cases depended on status of supplies from the MSD, instead of consumption data from the health facilities.

Strategies for improved commodities procurement systems in Tanzania

As part of a larger effort to expand accessibility and visibility of logistics data to inform supply chain decision making in Tanzania, the USAID | DELIVER PROJECT and the Tanzania Ministry of Health and Social Welfare (MOHSW) established the Integrated Logistic System (ILS) Gateway, a system that allows health facility personnel to use personal mobile phones to send SMS to a toll-free short code ("15018") reporting data on stock levels of commodities. An SMS aggregator then directs the messages to a web database, which analyzes the findings and makes them available to users through a web portal at www.ilsgateway.com. In addition to tracking and reporting on commodities stock status, health facility staff using ILSGateway also receive reminders from MSD zonal stores to submit their quarterly Report and Requisition (R&R) forms on time and even report when shipments of medicines are received.

A pilot program of the ILSGateway was initiated in November 2010 in Mtwara region, and based on its success in minimizing commodities stock-outs, it is currently being rolled out nationally and is already in use in more than 2,300 facilities across the country. Available evidence shows that the commodities stock status reporting rates are higher in the ILSGateway mobile system than for the paper based R&R [10]. On the other hand, the MSD is currently developing an electronic logistics management information system (eLMIS) that will enable online ordering from facilities with knowledge and capacity to use the system [10]. Once established, the eLMIS will provide more robust data visibility into the national supply chain for better informed decision making.

To tackle the challenges related to the long and bureaucratic procedures in purchasing contraceptives, in August 2013 the Government of Tanzania approved a major change, where it switched to a framework contract system to expedite ordering and improve availability of certain contraceptives. The change was prompted by a recommendation from the National Contraceptive Security Committee which is a collaborative technical group led by the Ministry of Health and Social Welfare (MoHSW). The Advance Family Planning (AFP) initiative, along with government officials and family planning service providers, worked through the contraceptive committee to make this change, which went into effect in September 2013. Under this new system, once a supplier is identified, the contracts can last up to three years. The Framework contract system is currently operating for three contraceptive i.e. Jadelle, Implanon, and male condoms, and have greatly minimized delays and provided timely responses to emergency facilities requirements of these commodities.

Potential opportunities and advocacy entry points towards further improvement in commodities procurement systems in Tanzania

- The FP program should advocate for hiring of responsible personnel for data management at the district level as this may significantly improve data reporting and utilization.
- Advocacy also needs to be directed to the World Bank to remove some of the unnecessary tendering procedures and minimize time in commodities procurement.

- Advocacy is also needed for inclusion of more family planning commodities in the framework contract system.

3) Supply chain management (contraceptive distribution systems)

Despite the well-structured integrated logistical system in Tanzania, contraceptive supply chain management is still facing major challenges. This is reported as being among the key areas that need considerable improvement for better functioning of the Tanzania FP Program. There are two systems currently being used for distribution of the reproductive and child health commodities (RHCs) in Tanzania: 1) The old three-level system in which the MSD headquarters (HQs) delivers commodities to the zone MSD, which delivered them to the district medical officers (DMOs), who then delivered them to health facilities, and 2) the new two-level (direct delivery) system in which the MSD central delivers commodities to the MSD zonal stores and the MSD zonal stores delivers the items directly to health facilities. MSD is currently rolling out the new two-level system and this system is already operating in more than half of all regions of Tanzania. However, available evidence is not clear yet whether it has improved facility product availability.

Key policy and implementation barriers to effective supply chain management systems in Tanzania

The availability of products at MSD zonal stores to distribute is a major determining factor to effectively measure the impact of the two-level (direct delivery) system. However, MSD central was reported not to generally adhere to the designed bimonthly distribution frequency of supplies to MSD zonal stores [11]. Moreover, according to system design parameters, facilities are supposed to receive products on a quarterly basis, roughly a month to six weeks after they place their report/order. However, in one assessment some facilities visited had not received a delivery for the last two quarters [11]. Some of this may be attributed to the out of stock status of some products at MSD; however, this was not the only cause, as every product needed by facilities was not out of stock. This situation could also be resulting from challenges facing MSD central from increased demand for funds and human resources from the direct delivery system. Moreover, with the new direct delivery system, facilities reported to often not be aware of the exact delivery date from MSD zonal stores [11], making planning at small facilities difficult as sometimes the officer responsible for receiving the stock needed to attend to meetings or training sessions and is then not available or has not made alternative arrangements for receipt when MSD arrives at the facility.

Other bottlenecks reported to be facing the new two-level (direct) commodities delivery system include: the already mentioned limited capacity of health facility officers in filling the R&R forms and R&R forms not flowing up to MSD central from MSD zonal stores or not reaching MSD zonal stores from health facilities, which altogether makes accurate commodities supply to facilities a big challenge [9, 10]. Due to this poor availability of consumption data, stakeholders reported MSD to at times deliver long acting and permanent methods (LAPMs) where there are no trained providers to provide such services leading to

non-use and hence expiry of such commodities [12].

Strategies for improved supply chain management systems in Tanzania

A major success in relation to the supply chain management of reproductive health supplies in Tanzania is the implementation of an ILSGateway by the Ministry of Health and Social Welfare (MOHSW), with technical support from the USAID DELIVER PROJECT (discussed above). Where ILSGateway is functional, health care facilities, including dispensaries and health centers, can effectively request for more contraceptive straight from zonal MSD using a text message. Moreover, with ILSGateway, the zonal MSD can send a reminder to facilities for them to check their commodities stock [13].

One best practice reported under this element was that in case of excess commodities supply, in-charges of health facilities communicated among themselves and redistributed the commodities to the needy facilities using an established internal mechanism [9].

Potential opportunities and advocacy entry points for improved commodities supply chain management systems in Tanzania

- Overall, available evidence indicates that commodities distribution systems from MSD central to MSD zonal stores and from MSD zonal stores to health facilities still face major challenges that need deep evaluations for potential solutions.
- There is also an obvious need for refresher training to providers in filling of R&R (attitude and timeliness) this being reported as the main problem causing delays in contraceptive reaching the facilities.

4) Service Delivery

Strengthening service delivery is a key to achieving optimal coverage of FP services and attaining contraceptive choice. Service delivery is an immediate output of the other inputs into the health system such as the health workforce, procurement and supplies and finances. Ideally, any increase in inputs to the FP program should go hand in hand with improved services delivery and enhanced access to contraceptive choice. However, this is often not the case secondary to various existing policy and operational barriers at the facility level.

Key service delivery policy and implementation barriers

Four main barriers: provider shortages, provider competence, provider bias and lack of equipment, have been cited as the main limiting factors towards optimal access to informed contraceptive choice by clients at the facility level in Tanzania, even in cases where facilities have a broad method mix. In one recent study in Tanzania, all the people consulted were strongly convinced that there was a significant shortage of staff particularly at lower levels for FP and other RH services [9]. The latter observation is in agreement with what the Health Sector Strategic Plan III (2009 – 2015) shows; that staffing in the health sector stands at only 35% of the actual needs according to defined staffing norms [14].

The scarcity of human resources is further aggravated by the fact that many of the available

staffs do not possess the needed skills to handle more advanced FP services particularly the LAPMs. On the other hand, provision of LAPMs was reported to as well be affected by lack of equipment and other supplies funded under the reproductive and child services umbrella. High workload due to shortage of staff and need for frequent sterilization due to shortage of equipment has in most cases resulted into providers' bias towards easier and quick to offer pills and injectables leaving LAPMs less often offered. This is significantly affecting access to contraceptive choice at the facility level in Tanzania.

Other frequently cited barriers for access to optimal contraceptive choice in Tanzania include; distance to health facilities; lack of privacy and confidentiality; unofficial fees for free FP services; negative attitudes of service providers; social-cultural barriers such as religious beliefs and negative gender norms; and misinformation, myths and misconceptions.

Strategies for improved FP service delivery in Tanzania

To tackle the problem of staff shortage, there have been various efforts towards delegating, where appropriate, various tasks to less specialized health workers. Known as task-shifting or task sharing, this process is currently being promoted worldwide as a strategy for expanding access to a wider contraceptive choice through enabling larger numbers of health workers to offer a wider range of methods. In Tanzania, one program that trained assistant medical officers (AMOs) to perform minilap as part of task shifting reported a significant increase in the number of women receiving minilap in areas where AMOs received training [15]. Following this success, the ministry of health in collaboration with Engender health has been doing countrywide training to all graduating AMO and their tutors on minilap procedure. On other hand however, there still exist significant policy barriers for task shifting in Tanzania. For instance, despite the human resources crisis and an obvious increase in demand for certain methods (e.g. injectables and implants), the government has been quite conservative to shift its policies to support task shifting for these methods.

On job training of staff is another widely used approach in Tanzania aiming at expanding skills of existing staff so that they are able to provide a wider range of FP methods. On-job training has been very effective in increasing not only the quality of FP services but also clients' access to a wider range of methods.

Mobile outreach services also widely used in Tanzania is a mechanism for improving access to quality FP services for the underserved populations. The Tanzanian Ministry of Health and Social Welfare offers routine mobile outreach throughout the year. In addition, various NGOs have been conducting out-reach services particularly for LAPMs and also injectables. Mobile services typically rely on highly trained and experienced providers, hence have been offering better quality services than those generally available in rural areas. Outreach services have been very successful in increasing access to FP services to underserved, hard-to-reach populations and particularly for the LAPMs.

Integration of FP into other services is another successfully implemented approach in Tanzania, but not without challenges. Various initiatives have been going on towards integrating FP into

other maternal, infant and child health services in Tanzania e.g. Immunization services, antenatal care, post-partum care, post-abortion care, and HIV/AIDS care and treatment services etc. Significant evidence exists concerning the feasibility, acceptability and effectiveness of the various models of integration. Overall, where well implemented, integration of FP into other services has served to increase access to FP services and reduce the unmet need.

Potential opportunities and advocacy entry points towards improve service delivery for FP in Tanzania

- More innovative interventions are needed to tackle the less often addressed barriers for optimal access to contraceptive choice in Tanzania e.g. issues of unofficial fees for free FP services, negative attitudes of service providers, social-cultural barriers such as religious beliefs and negative gender norms.
- Advocacy is needed to donors buying LAPMs e.g. USAID, to also buy methods provision equipment and other supplies (e.g. speculum, forceps, sterilizing agents etc.). These are usually unavailable/insufficient at the facility level which affects provision of such methods.
- Advocacy should also be directed to the government of Tanzania to allow lower cadres to provide a wider range of FP services e.g. allowing trained community health workers to provide injectables, which have been proven safe and effective in other countries.

Barriers for scaling up effective interventions

FP 2020 relies on the assumption that effective interventions on FP will be taken to, and implemented at scale. Donors agree that this requires the knowledge-base on scale-up to be strengthened, specifically addressing how to take programs that have already been proven effective to scale. On the other hand, interventions recipient countries have concerns other than knowledge on scale-up of effective interventions. Challenges in scaled-up effective initiatives are many and often prevent sustainability. The following have been cited as the two main challenges towards scaling up and sustaining effective FP interventions in Tanzania;

i. Most interventions, having sufficient funds on piloting stage, have expensive program designs which make it difficult for the recipient countries to take them over after the project period has ended. For example, one recent trial in Tanzania trained community health workers for nine months and hired them at a pay of 250,000 Tanzanian shillings per month, the rate exceeding the current pay for the facility-based health attendant. It is obvious that, the Tanzanian government cannot afford such a program.

ii. On the other hand, many programs are piloted outside the existing system structures. This way, systems' challenges are overlooked during program piloting and are faced during program scaling up. This has affected program performance and sustainability.

Recommendations for Accelerating Contraceptive Choice in Tanzania

Overall, Tanzania has made good progress in recent years towards achieving a wider contraceptive choice; however, some significant gaps remain in a few key areas. Based on findings from this report, the author recommend the following:

1. Continuing advocacy is needed to ensure more and stable funding for FP commodities and services in Tanzania. Strong advocacy should be directed towards high government officials in Tanzania, including members of the parliament, district managers etc. for them to realize and see FP as a national priority and allocate adequate financing to put policies into action.

2. For a stronger advocacy, the program should join forces with other government sectors directly facing challenges of high population growth e.g. population council, ministry of finance, ministry of education etc. in advocating for increased funding for FP as a remedy for tackling those challenges.

3. The FP program should seek to establish and tackle the underlying causes of persistent stock-outs of commodities at the facility level. This should go hand in hand with efforts towards obtaining actual commodities consumption data for use in quantification and forecasting of commodities instead of using information on commodities status at MSD central as this could be misleading.

4. To tackle problems associated with long procurement processes, the FP program should advocate for inclusion of other family planning commodities in the framework contract system while efforts are made to address any barriers emanating from procurement regulations.

5. The program should advocate for provision of responsible personnel for data management at the district level, as this could significantly improve data reporting and utilization, hence contributing to making available a wide-range of FP commodities.

6. Last but not least, available evidence shows that among public health facilities, dispensaries serve the majority of the FP clients. Hence, if FP services are to serve more people in Tanzania, increased attention should be given to these grassroots facilities, including promotion of task shifting at this level of care.

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