Tanzania National Family Planning Research Agenda 2013–2018
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Ministry of Health and Social Welfare,
Government of Tanzania.
Dar es Salaam
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<tr>
<td>ADDO</td>
<td>Accredited drug dispensing outlets</td>
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<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<tr>
<td>ASRH</td>
<td>Adult sexual and reproductive health</td>
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<tr>
<td>CBD</td>
<td>Community-based distributor</td>
</tr>
<tr>
<td>CBDs</td>
<td>Community-based distributors</td>
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<tr>
<td>CBFP</td>
<td>Community-based family planning</td>
</tr>
<tr>
<td>CHWs</td>
<td>Community health workers</td>
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<tr>
<td>COHRED</td>
<td>Commission on Health Research for Development</td>
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<tr>
<td>COSTECH</td>
<td>Tanzania Commission for Science and Technology</td>
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<tr>
<td>CPR</td>
<td>Contraceptive prevalence rate</td>
</tr>
<tr>
<td>CTC</td>
<td>Care and treatment clinic</td>
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<tr>
<td>DSS</td>
<td>Demographic surveillance system</td>
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<td>ENHR</td>
<td>Essential National Health Research</td>
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<td>ESA</td>
<td>Extended Service Delivery</td>
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<tr>
<td>FBO</td>
<td>Faith-based organization</td>
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<tr>
<td>FGD</td>
<td>Focus group discussion</td>
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<td>FHI</td>
<td>Family Health International</td>
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<tr>
<td>FP</td>
<td>Family planning</td>
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<tr>
<td>MNCHHMIS</td>
<td>Health management information system</td>
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<td>HRIS</td>
<td>Human resource information systems</td>
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<tr>
<td>HTSP</td>
<td>Healthy timing and spacing of pregnancy</td>
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<tr>
<td>IDC</td>
<td>Infectious diseases centre centre</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, education and communication</td>
</tr>
<tr>
<td>ILS</td>
<td>Integrated logistic system</td>
</tr>
<tr>
<td>IUCD</td>
<td>Intrauterine contraceptive device</td>
</tr>
<tr>
<td>KII</td>
<td>Key informant interview</td>
</tr>
<tr>
<td>LAPM</td>
<td>Long-acting and permanent methods</td>
</tr>
<tr>
<td>LAM</td>
<td>Lactation amenorrhea method</td>
</tr>
<tr>
<td>LGA</td>
<td>Local government authority</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and child health</td>
</tr>
</tbody>
</table>
## ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOCS&amp;T</td>
<td>Ministry of Communication, Science and Technology</td>
</tr>
<tr>
<td>MOEVT</td>
<td>Ministry of Education and Vocational Training</td>
</tr>
<tr>
<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
</tr>
<tr>
<td>MSD</td>
<td>Medical store department</td>
</tr>
<tr>
<td>MICH</td>
<td>Maternal, infant and child health</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>NBS</td>
<td>National Bureau of Statistics</td>
</tr>
<tr>
<td>NFPPRA</td>
<td>National Family Planning Research Agenda</td>
</tr>
<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
</tr>
<tr>
<td>NIMR</td>
<td>National Institute for Medical Research</td>
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<tr>
<td>NFPCIP</td>
<td>National Family Planning Implementation Program</td>
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<tr>
<td>PAC</td>
<td>Post abortion care</td>
</tr>
<tr>
<td>PHE</td>
<td>Population, health and environment</td>
</tr>
<tr>
<td>PNC</td>
<td>Postnatal care</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People living with human immunodeficiency virus</td>
</tr>
<tr>
<td>PPP</td>
<td>Public-private partnership</td>
</tr>
<tr>
<td>RCHS</td>
<td>Reproduction and child health services</td>
</tr>
<tr>
<td>RPS</td>
<td>Research priority scores</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive health</td>
</tr>
<tr>
<td>SAA</td>
<td>Strategic action area</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
</tr>
<tr>
<td>SBCC</td>
<td>Social and behavioral change communication</td>
</tr>
<tr>
<td>SDP</td>
<td>Service delivery point</td>
</tr>
<tr>
<td>SEED</td>
<td>Supply enabling environment demand</td>
</tr>
<tr>
<td>SPA</td>
<td>Service provision assessment</td>
</tr>
<tr>
<td>TFR</td>
<td>Total fertility rate</td>
</tr>
<tr>
<td>TDHS</td>
<td>Tanzania Demographic and Health Survey</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
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</table>
A high unmet need for family planning (FP) services and a continuing high rate of population growth (currently estimated at 2.7 percent) are presenting major challenges to social and economic development in Tanzania. The evidence clearly shows that equitable access to high-quality FP services saves the lives of women, newborns and adolescents and contributes to the nation’s socioeconomic development. In 2010, the Ministry of Health and Social Welfare (MOHSW) launched the National Family Planning Costed Implementation Program (NFPCIP), 2010–2015, to guide efforts to reposition and reinvigorate access to and the use of FP services in Tanzania. Its goal is to reach a national contraceptive prevalence rate of 60 percent for all methods by 2015. The program outlines five major strategic action areas (SAAs). Each SAA has a set of activities that must be implemented in order to address the issues and challenges to reposition FP in the country. Subsequently, in 2012, His Excellency President of the United Republic of Tanzania Dr. Jakaya Mrisho Kikwete, attended the high-profile London Summit on Family Planning and made six commitments that are intended to double the number of FP users by 2015.

In the context of limited time and resources, reaching NFPCIP’s national target by 2015 necessitates at-scale implementation of approaches that have been proven effective in producing desired results in an efficient manner. The Tanzanian FP program, however, lacks answers to critical questions that are needed to ensure that every person, everywhere, has the information and services that she/he needs to decide whether and when to have a child. It is with this principle that MOHSW decided to embark on a process of updating its National Family Planning Research Agenda (NFPRA), which was last generated in 1992, and to align priorities with the strategic results and actions of the FP program.

The overall intention of NFPRA is to assist the government and FP stakeholders to understand the findings of FP research conducted in Tanzania during the past 10 years and to identify current gaps in evidence-based knowledge needed to advance efforts to reposition FP in the country. The NFPRA provides a framework to define public health research priorities for FP; to help maintain a focus on less well-addressed areas; and to facilitate discussions and coordination among researchers, donors and public health professionals. The MOHSW calls for enhanced and collaborative efforts among stakeholders to integrate operational research in various ongoing interventions to ensure implementation of these research priorities. While conducting research to fill these evidence gaps, stakeholders are also encouraged to build program managers’ capacity to both generate and use research evidence.

This document is intended for use by national and international research institutions; academia program managers and supervisors, in the government, in nongovernmental organizations (NGOs), faith–based organizations (FBOs) and the private sector. Institutions engaged in research are expected to focus investments in research on the priorities elaborated upon in this updated NFPRA to ensure relevance and alignment with the NFPCIP goals.

Charles A. Pallangyo
Permanent Secretary
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Dr. Donan Mmbando
Chief Medical Officer
GLOSSARY

**Health systems research**: research addressing health system and policy questions that are not disease-specific but that concern systems problems that have repercussions on the performance of the health system as a whole. It addresses a wide range of questions, from health financing, governance and policy to problems with structuring, planning, management, human resources, service delivery, referral and quality of care in the public and private sector.

**Operational research**: any research producing usable knowledge (evidence, findings, information, etc.) that can improve program implementation (for example, effectiveness, efficiency, quality, access, scale-up and sustainability), regardless of the type of research (design, methodology or approach).

**Clinical research**: a branch of medical science that determines the safety and effectiveness of medications, devices, diagnostic products and treatment regimens that are intended for human use. These may be used for prevention, treatment, diagnosis or relieving symptoms of a disease.

**Behavioral and social science research**: research that focuses on the understanding of behavioral or social processes, or on the use of these processes to predict or influence health outcomes or health risk factors. The term *behavioral* refers to overt actions to underlying psychological processes (such as cognition, emotion, temperament and motivation). The term *social* encompasses sociocultural, socioeconomic and sociodemographic status to biosocial interactions and to the various levels of social context, from small groups to complex cultural systems and societal influences.

**Biomedical research**: research that involves the investigation of the biological process and the causes of disease through careful experimentation, observation, laboratory work, analysis and testing. Scientists expand this knowledge base to discover ways to prevent health problems and to develop beneficial products, medications and procedures to treat and cure diseases and conditions that cause illness and death in humans, pets, farm animals and wildlife.

**Clinical trial**: the prospective, biomedical or behavioral research study of human subjects that is designed to answer specific questions about biomedical or behavioral interventions (drugs, biologics, treatments, devices or new ways of using known drugs, biologics, treatments or devices).

**Implementation research**: research on promoting uptake of research findings into public health programs and expanding knowledge on strategies for implementation and wider scaling-up of effective health interventions and health services.
EXECUTIVE SUMMARY

The National Family Planning Research Agenda (NFPRA) summarizes the recent evidence on the status of family planning (FP) services in Tanzania as well as the perceived priorities for future research as discussed among a wide range of key stakeholders. The NFPRA relies primarily on two sources of information: descriptive findings from an examination of literature and the opinions of stakeholders who convened to identify high-priority research needs for the FP program. The team conducted an extensive review of the literature on this topic from 2002 to 2013 with the goal of summarizing the available evidence and identifying preliminary gaps to inform this assessment. Moreover, the team conducted several thematic consultations with experts in the field to gather their comments regarding the state of FP services research and important areas that need further investigation. Consultations were conducted through either focus group discussions or key informant interviews. The purpose of this exercise was to identify research opportunities that will build from the existing knowledge base and expand the availability of information that is useful for improving the quality of services.

The NFPRA will detail the findings from the consultation meetings among the key stakeholders. The evidence from the literature review will be provided in the appendix as an annotated bibliography. Overall, the majority of research questions generated were related to the issues of implementation research, which implies that there is still a major gap in understanding of the effective approaches for addressing many of the critical FP issues in Tanzania. Furthermore, findings from the literature indicate that even though many innovative ideas are being tested, very few interventions are designed within a rigorous research framework to enable quantification and documentation of their effects. As a result, much of the available program documentation is not useful for informing future policy and program efforts.

The objective of this work is to promote production of evidence that will lead to improvements in equitable access to high quality FP knowledge, services and methods — particularly among vulnerable women and families throughout Tanzania. The NFPRA presents essential FP research areas that will lead to improvement in the health of Tanzanian women and families by reducing the number of unintended pregnancies and improving the recognition of optimal pregnancy timing, so that women are able to achieve the healthiest pregnancies. This information should be useful to policy makers, program directors and practitioners as they consider their own efforts towards improving equitable access to quality FP services. Finally, the NFPRA calls for enhanced and collaborative efforts to ensure that the established research priorities guide the production and management of national FP evidence for a given period of time. Moreover, stakeholders are encouraged to systematically integrate operational research in the various ongoing interventions to enhance documentation of the key components of interventions that are effective, for whom they are effective and under what conditions they are effective. This documentation is crucial for informing future program efforts.
INTRODUCTION

1.1 Background and Rationale for the NFPRA

Preventing unintended pregnancies through equitable access to high-quality family planning (FP) services has a great potential of not only contributing to significant reduction in maternal, neonatal and child mortality but also improving women’s participation in economic productivity and fostering educational attainment for girls [2]. Tanzania’s FP program lost momentum over the last decade because of the other competing health priorities, such as tuberculosis, malaria and HIV/AIDS [3]. In the 1990s, Tanzania had one of the largest annual increases (two percentage points per annum) in contraceptive prevalence rates in the East Africa region [3]. The contraceptive prevalence rate has, however, slowed considerably since the 1990s, during which the annual increase in the use of any method dropped to 0.2 percentage points per year, with prevalence reaching only 26.4 percent in 2004/2005 [3]. On the other hand, the population of Tanzania has grown from 34.4 million in 2002 to 44.9 million in 2012 [4, 5] — a 30.5 percent increase in a period of 10 years. Early initiation of childbearing and a high rate of fertility are the principal factors contributing to this rapid population growth with detrimental effects on the health of women and children.

According to 2010 TDHS, 23 percent of women between the ages of 15 and 19 have begun child-bearing, while the total fertility rate (TFR) has remained high at 5.4 children per woman [1]. TFR was reported at 5.8 and 5.7 births per woman in 1996 and 2005, respectively [1, 6].
Recognizing the need to reposition FP in the country, the Tanzanian Ministry of Health and Social Welfare (MOHSW) launched the National Family Planning Costed Implementation Program (NFPCIP) [2] in 2010 with a goal to increase the contraceptive prevalence rate (CPR) from 20 to 60 percent by 2015. The NFPCIP stipulates five strategic action areas, each of which has a set of activities for implementation in order to address the issues and challenges for repositioning FP as a national priority for health and development. Subsequently, on July 11, 2012, his Excellency President Dr. Jakaya Kikwete attended the high-profile London Summit on Family Planning and made six commitments that are expected to double the number FP users by 2015. These commitments are especially important in light of the release by the National Bureau of Statistics (NBS) of the 2012 Tanzania Population and Housing Census Report.

In the context of limited resources, however, evidence-based approaches are needed to inform such an implementation in order to align the available resources towards program activities that have the greatest potential impact in reducing the unmet need and achieving optimum coverage of quality FP services and equity in contraceptive access. The National Family Planning Research Agenda (NFPRA) will serve as a framework to guide the generation of essential evidence-based knowledge to inform strategic planning and decision making towards effective and efficient interventions for implementation in order to achieve NFPCIP’s targets.

1.2 Purpose of NFPRA

The generation of knowledge through research is a mechanism that has been widely used to inform effective and efficient conduct of programs worldwide and it could play a critical role in responding to the challenges of unmet need for FP in Tanzania. The NFPRA describes priority gaps in knowledge that need to be addressed so as to inform effective and efficient implementation of FP interventions to reach the country’s goal of a CPR of 60 percent.

1.3 Intended Audience

The intended audience for the NFPRA includes, but is not limited to, researchers and program managers in research institutions, academia and civil society, the ministry of health, technical agencies, donor agencies and the private sector. The primary aim is to ensure that stakeholders carrying out research in the area of FP are informed of the country’s priority needs for evidence-based information to advance its program.
METHODOLOGY

The process of identifying knowledge gaps for FP research was informed by the six steps proposed by the Commission on Health Research for Development (COHRED), and used the Essential National Health Research (ENHR) priority-setting methodology. The data collection processes, including consultations with a sample of key stakeholders and a review of the literature, were guided by the Supply, Enabling Environment and Demand (SEED) assessment model that was developed by EngenderHealth. Thematic areas that formed the basis for discussions among a sample of key stakeholders were based on the five strategic action areas of the NFPCIP. Participants included researchers, program managers, decision-makers at different levels and health services providers, both from the public and the private sector. Activities for identifying knowledge gaps and setting priorities for FP research were categorized into four main phases: (1) the preparatory phase, (2) the identification of research areas, (3) the setting of priorities and (4) the action plan for making the priorities work. The activities of each phase are summarized below. A full description of the methodology is provided as Appendix I.

i) Preparatory phase: The team commenced the priority setting exercise by reviewing relevant country FP statistics, reviewing FP-related national policies and guidelines and mapping out all the key FP stakeholders. The team selected from a broad list a sample of key stakeholders for participation in thematic consultations. It was agreed that information would be gathered from the key stakeholders primarily by three main methods: focus group discussions (FGDs), key informant interviews (KIIs) and a review of the literature. At the end of this phase the team had a clear focus and defined scope of the priority setting exercise to be undertaken and developed a detailed work plan to guide the whole process.

ii) Identification of research areas: The goal of this phase was to draw up an initial list of research areas through consultations with a selected sample of key FP stakeholders and a review of the literature. A total of 12 themes and sub-themes were developed based on the five strategic action areas of the NFPCIP to be used for guiding the stakeholders’ consultation processes (refer to Appendix I for more details). At the end of this phase the team had assembled an initial list of key research questions, which were further reviewed against existing evidence to identify research questions with no sufficient evidence. These were carried forward to the next step of priority setting.

iii) The setting of priorities: Using a pre-tested scoring form with three pre-determined criteria, namely: relevance, applicability/use and impact (refer to Appendix II), participating stakeholders were asked to assign scores to each of the research questions in the above list. (An online survey was used to facilitate participation of key stakeholders that were not available to participate on the dates of the priority setting exercise).
The completed forms were then entered into an Excel worksheet where the weights assigned for each criterion were applied to obtain the final weighted scores. This was followed by ranking of the questions according to their final total weighted research priority scores (RPS).

**iv) Action plan for making the priorities work:** Having set priorities for FP research in Tanzania, the team involved a sample of key stakeholders in discussions on how to best ensure that the identified priorities will guide the production and management of the national FP evidence for a given period of time, which was the final step.

Figure 2: Summary of the Processes for Developing the NFPR A

Sources:

1. *Supply Enabling Environment and Demand (SEED)*
2. *National Family Planning Costed Implementation Program (NFPCIP)*
3. *Commissions on Health Research for Development (COHRED)*
4. *Essential National Health Research (ENHR)*
PRIORITIES FOR FAMILY PLANNING RESEARCH IN TANZANIA

Overview

The majority of research questions generated through consultations with a sample of key stakeholders were related to the issues of implementation research, which implies that the effective approaches for addressing many of the critical FP issues in Tanzania are not well understood. On the other hand, the majority of studies reviewed fell into the behavioral and social science research category. They focused on an understanding of the behavioral and social processes that influence access and use of FP information and services among various population subgroups. Numerous interventional studies existed, testing many innovative ideas towards improving access to quality FP services. The majority of interventions were targeted at youths, followed by those aiming at integrating FP into other maternal and child health (MCH) services. Very few interventions, however, were designed within a rigorous research framework to enable the quantification and documentation of their effects. Moreover, very few interventions incorporated cost-effectiveness analysis in their assessment, while randomized controlled trials (RCTs) almost never existed. The remainder of this section elaborates on the findings from both the literature and opinions of key stakeholders on a set of research questions that were deemed most important and promising in ensuring effective delivery of and equitable access to quality FP services within each of the 12 thematic areas used for this assessment.

3.1 Contraceptive security

Problems with FP commodity forecasting, procurement, efficient supply logistics and quality assurance have all been identified as key barriers that restrict access and choice for women wishing to use FP, thereby contributing to unmet need [7]. Of the 161 reports reviewed, only 8 (5 percent) examined issues related to contraceptive security. Findings from both the reviewed literature and consultations among the key stakeholders indicate that contraceptive shortages and stock-outs persist in many places of Tanzania, despite numerous efforts to achieve contraceptive security. This is due to a combination of factors. One multi-country study documented funding constraints combined with a weak commitment to prioritize the purchase of RH supplies on the side of the recipient countries and a limited capacity for distribution, which created an unstable environment for supplies in the studied countries, including Tanzania [8].

Before 2005, the health care system in Tanzania was made up of a number of parallel systems for restocking health care facilities with the supplies needed. This plethora of systems was chaotic. Each cluster of facilities had separate procedures for ordering supplies from the Medical Stores Department (MSD). The successful implementation of an integrated logistics system (ILS) by MOHSW, with technical support from the USAID DELIVER PROJECT, addressed the havoc by putting in place one system with a single set of procedures [9]. With the ILS in place, health care facilities, including dispensaries and health centers, can effectively order products based on their needs and budget. The ILS was a major step towards keeping Tanzania’s health facilities supplied, but stockouts remained high. The ILS relies on a regular, predictable, steady ordering process where all actors are fulfilling their assigned responsibilities effectively and in a timely fashion, but the program was experiencing significant order non-submission, irregular delivery patterns, and...
a lack of communication between levels (facility, district, zone, etc.). Furthermore, facility-level data was not available for decision making. Even district officials did not have access to stock status data, leaving them with little information to use for making decisions. Moreover, with the new direct delivery system of commodities from zonal MSDs to health facilities in Tanzania, stakeholders reported that MSDs 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. Not surprisingly, effective mechanisms for commodities requisition and supply at the facility level rose as a number-one priority of the research needs under this theme, followed by effective approaches for commodities data management, such as recording, reporting, analysis and feedback at all levels of commodities pipeline.

Table 1: Research Priorities: Contraceptive Security

<table>
<thead>
<tr>
<th>No.</th>
<th>Research priorities: contraceptive security</th>
<th>Final weighed score</th>
<th>Level of priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>What are the effective and sustainable mechanisms for commodities requisition and supply at facility level?</td>
<td>5.6</td>
<td>High</td>
</tr>
<tr>
<td>2.</td>
<td>What are the effective approaches for commodities data management, that is, recording, reporting, analysis and feedback?</td>
<td>5.3</td>
<td>High</td>
</tr>
<tr>
<td>3.</td>
<td>What are the effective strategies for commodities budgeting and accountability, both at central government and district level?</td>
<td>5.0</td>
<td>High</td>
</tr>
<tr>
<td>4.</td>
<td>How can commodities’ quality and efficacy be better monitored?</td>
<td>4.7</td>
<td>Medium</td>
</tr>
<tr>
<td>5.</td>
<td>What is the safety and effectiveness of traditional methods in fertility control?</td>
<td>3.5</td>
<td>Low</td>
</tr>
</tbody>
</table>

On the policy environment, evidence indicate that Tanzania has a high commitment level in ensuring its people have access to RH, but this commitment has not been backed by adequate financing to reflect what the policies are promising. Generally, evidence on financing for RH commodities showed that funding for the commodities is generally low and shortfalls remain between funds committed and allocated, and between funds allocated and spent [10]. A recent analysis (2013) of budget in eight Districts of Mainland Tanzania showed that overall the RH budget had significantly increased, but the large increase in the FP budget has predominantly come from development partners (donors) and basket funds with no contribution from the districts’ own sources [11]. In line with these findings, effective mechanisms for commodities budgeting and accountability, both at the central government and district levels, was deemed a research need towards achieving contraceptive security at the district level. Moreover, stakeholders called for effective mechanisms for mobilization and allocation of the districts’ own resources for FP as among the very crucial steps for achieving sustainability of FP commodities and services at the district level.

3.2 Capacity building

Staff shortages, competency, their distribution and rotation, lack of supervision and other human resource issues are well documented as barriers towards the implementation of various FP interventions in Tanzania. And even though there have been numerous efforts towards increasing providers’ numbers and skills, limited evidence exists on the effectiveness and even less on the cost-effectiveness of such efforts. Our review of literature established only three studies under this theme. One study that analyzed the pre-service FP teaching in Tanzania established a number of gaps in the FP training provided to various degree and non-degree graduates in Tanzania [12]. It was found in this study that FP was included in 64 percent of the schools’ curricula. Moreover, even though some schools taught all types of FP methods, practical training was erratic and lacked effective evaluation.
Most of the discussions among the key stakeholders under this theme focused on the need to learn more about the effective approaches for in-service training and staff retention. Evidence suggests that the MOHSW and other stakeholders have been providing in-service training; however, the implementation and monitoring of the various ongoing trainings was deemed insufficient. Stakeholders reported inadequate coordination of various currently ongoing trainings, leading to poor documentation of trained providers, which has made it difficult to capture all trained providers by type of training nationally. This information was deemed very useful for planning successive trainings to prevent the duplication of efforts and misuse of resources. Particular emphasis was put on effective mechanism to capture information on trainings organized and implemented by district councils, which were reported to hardly reach the MOHSW currently.

Currently, the majority of trainings are being provided centrally, where providers leave their work stations to attend training. Stakeholders called for operational research to evaluate the feasibility, effectiveness and cost-effectiveness of alternative approaches for in-service training that could be more effective and less costly. Such approaches could include the use of electronic and mobile information and communication technology for training, monitoring and supervising health workers. A research need was also established to assess and monitor the availability and performance of trained providers overtime, particularly those providing invasive procedures. A significant concern was raised among the key stakeholders regarding the frequently observed in-facility and out-of-facility migration of trained workers. This has at times resulted in trained providers being shifted to departments where they cannot use their skills, while leaving non-trained personnel at FP service delivery points. Research to determine the prevalence of this problem was identified as a number-one priority, along with effective approaches to deal with it.

### Table 2: Research Priorities: Capacity Building

<table>
<thead>
<tr>
<th>No.</th>
<th>Research questions</th>
<th>Final weighted score</th>
<th>Level of priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>What are the underlying factors for staff migration and effective mechanisms for staff retention?</td>
<td>5.1</td>
<td>High</td>
</tr>
<tr>
<td>2.</td>
<td>What is the effectiveness and cost-effectiveness of various approaches for in-service training implementation and monitoring?</td>
<td>4.8</td>
<td>High</td>
</tr>
<tr>
<td>3.</td>
<td>How can the FP program best ensure competency of FP trainers?</td>
<td>4.8</td>
<td>High</td>
</tr>
<tr>
<td>4.</td>
<td>What are the safety, feasibility, effectiveness and cost-effectiveness of various task-shifting approaches?</td>
<td>4.3</td>
<td>Medium</td>
</tr>
</tbody>
</table>

Task-shifting and sharing refers to the process of delegation whereby tasks are reassigned, where appropriate, to less specialized health workers. This process is currently being promoted as a strategy for expanding access to FP through enabling larger numbers of health workers to offer a wider range of methods. Where appropriately implemented, task-shifting has resulted in a significant increase in access to various FP services, and thereby addressing the unmet need for FP [13]. On the other hand however, evidence indicates, however, that informal (and sometimes inappropriate) task-shifting has been associated with a questionable quality of services [14]. Stakeholders called for operational research to examine the safety, feasibility, effectiveness and cost-effectiveness of various existing task-shifting approaches in Tanzania for informing future task-shifting efforts.
3.3 Service Delivery

This theme refers to strengthened service delivery systems and increased options for delivering quality, affordable and sustainable FP services. Service delivery systems include physical infrastructure, equipment and supplies, as well as special considerations and opportunities, such as integration of services, to meet the needs of vulnerable populations such as youths, men and women receiving postnatal care (PNC) or post abortion care (PAC), or HIV-infected women. About half of the literature reviewed fell under this theme, with research for services targeting the youth comprising most of the studies under this category. We categorized the research questions under this theme into six sub-themes that were used for data collection: (1) service delivery general and public, (2) private and faith-based organizations (FBO), (3) community-based family planning (CBFP), (4) youth services, (5) male involvement, and (6) integration of services.

3.3.1 Service delivery general/public

The 2010 Tanzania Demographic and Health Survey (TDHS) documented that government and parastatal facilities are still the main delivery channel for modern contraceptives, serving two-thirds of current modern method users [1]. Several barriers exist, however, that hinder access to and use of such services, particularly by the disadvantaged populations. The most frequently cited barriers are distance to such facilities; lack of privacy and confidentiality; negative attitudes from service providers; provider bias; and social-cultural barriers such as early marriages, religious beliefs and negative gender norms [15-17]. As a number-one priority, stakeholders called for innovative approaches to identify and reach sub-groups mostly affected by such barriers and hence with the highest unmet needs for FP services — for example, marginalized populations, drug addicts, disabled, sex workers, people living with HIV (PLHIV), etc.

National guidelines and protocols exist on how to provide quality FP services in Tanzania [18]; however, only half of facilities were reported having them [19]; Public facilities were more likely to report having guidelines or protocols for FP services compared to private facilities [20]. The extent to which such guidelines are being translated, understood and consistently adhered to by providers to ensure quality FP services is not known. For instance, a few studies have documented clients’ counseling on method mix to be insufficient [21, 22], particularly the extent to which providers consistently and adequately counsel clients to determine and meet their individual needs. In relation to this finding, stakeholders called for operational research to test the effectiveness of various counseling approaches in attracting new users and reducing discontinuation of FP services. On the other hand, the Tanzania Service Provision Assessment Survey and other studies have documented poor availability of infrastructures and other supplies as operational barriers for providers to consistently offer quality FP counseling and services [19, 23, 24]. Stakeholders have called for effective approaches to tackle this problem.
### Table 3: Key Research Questions: Service Delivery General/Public

<table>
<thead>
<tr>
<th>No.</th>
<th>Research questions</th>
<th>Final weighed score</th>
<th>Level of priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>What are the effective approaches for reaching subgroups with the highest unmet need for FP?</td>
<td>5.0</td>
<td>High</td>
</tr>
<tr>
<td>2.</td>
<td>What is the role of various provider incentives in improving access to quality FP services?</td>
<td>4.3</td>
<td>Medium</td>
</tr>
<tr>
<td>3.</td>
<td>How can the FP program best ensure that providers consistently have access to regular and adequate supplies to provide quality FP services?</td>
<td>4.1</td>
<td>Medium</td>
</tr>
<tr>
<td>4.</td>
<td>To what extent are FP service provision guidelines being disseminated, translated, understood and consistently adhered to by providers?</td>
<td>4.0</td>
<td>Low</td>
</tr>
<tr>
<td>5.</td>
<td>To what extent do providers consistently counsel clients on a broad range of FP methods and refer them for LAPMs when necessary?</td>
<td>4.0</td>
<td>Low</td>
</tr>
<tr>
<td>6.</td>
<td>What is the feasibility, acceptability and effectiveness of various approaches to FP counseling?</td>
<td>3.8</td>
<td>Low</td>
</tr>
<tr>
<td>7.</td>
<td>What are the feasibility, effectiveness and cost-effectiveness of quality assurance and monitoring mechanisms for various existing services?</td>
<td>3.7</td>
<td>Low</td>
</tr>
</tbody>
</table>

Many innovative ideas for quality improvement are being tested in a variety of service-delivery settings, but because very few interventions are designed within a rigorous research framework so as to measure and quantify their effects [25], most are not useful for informing future policy and program efforts. On the other hand, a review of the literature suggests that interventions that improve client-provider interactions show the greatest promise [25]. A second challenge with the existing literature on quality improvement interventions is that it relies on interventions that are typically difficult to bring to scale. Stakeholders called for evidence generation around quality improvement interventions that would enable the Tanzanian FP program to address program-related factors, which are the most commonly cited reasons for non-use of FP services among Tanzania women with the highest unmet needs.

### 3.3.2 Private and faith-based organization

Private-sector facilities, pharmacies, drug sellers, and commercial retail outlets, either independently or within social marketing programs, have tremendous potential to complement public facilities in the provision of FP services, but evidence of feasibility, affordability, quality of care and effectiveness is currently insufficient in Tanzania. Among studies reviewed, very few have examined the quality of FP services offered by the private sector, and the findings of those which attempted to do so are inconclusive [20, 26, 27]. One study conducted in Kenya, Ghana and Tanzania reported FP client satisfaction to be considerably higher at private-sector facilities compared to public facilities. This is most likely attributable to both process and structural factors, such as shorter waiting times and fewer stock-outs of methods and supplies [26]. In another study, the most important structural factor associated with clients’ preference for a private-sector facility for FP services was the presence of a trained provider at all times [27]. On the other hand, a study in Tanzania documented private facilities to be less likely to offer modern contraceptives and less likely to report having guidelines or protocols for FP services or visual aids for FP and STIs when compared to public facilities [20]. As a number-one priority under this theme, stakeholders called for effective approaches to ensure good quality of FP services offered through the private sector in Tanzania.
Table 4: Key Research Questions: Private/FBO-based FP Services

<table>
<thead>
<tr>
<th>No.</th>
<th>Research Questions</th>
<th>Final weighed score</th>
<th>Level of priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>How can the FP program best ensure quality of services offered through the private sector?</td>
<td>4.1</td>
<td>Medium</td>
</tr>
<tr>
<td>2.</td>
<td>How can the FP program best facilitate referrals for methods, particularly LAPMs, between private (for example, ADDOs) and public facilities?</td>
<td>3.8</td>
<td>Low</td>
</tr>
<tr>
<td>3.</td>
<td>What are the effective approaches for involving FBOs in promoting FP services?</td>
<td>3.4</td>
<td>Low</td>
</tr>
</tbody>
</table>

Little evidence exists in the public health literature in Tanzania on quality improvement interventions that target the private sector. What has been addressed mostly concerns private pharmacies (most commonly known as accredited drug dispensing outlets [ADDOs]), while not much has been done on private clinics. On the other hand, the engagement of the commercial sector in providing FP through private clinics is particularly noticeable through the burgeoning of social franchising. Recent reviews find strong evidence that franchising does increase access to and use of FP services, moderate evidence of improved quality and moderate evidence of increased use by the poor [28–30]. In relation to this, stakeholders called for research to investigate the feasibility, effectiveness and cost-effectiveness of various approaches of FP services provision through private clinics, including franchising. Especially needed was operational research on the effectiveness of approaches for engaging the private sector in the various ongoing quality improvement efforts by the public sector, such as dissemination of new guidelines, trainings, monitoring and supervision. On the other hand, even though sufficient evidence exists on opposition to modern FP by FBOs, we found no evidence on efforts/interventions targeted at this sector. Hence, stakeholders also called for research to identify and test the effectiveness of various approaches for involving FBOs in promoting FP services.

3.3.3 Community-based family planning (CBFP)

Community-based distribution (CBD) of FP has been an important strategy in all regions of the world for more than three decades now. CBD programs use community organizations, structures and institutions to promote the use of safe and simple contraceptive technologies. CBDs have been proven to safely and effectively provide pills (including emergency contraception) and condoms, as well as education on prevention strategies for HIV/AIDS and other sexually transmitted diseases in Tanzania [31]. CBD also play a pivotal role in mobilizing the community and generate demand for FP Services. As one of the research needs under this theme, stakeholders called for evidence generation regarding the safety, feasibility and cost-effectiveness of expanding the method mix in CBFP programs. Particularly, stakeholders called for research to investigate the feasibility and effectiveness of CBDs in providing the Standard Days Method (SDM) and lactational amenorrhea method (LAM), urging that these methods would cater to those opposing artificial FP methods.

A vast body of literature from numerous evaluations has demonstrated the acceptability and effectiveness of CBD programs in generating demand and increasing access and use of modern contraceptives in Tanzania, particularly among the hard to reach populations [32–35]. One study documented CBD programs to be very effective in reaching the poor, who were also reported to be as enthusiastic to use FP as the average group [32]. Evidence gaps remain, however, concerning the role of CBDs in meeting the needs of unmarried adolescents, recently married girls, males and urban slum populations who may be stigmatized when visiting clinics. Moreover, stakeholders called for operational research to establish the relative cost-effectiveness of CBD programs compared to clinic-based and mobile outreach models, as well as the feasibility and effectiveness of outreach workers in other sectors (such as agriculture and development) as...
FP providers. In addition, client referrals were another important aspect of CBD programs that stakeholders felt needs to be strengthened through evidence generation: particularly research needs were raised to establish the effectiveness of the referrals for have access to LAPMs, which are not usually available under CBD programs.

The policy environment in Tanzania is very supportive of CBDs/CHWs, but to sustaining. Evidence suggests that CBD programs exist as individual projects that are mostly answerable to the donors and organizations who do the planning and administration, facilitate implementation, and undertake monitoring and evaluation of their activities. Studies further document that the recruitment, training and remuneration of CHWs vary significantly across organizations and occasionally do not follow the national guidelines [31, 36]. In relation to this, stakeholders called for research to investigate the national coverage of CHWs, their qualifications and the activities they perform in various programs. Stakeholders would also like to see operational research to identify and test various approaches for improving the sustainability of CBD programs, which arose as a number-one priority for research needs under this sub-theme, followed by identification of factors affecting CBDs’ skills and performance.

Table 5: Key Research Questions: CBFP

<table>
<thead>
<tr>
<th>No.</th>
<th>Research questions</th>
<th>Final weighed score</th>
<th>Level of priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>What are the effective approaches for improving sustainability of CBFP programs?</td>
<td>4.9</td>
<td>High</td>
</tr>
<tr>
<td>2.</td>
<td>What are the key factors affecting CHWs' skills and performance?</td>
<td>4.9</td>
<td>High</td>
</tr>
<tr>
<td>3.</td>
<td>What are the effective mechanisms for CBFP data production, reporting and integration into the national CPR?</td>
<td>4.8</td>
<td>High</td>
</tr>
<tr>
<td>4.</td>
<td>How safe, feasible and cost-effective is it to expand the method mix in CBFP?</td>
<td>4.7</td>
<td>Medium</td>
</tr>
<tr>
<td>5.</td>
<td>What is the national coverage of CHWs? What are their qualifications and what activities do they perform in various programs?</td>
<td>4.7</td>
<td>Medium</td>
</tr>
<tr>
<td>6.</td>
<td>What are the effectiveness and cost-effectiveness of various approaches for CBFP programs compared with clinic-based and mobile outreach models?</td>
<td>4.6</td>
<td>Medium</td>
</tr>
<tr>
<td>7.</td>
<td>How can we best ensure timely and sustainable supplies for community-based programs?</td>
<td>4.6</td>
<td>Medium</td>
</tr>
</tbody>
</table>

3.3.4 Youth/adolescents services

Adolescent girls and boys both married and unmarried form substantial proportions of those with unmet needs for FP in Tanzania. According to TDHS 2010, the use of any contraceptive method among all adolescents between the ages of 15 and 19 was only 10.7 percent, of which 6.1 percent was attributed to male condoms [1]. On the other hand, studies on adolescents’ sexual and reproductive health (SRH) behaviors in Tanzania indicate high prevalence rates of sexual intercourse, significant proportions of adolescents with two or more lifetime sexual partners and infrequent use of condoms and other contraceptives [37]. Moreover, studies are reporting progressively early age of the onset of sexual behavior among the youth in Tanzania. In relation to these findings, research to establish the proper timing for interventions aimed at preventing pregnancies among various adolescent subgroups rose as a number-one priority for research needs under this sub-theme. On the other hand, interventions that seek to reduce sexual risk-taking among adolescents and prevent unintended teenage pregnancies are becoming increasingly common in Tanzania. Few of these, however, have been rigorously evaluated, and the majority of programs that have been evaluated are small in scale and implemented over a relatively brief period. Stakeholders
felt there is a scarcity of information concerning the costs, feasibility, acceptability and impact of various models of SRH information and FP service provision to youths, and little evidence exists regarding long-term behavioral effects. Moreover, stakeholders called for research to identify and test approaches for involving parents in interventions targeting adolescents, as this was deemed critical in increasing the effectiveness of various ongoing efforts.

Table 6: Key Research Questions: Youth/Adolescents Services

<table>
<thead>
<tr>
<th>No.</th>
<th>Research questions</th>
<th>Final weighed score</th>
<th>Level of priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>What is the best timing for interventions to prevent teenage pregnancies among various youth subgroups?</td>
<td>5.1</td>
<td>High</td>
</tr>
<tr>
<td>2.</td>
<td>What are the feasibility, acceptability and impact of various models of FP service provision to youths, for example, out-reach activities, CBDs and drug shops?</td>
<td>4.8</td>
<td>High</td>
</tr>
<tr>
<td>3.</td>
<td>How can the program best strengthen sexual and reproductive rights of youths?</td>
<td>4.8</td>
<td>High</td>
</tr>
<tr>
<td>4.</td>
<td>How can the FP program best involve parents in interventions targeting adolescents?</td>
<td>4.7</td>
<td>Medium</td>
</tr>
<tr>
<td>5.</td>
<td>What is the magnitude of abortion among young people?</td>
<td>4.6</td>
<td>Medium</td>
</tr>
<tr>
<td>6.</td>
<td>What are the effective approaches for providing youths with SRH education in private schools?</td>
<td>4.4</td>
<td>Medium</td>
</tr>
<tr>
<td>7.</td>
<td>How do various social and traditional practices (ngoma, unyago, etc.) impact adolescent SRH behaviors and teenage pregnancies?</td>
<td>4.1</td>
<td>Medium</td>
</tr>
</tbody>
</table>

Findings on youths’ awareness of SRH services show that on average 87 percent of youths have heard about SRH, with a majority having heard of FP services (83 percent) and VCT services (80 percent), while only half have heard of STI services [38]. Mass media was ranked first in a study that examined adolescents’ sources of RH information, followed by teachers and health workers [39]. Some of the reported barriers to SRH information, rights and services among young people were documented to be cultural beliefs and sexual norms, stigma and fear, long distances to health facilities, lack of privacy and confidentiality and negative attitudes from service providers [15, 40]. In relation to these findings, stakeholders called for research to establish effective approaches for strengthening sexual and reproductive rights of youths as well as effective approaches for providing youths with SRH education, particularly in private schools, in which prevalence is growing in Tanzania, but these have been less commonly targeted. Studies to investigate the impact of various social and traditional practices (ngoma, unyago, etc.) on adolescents’ SRH behaviors and teenage pregnancies were identified as another research need under this theme. Another growing problem among the youth in Tanzania is that of drug and substance abuse. Evidence is needed to establish how this problem is related to SRH behaviors among youth as well as teenage pregnancies. On the other hand, urban slum populations continue to grow exponentially and with young populations. Hence, evidence is also needed to guide programming for meeting the needs of these urban youths living in poverty.

Also worth mentioning is a recent systematic review [41] that found little evidence concerning the effect of various non-health interventions on unintended pregnancy. This review quickly prompted the WHO to make several research recommendations: (1) assess the impact of improved educational availability on the age of marriage, (2) assess the feasibility and long-term impact of economic incentives to girls and their families as a means of delaying the age of marriage, (3) determine the effect of formal and non-formal education on adolescent pregnancy prevention and (4) determine the effect of school-retention interventions (such as conditional or unconditional cash-transfer interventions) on delaying pregnancy [7]. For addressing coerced sex, WHO recommends engaging men and boys to alter gender norms and normative behaviors and suggests research to assess how laws and policies to prevent coerced sex have been formulated, enforced and monitored and to determine the effectiveness of these laws and policies in preventing coerced sex among adolescents.
3.3.5 Male involvement

Males’ unfavorable attitudes towards contraceptive use and their generally high preference for large family sizes are among the key drawbacks of the FP program in Tanzania. African men are often key figures in domestic decision making, particularly on fertility behavior. Given the importance of FP in improving the health of women and children, and in reducing population growth rates, men’s support and involvement are essential for FP to be widely accepted. Evidence in Tanzania indicates a high level of awareness of FP methods among most men [1], as well as knowledge on the benefits of FP, but there has been limited readiness among most men to use the services, both as clients and supportive partners. As a number-one priority, stakeholders felt there is a high need to better understand males’ attitudes and perceptions and other key underlying factors promoting or inhibiting their support/use of FP services.

One study conducted in northern Tanzania that examined factors associated with men’s preferences for smaller families found that men who desired fewer children were younger, educated at least to the primary and often to the secondary level, more affluent and likely to be Christian [42]. They had wives who had also completed at least primary school. Furthermore, these men were in a marital relationship where the partners chose each other, they communicated with their wives about important issues and made joint decisions, including the number of children they should have [42]. In relation to this finding, stakeholders called for research to identify effective mechanisms for promoting inter-spousal communication on FP. Also, it was deemed important to establish key motivating factors among men in support of FP in Tanzania and how these factors can best be used to influence other men to use the services.

Table 7: Key Research Questions: Male Involvement

<table>
<thead>
<tr>
<th>No.</th>
<th>Research questions</th>
<th>Final weighed score</th>
<th>Level of priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>What are the key factors underlying males’ opposition to FP and how can the FP program best address them?</td>
<td>5.6</td>
<td>High</td>
</tr>
<tr>
<td>2.</td>
<td>What are the key motivating factors among men in support of FP in Tanzania and how can the FP programs best use them to influence other men to support and/or use FP services?</td>
<td>48</td>
<td>High</td>
</tr>
<tr>
<td>3.</td>
<td>What are the effective mechanisms for promoting inter-spousal communication on FP in Tanzania?</td>
<td>4.6</td>
<td>Medium</td>
</tr>
<tr>
<td>4.</td>
<td>How can the FP program organize services to better meet the needs of male clients, for example, improving the effectiveness of male providers?</td>
<td>4.5</td>
<td>Medium</td>
</tr>
<tr>
<td>5.</td>
<td>What are the effective mechanisms for preventing FP-associated, gender-based violence among FP clients?</td>
<td>3.1</td>
<td>Low</td>
</tr>
</tbody>
</table>

FP-associated, gender-based violence among FP clients is another under-researched but growing problem in Tanzania. Among factors reported to fuel this problem is the fact that some women avoid consulting their male partners about the use of contraception. Discussions about sexual matters remains a taboo among most women in Tanzania and the majority of women feel uncomfortable to do so. In contrast, another study in Tanzania reported that men believe women should seek their male partners’ approval for contraception. These findings are useful in addressing gender barriers to joint decisions for contraception and service provision systems promoting gender-equitable FP services. Stakeholders felt there is a high need to establish the prevalence of this problem and test effective approaches to prevent it. Several initiatives exist in Tanzania that target male involvement in SRH services, including FP services; however, very few incorporate research on the effectiveness of these approaches. Stakeholders urged for evidence on how best to organize services to better meet the needs of male clients. For example, studies are needed to establish the effectiveness of male providers compared to female providers for male-targeted FP services.
3.3.6 **Integration of services**

Increasingly, much emphasis is being placed on integrating FP into other health services, acknowledging both that women’s RH needs are often multiple and that a visit to a clinic represents a valuable and perhaps rare opportunity to address a woman’s FP needs. The 2010 TDHS documented that of the 52 percent FP non-users who had visited a health facility in the past 12 months, only 20 percent had discussed FP with a provider at the facility, while 32 percent did not. This indicates missed opportunities for increasing FP acceptance and use. Various initiatives exist in Tanzania towards integrating FP into other maternal, infant and child health (MICH) services. Significant evidence exists concerning the feasibility, acceptability and effectiveness of various models of integration. Studies in Tanzania however have most commonly examined the integration of FP into various aspects of HIV care and treatment and postabortion care (PAC). Evidence remains remarkably limited on the integration of FP into other MICH services, such as antenatal care (ANC), immunization services, postpartum care, etc. Moreover, available studies rarely examined the cost-effectiveness of integrated models compared to non-integrated programs, and scanty evidence exists on the ways and extent to which the quality and uptake of FP and other services are affected in integrated services. The latter has become a number-one research priority under this sub-theme. Stakeholders called for operations research to describe and analyze the processes involved in linking FP and other reproduction and child health services (RCHS) programs in terms of systemic, personnel, logistical and budgetary elements. Specific issues that would benefit from further evidence under this sub-theme were determined to be how best to link FP counseling during ANC with postpartum use, whether tubal ligations can be offered safely and with informed choice following caesarean sections, and whether child immunization visits are a cost-effective opportunity for providing FP services.

**Table 8: Key Research Questions: Integration of Services**

<table>
<thead>
<tr>
<th>No.</th>
<th>Research questions</th>
<th>Final weighed score</th>
<th>Level of priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>In what ways and to what extent does integration affect the quality and uptake of FP and other services?</td>
<td>5.4</td>
<td>High</td>
</tr>
<tr>
<td>2.</td>
<td>What are the feasibility, acceptability, effectiveness and cost-effectiveness of various integration approaches?</td>
<td>5.4</td>
<td>High</td>
</tr>
<tr>
<td>3.</td>
<td>In what ways and to what extent do various policies and other operational factors affect the integration of FP services?</td>
<td>5.4</td>
<td>High</td>
</tr>
<tr>
<td>4.</td>
<td>How well equipped or skilled to provide quality FP counseling and services are the providers in other health services into which FP is integrated?</td>
<td>5.1</td>
<td>High</td>
</tr>
<tr>
<td>5.</td>
<td>To what extent do clients referred from integrated FP services with a limited method mix actually reach out to the referred facilities and receive the methods for which they were referred?</td>
<td>5.0</td>
<td>High</td>
</tr>
</tbody>
</table>

On the other hand, while service integration can happen operationally at the field level, program administration and policy factors can influence the implementation, particularly in terms of access to and the extent of budgetary resources. In relation to this, stakeholders called for evidence generation on the ways and extent to which various policies and other program factors affect service integration, as well as the extent to which various donor funding mechanisms discourage or encourage integration.
3.4 Advocacy

We divided the available evidence and knowledge gaps under this theme into two sub-themes: (1) advocacy efforts targeting policy/operational barriers to FP goals in Tanzania and (2) social and behavioral change communication (SBCC) efforts addressing factors associated with low up-take of FP services (myths and misconceptions, social norms, religious restrictions, etc. While the first sub-theme targets policy and other decision makers, the second targets FP services users.

3.4.1. Advocacy efforts targeting policy/operational barriers

The Tanzanian policy environment is generally supportive of FP; however, the documented political commitment is not matched by a commensurate resource and operational support. A recent analysis (2013) identified the following among policy/operational barriers to achieving FP goals in Tanzania: (1) lack of sustainable means for financing FP services, (2) restrictions on what level of provider is authorized to provide certain contraceptive methods, (3) FP-fee for services in private facilities, (4) lack of insurance schemes in financing FP services, (5) low engagement of the private sector in the provision of FP services, (6) lack of registered FP products in the essential drug list, and (7) shortage of FP providers [43]. Several advocacy initiatives have been targeted at some of these barriers in Tanzania, but most of these efforts are largely undocumented and exist only in the realm of anecdotal evidence, and information about them is disseminated verbally. Extremely few interventions under this category were designed within a rigorous research framework and hence are of limited usefulness in informing future policy and program efforts. In relation to this, stakeholders called for operations research to establish the feasibility, acceptability, effectiveness and cost-effectiveness of various currently ongoing advocacy efforts.

Several previous studies have documented the greatest potential of investing in FP towards averting maternal deaths, reducing infant and child deaths and reducing expenditures in various public services [44, 45]. One study documented that addressing unmet need for FP in Tanzania could avert 5,172 maternal deaths and 298,926 child deaths by the targeted date of 2015 [45]; furthermore, the cost savings in meeting the five MDGs by satisfying unmet need in that study outweighed the additional costs of FP by a factor of 4 to 1 [45]. Even though it emerged as a low priority, stakeholders felt evidence for investing in FP planning is still needed in Tanzania as a basis for advocacy efforts towards improved country political and financial commitment towards FP. Additionally, stakeholders called for research to improve the understanding of the criteria policy makers use in setting priorities, so as to inform the ongoing advocacy efforts. On the other hand, improving knowledge of the effective approaches for addressing barriers to FP advocacy efforts at all levels — for example, religious leaders and other individuals or groups that may not be pleased with the advocacy objectives — rose as a number-one priority under this sub-theme.

Table 9: Research Priorities: Advocacy Efforts Targeting Operational Barriers

<table>
<thead>
<tr>
<th>No.</th>
<th>Research questions</th>
<th>Final weighed score</th>
<th>Level of priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>What are the effective approaches for addressing barriers to FP advocacy efforts at all levels?</td>
<td>5.0</td>
<td>High</td>
</tr>
<tr>
<td>2.</td>
<td>How are the FP-related policies interpreted by various key FP players, and how does this impact the FP services currently being provided?</td>
<td>4.9</td>
<td>High</td>
</tr>
<tr>
<td>3.</td>
<td>What are the criteria that policy makers use in setting priorities for various competing national programs?</td>
<td>4.5</td>
<td>Medium</td>
</tr>
<tr>
<td>4.</td>
<td>Who are the most influential individuals and/or groups, and how can the program best use them in advocating for FP?</td>
<td>4.4</td>
<td>Medium</td>
</tr>
<tr>
<td>5.</td>
<td>What are the feasibility, acceptability, effectiveness and cost-effectiveness of various, currently ongoing advocacy efforts?</td>
<td>4.4</td>
<td>Medium</td>
</tr>
<tr>
<td>6.</td>
<td>What is the impact of investing in FP planning on various national indicators?</td>
<td>3.7</td>
<td>Low</td>
</tr>
</tbody>
</table>
Various computer-based tools exist that can help stakeholders demonstrate the effect of rapid population growth and the benefits of FP programs on different sectors. An example is the RAPID model developed by Futures Group International [46], which combines socioeconomic indicators — such as labor force participation, primary school enrollment and number of nurses per capita — with demographic information and population projections to estimate impacts up to 30 years into the future. The model uses the latter information to project different scenarios that enable policymakers to compare the consequences if the country continues to have high fertility versus the benefits of reducing fertility, in part, through FP programs. This evidence-based advocacy tool can help renew commitment to FP programs by policy/decision makers. Literature suggests that the RAPID tool has been implemented in Tanzania, but there is limited research-based evidence on whether the tool was effective in ensuring that commitments were actually made and investment done appropriately.

### 3.4.2 Social and behavior change communications (SBCC)

A review of the literature revealed widespread myths and misconceptions regarding FP services in general as well as on specific contraceptive methods. For instance, evidence revealed high levels of negative beliefs about condoms (such as, they cause cancer, have holes, contain HIV, reduce male pleasure), and their use was associated with promiscuity [47, 48]. In one of the studies, two out of three respondents affirmed believing in at least one negative condom rumor [49]. In this study, negative perception about condoms was the strongest, single predictor of willingness to use condoms, followed by greater perceived anonymity in acquiring condoms. The findings also suggest that gender factors, such as men’s dominance in decision making, do function as barriers to the use of modern contraceptives, but that fear of side effects among both men and women might be an even more important deterrent [17]. Even though widely documented generally, stakeholders felt there is still a need to clearly understand the key myths and misconceptions hindering the use of FP services for specific population sub-groups, such as out-of-school youths, men, commercial sex workers, PLHIV, and religious groups. The latter has risen to a number-one priority of the research needs under this sub-theme.

On the other hand, a substantial evidence base exists regarding the use of information, education and communication (IEC), and social and behavior change communications (SBCC) strategies to address barriers to contraceptive use and generate demand for FP generally. Literature indicates that mass media campaigns are very effective in generating an immediate demand for FP services and are associated with approval of FP and greater partner communication about FP and increased contraceptive use [50]. Recent developments have demonstrated the effectiveness of mobile health (m-health) in generating demand for FP services [51]. The extent to which various vulnerable subpopulations are reached by these types of interventions, however, remain under-researched — as well as the extent to which these interventions impact use of FP services in the long run. Additionally, stakeholders called for research to identify the preferred/trusted source of SRH information among the various population subgroups mentioned above and the best approaches for using such sources towards creating demand and reducing the unmet need.

<table>
<thead>
<tr>
<th>No.</th>
<th>Research questions</th>
<th>Final weighed score</th>
<th>Level of priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>What are the key myths and social norms hindering the use of FP services among various population subgroups?</td>
<td>5.6</td>
<td>High</td>
</tr>
<tr>
<td>2.</td>
<td>How can the FP program best make use of the preferred/trusted source of SRH information among various population subgroups to advocate for FP and reduce barriers to methods use?</td>
<td>4.8</td>
<td>High</td>
</tr>
<tr>
<td>3.</td>
<td>What is the accuracy and timeliness of various FP messages in relation to their impact on using FP services?</td>
<td>4.7</td>
<td>Medium</td>
</tr>
</tbody>
</table>

Table 10: Research Priorities: Social and Behavior Change Communications (SBCC)
3.5 Health Systems Management

Much of the focus in this review has been on research to improve the health systems. This is because the strength of particular national health systems will always influence the effectiveness and impact of interventions targeting any of its building blocks — service delivery, capacity building, financing, etc. Effective management systems include (1) ensuring that financial resources are made available in a timely manner to all implementing levels, (2) coordinating with other governmental and nongovernmental implementing partners, (3) regular tracking of all activities and deliverables needed to achieve the planned objectives and (4) using a health management information system (HMIS) for monitoring and evaluation to improve program performance. The available evidence on systems management in Tanzania indicates significant deficiencies in all the above aspects for the Tanzanian FP program. Moreover, when considering a national FP program, it is important to consider it in the perspective of the total market (TM) through which FP is made available, which includes public, commercial, not-for-profit and faith-based sectors. Interviewed stakeholders and the literature review, however, both indicate the existence of segmented FP delivery systems in Tanzania in which various organizations have their own activities, with individual monitoring and evaluation systems in which accountability happens at the organization instead of the national program level. In relation to this and as a number-one priority stakeholders called for effective approaches for improving the coordination of FP activities among the various stakeholders offering FP services in Tanzania. This will not only prevent the duplication of efforts but also enhance synergistic effects of activities by various stakeholders.

On the other hand, locally generated data and other evidence to guide program strategies, services implementation and the scale-up of effective models are well documented as being among the key factors that account for the relative success of FP programs in sub-Saharan Africa [52]. Available evidence in Tanzania, however, indicates poor use of data for decision making at all levels of the health system [53]. As a result, effective approaches for strengthening HMISs, especially through computerization, as well as building capacity of program managers to extract and use the data rose as a number-two priority under this theme. Stakeholders also called for research to establish the effective mechanisms for timely evidence sharing among various FP stakeholders in Tanzania, which was reported as being very poor.

Table 11: Key Research Questions: Health Systems Management

<table>
<thead>
<tr>
<th>No.</th>
<th>Research questions</th>
<th>Final weighed score</th>
<th>Level of priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>What are the effective approaches for improving the coordination of various FP activities in Tanzania to prevent duplication and enhance the synergy of effect of various programs?</td>
<td>5.0</td>
<td>High</td>
</tr>
<tr>
<td>2.</td>
<td>How can the FP program best facilitate the quality and use of data for decision making at various levels of the health system?</td>
<td>4.9</td>
<td>High</td>
</tr>
<tr>
<td>3.</td>
<td>What are the effective approaches for public-private partnership in FP service provision?</td>
<td>4.8</td>
<td>High</td>
</tr>
<tr>
<td>4.</td>
<td>What are the innovative and sustainable financing mechanisms for various FP programs activities in Tanzania?</td>
<td>4.8</td>
<td>High</td>
</tr>
<tr>
<td>5.</td>
<td>What are the key weaknesses in the current supervision of FP program staff and activities, and how can the program best deal with them?</td>
<td>4.6</td>
<td>Medium</td>
</tr>
<tr>
<td>6.</td>
<td>What are the effective approaches for timely evidence sharing among various FP stakeholders?</td>
<td>4.5</td>
<td>Medium</td>
</tr>
<tr>
<td>7.</td>
<td>How can the program best ensure accountability at all levels of the health system?</td>
<td>4.4</td>
<td>Medium</td>
</tr>
</tbody>
</table>
Lack of sustainable means for financing FP services is documented as being among the key challenges hindering achievement of the FP program goals in Tanzania [8]. In relation to this, stakeholders called for more up-to-date and rigorously designed studies to test innovative and sustainable financing mechanisms for various FP program activities in Tanzania. For instance, stakeholders called for research to establish the impact on use of services by including FP into various health insurance schemes. On the other hand, a review of evidence indicates that most poor people, who are also the least users of FP services, get most of their health care from private rather than public sources [28]. Hence, stakeholders called for identification of effective approaches for public–private partnership (PPP) in order to enable the expansion of FP services through existing private networks. Another research need under this theme was operations research to evaluate the feasibility, effectiveness and cost-effectiveness of the currently ongoing and new innovative monitoring and supervision mechanisms of program staff and activities in Tanzania.

3.6 Cross-Cutting

To reduce unmet need effectively, a national program first needs to fully understand the reasons why women, girls and their partners do or do not use contraception when they are at risk of an unintended pregnancy, and how these reasons vary among different population subgroups. Stakeholders called for research to analyze these reasons and their determining factors so as to identify which service delivery strategies, financing mechanisms, demand-generation strategies or commodity-mix options would best address the various barriers to use, disaggregated by key population subgroups. Additionally, methodological developments are needed to better measure and explain sociobehavioral determinants of demand and use, including risk perception, ambivalence, and fear, both for the women and their partners. This research is particularly needed for populations marked by low literacy rates, poverty and low contraceptive prevalence. Stakeholders also called for evidence generation to inform the program of the reasons for method discontinuation or failure so that interventions can be developed and tested through operations research to reduce the causative factors. Such evidence can also inform market shaping (to identify appropriate method mixes for particular populations) and product development (to guide new product designs).

**Table 12: Key Research Questions: Cross-Cutting**

<table>
<thead>
<tr>
<th>No.</th>
<th>Research questions</th>
<th>Final weighed score</th>
<th>Level of priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>What is the relationship between FP knowledge and contraceptives uptake among various key population subgroups?</td>
<td>5.2</td>
<td>High</td>
</tr>
<tr>
<td>2.</td>
<td>What is the prevalence of discontinuation of various FP methods, and what are their associated factors?</td>
<td>4.7</td>
<td>Medium</td>
</tr>
</tbody>
</table>
INSTITUTIONAL ARRANGEMENTS FOR IMPLEMENTATION

The NFPRA will be implemented under the leadership and management of existing governance structures of the Tanzanian health research architecture supported by MOHSW, the Ministry of Communication, Science and Technology (MoCS&T) and the Ministry of Education and Vocational Training (MOEVT). The cooperation, input and actions of a wide range of partners and stakeholders at all levels are required for the successful conduct of research to answer priority questions, as well as essential deliberate efforts to facilitate dissemination and use of findings with the principle focus of improving health outcomes.

Pursuant to its mandate, the National Institute for Medical Research (NIMR) will conduct high quality research to answer priority questions and ensure that the research conducted is of the utmost highest quality and follows ethical principles. Similarly, the Tanzania Commission for Science and Technology (COSTECH) will mobilize funds for the support and promotion of scientific research and foster co-operation among stakeholders. Academia under the MOEVT also has a role to not only conduct cutting-edge research, but also build a pool of future scientific researchers interested in FP research.

Research is not an end in itself, but a means to improve health outcomes through the application of the evidence generated from research to policies, programs and practice. As such, the RCHS in its role for overall coordination and oversight for the FP program, will ensure that the research studies conducted are in alignment with the priorities listed in this NFPRA, to ensure relevance as well as to facilitate adoption of evidence generated to advance the NFPCIP. The local government authorities (LGAs) play a critical role in providing the platform on which the research is conducted at facility and community levels, as well as monitoring and reporting on the research conducted in their respective locations.

Stakeholders, including NGOs and the private sector, are fundamental partners in securing funding resources for research, conducting the research to implement the NFPRA and advocating for turning evidence into policy and practice.
REFERENCES


Methodology

Activities for generating knowledge gaps and setting priorities for FP research followed the six steps proposed by the Commission on Health Research for Development (COHRED) and were divided into four main phases as described in details below.

i) Preparatory phase

The priority-setting exercise commenced by allowing for the team to understand the environment within which the exercise will take place. This was accomplished through reviewing relevant country family planning (FP) statistics; reviewing FP-related national policies and guidelines; and mapping out the key FP stakeholders, which included policy makers at different levels, donors and development partners, technical organizations, facility and community-based FP providers, and researchers. Following this, the team defined a clear focus and scope of the priority-setting exercise to be undertaken. They decided on five strategic action areas of the NFPCIP as themes to guide the data collection process. These five areas included contraceptive security, capacity building, service delivery, advocacy and health systems management. In addition, a sixth theme, cross-cutting issues, was added to incorporate issues not addressed under the other five themes. Moreover, service delivery and advocacy themes were further subdivided into six and two sub-themes, respectively, to make a total of 12 themes.

The team then selected a representative sample of key stakeholders from a list of all the key FP stakeholders developed above for participation in expert consultation meetings under each of the 12 themes. The team had agreed that three main methods (focus group discussions [FGDs], key informant interviews [KIIs] and review of literature) would be used for information gathering from key stakeholders to identify the key research questions for the national FP program. It was predetermined that research under NFPRA will include health systems research; operational research; and clinical, behavioral and social sciences research. It will exclude biomedical and clinical trials research.

During this preparatory phase, the team also explored and discussed the various existing methods for setting priorities. The team chose the Essential National Health Research (ENHR) methodology as this was found to be easier to understand and apply than the other two methods considered, the 3D Combined Approach Matrix (CAM) and the Child Health and Nutritional Research Initiative (CHNRI).

After analyzing the context, defining the focus and scope and deciding on methods to be used, the team defined a detailed work plan to manage the priority-setting exercise. The workplan defined various activities to be undertaken, with their corresponding deliverables and timelines, and assigned specific roles and responsibilities to the team members.

ii) Identification of research areas

The goal of this phase was to draw up an initial list of research areas that emerged both from the inputs of a sample of key FP stakeholders (selected in phase 2.1 above) and a review of literature, published and unpublished, in the past 10 years (including program reports/documents).
Consultations with key FP stakeholders: Consultation with a sample of key stakeholders through FGDs and/or KIIs was conducted separately for each of the 12 themes. Prior to conducting the consultation meetings, questions to guide the FGDs and KIIs were developed for each of the 12 thematic areas above. The process of developing the FGD and KII guides was guided by the Supply, Enabling Environment and Demand (SEED) assessment model developed by EngenderHealth. The model provides 25 criteria for assessing the functioning of a strong, comprehensive and high quality FP program. Questions were developed to assess the existence of evidence around each of the 25 criteria of the SEED model. Questions not covered by the 25 criteria of the model were added to the guides as required. FGDs and KIIs were carried out between May and June 2013, during which period the team had come up with a set of key research questions as proposed by various stakeholders participating in each of the 12 thematic consultations. Participating stakeholders included researchers, program managers and decision-makers at different levels and health services providers, both from the public and private sector.

Literature review: We conducted a literature search to capture existing evidence on the FP program published in peer-reviewed and gray literature between 2002 and 2012/13. Moreover, information from other program documents with relevant evidence, such as meeting proceedings, was gathered from various stakeholders and reviewed. To be eligible for inclusion, an article/report had to describe findings from primary or secondary data, and the research had to be conducted in Tanzania. Multi-country studies, including Tanzania as one of the study sites, were also included. The process of obtaining and reviewing available literature commenced prior to and continued throughout and beyond the stakeholders’ consultations. A total of 161 articles and program documents qualified for inclusion and were reviewed. The majority of the reviewed literature fell under the service delivery category (82/161 [50.9 percent]), with youth-targeted services comprising most of the studies (25/82 [30.5 percent]) under this category, followed by service delivery general/public (20/82 [24.4 percent]), integration of services (16/82 [19.5 percent]), CBFP (13/161 [15.5 percent]), male services (6/82 [7.3 percent]), and private/FBO (2/82 [2.4 percent]). Studies on cross-cutting issues came next after service delivery with a total of 46/161 studies (28.6 percent). The proportion of studies under other categories were as follows: contraceptive security (8/161 [5.0 percent]), capacity building (3/161 [1.7 percent]), advocacy general (7/161 [4.3 percent]), social and behavioral change communication (SBCC) (11/161 [6.8 percent]) and health systems management (4/161 [2.5 percent]). Through the review of literature, further key research questions that were proposed in various studies were incorporated into the corresponding lists of key research questions from the thematic stakeholders’ consultations.

Review of assembled literature against the key FP research questions: The assembled key research questions, both from the stakeholders’ consultations and literature review, were reviewed against the existing evidence from the literature review above. This was done to aid the identification of research questions with no sufficient existing evidence, which were carried forward to the prioritization process.
iii) Setting priorities

After a list of questions that needed further research was developed, the next step was to rank them in order of increasing/decreasing priority by applying the selected methodology for priority setting. The team commenced this process by involving a small number of stakeholders in selecting, from a broad list, a few criteria to be used for assigning priority scores to various established research questions. Three criteria were agreed upon for use: relevance, applicability/use and impact. Two assessment questions, each with three score choices, were assigned to each of the three criteria. The first two criteria were assigned 30 percent weight while the third (impact) was given a higher weight of 40 percent.

Following this, a two-full-day’s workshop was dedicated to the priority setting in which a broader number of stakeholders began the exercise by reducing the research questions to a manageable list of priorities by omitting questions that stakeholders felt could be answered through other non-research program initiatives. The remaining questions were carried forward for priority setting and final ranking. Using a pre-tested scoring form (refer to appendix), participating stakeholders were asked to assign scores to each of the research questions using the three criteria established above (An online priority setting survey was used to facilitate the participation of key stakeholders that were not available to participate on the dates of the priority-setting exercise). The completed forms were then entered into an Excel program and weight for each criterion was applied to obtain the individual questions’ final weighted scores. This was followed by the ranking of the questions in accordance with their final research priority scores (RPS).

<table>
<thead>
<tr>
<th>Score</th>
<th>Rank</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.8 &lt; x ≤ 6</td>
<td>High priority RQ</td>
<td>Do now</td>
</tr>
<tr>
<td>4 &lt; x ≤ 4.8</td>
<td>Medium priority RQ</td>
<td>Do later</td>
</tr>
<tr>
<td>3 &lt; x ≤ 4</td>
<td>Low priority RQ</td>
<td>Reconsider</td>
</tr>
</tbody>
</table>

Table: Final Ranking of Established FP Research Questions

iv) Action plan/Making priorities work

Having identified the priority areas for FP research in Tanzania, the team involved a sample of the key stakeholders in discussions on how best to ensure that the identified research priorities guide the production and management of the national FP evidence for a given period of time.
### Priority-Setting Form

| STRATEGIC ACTION AREA: __________________________ |
| QUESTION NO: ______ |

**INSTRUCTIONS:** For each of the criteria below, enter the appropriate score for the research topic in the box to the left of the title. Add up all the scores and write the total in the aggregate score box at the bottom of the page.

1. **RELEVANCY**  
The purpose of this category is to make sure the proposed research is the right kind for the right people, and is pertinent to the health problem of the community without ignoring equity issues. The key question is "Why should we do it?"
   
   a. How severe is the problem addressed by this research question?  
   - High: 3  
   - Moderate: 2  
   - Low or none: 1  
   
   b. To what extent will the research outcome directly address the identified FP gap or issue?  
   - Very much: 3  
   - Not very much: 2  
   - Not at all: 1  

2. **APPLICABILITY AND USE**  
The purpose of this category is to assess the extent with which the research outcomes will be utilized to inform decision-making.
   
   a. What are the chances that the research outcomes will be implemented at a scale or applied to inform decision-making?  
   - High: 3  
   - Moderate: 2  
   - Low or none: 1  
   
   b. How urgent are the data needed for decision making?  
   - Very urgent: 3  
   - Urgent: 2  
   - Not urgent: 1  

3. **IMPACT**  
The purpose of this category is to estimate the benefit of using or implementing the research results, and assessing their merit and usefulness. The key question is "to what extent will implementation of the research outcome contribute to attaining the CPR of 60%?"
   
   a. To what extent will the knowledge generated from this research contribute to efforts to increase access and utilization of FP services?  
   - Very much: 3  
   - Not very much: 2  
   - Not at all: 1  
   
   b. To what extent will this research question inform and advance achievement of the strategic results of the NFPCHIP?  
   - Very much: 3  
   - Not very much: 2  
   - Not at all: 1  

**AGGREGATE SCORE:**  

3/18
### Annotated Bibliography

#### 1. CONTRACEPTIVE SECURITY

**David S et al., 2006: Contraceptive security: practical experience in improving global, national and local product availability**

<table>
<thead>
<tr>
<th>Study Objectives:</th>
<th>Contraceptive security: practical experience in improving contraceptive security five years after the 2001 Istanbul Conference.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Results Summary:</td>
<td>The report documents the lessons learned in increasing and diversifying contraceptive finance; understanding and expanding the total market; and working with the public, private and NGO sectors to improve service delivery and product availability.</td>
</tr>
<tr>
<td>Policy/Programmatic Implications:</td>
<td>The report describes what has been done and defines what remains to be done to improve contraceptive product availability.</td>
</tr>
<tr>
<td>Source: Arlington, Va: DELIVER, for the U.S. Agency for International Development.</td>
<td></td>
</tr>
</tbody>
</table>

**Snow John D et al., 2007: Tanzania: final country report**

<table>
<thead>
<tr>
<th>Study Objectives:</th>
<th>To explore program results for DELIVER in Tanzania and offer lessons learned and directions for future programs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study Design/Setting:</td>
<td>DELIVER's activities in Tanzania concentrate primarily on three main areas of intervention: (1) the development of a health management integrated logistics system, (2) commodity security (in particular, contraceptives), and (3) the quantification and procurement of antiretroviral drugs.</td>
</tr>
<tr>
<td>Results Summary:</td>
<td>A forum of monthly contraceptive security meetings was established, bringing together all of the major actors in contraceptive distribution to analyze stock levels, pipeline data and distribution rates. This forum, coupled with the annual contraceptive-procurement table exercise, improved procurement planning and monitoring of both USAID-supplied contraceptives and those procured with other sources of funding.</td>
</tr>
<tr>
<td>Policy/Programmatic Implications:</td>
<td>DELIVER's success was founded not only in its considerable achievements in the core areas of its contract scope of work but also in its flexibility and ability to expand into related areas of intervention as the environment in which it operated evolved, and its ability to respond to the needs of both the donor and the beneficiary.</td>
</tr>
</tbody>
</table>

**Leaby E et al., 2009: A case study of reproductive health supplies in Tanzania**

<table>
<thead>
<tr>
<th>Study Objectives:</th>
<th>To provide an overview of how reproductive health (RH) supplies, specifically contraceptives and condoms, are programmed, managed and funded in Tanzania.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study Design/Setting:</td>
<td>The Tanzania case study was conducted based on two research processes: (1) reviewing documents and (2) interviewing representatives of governmental agencies, donor agencies and nongovernmental organizations (NGOs) active in contraceptive supplies.</td>
</tr>
<tr>
<td>Results Summary:</td>
<td>The project identified four indicators by which to assess tangible results at the country level in contraceptive security: (1) the existence of a contraceptive supply-coordination mechanism, (2) the inclusion of contraceptives on the national essential drug list, (3) a functioning government budget line item for contraceptive supplies, and (4) the integration of contraceptive supplies into a financing mechanism.</td>
</tr>
<tr>
<td>Policy/Programmatic implications:</td>
<td>This information should also facilitate collaboration and coordination with advocacy efforts at the global and regional levels.</td>
</tr>
</tbody>
</table>
Leahy E, 2009: Reproductive health supplies in six countries: themes and entry points in policies, systems and financing

Study Objectives: To identify the challenges faced by RH programs.

Results Summary: Funding constraints, combined with a weak commitment to prioritize the purchase of RH supplies on the side of the recipient countries and a limited capacity for distribution, have created an unstable environment for supplies worldwide.

Policy/Programmatic implications: The report calls for renewed attention to RH supplies to avoid putting the health of millions of women at risk.


Directorate of External Linkage and Community Engagement, Mzumbe University, 2011; A comprehensive reproductive health commodity security (RHCS) assessment in Tanzania mainland

Study Objectives: To assess the supply chain of the family planning (FP) and other reproductive health commodities (RHCs) in Tanzania mainland.

Results Summary: On the policy environment, the results showed that Tanzania had a high commitment level in ensuring its people had access to RH, but this commitment had not been backed by adequate financing to reflect what the policies were promising. Generally, data on financing for RHCs showed that funding for the commodities was low. Financing of FP was largely left to the development partners.

Policy/Programmatic implications: Local government authorities (LGAs) could raise their own resources to finance the commodities; however, when they were able to raise funds for medical supplies, priority was given to other RHCs on the grounds that lack of these other RHCs had more immediate consequences than the lack of FP services.

Source:

Madsen EL et al., 2011: The road from Istanbul to Addis and beyond. Setting an agenda for reproductive health supplies

Study Objectives: To inform stakeholders of the successes, challenges and opportunities for RH supplies following recommendations from the Istanbul meeting of May 2001.

Results Summary: Shortages and stockouts persist in many places due to any combination of factors. Shortfalls remain between funds committed and allocated and between funds allocated and spent. Low government funding and heavy dependence on donors for RH supplies remain chief concerns across all sectors.

Policy/Programmatic implications: Several underlying challenges and barriers to RH supplies identified in Istanbul are alive and well, as evidenced by the country-level responses reflected in this report. A new agenda for action must be established for the coming years.


Snow John D, 2012: Contraceptive Security and Decentralization: Tips for Engaging Lower-Level Health Managers in the SPARHCS Process

Study Objectives: To assess and improve RH commodity availability.

Study Design/Setting: N/A

Results Summary: The Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) framework and tool has inspired the use of multiple methodologies for assessing and improving RH commodity availability.

Policy/Programmatic implications: This brief includes practical tips for RH commodity security (RHCS) champions working at all levels on how to engage the lower health system-levels throughout the SPARHCS assessment, strategic planning and implementation phases.

2. CAPACITY BUILDING

Snow John D, 2012: Contraceptive security and decentralization: Lessons on improving reproductive health commodity security in a decentralized setting

Study Objectives: To analyze country experiences on contraceptive security and decentralization.

Results Summary: During the last decade, RHCS advocates have increasingly recognized that certain commodity security issues occur more often in decentralized settings. They have also learned the value of engaging lower-level stakeholders (regional, district and facility managers and health providers, as well as community members) throughout the commodity security strengthening process.

Study Design/Setting: Multi-country

Policy/Programmatic implications: Several countries have devised their own RHCS strategies in their decentralized settings.


2. CAPACITY BUILDING

Muganyizi PS et al., 2009: Analysis of pre-service family planning teaching in Tanzania

Study Objectives: To analyze the current pre-service training curricula and the actual training of FP.

Results Summary: FP was included in 64 percent (7/11) of the schools’ curricula. Due to irregularities in the inclusion of FP in the curricula, only the clinical medicine NTA-5 curriculum was ranked suitable for FP teaching. All types of FP methods were taught in all the schools, but practical training was erratic and lacked effective evaluation. Skills for permanent methods of FP were lacking in all of the schools except one AMO school. Schools were short of teaching facilities, teachers, knowledge updates and varieties of FP methods.

Study Design/Setting: An analysis of pre-service technical and medical curricula and observation of the actual teaching at 35 representative schools in Tanzania.

Policy/Programmatic implications: FP partners as well as other Development partners should advocate for the wide adoption of a competency-based national qualification system in FP for all the programs and schools.

Source: USAID, ACQUIRE, EngenderHealth.

IntraHealth International, Capacity Project, 2009: Starting with the classroom: updating family planning knowledge in East Africa

Study Objectives: To build instructors’ capacity and address the knowledge gaps.

Results Summary: A quantitative and qualitative evaluation showed the workshop to be highly successful. Average knowledge scores climbed from 58 percent on the pre-test to 81 percent on the post-test. Additionally, 94 percent reported that they have used the workshop information and resources to update their colleagues.

Study Design/Setting: A week-long workshop on contemporary issues in family planning for midwifery tutors in Kenya, Tanzania and Uganda.

Policy/Programmatic implications: N/A


Study Objectives: To address the various forces that affect the health workforce in developing countries.

Results Summary: The most significant results included developing and applying a HRIS strengthening process and transferring HRIS software technology to the field; supporting human resources (HR) strategic policy and plan development and implementation; and building human resources for health (HRH) leadership and management skills, both at the country level and by contributing to the growth of an HRH leadership cadre in sub-Saharan Africa.

Study Design/Setting: The Capacity Project worked across sectors such as health, education, planning, public service commissions and local government entities to address the varied forces that affect the health workforce in developing countries.

Policy/Programmatic implications: N/A

Source: IntraHealth International.
3. SERVICE DELIVERY

1.1 General & Public Sector

Hatchkiss DR et al., 2002: The influence of maternal and child health service utilization and access to private sector family planning services on subsequent contraceptive use: a multi-country study

Study Objectives: To examine the relationship between the intensity of MCH services use and contraceptive use, and the relationship between access to private-sector FP services and contraceptives.

Results Summary: The intensity of MCH services use was positively associated with subsequent contraceptive use among women — even after controlling for observed and unobserved factors at the individual, household and community levels. Proximity to private-sector facilities was strongly associated with contraceptive use, even after controlling for physical proximity to any FP services and observed and unobserved factors at multiple levels.

Study Design/Setting: The study was based on household survey data and data on the supply environment for health and FP services gathered during the 1990s in Morocco, Tanzania, Bolivia, Guatemala and Indonesia.

Policy/Programmatic implications: The findings suggest that investing in programs that are effective in improving the use of MCH services can be a viable policy strategy, not only to improve MCH service use but also to improve the use of FP services.


Richey LA, 2003; HIV/AIDS in the shadows of reproductive health interventions

Study Objectives: To analyze why AIDS and RH programs are still thought of separately and implemented through separate channels in spite of the impact of HIV on RH.

Results Summary: Although the service providers were never shy about giving their clients health care advice, both solicited and unsolicited, HIV/AIDS was not a topic in these conversations. AIDS was confined to a brief mention during counseling for informed choice, in the course of the “normal” visit for FP, in which women were told that condoms prevent STIs such as HIV, and other methods do not.


Policy/Programmatic implications: The reinvigorated effort on the part of the Tanzanian government and its donors should aim at reinforcing a multi-sectoral approach that will balance service provision, funding and coordination efforts throughout the country.


RamaRao S et al., 2003: The quality of family planning programs: concepts, measurements, interventions, and effects

Study Objectives: To identify and describe the principal methodological research including conceptual frameworks, perspectives, and tools for measuring and improving quality of services.

Results Summary: Many innovative ideas for improving quality are being tested and the review suggests that interventions that improve client–provider interactions show the greatest promise; however, these efforts are largely undocumented and exist primarily in the realm of anecdotal evidence, and information about them is disseminated verbally. As a result, they are not useful for informing future policy and program efforts. Few interventions are designed within a rigorous research framework so as to measure and quantify their effects.

Study Design/Setting: Systematic review of FP programs conducted in a variety of settings in the developing world (including Tanzania).

Policy/Programmatic implications: One important objective of this review is to provide rigorous documentation of successful efforts, lessons learned and pathways of influence that are useful for guiding future policy and programs.


Clements S et al., 2004: Who is being served least by family planning providers? A study of modern contraceptive use in Ghana, Tanzania and Zimbabwe

Study Objectives: To identify the poorest and other vulnerable subgroups being served least by FP providers.

Results Summary: The poorest subgroup, with fewer amenities, was less likely to be using a modern method. Rural women and those whose partners had received no education were the least likely to be using modern methods, while women from traditional religions typically had the lowest use of modern contraception.
### Study Design/Setting: Demographic and health surveys of Ghana, Tanzania and Zimbabwe.

**Source:** *Afr J Reprod Health* 2004, 8(2):124–36.

**Policy/Programmatic implications:** N/A


**Agha S et al., 2004: The availability of socially marketed condoms in urban Tanzania, 1997–99**

**Study Objectives:** To evaluate trends in the availability of socially marketed condoms in urban Tanzania, and to assess the effect of changes in the social marketing program's strategy for distributing condoms to retail outlets.

**Results Summary:** The proportion of condom outlets that were supplied by wholesalers increased from 42 percent in 1997 to 60 percent in 1999. The percentage of outlets that had been solicited to sell condoms by social marketing condom sales persons increased from 14 percent in 1997 to 25 percent in 1999. The increasing use of wholesalers allowed sales agents to devote more time to opening new outlets.

**Study Design/Setting:** Three retail outlet surveys conducted in urban Tanzania in 1996/97, 1998 and 1999.

**Policy/Programmatic implications:** Because many high-risk sexual contacts are initiated in bars, and because women at bars are more likely obtain condoms from bars than men at bars, it may be worthwhile to step up efforts to increase the availability of socially marketed condoms in bars.


### Jain A et al., 2006: Tanzania baseline survey 2004-2005: technical report

**Study Objectives:** To measure the situation of RH/FP services in 10 regions of Tanzania by assessing the indicators of availability, quality of care, client satisfaction and perception of services.

**Results Summary:** Twenty-eight percent of hospitals were able to provide the intrauterine contraceptive device (IUCD), and 15 percent of hospitals were able to provide no-scalpel vasectomy (NSV) on the day of the visit. Thirty-eight percent of trained providers were not able to implement their mini-laparotomy skills, either because their health facility or department did not offer the service or because they lacked the equipment to provide it. Fewer than half the facilities had a trained person available to provide PAC services. More than half of the facilities had received supervision in less than three months. Provider counseling on method mix was insufficient. Discussions about the risk of sexually transmitted infections (STIs) were observed in fewer than one in 10 client-provider interactions.

**Study Design/Setting:** The study was conducted in 2004 and 2005 and it collected data from 325 visited sites across the 10 regions of Tanzania. The study included facility audits, provider interviews, client-provider interaction checklists and client exit interviews.

**Policy/Programmatic implications:** The study provides a great deal of information that will enable the Tanzania National Reproductive and Child Health program to develop appropriate interventions to address the issues identified.

**Source:** In. New York, New York, EngenderHealth, ACQUIRE Project, 2006 May.


**Study Objectives:** To assess the capacity of facilities to provide good quality services and the existence of functioning systems to support these services.

**Results Summary:** Most facilities offering temporary FP methods had them in stock on the day of the survey. Nearly all the facilities assure both visual and auditory privacy, and visual aids for client education are also widely available. Only half of the facilities have FP guidelines and protocols available. Less than one-third of the facilities have everything needed for infection control in the FP service area, with running water being the item most often missing. Up-to-date FP registers are available in most facilities, especially in government facilities.

**Study Design/Setting:** Data from a representative sample of 611 health facilities throughout Tanzania.

**Policy/Programmatic implications:** N/A

**Source:** Dar es Salaam, Tanzania, National Bureau of Statistics, 2007 Nov.
### Arendt-Kuenning M et al., 2007: The impact of demand factors, quality of care and access to facilities on contraceptive use in Tanzania

**Study Objectives:** To examine the impact of quality of care of FP services and access to services on current contraceptive use in Tanzania.

**Results Summary:** The quality-of-care variables that have positive and significant impacts on contraceptive use for urban and rural women are the information given to the clients and technical competence. Qualitative data indicated that lack of privacy was an important barrier to women’s contraceptive use in Tanzania. Decreasing the distance to the nearest rural health facility with FP services is weakly associated with higher contraceptive use. While increasing women’s total years of schooling would increase contraceptive use for urban women, increasing the literacy rate would increase contraceptive use for rural women.

**Policy/Programmatic implications:** Policies to raise female schooling and literacy and to give them enough information would result in greater contraceptive use in urban and rural Tanzania.


### Wanjiru M et al., 2007: Assessing the feasibility, acceptability and cost of introducing postabortion care in health centres and dispensaries in rural Tanzania. Final report

**Study Objectives:** To assess the feasibility, acceptability and cost of introducing postabortion care (PAC).

**Results Summary:** Overall, the results indicate that PAC services are feasible and easy to set up in the lower health facilities, and are considered to have offered a satisfactory level of quality of care for clients. However, the assessment also revealed some key weaknesses. Interviews with clients and service records indicate that the majorities were not given information on all contraceptives or common side effects and most were not getting any counseling or information on STIs and HIV.

**Policy/Programmatic implications:** The pilot findings demonstrated that decentralizing PAC services to health centers and dispensaries is feasible and effective, and that the approach could be scaled up at a reasonable cost ($726 per health center or dispensary) to other lower level facilities in Tanzania.


### Lees S et al., 2009: Sexual risk behaviour for women working in recreational venues in Mwanza, Tanzania: considerations for the acceptability and use of vaginal microbicide gels

**Study Objectives:** To explore the social context of sexual-risk behavior among women working in recreational occupations.

**Results Summary:** The environments in which women work, which involve low incomes, use of alcohol, the norm of transactional sex, male sexual coercion and, violence at times, lead to risky sexual encounters. The study revealed the ways that women countered these phenomena. These ways included selecting partners who accepted condom use more readily seemed “less risky” and/or negotiating for condom use either financially or for contraceptive use.

**Policy/Programmatic implications:** Sustained use of microbicide will depend on how formulations overcome the difficulties women currently experience with condom negotiation and the specific environments and relationships in which they engage in sex.

**Source:** *Culture, Health and Sexuality* 2009, 11(6).
### EngenderHealth AP, 2010: Increasing access to family planning: the case for task-shifting female surgical contraceptive services

**Study Objectives:** To assess the possibility of task-shifting Mini-Laparatomy under Local Anesthesia (ML/LA) services from medical officers and Assistant Medical Officers (AMOs) to Clinical officers (COs).

**Results Summary:** Although the majority of those interviewed supported task-shifting for ML/LA, several barriers were identified. Many providers mistakenly believe that there is a policy restricting COs from performing ML/LA. Current policies in Tanzania are too vague on its classification as such the current needs of the population and the demand for female surgical contraception have resulted in some doctors and AMOs providing on-the-job training to COs in ML/LA and other services. The COs who already offer ML/LA services have all been favorably assessed by higher-level providers, with no concerns regarding complications or quality of care.

**Study Design/Setting:** Review of national and international policies and experiences regarding provision of ML/LA by COs and in-depth interviews with key informants at the national level and with 35 service providers from the Morogoro, Kagera and Pwani regions, Tanzania.

**Policy/Programmatic implications:** Training and equipping COs to perform ML/LA would significantly increase access to FP, address unmet need for FP and help women and couples in Tanzania meet their reproductive goals.

**Source:** Dar es Salaam, Tanzania, EngenderHealth, ACQUIRE Project, 2010 May.

### Cisek C, et al., 2010: Promoting hormonal implants within a range of long-acting and permanent methods: the Tanzania experience

**Study Objectives:** To support the Tanzanian Ministry of Health and Social Welfare (MOHSW) in introducing and expanding access to long-acting and permanent methods of contraception (LA/PMs).

**Results Summary:** The service delivery statistics showed an overall increase in implant use compared with other LA/PMs.

**Study Design/Setting:** The project used the Supply-Demand-Advocacy (SDA) approach for increasing access to LA/PMs. In this approach: (1) SUPPLY refers to provider training, improvements in service quality, etc.; (2) DEMAND is for services; and (3) ADVOCACY is for a supportive policy environment.

**Policy/Programmatic implications:** These results demonstrate the positive effect of expansion of services to lower-level facilities and the importance of task-sharing.

**Source:** New York, New York, EngenderHealth, RESPOND Project, 2010 May.

### Guindon GE et al., 2010: Bridging the gaps between research, policy and practice in low- and middle-income countries: a survey of health care providers

**Study Objectives:** To investigate the use of research-based evidence in defined clinical areas among a sample of health care providers, and examine factors that may facilitate or impede such use.

**Results Summary:** The study found that those who reported using clinical practice guidelines in paper format or scientific journals from their own country in paper format had significantly increased odds of reporting that the use of research-based evidence has led to concrete changes in their professional practice.

**Study Design/Setting:** A survey of health care providers in 10 low- and middle income countries, including Tanzania.

**Policy/Programmatic implications:** Increased investments in local research, or at least in locally adapted publications of research-based evidence from other settings, are needed.

**Source:** CMAJ 2010, 182(9):E362–72.

**Study Objectives:** To quantify differences in the quality of FP services at public and private providers in three representative sub-Saharan African countries (Tanzania, Kenya and Ghana).

**Results Summary:** Private health facilities appeared to be of higher quality than public facilities in the interpersonal process, but not necessarily higher technical quality. These differentials were considerably larger at lower level facilities (clinics, health centers, dispensaries) than at hospitals. Client satisfaction with FP appeared considerably higher at private facilities, both hospitals and clinics.

**Policy/Programmatic implications:** The private sector appears to be an important provider of RH services in the three countries studied. Care should be taken to prevent the implementation of policies or regulations that significantly burden or hamper the functioning of the private sector, lest national-level RH indicators suffer as a result.

**Source:** BMC Health Serv Res. 2011 Aug 24;11:203.

### Sutherland EG et al., 2011: What happens to contraceptive use after injectables are introduced? An analysis of 13 countries

**Study Objectives:** To analyze changes in method use and method mix after the introduction of the injectables in the early 1990s.

**Results Summary:** The use of modern methods and injectables rose for each study country. Increases in the use of modern methods exceeded those in the use of injectables in all but three countries. The use of injectables rose among spacers, as well as among limiters of all ages, particularly those younger than 35. In general, the increase in the use of injectables was partially offset by declines in the use of other methods, especially long-acting or permanent methods.

**Policy/Programmatic Implications:** Family planning programs could face higher costs and women could experience more unintended pregnancies if limiters use injectables for long periods instead of changing to longer acting and permanent methods, which provide greater contraceptive efficacy at lower cost, when they are sure they want no more children.


### Sandoy IF et al., 2012: Condom availability in high risk places and condom use: a study at district level in Kenya, Tanzania and Zambia

**Study Objectives:** To assess equity aspects of condom availability and uptake in three African districts to evaluate whether condom programs are given sufficient priority.

**Results Summary:** In the population-based surveys, rural respondents perceived condoms to be less available and tended to be less likely to report condom use than urban respondents. Although focus group participants reported that condoms were largely available in their district, they expressed concerns related to the accessibility of free condoms.

**Policy/Programmatic Implications:** Establishing formal guidelines for condom supply chains, including the involvement of venue owners, may be helpful at the district level to ensure the reliable provision and frequent replenishing of free or inexpensive condoms in venues where people meet new sexual partners.

**Source:** BMC Public Health 2012, 12(1):1030.
### 3.2. Community-Based Family Planning (CBFP)

**Wang W et al., 2012: How family planning supply and the service environment affect contraceptive use: Findings from four East African countries**

**Study Objectives:** To examine the extent to which contraceptive use is associated with the regional FP supply and service environment and to assess the regional variability in contraceptive use that is explained by these two factors.

**Results Summary:** An average increase in the availability of one contraceptive method in a region increases women's odds of using modern contraception by 50 percent if FP-facility density in the region and other individual-level variables are held constant. Women in regions with a more favorable service environment (as measured by a higher service environment score) in facilities are more likely to use a modern contraceptive method.

**Policy/Programmatic Implications:** Family planning supply plays an important role in increasing the prevalence of modern contraceptive use.

**Source:** Calverton, Maryland, ICF International, MEASURE DHS, Apr; 2012.

**National Institute for Medical Research (NIMR), 2013: Situational analysis of existing task-shifting practices among health workers in the context of HIV/AIDS and Reproductive and Child Health service delivery in Tanzania**

**Study Objectives:** To explore the occurrence and types of task-shifting practices and their determinants within the current health delivery system.

**Results Summary:** Despite the fact that there are no guidelines or policies regarding task-shifting, findings clearly indicate that task-shifting practices existed at all levels of health facilities, regardless of their ownership and geographical location. Nurses and medical attendants were cadres in which the most task-shifting practices were found.

**Study Design/Setting:** A cross-sectional study in nine randomly selected districts in nine randomly selected regions. Respondents were drawn from district hospitals, health centers and dispensaries.

**Policy/Programmatic Implications:** The study reports some operational challenges, such as those related to the quality of the HIV, AIDS and RCHS services that were provided.

**Source:**

**Chin-Quee D et al., 2013: Assessing women's ability to self-screen for contraindication to hormonal methods in Tanzania**

**Study Objectives:** To estimate the accuracy of self-screening for contraindications to combined oral contraceptive pills (COCs) and to estimate the proportion of women with contraindications to hormonal methods among those using drug shops in Tanzania.

**Results Summary:** Self-screening among women in rural and peri-urban Tanzania with regard to contraindications to COC use is comparable to assessment by trained nurses.

**Study Design/Setting:** Interviews with 1,651 women between the ages of 18 and 39 who self-screened for contraindications to COCs with the help of a poster at drug shops in Tanzania.

**Policy/Programmatic implications:** N/A

**Source:** International Journal of Gynecology & Obstetrics (2013).

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**Sangale L, 2003: Community views on CBD activities in Maweza and Lushoto in Tanga region**

**Study Objectives:** To assess the views of the various groups at community level concerning the Community-Based Distributors (CBDs) intervention in Tanga region.

**Results Summary:** The various groups interviewed admit that the CBD program has been useful. Each group has experienced certain benefits depending on their specific role in the program. Community leaders and community members generally indicated that where sensitization had been undertaken at community level, there was good participation in the selection of CBDs.

**Study Design/Setting:** The study used participatory tools to seek the views of the various stakeholders on the CBD program.

**Policy/Programmatic implications:** N/A

**Source:**
**Kraut A et al., 2004: Follow up reproductive health needs assessment in the process of evaluating a Community-Based Distribution (CBD) programme in Lushoto Division, Lushoto District**

**Study Objectives:** To evaluate the impact of the CBD program in the Lushoto division by carrying out a follow-up study in 2004 and comparing the results with the baseline study from 2000.

**Results Summary:** Villages without CBD activities had nearly the same overall contraceptive prevalence as CBD villages (CBD villages: 43.2 percent, non-CBD villages 39.5 percent). In the non-CBD villages, however, a statistically significant higher percentage of women were still using traditional methods (8.3 percent for CBD villages and 14.7 percent for non-CBD villages). The number of unplanned pregnancies has significantly decreased from 58.3 percent in 2000 to 26.8 percent in 2004.

**Policy/Programmatic implications:** CBDs can propel women who are already using a traditional FP method towards a modern method. CBDs can serve as referring agents in the villages and have an important function in providing a social link between village community and the professional health care sector.

**Source:** [Unpublished] Tanzanian-German Programme to Support Health (TGPSH), 2004 Apr.

**Harris NP, 2004: Perspectives and Recommendations for USAID/Tanzania on Community-based Distribution (CBD) Programs**

**Study Objectives:** To provide USAID/Tanzania with a summary of the main program and technical issues related to the expansion of FP service delivery using CBD and linking CBD programs to improved long-term method sites and possibly other health activities.

**Results Summary:** The principal lessons learned included the following: (1) local partnership between communities and district governments, churches and communities, etc., is seen as crucial to success; (2) cost sharing should begin at the start; (3) CBDs perform best in the first two to three years of work; (4) training, supervision and non-financial incentives are seen to be very important, but this raises cost questions; (5) CBD drop-out rates are predictable and should be planned for; (6) once established and functioning, most CBDs can (and usually desire to) add health activities; (7) CBDs can play an important role in referral for LTPMs; and 8) monitoring and evaluation and record keeping are weak in almost all programs.

**Policy/Programmatic implications:** Improved CBD programs need to be correctly targeted (to rural, isolated areas, integrating LTPMs and HIV/AIDS), managed (community participation, M&E, information, education and communication [IEC], logistics), financed (basket funding, cost containment for scaling up) and supported by donors (collaborative efforts).

**Source:** Deliver Project, 2004.

**Kibuga KF, 2005: Who do the CBD reach? A study for the Tanzanian German Programme to Support Health (TGPSH)**

**Study Objectives:** (1) To determine whether the services of CBDs reach poorer people, (2) To explore the reasons behind the choices that people make between using the services of the CBDs or the local health facilities and whether this was influenced by poverty, and (3) To develop and test a methodology regarding the research objectives to determine if it is suitable for wider application.

**Results Summary:** The maps and discussions from the CBDs indicated that the poorer people in the villages are very effectively reached by the CBDs, but that they are not reached in such high proportions as the average-income people, who appear to have seized the opportunity to access village-based FP services. Most CBDs claimed that poorer people were as enthusiastic to use FP as the average-income group.

**Policy/Programmatic implications:** Sensitization should be carried out to increase the CBDs' awareness of the discrepancies and to encourage them to make more efforts to reach the poorest groups in their areas.

**Source:** Tanzanian German Programme to Support Health (TGPSH).
| Study Objectives: This paper reviews the experience and findings from the Jane Goodall Institute's (JGI) TACARE program in the Kigoma region of Tanzania. | Results Summary: Rates of the use of modern FP methods rose to 45 percent in TACARE villages by 2006, a level never previously recorded in Kigoma Rural. Among clients of CBD services \( n = 60 \), the user rate was an impressive 93 percent for any modern method. Nine out of ten people surveyed knew at least one modern method of FP, the most commonly cited methods being the pill (88 percent), injectables (78 percent) and condoms (58 percent). |

| Study Design/Setting: FP education and CBD of contraceptives in Kigoma Rural District, 1999-2005. | Policy/Programmatic implications: For conservation efforts to work, population issues must receive equal attention. Otherwise, the demand for natural resources will grow unchecked. |


| Study Objectives: To describe mobile outreach models in Tanzania in terms of their resource use and costs to assist stakeholders in assessing the value for money that is obtained through these services. | Results Summary: Overall, there is very little difference in the average costs between Family Planning Weeks and Regular Outreach expeditions. The average cost for the former was 25.52 USD per acceptor and 25.62 USD for the latter. |

| Study Design/Setting: The cost analysis examines resource use in terms of efficiency (cost per unit of output) and drivers of cost for each of the models. | Policy/Programmatic implications: N/A |

Source: |

| Study Objectives: To capture the experiences of founding and implementing CBD programs. | Results Summary: The findings indicate that the policy environment at the international and national levels is very supportive of CBDs, but the recognition of CBDs’ potential is not matched by commensurate resource support. |

| Study Design/Setting: A descriptive study in 11 districts of Tanzania. | Policy/Programmatic implications: The Government should make CBDs (or their equivalent as the case may be) an official structure with full government support. |

Source: |

| Study Objectives: To determine access to information and modern contraceptives services among people of different wealth status in a rural setting in Muheza, Tanzania. | Results Summary: There was no difference in the access to information \( P=0.44 \) and to contraceptives \( P=0.83 \) between the poorer and the less poor. Half of the respondents (49.4 percent; 214/431) reported paying for services, with no difference between the less poor and the poorer \( P=0.75 \). Respondents receiving services from health facilities were more likely to pay for services (61.3 percent) compared to CBD agents (25.0 percent). The level of satisfaction was high (approximately 70 percent) in both health facilities and CBD agents. |

| Study Design/Setting: Cross-sectional descriptive study among people of reproductive age (between the ages of 15 and 49) in three villages of Muheza district in northeastern Tanzania in August 2005. | Policy/Programmatic implications: There is a need to address the issue of informal payments by creating formal mechanisms of remunerating or providing incentives to CBD agents. |


**Study Objectives:** To solicit ideas on how to promote community health through community health workers in a sustainable, affordable and effective way that is in line with policy guidance from the PHC Development Programme, as well as the 3rd Health Sector Strategic Plan (HSSP III).

**Results Summary:** The report provides information from a series of presentations that were delivered, incorporating findings from several exploratory and interventional studies, for example, Findings from the CHW Mapping Exercise, CHW Rewarding Options and Nomenclature, CHWs’ Multitasking, Cost-effectiveness & Sustainability (CCONNECT Project) as well as experiences of CHWs working in various health programs.

**Study Design/Setting:** People with diverse experiences shared their thoughts and beliefs. Stakeholders revisited what is being done and helped to identify ways to translate some of the policy issues into action, not to mention reaching a common understanding on how things should be.

**Policy/Programmatic implications:** The report presents several recommendations for policy and practice for CHWs programs in Tanzania.

**Source:**

### KiIlewo J et al., 2012: Community health workers (CHW) training and deployment in Tanzania; a review of PEPFAR funded programs

**Study Objectives:** (1) To examine CHW training programs and curricula under the different USG PEPFAR funded HIV programs, (2) To determine areas of commonalities and distinctive differences, and (3) To develop a policy advocacy strategy and plan for accreditation of CHW.

**Results Summary:** Training programs, curricula and materials were found to vary greatly in content, methodology, assessment of trainees and length. Programs were found to use a range of criteria to select CHWs. While all CHWs in the programs reviewed worked on a voluntary basis, most programs offered some cash remuneration.

**Study Design/Setting:** A semi-structured questionnaire to PEPFAR-funded partner organizations involved in the training and deployment of CHWs and qualitative interviews with CHWs and community leaders in the six regions.

**Policy/Programmatic implications:** Based on the findings, the project recommended the following: (1) Create a mechanism for combining some existing CHWs into a new cadre to be called Community Health Extension Worker (CHEW), (2) Develop a combined HBC/CBD/MNCH curriculum using existing modules to create one comprehensive curriculum, (3) Create a mechanism whereby CHWs are paid a standard wage consistent with the government minimum wage scales and develop a clearly defined career ladder for this cadre.

**Source:**

### Baynes C et al., 2012: A strategic approach for re-positioning family planning within comprehensive community-based health services: the Connect Project, Tanzania

**Study Objectives:** To present a strategy for scaling-up a community health agents (CHAs) field trial to become a national program.

**Results Summary:** What was feasible for re-orienting health and village systems for community-based services was learned through a pilot and was scaled-up in a case study assessing service coverage, quality, utilization, method continuity and organization normalization of new service capabilities. The design of the Connect Project permitted a scale-up of the innovation into a trial of fertility and MDG 5 impact.

**Study Design/Setting:** It commenced in 2011 as a randomized controlled trial with features to study the acceptability, effectiveness and cost-effectiveness of multitasked CHAs. Then it expanded the breadth of the project to address two problems: (1) the inadequate availability of RH services to study populations, (2) the tendency of research to produce nonreplicable service delivery capabilities.

**Policy/Programmatic implications:** If a committed and versatile group of health system scientists, managers and policymakers join forces and apply this framework together, they make progress toward universal RH.

**Source:** Ifakara Health Institute, Tanzania.
### PRAXIS Team, 2013: The current situation of community-based family planning (CBFP) in Tanzania

**Study Objectives:** To assess the current situation of the Community-Based Family Planning (CBFP) and Accredited Drugs Distributors Outlets (ADDO).

**Results Summary:** The assessment showed several key challenges, including poor retention of CBDs, inaccessibility of FP commodities to ADDOs, lack of financial resources, poor documentation, poor linkages between stakeholders, mismatches between organizations’ guidelines and national guidelines, poor supervision structure, mismatches between the strategic plan and CBD operations, lack of refresher trainings and donor dependence. In addition, the recruitment process of CBDs varied relatively across districts and community, and direct and meaningful participation of communities in the selection process was poor.

**Study Design/Setting:** Literature review and consultations with stakeholders at multiple levels.

**Policy/Programmatic implications:** Community-based distribution of injectables is an innovation that deserves consideration by decision makers who are seeking measures to strengthen FP services.

**Source:** PRAXIS Team.

### Mehta S, 2013: Evaluating CBDs as agents for increasing access to family planning services and commodities

**Study Objectives:** To assess current CBD activity, strengths and weaknesses in order to devise recommendations for sustainability once the responsibility for CBD programming is fully handed over to respective health governance teams and authorities.

**Results Summary:** Only a small proportion of community members received a sufficient and regular supply of FP commodities from the CBDs. Distribution of emergency contraceptives and ORS/zinc packets was low. Over 85 percent of all clients received health education on FP, STIs and HIV; however, less than 5 percent received education on safe motherhood, nutrition, childhood health and mosquito nets. Less than 4 percent of all clients were reportedly referred for further services.

**Study Design/Setting:** A sample of 134 CBDs active in Korogwe, Kilindi, Pangani and Lushoto districts of Tanga region.

**Policy/Programmatic implications:** Although CBDs have been trained on many significant health issues, the assessment revealed that they were primarily viewed as agents for promoting FP.

**Source:** Tanzanian German Programme to Support Health (TGPSh).

## 1.3. Integration of Services

### Rasch V et al., 2004: A longitudinal study on different models of postabortion care in Tanzania

**Study Objectives:** To identify women having unsafe abortions and determine whether an acceptable follow-up rate among these women can be retrieved.

**Results Summary:** Fifty percent of all gynecological/obstetrical admissions were due to incomplete abortions and 48 percent of these women had had an unsafe abortion. Being 19 years of age or younger, being single, and having given birth three or more times were positively associated with having an unsafe abortion. Being 30 years of age or older and not having given birth previously were negatively associated with having an unsafe abortion.

**Study Design/Setting:** A cohort study among women attended at Temeke Municipal Hospital, Dar es Salaam with an abortion-related diagnosis from January 2001 through to July 2002.

**Policy/Programmatic implications:** If hospital-based and confidential home-based interviews are used in combination, and if the women having unsafe abortions are counseled by technically well-skilled counselors, it is possible to achieve a reasonable follow-up rate among women having unsafe abortions.

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<tr>
<td>Rasch V et al., 2004: Acceptance of contraceptives among women who had an unsafe abortion in Dar es Salaam</td>
<td>To assess the need for postabortion contraception and to determine if women who had an unsafe abortion will use a contraceptive method to avoid repeated unwanted pregnancies and STDs and HIV.</td>
<td>Ninety percent of participants accepted the postabortion contraceptive service. Of these, 86 percent stated they were still using contraception 1 to 6 months after discharge. Women 19 years of age or younger and women who had not been pregnant before were less likely to accept the service offered than women 20 years of age or older and women who had given birth previously. The women's marital situation was not found to influence the acceptance.</td>
<td>High-quality contraceptive service counseling can induce women to use contraception after having had an unsafe abortion.</td>
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<td>Richey LA, 2005: Lover, mother or worker: women's multiple roles and the HIV/AIDS and reproductive health agenda in Tanzania</td>
<td>To explore how one woman's experience and her knowledge of AIDS can teach us to take HIV/AIDS into account when theorizing, promoting or providing services for improving African women's RH.</td>
<td>Rehema's story shows that AIDS, like other diseases, is significantly linked to host-susceptibility and economic vulnerability.</td>
<td>Separate and competing vertical programs on AIDS and MCH/FP, as commonly encountered throughout Africa, cannot meet the needs of women in countries like Tanzania.</td>
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<td>Rasch V et al., 2006: Postabortion care and voluntary HIV counselling and testing—an example of integrating HIV prevention into reproductive health services</td>
<td>To assess the acceptance and outcome of voluntary HIV counseling and testing (VCT) among women who had an unsafe abortion.</td>
<td>Most participants in this study accepted HIV testing and condoms as part of postabortion care. Women who earned an income were more likely to accept HIV testing than housewives. Furthermore, women who accepted HIV testing were more likely to accept using condoms.</td>
<td>The implementation of high quality postabortion care programs, which include both contraceptive counseling and VCT service, would be a logical way to address the poor RH among women experiencing unsafe abortions.</td>
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<td>Curtis C, 2007: Meeting health care needs of women experiencing complications of miscarriage and unsafe abortion: USAID’s postabortion care program</td>
<td>To describe the United States Agency for International Development (USAID) PAC program and its related policies.</td>
<td>Since 2003, more than 3,000 women have been seen in health centers and health posts for PAC services; more than 14,000 community members have received messages on unsafe abortions, FP, and complications of unsafe abortions and miscarriages; and more than 600 documents were reviewed for inclusion in a global PAC resource package.</td>
<td>More attention is needed to ensure FP counseling and services for all clients, whether they received MVA or sharp curettage emergency treatment.</td>
</tr>
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</table>
### Rasch V, 2007: Acceptance and use of the female condom among women with incomplete abortion in rural Tanzania

**Study Objectives:** To describe the outcome of a postabortion care intervention aimed at introducing the female condom as a means of preventing women from having unwanted pregnancies or contracting STIs or HIV.

**Results Summary:** In total, 521 women (95 percent) accepted contraception. Contraceptive use was assessed three months after abortion among 475 women (91 percent). The female condom was accepted by 201 of 521 women (39 percent) and was used by 158 of 521 women (30 percent). Women who had experienced an unsafe abortion, had attended secondary school or earned an income were more likely to accept the female condom.

**Policy/Programmatic implications:** PAC programs provide an excellent entry point for introducing the female condom as a contraceptive method for the prevention of unwanted pregnancies, STIs and HIV infection.

**Source:** Contraception 2007, 75(1):66–70.

### Rasch V et al., 2008: Medium and long-term adherence to postabortion contraception among women having experienced unsafe abortion in Dar es Salaam, Tanzania

**Study Objectives:** To describe the impact of a postabortion contraceptive service intervention among women admitted with complications from unsafe abortions and to explore the women's long-term contraceptive adherence.

**Results Summary:** Eighty-nine percent of the women accepted postabortion contraception. Follow-up information was obtained 12 months after the abortion among 59 percent of the women. Among these, 79 percent of the married women and 84 percent of the single women stated they were using contraception at 12 months. Condom use among the single women increased significantly during the 12 months follow-up.

**Policy/Programmatic implications:** There is a need for comprehensive PAC programs. Postabortion women are likely to accept and use contraception when the service is offered as an integrated part of PAC.

**Source:** BMC Pregnancy Childbirth 2008, 8:32.

### United States Agency for International Development, 2008: Decentralization of postabortion care in Senegal and Tanzania

**Study Objectives:** To improve access by decentralizing PAC activities.

**Results Summary:** Decentralized PAC services resulted in increased contraceptive counseling and acceptance of a contraceptive method prior to discharge from the facility. The process for obtaining a contraceptive before discharge, however, was not client-friendly.

**Policy/Programmatic implications:** The evaluation showed that PAC can be safely and successfully decentralized, with services capably provided by mid-level personnel in health centers, dispensaries and some health posts when the providers are trained and supervised, and equipment and supplies are available.

**Source:**

### Keogh SC et al., 2009: Reproductive behaviour and HIV status of antenatal clients in northern Tanzania: opportunities for family planning and preventing mother-to-child transmission integration

**Study Objectives:** To examine reproductive and contraceptive history and intentions by HIV status among women at antenatal clinics.

**Results Summary:** The study showed that among women in antenatal clinics, only a minority of women have ever used FP, and unmet need before pregnancy was high, but the reported future need for FP was very high. HIV-positive women were more likely to have used FP, particularly hormonal methods.

**Policy/Programmatic implications:** FP counseling as a part of ANC services can fill the gaps between past use, intentions and needs by providing tailored information to every pregnant woman.

**Source:** AIDS 2009, 23 Suppl 1:S27–35.
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<td>Kibuuka H et al., 2009: Contraceptive use in women enrolled into preventive HIV vaccine trials: experience from a phase I/II trial in East Africa</td>
<td>To assess the level and factors influencing use of contraceptives among participants of an HIV vaccine trial.</td>
<td>Only a minority of women entering the vaccine study initiated contraception at the time of study entry. The reasons for not using contraception included access to quality services, insufficient knowledge of certain methods and misconceptions.</td>
<td>Integrating provision of FP services with research activities, such as HIV vaccine trials, may ensure the appropriate use of quality contraceptive products.</td>
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<td>Nielsen KK et al., 2009: Expanding comprehensive postabortion care to primary health facilities in Geita District, Tanzania</td>
<td>To decentralize comprehensive PAC to the community level.</td>
<td>2,025 evacuations had been performed, with MVA and D&amp;C accounting for 65.6 percent and 34.4 percent, respectively. Among the women admitted with abortion complications, 59.8 percent left with an FP method. The proportion of women offered FP services differed by evacuation procedure; the proportion was higher among women evacuated by MVA.</td>
<td>Upgrading mid-level providers to perform MVA is an efficient means to address the problem of unsafe abortion in rural areas.</td>
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<td>FHI360, 2010: Integration of family planning and HIV care and treatment in Tanzania: FHI 360’s past and future role</td>
<td>To develop and test a facilitated referral model to integrate FP and HIV care and treatment services.</td>
<td>There was a decrease of unmet need from 12 percent (baseline) to 8 percent (post-intervention); modern method use (noncondom) more than doubled 17 percent (baseline) to 39 percent (post-intervention), with a higher increase on pills, injectables and implants; dual method use increased from 12 percent (baseline) to 31 percent (post-intervention) and clients preferred receiving FP services at the CTC clinic versus the FP clinic.</td>
<td>The MOHSW should mandate the scale-up of integrated service delivery to best meet the needs of PLHIV across Tanzania.</td>
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<td>Awadhi B, 2012: Assessing the need and capacity for integration of family planning and HIV counseling and testing in Tanzania</td>
<td>To assess the capacity for integrating FP into HIV VCT services.</td>
<td>Although there was a gap in policy and guidelines with regards to integration, policy makers were willing to pioneer the integration of FP and HIV services. Only 25 percent of health providers were trained on both FP and HIV VCT services. The majority of clients, however, indicated satisfaction with integrated services.</td>
<td>The integration of FP and HIV VCT services is feasible and acceptable with minor re-arrangement. Involvement of multiple stakeholders, especially at the district level, is critical in enhancing integration.</td>
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Source: FHI360 Dar es salaam, Tanzania.  
### 1.4. Youth/Adolescents Services

**Kaaya SF et al., 2002: A review of studies of sexual behaviour of school students in sub-Saharan Africa (SSA)**

**Study Objectives:** To describe what is known about sexual behavior of school students and identify gaps in knowledge.

**Results Summary:** The findings indicate; high prevalence rates of sexual intercourse; an early age of onset of sexual behavior, infrequent use of condoms and other contraceptives; and significant proportions of adolescents who have two or more lifetime sexual partners.

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**Johnson K et al., 2012: Integration of HIV and family planning health services in sub-Saharan Africa: A review of the literature, current recommendations, and evidence from the Service Provision Assessment Health Facility Surveys**

**Study Objectives:** To review the literature on integration of HIV-related services with other areas of service delivery that have important synergies with HIV services.

**Results Summary:** This report documents considerable disparities between the availability of elements of integrated HIV/FP services and the actual delivery of fully integrated ANC or STI services by a health care provider. The proportion of health workers receiving training in FP-related services was considerably lower than those receiving training in HIV-related services.

**Policy/Programmatic implications:** In countries with high HIV seroprevalence, ensuring that FP service providers are aware of the special contraceptive needs of women living with HIV should be a priority.

**Study Design/Setting:** Data from the Service Provision Assessment (SPA) surveys in five African countries: Kenya, Namibia, Rwanda, Tanzania and Uganda.

**Source:** Calverton, Maryland, ICF International, MEASURE DHS, 2012.

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**Moroni M et al., 2013: Assessing the integration of family planning into HIV care & treatment services in Shinyanga Region, Tanzania**

**Study Objectives:** To assess changes resulting from the integration of FP services into HIV Care and Treatment Clinics (CTCs) and the acceptability of the integrated model among district health managers, service providers and clients.

**Results Summary:** Family planning integration into CTC services resulted in an increase of provision of counseling to CTC clients and clients' knowledge on safe FP methods. The overall use of modern FP methods to avoid pregnancy did not significantly change, but overall, providers felt integration was acceptable to health workers and clients, acknowledging challenges that should be addressed.

**Policy/Programmatic implications:** These results will allow all the partners involved with the national rollout of FP/HIV integration to make course corrections as needed to guide implementation and scale-up of this new intervention throughout the country.

**Study Design/Setting:** Quantitative and qualitative data, on acceptability of the model from the client and provider perspective.

**Source:** Elizabeth Glaser Pediatric AIDS Foundation Tanzania.

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**Murashani J et al., 2013: Quality of family planning services in HIV/AIDS care and treatment clinics in Tanzania**

**Study Objectives:** To examine the quality of FP services delivered in CTCs using the facilitated referral model and the expanded facilitated referral model in terms of quality of care as defined by WHO and the Tanzania national FP guidelines.

**Results Summary:** The study found a significant shortage of health providers compared to the number of clients. Furthermore, most health providers lacked adequate skills and did not have access to on-the-job training for service provision. Most of the health facilities had noticeable deficiencies in equipment and supplies.

**Policy/Programmatic implications:** Government should put more effort into sensitizing the providers to recognize the importance of offering integrated services at CTCs. This should go hand in hand with finding the best ways to train health providers, as well as assuring adequate supplies and equipment.

**Study Design/Setting:** A nonexperimental, descriptive and cross-sectional design with a representative sample of clients, providers, and CTC facility in-charges in eight health facilities in Iringa and Morogoro, Tanzania.

**Source:** MEASURE Evaluation PRH.
**Study Design/Setting:** A review of articles on sexual behavior of school-based young persons between the ages of 14 and 24 in sub-Saharan Africa.

**Policy/Programmatic implications:** An emphasis on abstinence or faithfulness alone in interventions in SSA ignores a significant proportion of adolescents who are already involved in high-risk sexual practices. The age of 13 to 14 is an important transition point for interventions that aim to delay the onset of sexual activity in younger populations.


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**Dilger H, 2003: Sexuality, AIDS, and the lures of modernity: reflexivity and morality among young people in rural Tanzania**

**Study Objectives:** To understand young people’s perceptions of HIV/AIDS, own sexuality and gender relations within the context of socioeconomic change.

**Results Summary:** The values that are imparted to young people from family or peers often conflict with the preventive advice provided by both governmental organizations and NGOs. By critically reflecting upon the ambiguities and inconsistencies in their lives, however, the young Luo have proven to be self-conscious actors and moral subjects who are actively involved in the process of social change.

**Policy/Programmatic implications:** Prevention campaigns that take into account the needs of young men can also have positive outcomes for women.

**Study Design/Setting:** Interviews and two group discussions with young Luo men and women, as well as two informal talks and observations in Mara Region in Northwestern Tanzania.


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**Masatu MC, 2003: Frequency and perceived credibility of reported sources of reproductive health information among primary school adolescents in Arusha, Tanzania**

**Study Objectives:** To describe adolescents’ sources of RH information and the perceived credibility of these sources.

**Results Summary:** Mass media ranked first as sources of RH information, followed by teachers and health workers. Health workers ranked first in credibility, followed by parents. Credibility rating for the media was low. Religious leaders and respondents’ friends played a minor role as sources of RH information, and their credibility ratings were also low.

**Policy/Programmatic implications:** Programs seeking to promote young people’s RH should take into account the diverse arenas through which young people obtain RH information and strive to tap into and strengthen the full range of these arenas.

**Study Design/Setting:** A questionnaire survey among 1,247 seventh grade pupils in Arusha district.

**Source:** *Scand J Public Health* 2003, 31(3):216-223.

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**Thomsen S, 2005: Youth need HIV counseling when seeking reproductive health services. A research study in Tanzania found large differences between actual and perceived risk for HIV infection among young reproductive health clients**

**Study Objectives:** To identify where clients at most risk of acquiring HIV are seeking services, from both an objective perspective and from the clients’ own perspectives.

**Results Summary:** It appears that more clients who seek RH services (such as contraceptive services and STI treatment), especially females, are at elevated risk of acquiring HIV/AIDS. Both male and female RH clients were less likely to perceive themselves at risk of HIV than VCT clients.

**Policy/Programmatic implications:** Both male and female RH clients lack a realistic perception of their risk of HIV infection. This finding points to a clear need: when clients seek contraception or STI testing and treatment, they need counseling on their risk of acquiring HIV/AIDS.

**Study Design/Setting:** A descriptive study of youths between the ages of 15 and 24, accessing VCT and other RH services in Dar es Salaam Tanzania.

**Source:** Dar es Salaam, Tanzania, Family Health International [FHI], YouthNet, 2005 Nov.; 2005.
### Obasi AI et al., 2005: Rationale and design of the MEMA kwa Vijana adolescent sexual and reproductive health intervention in Mwanza Region, Tanzania

**Study Objectives:** To discuss the rationale and design of the intervention and the nature and effect of the socioeconomic, political and cultural factors that influenced its structure, content and implementation.

**Results Summary:** The intervention demonstrates that it is feasible to use existing government structures to implement an innovative, integrated, multifaceted adolescent sexual and RH (ASRH) intervention in rural African communities on a large scale, to a high standard and in a potentially sustainable way.

**Policy/Programmatic implications:** Integration into the existing Ministry of Education and Culture and Ministry of Health systems, and close involvement of senior government officials legitimized the intervention, hence increasing its acceptability to parents, teachers, health workers and pupils.

**Source:** *AIDS Care* 2006, 18(4):311–22.

### Terris-Prestholt F et al., 2006: From trial intervention to scale-up: costs of an adolescent sexual health program in Mwanza, Tanzania

**Study Objectives:** To estimate annual costs by input (capital and recurrent), component (in-school, community activities, youth-friendly health services, condom distribution) and phase (development, start-up, trial implementation, scale-up).

**Results Summary:** The three-year economic costs of trial implementation were $879,032, of which ~70 percent was for the school-based component. Costs of initial development and startup were relatively substantial (~21 percent of total costs); however, annual costs per school child dropped from $16 in 1999 to $10 in 2001. The incremental scale-up cost is ~1/5 of ward trial implementation running costs.

**Policy/Programmatic implications:** Annual costs can be reduced by almost 40 percent as project implementation matures. When scaled up, only an additional $1.54 is needed per pupil per year to continue the intervention.

**Source:** *Sexually Transmitted Diseases* 2006, 33 Suppl (10):S133–S139.

### Klein M et al., 2005: Trust and condom use: the role of sexual caution and sexual assurances for Tanzanian youth (a baseline survey)

**Study Objectives:** To assess the extent to which trust in one's partner can explain a lack of protective behavior.

**Results Summary:** Youths who have higher caution (p < .01) and assurances (p < .01) are more likely to report accurate risk perception. Fidelity in the past month and past three months has the same predictors, with individuals reporting higher caution (p < .05). Consistent condom use with a regular partner and ever having used a condom have the same predictors. Individuals with higher caution are more likely to use condoms (p < .01).

**Policy/Programmatic implications:** Caution and sexual assurances are two elements of trust that are associated with protective behavior. Elucidation of these elements improves our understanding of trust and helps programs better target behavior-change messages.

**Source:** Washington, DC, Population Services International [PSI], Research Division, 2005 Apr.19 p.

### Scholl E, 2005: Assessing youth needs and identifying program opportunities. YouthNet's country assessments identify common themes among diverse countries

**Study Objectives:** To assess the RH and HIV/AIDS issues related to youths aimed at strengthening the programs and services offered to them.

**Results Summary:** Respondents and survey data highlighted age at marriage, educational differences between boys and girls, poverty and orphanhood as underlying factors in young people's sexual and RH. Respondents, especially young people, perceived the formal educational sector as failing to provide sufficient information to help young people know their bodies and prevent pregnancy and STIs, including HIV.
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<th>Study Design/Setting: Process included: (1) on-site assessments of youth programs, and (2) Desk review and analyzing program data in Burundi, Ethiopia, Namibia, Nepal, Nicaragua, Paraguay and Tanzania.</th>
<th>Policy/Programmatic implications: Classrooms, health facilities, sports clubs, and workplaces should take better advantage of these opportunities to provide young people with RH/HIV education and services.</th>
<th>Source: Arlington, Virginia, Family Health International [FHI], YouthNet, 2005 Jun.</th>
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<tr>
<td>Katz K, 2006: Youth survey provides wealth of data on behavior to inform intervention strategies. Fear of HIV/AIDS and other sexually transmitted infections is strongest motivator to remain abstinent</td>
<td>Results Summary: The median age for sexual debut was 15 for girls and between 15 and 17 for boys. Across all subgroups (boys/girls, rural/urban, older/younger), about half of those who reported they had not had sex said they remained abstinent because of fear of STIs and HIV/AIDS.</td>
<td>Study Objectives: To understand youths’ knowledge, attitudes and behaviors regarding HIV and RH.</td>
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<td>Study Design/Setting: Population-based, cross-sectional survey of youth between the ages of 13 and 24 in 2004 in the Iringa region in the southern part of Tanzania.</td>
<td>Policy/Programmatic implications: Classrooms, health facilities, sports clubs, and workplaces should take better advantage of these opportunities to provide young people with RH/HIV education and services.</td>
<td>Source: Arlington, Virginia, Family Health International [FHI], YouthNet, 2006.</td>
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<td>Thomsen S et al., 2006: Voluntary HIV counseling and testing services for youth and linkages with other reproductive health services in Tanzania</td>
<td>Results Summary: Single male and female RH clients were most likely to report two or more risky behaviors, while female VCT clients were the least likely. Close to half of those reporting no or one risk factor believed they were at moderate-to-high risk. Nearly one-third reporting two or three risk behaviors believed they were at no-to-low risk.</td>
<td>Study Objectives: To provide information to policymakers to improve services at clinics providing a mix of VCT and RH services in Tanzania.</td>
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<td>Study Design/Setting: Exit interviews with 719 youths (310 males and 409 females) between the ages of 15 and 24 as they were leaving four clinics in Dar es Salaam.</td>
<td>Policy/Programmatic implications: Interviews with youths revealed some misunderstandings about the being-faithful messages that could be affecting their risk perceptions. Providers should be trained to nuance messages when counseling youth clients to be faithful.</td>
<td>Source: Research Triangle Park, North Carolina, Family Health International [FHI], 2006.</td>
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<tr>
<td>Scholl E et al., 2007: Integrating reproductive health and HIV services for youth</td>
<td>Results Summary: Studies of HIV VTC services in Tanzania and Haiti found a high level of unmet need for contraception among VCT clients. Moreover, whereas most of these younger adolescents wished to wait two or more years before becoming pregnant again, 94 percent had never previously used a contraceptive method.</td>
<td>Study Objectives: To examine the extent of service integration and the unmet need for different services in various types of delivery models for youth services in Tanzania, Haiti and Kenya.</td>
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<td>Study Design/Setting: Exit interviews at both youth-only and general delivery sites in Tanzania, Haiti and Kenya. Other data came from mystery clients, analysis of referral systems and provider interviews.</td>
<td>Policy/Programmatic implications: These studies indicate a strong need for integrated services, especially pregnancy prevention.</td>
<td>Source: Research Triangle Park, North Carolina, Family Health International [FHI], Interagency Youth Working Group, 2007 Mar.</td>
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### Study Objectives: To present various demographic and health data for Tanzanian youths.

#### Results Summary:
More than half of women under the age of 19 are pregnant or already mothers. Only 12 percent of women between the ages of 15 and 24 are using a modern method of FP. Almost all young pregnant women receive ANC, but only half of young women birth in a health facility and with the assistance of a health professional. Four percent of women between the ages of 15 and 24, and 3 percent of men between the ages of 15 and 24 are HIV-positive. Youths account for over 60 percent of the new HIV infections in Tanzania.

#### Study Design/Setting:
The study used data from the 2004–05 Demographic and Health Survey (TDHS) and the 2003 Tanzania AIDS Indicator Survey (THIS).

#### Policy/Programmatic implications:
N/A

#### Source:

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### Williams T et al., 2007: Evaluation of the African Youth Alliance program in Ghana, Tanzania, and Uganda. Impact on sexual and reproductive health behavior among young people. Summary report

#### Study Objectives:
To evaluate the impact of African Youth Alliance (AYA) program on improving adolescent sexual and reproductive health (ASRH) knowledge and attitudes among young people between the ages of 10 and 24.

#### Results Summary:
Results demonstrated a significant positive impact of AYA on several variables, most notably condom use, contraceptive use, partner reduction, and several self-efficacy and knowledge antecedents. Overall, the impact of AYA on ASRH behaviors and their antecedents was greater for young women than for young men, especially in Ghana and Uganda.

#### Study Design/Setting:
Botswana, Ghana, Tanzania and Uganda.

#### Policy/Programmatic implications:
Evidence from this impact evaluation suggests that multiple component programs that combine strategies such as (a) behavior change communication (BCC) to address risk behaviors, (b) youth-friendly services, and (c) outreach services, can be an effective approach to addressing young people's ASRH needs.

#### Source:
Rosslyn, Virginia, JSI Research and Training Institute, 2007.

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### Urassa W et al., 2008: Risky sexual practices among youth attending a sexually transmitted infection clinic in Dar es Salaam, Tanzania

#### Study Objectives:
To describe the sexual practices in relation to HIV infection among adolescents and youths below the age of 25.

#### Results Summary:
The study concluded that male and female youths are actively engaging in risky sexual practices at a relatively young age. Female youths are having their first sexual intercourse with older male partners, and male youths have an exceptionally high number of sexual partners.

#### Study Design/Setting:
Cross-sectional study among youths between the ages of 18 and 25 attending an STI clinic at the Infectious Diseases Centre (IDC) of Dar es Salaam.

#### Policy/Programmatic implications:
There is a great need to establish more youth-friendly RH clinics, encourage consistent and correct use of condoms, delay sexual debut and encourage young females to avoid older sexual partners.

#### Source:
BMC Infect Dis 2008, 8:159.

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### Brock S et al., 2008: Family planning, HIV/AIDS & STIs, and gender matrix: a tool for youth reproductive health programming

#### Study Objectives:
To provide youth-serving organizations with a guide of topics on FP, HIV/AIDS, STIs and gender.

#### Results Summary:
The tool can be applied in any setting or program serving youths such as schools, outreach and peer education programs, community-based youth services or youth-friendly clinics. Special attention should be given to vulnerable groups, such as working youths, street children, refugees and migrant workers, who may need more information on risk reduction and preventive behaviors at earlier ages. Additionally, certain topics such as PAC, child marriage and female genital mutilation (FGM) should be introduced in a manner that is mindful of both country relevance and cultural appropriateness.
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<th>Study Design/Setting: The matrix was developed by International Youth Foundation (IYF) in consultation with partner organizations and YRH experts from around the world, and field tested in workshops in Tanzania, India and the Philippines.</th>
<th>Policy/Programmatic implications: The matrix can assist technical experts, program managers, health providers, peer educators and others to determine what topics and interventions best fit into their own respective programs while taking cultural paradigms into consideration.</th>
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<th>Study Design/Setting: An interactive website in Kiswahili and English targeting Tanzanian youths between the ages of 12 and 24, covering topics such as falling in love, having sex, condoms, and drug use, and taking an &quot;edutainment&quot; (entertaining and educating) approach.</th>
<th>Policy/Programmatic implications: Great satisfaction was derived from this initiative by all involved due to its wide appeal and overall appreciation by young people.</th>
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<th>Study Design/Setting: An interactive website in Kiswahili and English targeting Tanzanian youths between the ages of 12 and 24, covering topics such as falling in love, having sex, condoms, and drug use, and taking an &quot;edutainment&quot; (entertaining and educating) approach.</th>
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<th>Policy/Programmatic implications: Intervention programs should provide accurate information about the benefits of sexual abstinence, address gender norms and adolescents' relationships, and involve parents.</th>
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<th>Policy/Programmatic implications: Programs need to more explicitly address the issues of trust and repeat HIV testing within “faithful” relationships, which is an uncomfortable but necessary reality for many adolescents.</th>
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<td>Source: <em>AIDS Care</em> 2010, 22(9):1153–58.</td>
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</table>
Renju J et al., 2010: A process evaluation of the scale-up of a youth-friendly health services initiative in northern Tanzania

Study Objectives: To evaluate the 10-fold scale-up of a youth-friendly services intervention in order to identify key facilitating and inhibitory factors from both user and provider perspectives.

Results Summary: The scaling-up process did affect some aspects of intervention quality, and the research supports others in emphasizing the need to train more staff (both clinical and nonclinical) per facility in order to ensure youth-friendly delivery of services.

Study Design/Setting: Triangulation of multiple methods: (1) a simulated patient study; (2) FGDs and semi-structured interviews; (3) training observations; and (4) pre- and post-training questionnaires, in Mwanza Region, Tanzania.

Policy/Programmatic implications: Youth-friendly services interventions can continue to be delivered well, even after expansion through existing systems.


Gribble J, 2010: Reproductive health of youth in East Africa

Study Objectives: To explore the variation in sexual and FP knowledge and practices among youths between the ages of 15 and 24.

Results Summary: Approximately 35 to 40 percent of young unmarried women reported that they had been sexually active. The median age of first sexual intercourse for women between the ages 20 and 24 is 17.1. Young women in urban areas and those from wealthier households were more likely to have initiated sexual activity than those in rural areas and from poorer households. Fifteen percent of married young women use modern contraception; in contrast, 36 percent of unmarried sexually active young women use modern contraception.

Study Design/Setting: Demographic and Health Surveys (DHS) conducted in three East African countries—Tanzania, Uganda, and Rwanda.

Policy/Programmatic implications: Understanding the sexual behavior and contraceptive use of East African youths can help improve policies that address RH knowledge and behavior among young women in the region.


Exavery A et al., 2011: Acceptability of condom promotion and distribution among 10 to 19 year-old adolescents in Mwapwa and Mbeya rural districts, Tanzania

Study Objectives: To assess factors affecting acceptability of condom promotion and distribution among adolescents.

Results Summary: Feeling comfortable being seen by parents/guardians buying or holding condoms, perceived ability of condoms to offer protection against HIV/AIDS infections, the district of residence and living arrangements offered significant predictive effect.

Study Design/Setting: A cross-sectional survey on condom use among youths between the ages of 10 and 19 in Mwapwa and Mbeya rural districts of Tanzania.

Policy/Programmatic implications: Changing negative perceptions about condoms can be achieved through a rigorous context-specific and social-cultural-based sexual and RH education, and should be prioritized as an integral component for successful HIV/AIDS prevention programs in Tanzania.


Ernest H et al., 2011: Promoting modern family planning among Tanzania’s nomadic communities
<table>
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<tr>
<th>Study Objectives: To establish factors relating to the uptake of FP and maternal healthcare services among youths in Kilindi district.</th>
<th>Results Summary: The study revealed that although many nomadic youths know about modern FP methods, they do not use them due to various factors, including cultural beliefs, sexual norms, stigma and fear, long distances to health facilities and male dominance in decision making. Traditional FP methods were popular.</th>
<th>Policy/Programmatic implications: Approaches toward providing education on modern FP should include use of peer educators, health educators and other educational networks.</th>
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<tr>
<td>Study Design/Setting: A questionnaire to which 583 youths responded. Additionally, observational checklists, FGDs and in-depth interviews were used.</td>
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<th>Study Objectives: To present findings from a BCC strategy formative research that was aimed at informing the design of a strategy for youth BCC for MST’s AACES project.</th>
<th>Results Summary: On average, 87 percent of youths have heard about ASRH, a majority have heard of FP services (83 percent) and VCT services (80 percent), while only half have heard of STI services and IEC materials. The main sources of ASRH awareness include: school mates, peer friends, teachers and community members. On average, 45 percent of the youths discuss ASRH with parents. Youths were willing to receive ASRH services, particularly FP services, but they could not because of a number of reasons, including: the lack of an FP expert, particularly in rural health facilities; the lack of female condoms; lack of contraceptives in rural health facilities; and the side effects of FP methods.</th>
<th>Policy/Programmatic implications: This BCC formative research established target population profiles that can be used in developing focused BCC strategies and should offer suggestions for the way BCC can be conceptualized and implemented.</th>
</tr>
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<tr>
<td>Study Design/Setting: 56 FGDs and 1,114 interviewer-administered questionnaires with youths between the ages of 10 and 24 in five regions.</td>
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<tr>
<th>Study Objectives: To gain insights on barriers to using RHS.</th>
<th>Results Summary: The study revealed that a good number of health facilities do not have skilled providers (SPs) on SRH rights. Services sought included: education, FP and VTC. These services were inaccessible due to lack of privacy, confidentiality, equipment and negative attitudes from SPs. Initiation ceremonies, early marriages and gender disparities were mentioned as sociocultural barriers to SRH rights.</th>
<th>Policy/Programmatic implications: There is a need of integrating youth friendly services in health facilities and advocate for behavior change at the community level.</th>
</tr>
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<tr>
<td>Study Design/Setting: Focus group discussions, facility assessment interviews and case studies among girls between the ages of 10 and 18, community leaders and adults in Mtwara district.</td>
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| Wight D et al., 2012: The need to promote behavior change at the cultural level: one factor explaining the limited impact of the MEMA kwa Vijana adolescent sexual health intervention in rural Tanzania. a process evaluation | Wight D et al., 2012: The need to promote behavior change at the cultural level: one factor explaining the limited impact of the MEMA kwa Vijana adolescent sexual health intervention in rural Tanzania. a process evaluation | Wight D et al., 2012: The need to promote behavior change at the cultural level: one factor explaining the limited impact of the MEMA kwa Vijana adolescent sexual health intervention in rural Tanzania. a process evaluation |
### Study Objectives:
To explain why one rigorous trial showed improvements in knowledge and reported attitudes and behavior, but none in biological outcomes by reviewing the process evaluation findings, particularly in terms of contextual factors.

### Results Summary:
The findings show that social norms are extremely important at an individual level; but these are elements of a broader culture, which is shared, made up of systems of belief, and should be regarded as structural.

### Study Design/Setting:
A large-scale, primarily qualitative process evaluation based mainly on participant observation.

### Policy/Programmatic implications:
Preventative interventions should therefore address behavior change at multiple levels simultaneously — including the often neglected, but very important, level of culture.

### Source:
*BMC Public Health* 2012, 12(788).

#### 1.5. Male Services

**Hollos M et al., 2004: Which African men promote smaller families and why? Marital relations and fertility in a Pare community in northern Tanzania**

### Study Objectives:
To identify which men desire fewer children, under what circumstances and why.

### Results Summary:
Findings show that men who desire fewer children are younger, educated to at least the primary and often to the secondary level, have wives who have also completed at least primary school, are more affluent and are likely to be Christian. They are in a marital relationship where the partners chose each other. They communicate with their wives about important issues and make joint decisions, including the number of children they should have.

### Study Design/Setting:
A combination of an ethnographic study and in-depth interviews in a Pare community in Northern Tanzania.

### Policy/Programmatic implications:
N/A

### Source:
*Social Science and Medicine* 2004, 58(9):1733–49.

**Rasch V, 2005: Unsafe abortion in Tanzania and the need for involving men in postabortion contraceptive counseling**

### Study Objectives:
To assess the need for and determine the content of postabortion contraceptive counseling for men.

### Results Summary:
The men's different relationships with the woman they accompanied influenced their contraceptive use. The majority of men accompanying their wives and the majority of single men had used either hormonal contraceptives or condoms during the past six months, as had fewer than half of the men accompanying their extramarital partners.

### Study Design/Setting:
A survey of 213 men accompanying female partners receiving hospital care after having undergone an unsafe abortion in Dar es Salaam, Tanzania. Twenty of these men participated in in-depth interviews.

### Policy/Programmatic implications:
The provision of contraceptive counseling and service to men involved in unsafe abortions may result in the creation of a group who will serve as important sources of correct information for other men.

### Source:

**Frajzyngier V et al., 2006: Factors affecting vasectomy acceptability in the Kigoma region of Tanzania**
<table>
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<tr>
<th>Study Objectives: To refine existing vasectomy programs and to replicate and scale-up best practices and lessons learned from the study sites to areas of low vasectomy acceptance.</th>
<th>Results Summary: Service statistics showed inconsistent levels of vasectomy service provision in the Kigoma region, as well as a lack of infrastructure and supplies within some of the facilities. The primary themes that emerged as factors encouraging men to limit family size and undergo a vasectomy were economic hardship and concern for the wife's health. Barriers to vasectomy uptake included the desire to have more children, poor knowledge of and understanding about vasectomy, a lack of trust in one's spouse, and an inability to predict the desire for children in the future.</th>
</tr>
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<tbody>
<tr>
<td>Study Design/Setting: Service statistics and qualitative data collection through in-depth interviews and focus groups in adjacent communities of Kigoma region.</td>
<td>Policy/Programmatic implications: Both sterilized and nonsterilized men in the study recommended that men should have a dedicated space where they can learn about FP. Pre-vasectomy and post-vasectomy counseling should be conducted with the husband and wife together.</td>
</tr>
<tr>
<td></td>
<td>Bunce A et al., 2007: Factors affecting vasectomy acceptability in Tanzania</td>
</tr>
<tr>
<td>Study Objectives: To determine vasectomy acceptability and decision making.</td>
<td>Results Summary: Six themes emerged as overarching factors contributing to the vasectomy decision-making process: economics, spousal influence, religion, provider reputation and availability, uncertainty about the future, and poor vasectomy knowledge and understanding. There was substantial communication between partners regarding the vasectomy decision, and wives had a strong influence on the outcome; however, men and women agreed that husbands would resist a vasectomy if wives initially raised the topic.</td>
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<td></td>
<td>Study Design/Setting: Focus group discussions and in-depth interviews with potential and actual sterilization clients and their partners in Kigoma Region of Tanzania.</td>
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<td></td>
<td>Policy/Programmatic implications: Spousal discussions are important in the decision to get a vasectomy, but these discussions should be initiated by the male partner. Programs need to educate men about contraceptive options, including vasectomies.</td>
</tr>
<tr>
<td>2008: Vasectomy in Tanzania. Study examines acceptability among men and women</td>
<td>Results Summary: Economic hardship due to the expense of raising children was the most common reason participants gave for finding vasectomy acceptable. Wives played an important role in the decision to undergo a vasectomy. Several men decided not to have a vasectomy for religious reasons, but an equal number of participants had been sterilized despite the disapproval of their churches. A general lack of knowledge was the most common reason why potential clients had not undergone the procedure. Both men and women cited specific rumors and misconceptions about vasectomies.</td>
</tr>
<tr>
<td>Study Objectives: To examine vasectomy acceptability among men and women in Tanzania.</td>
<td>Study Design/Setting: Interviews and group discussions with vasectomy clients, their wives and women who had undergone tubal sterilization.</td>
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<td></td>
<td>Policy/Programmatic implications: N/A</td>
</tr>
<tr>
<td>Pathfinder International. Extending Service Delivery P, 2010: Healthy images of manhood (HMI): a male engagement approach for workplaces and community programs integrating gender, family planning and HIV/AIDS. A case study</td>
<td>Study Objectives: To develop, in partnership with Unilever Tea Tanzania Ltd (UTTL), the HMI approach as an intervention to increase both the adoption of healthier behaviors and the use of services by UTTL employees, especially men.</td>
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<tr>
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<td>Results Summary: Since the inception of HMI, Extending Service Delivery (ESD) found the following: (1) increased use of services by men, (2) better male/female relations in the workplace and at home, (3) increased use of FP and (4) personal behavior and attitude changes by male Population, Health and Environment Educators (PHEs).</td>
</tr>
</tbody>
</table>
1.6. Private /Faith-Based Services

Agha S et al., 2009: Determinants of the choice of a private health facility for family planning services among the poor: Evidence from three countries

Study Objectives: To determine how the structure, process and outcomes of quality influence the choice of a public or private facility for FP services among poor clients.

Results Summary: Findings suggest that private facilities are more responsive to the poor. It is possible that because of their higher social status, those who are not poor may be able to extract similar levels of quality of care from both public and private facilities.

Policy/Programmatic implications: Companies should recognize the importance of gender and FP in their workplace health programs.


Lasway C et al., 2012: Assessing the potential of the accredited drug dispensing outlets (ADDOs) in the provision of expanded family planning services in Tanzania

Study Design/Setting: A cross-sectional survey of ADDOs and ADDO dispensers selected via purposive sampling from two regions, Ruvuma and Morogoro.

Results Summary: The findings suggest that the FP services provided by ADDOs can be considered for expansion only after a variety of challenges and opportunities are addressed. For example, most of the ADDOs lacked enough space for privacy, especially for counseling and administering injectables.

Policy/Programmatic implications: The unwillingness of administrators and other key stakeholders to expand FP services suggests that donors and other stakeholders need to advocate more for the importance and possibility of expansion.

Source: FHI 360, Dar es Salaam, Tanzania.

4. ADVOCACY

1.1. Advocacy General

Moreland S et al., 2006: Achieving the Millennium Development Goals: the contribution of fulfilling the unmet need for family planning

Study Objectives: To analyze how meeting the unmet need for FP could help countries in sub-Saharan Africa also meet the MDGs. The study also compares those cost savings with the extra costs of increased FP using a benefit-cost framework.

Results Summary: The benefits from meeting unmet needs outweigh the extra costs of meeting the unmet needs in all countries. The greatest potential for cost savings in most countries is in education and maternal health. Furthermore, meeting unmet need can help avert maternal deaths during childbirth by reducing the number of pregnancies and induced abortions. Reducing unmet need for FP can also reduce the number of infant and child deaths by reducing the number of high-risk births.

Policy/Programmatic implications: A strategy to increase contraceptive use by reducing the unmet need for FP can play a valuable complementary role and help countries to move closer to achieving their MDGs by freeing up resources to meet these goals, while at the same time saving lives.

**Constella Futures, 2007: Achieving the MDGs: the contribution of family planning**

**Study Objectives:** To show how one strategy for meeting the need for FP can reduce population growth and make achieving the MDGs more affordable in Tanzania.

**Results Summary:** The study showed that addressing unmet need in Tanzania could be expected to avert 5,172 maternal deaths and 298,926 child deaths by the target date of 2015. Furthermore, the cost savings in meeting the five MDGs by satisfying unmet need outweigh the additional costs of FP by a factor of 4 to 1.

**Study Design/Setting:** Estimates of the cost savings for five of the eight MDGs. Costs were calculated under two scenarios: when unmet need for FP remains constant and when all unmet need is gradually met by 2020.

**Policy/Programmatic implications:** Increasing access to and use of FP is not one of the MDGs; however, as analysis has shown, it can make valuable contributions to achieving many of the goals.

**Source:** Washington, DC, Constella Futures, Health Policy Initiative, [2007].

**Futures Group International, 2009: The RAPID (Recommend, Agree, Perform, Input and Decide) model: an evidence-based advocacy tool to help renew commitment to family planning programs**

**Study Objectives:** To demonstrate the effect of rapid population growth on different sectors and the benefits of FP programs.

**Results Summary:** Different scenarios are projected so that policymakers can compare the consequences if the country/region continues to have high fertility versus the benefits of reducing fertility, in part, through FP programs. RAPID analyses have been presented to cabinet-level officials in more than 40 countries, including 15 heads of state. In many countries, advocacy using RAPID has led to policy and programmatic change.

**Study Design/Setting:** A computer-based tool that combines demographic and other data to assess the impact of high and declining fertility scenarios on health and education systems, the economy, and the environment, among other things.

**Policy/Programmatic implications:** N/A

**Source:** [Washington, DC], Futures Group International, Health Policy Initiative; 2009.

**Futures Group International. Health Policy Initiative, 2009: Using the RAPID (Recommend, Agree, Perform, Input and Decide) model to make the case for renewed attention to family planning in sub-Saharan African. Focus on Tanzania**

**Study Objectives:** To examine the effects of population factors on education, the economy, health, urbanization and housing, agriculture, food security and natural resources.

**Results Summary:** This brief offers step-by-step guidance with examples from Tanzania on using the RAPID Model as an evidence-based advocacy tool to help make the case for renewed attention to FP. Different scenarios are projected so that policymakers can compare the consequences if the country/region continues to have high fertility, compared to the benefits of reducing fertility, in part, through FP programs.

**Study Design/Setting:** A computer model that combines socioeconomic indicators (such as labor force participation, primary school enrollment, and number of nurses per capita) with demographic information and population projections to estimate impacts as much as 30 years into the future.

**Policy/Programmatic implications:** N/A

**Source:** Washington, DC, Futures Group International, Health Policy Initiative, 2009 Sep.

**Wofford D, 2010: Promoting healthy timing and spacing of pregnancy (HTSP) through pharmaceutical partnerships and professional associations**

**Study Objectives:** To promote the use of field-friendly healthy timing and spacing of pregnancy (HTSP) messages based on evidence of the health benefits of pregnancy spacing.

**Results Summary:** Bayer Schering Pharma (BSP), a global pharmaceutical company that manufactures family planning products and holds the USAID contract for contraceptives, distributed 40,000 materials (20,000 of each) in nine African countries through BSP’s country representatives, including Tanzania. Extending Service Delivery’s (ESD’s) partnership with MEWATA expanded into a broader role for MEWATA to promote HTSP in Tanzania as ESD’s HTSP secretariat. ESD leveraged more than $50,000 from BSP in in-kind costs, with a commitment from ESD of $20,000 in staff time during the initial development and revisions of the HTSP materials, etc.
<table>
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<tr>
<th>Study Design/Setting: IEC materials, including educational materials designed specifically for consumers and health providers in nine African countries, including Tanzania.</th>
<th>Policy/Programmatic implications: N/A</th>
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**Baggaley RF et al., 2010: The potential of medical abortion to reduce maternal mortality in Africa: what benefits for Tanzania and Ethiopia?**

**Study Objectives:** To explore the different factors influencing a woman’s successful use of medical abortion and its potential impact on maternal mortality within sub-Saharan Africa.

**Results Summary:** Thousands of lives could be saved each year in each country by implementing medical abortion using misoprostol (2,122 in Tanzania and 2,551 in Ethiopia, assuming coverage equals FP services levels: 56 percent for Tanzania, 31 percent for Ethiopia). Changes in Maternal Mortality Ratios would be less pronounced because the intervention would also affect national birth rates.

**Study Design/Setting:** A model to explore the wider social impact of introducing legal medical abortion, by examining its uptake by women who would otherwise have carried to term, as well as women who would have undergone unsafe abortions.

**Policy/Programmatic implications:** Thousands of lives could be saved by introducing medical abortion in Ethiopia and Tanzania, reducing their national maternal mortality ratios.


**Study Objectives:** To promote simple economic, environmental and health behaviors messages, including FP messages, that can improve peoples’ lives.

**Results Summary:** This PHE champion’s story describes how she implements PHE approaches to help her community improve health and environmental conditions.

**Study Design/Setting:** As a PHE peer educator, Rukia talks with her fellow community members about simple things they can do to improve their lives, including FP. Her messages are simple and clear.

**Policy/Programmatic implications:** Rukia sets a good example of how doing these simple things can improve a family’s life and protect the environment.

**Source:** [Narragansett], Rhode Island, University of Rhode Island, Coastal Resources Center, BALANCED Project, [2011].

### 4.2. Social and Behavioral Change Communication (SBCC)

**Marchant T et al., 2004: Planning a family: priorities and concerns in rural Tanzania**

**Study Objectives:** To describe fertility in Ulanga and Kilombero districts, to identify the concerns of women during the process of family formation and to identify how best they would like to be served.

**Results Summary:** The study established a large unmet need for FP services in the area, particularly among teenagers for whom it was associated with induced abortion. FP was being used predominantly for spacing, but fears associated with it often curtail effective use. Service provision was perceived to be lacking in two main areas — regularity of supply, and addressing rumors and fears associated with FP. The single biggest fear of FP use was the extent to which it could be damaging and thereby limit a woman’s future fertility potential.

**Study Design/Setting:** FGDs and questionnaire survey as well as a review of data from a demographic surveillance system (DSS) in Kilombero and Ulanga Districts.

**Policy/Programmatic implications:** RH interventions in the area should ultimately be more widespread and, in particular, highlight abortion as an urgent issue for further research.


**Hutchinson P et al., 2005: Advanced methods for evaluating the impact of family planning communication programs: evidence from Tanzania and Nepal**

**Study Objectives:** To evaluate the impact of FP health-communication campaigns on the use of modern FP methods, focusing primarily on the radio drama *Zinduka* in Tanzania and *Ghanti Heri Haad Nilaun* in Nepal.

**Results Summary:** Self-reported exposure to each radio program was exogenously related to FP use, and Propensity Score Matching (PSM) and multiple regression analysis gave similar estimates in those situations.
<table>
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<tr>
<th>Study Design/Setting: DHS data of women's RH and FP history in Tanzania and Nepal.</th>
<th>Policy/Programmatic implications: Researchers should pay close attention to the results of tests for endogeneity and identification that guide the appropriate use of the different methods.</th>
</tr>
</thead>
</table>

**Plummer ML et al., 2006: Farming with your hoe in a sack: condom attitudes, access, and use in rural Tanzania**

Study Objectives: To examine condom knowledge, attitudes, access and practices in rural Mwanza, Tanzania.

Results Summary: Condoms were negatively perceived in rural Mwanza for multiple reasons: for example, the method's association with infection or promiscuity; reduced male sexual pleasure; and cultural understandings of meaningful sex. Men controlled the terms of sexual encounters and reported that they would use condoms only with risky partners, but few perceived their partners as such.


**Mwambete KD et al., 2007: Knowledge, attitude and acceptability of spermicidal contraception among university students in Dar es Salaam**

Study Objectives: To assess the knowledge, acceptability and attitude towards the use of spermicides among students of the University of Dar es Salaam (UDSM).

Results Summary: Spermicides were not very much accepted by the respondents due to their presumed side effects, expense and unavailability. The respondents did, however, accept spermicide usage as an ideal alternative to condoms and effective means for a female-controlled method to prevent or reduce unwanted pregnancies and risk of HIV infection.

Study Design/Setting: A cross-sectional study of university students from all three university campuses: University College of Land and Architectural Studies (UCLAS), Muhimbili University College of Health Sciences (MUCHS) and Mlimani Campus (MC).

Policy/Programmatic implications: Government and responsible authorities should encourage spermicide usage, particularly when coupled with microbicides, to reduce unplanned pregnancies, STDs and HIV infection, inclusive.


**Coast E, 2007: Wasting semen: context and condom use among the Maasai**

Study Objectives: To examine the sociocultural context of condom use among the Maasai, an east African agropastoralist population.

Results Summary: While reported knowledge of HIV/AIDS was high (100 percent), unprompted reporting of condoms as a way of preventing HIV infection was low. Of those individuals who reported that they knew what a condom was, only 17 percent said that they knew how it worked. FGDs reveal strongly held opinions and beliefs connected to condoms and their use, including contraceptive effects, the negative impact on quality of sex, the wasting of semen and the *otergene* of condoms.

Study Design/Setting: A qualitative study and cross-sectional survey among Maasai men and women in the Ngorongoro District in rural northern Tanzania.

Policy/Programmatic implications: In such settings, where giving and receiving of semen is highly valued, microbicides may represent a real alternative to condoms (both male and female) for HIV prevention.

### Schuler S et al., 2009: Gender norms and family planning decision making in Tanzania: a qualitative study

**Study Objectives:** To examine the role of gender norms in reproductive decision making and contraceptive use among young married men and women in Tanzania.

**Results Summary:** Gender factors, such as men's dominance in decision making, do function as barriers to the use of modern contraceptives, but fear of side effects among both men and women might be an even more important deterrent. To users, the benefits of being able to space their children apparently outweighed the risks of side effects, and after trying one method and finding minimal problems with side effects, they continued to use contraceptives. Women rarely initiated contraceptive use on their own, without the husband's consent.

**Policy/Programmatic implications:** The findings from this study underscore the importance of addressing factors related to both genders and to misinformation and exaggerated fears about modern contraceptive methods in the design of communications interventions.

**Source:** Washington, DC, Academy for Educational Development [AED], C-Change, 2009.

### Plumer ML et al., 2010: Seek any means, and keep it your secret: Young women's attempts to control their reproduction through contraceptive and fertility practices in rural Tanzania

**Study Objectives:** To examine young women's attempts to control reproduction through contraception and fertility protection or promotion in rural Tanzania.

**Results Summary:** Many girls used traditional contraception, such as wearing charms or drinking ash solutions. Young single mothers sometimes used modern contraception, including Depo Provera, because injections were accessible, private and infrequent. However, use was ambivalent and inconsistent for fear of side effects, such as infertility (associated with hormonal contraceptives) and reduced male pleasure (associated with condoms). Traditional treatments were used for infertility, miscarriage or difficult deliveries.

**Study Design/Setting:** Participant observation in nine villages, group discussions and interviews in three others, and 16 health facility simulated patient visits.

**Policy/Programmatic implications:** The potential of condoms to protect future fertility should be emphasized.

**Source:** Tanzania Journal of Health Research 2010, 12(3).

### L’Engle KL et al., 2012: Evaluating feasibility, reach and potential impact of a text message family planning information service in Tanzania

**Study Objectives:** To evaluate the feasibility, reach and potential behavioral impact of providing automated FP information via mobile phones to the general public in Tanzania.

**Results Summary:** Adolescents and young adults were the heaviest users of m4RH among those reporting their age. Although frequent queries were made about all contraceptive methods included in the m4RH system, information about natural FP and emergency contraception was most popular. Interest in oral contraceptive pills was lower than interest in most other methods, regardless of gender or age. In contrast, interest in emergency contraception was much higher.

**Study Design/Setting:** Cross-sectional descriptive study among m4RH users in Tanzania.

**Policy/Programmatic implications:** Data from this study suggest that using mobile phones may help to overcome barriers that limit the use of modern contraceptive methods, such as lack of knowledge, limited access and concerns about side effects.

**Source:** Contraception 2013, 87(2):251–56.

### Siegler AJ et al., 2012: Condoms "contain worms" and "cause HIV" in Tanzania: negative condom beliefs scale development and implications for HIV prevention

**Study Objectives:** To evaluate levels of belief in negative rumors about condoms, develop a Negative Condom Beliefs Scale, and assess its accuracy in predicting willingness to use condoms.

**Results Summary:** Findings indicate high levels of subscription to negative beliefs about condoms, with two out of three respondents affirming belief in at least one negative condom rumor. Item agreement ranged from 35 to 53 percent for the following rumors regarding condoms: they cause cancer, have holes, contain HIV, have worms that cause HIV.
**Study Design/Setting:** A cross-sectional, cluster survey \( n = 370 \) representing adults in two rural districts in Northern Tanzania in 2008.

**Policy/Programmatic implications:** This study highlights the relation between condom rumor beliefs and willingness to use condoms, and indicates avenues for future research and means for improving the design of HIV prevention programs.

**Source:** Social Science and Medicine 2012.

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**Mbekenga CK et al., 2013: Prolonged sexual abstinence after childbirth: gendered norms and perceived family health risks. Focus group discussions in a Tanzanian suburb**

**Study Objectives:** To explore discourses on prolonged postpartum sexual abstinence in relation to family health after childbirth.

**Results Summary:** Prolonged sexual abstinence after childbirth for protecting the infant’s health and avoiding kubemenda was the dominant and socially desirable discourse in this study setting. In this discourse, sexual abstinence was given several meanings, ranging from total abstinence from sex for both parents, to occasional or less frequent sex, to the woman abstaining while the man has sex with another woman.

**Policy/Programmatic implications:** Interventions that create openness in discussing sexual relations and health-related matters after childbirth and mitigate gendered norms suppressing women and perpetuating harmful behaviors are needed. The involvement of males in the interventions would benefit men, women, and children through improving the gender relations that promote family health.

**Source:** BMC Int Health Hum Rights 2013, 13(1):4.

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**Nanda G et al., 2013: The influence of gender attitudes on contraceptive use in Tanzania: new evidence using husbands’ and wives’ survey data**

**Study Objectives:** To test the hypothesis that gender attitude scales (which measure the degree of equity in gender attitudes) are associated with contraceptive use.

**Results Summary:** On average, wives endorsed more inequitable gender attitudes compared with husbands on all gender attitude scales. For wives, more equitable gender attitudes were positively associated with contraceptive use. For husbands, the role of gender attitudes had no significant association with wives’ reported contraceptive use.

**Policy/Programmatic implications:** FP programs that aim to challenge inequitarian gender norms should not overlook women in their efforts, because both men and women often accept and support inequality in a social system.

**Source:** J Biosoc Sci 2013, 45(3):331–44.

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### 5. HEALTH SYSTEMS MANAGEMENT

**Bradley JE et al., 2002: Participatory evaluation of reproductive health care quality in developing countries**

**Study Objectives:** To build the capacity of local staff to take charge of managing the quality improvement process themselves.

**Results Summary:** Overall, COPE received widespread approval by providers. The review found that the tool helped staff and supervisors to understand the different components of quality and to define some standards of practice, provided a structure for supervisory visits, aided them in planning, and reinforced the focus on clients’ rights and staff needs.

**Policy/Programmatic implications:** Donors need to be oriented to realize that more participatory project management and evaluation can improve project performance.
6. CROSS-CUTTING

Stephenson A et al., 2002: Measuring family planning sustainability at the outcome and program levels

Study Objectives: To examine the validity of two indices of sustainability: FP program sustainability (PSI) and outcome sustainability (OSI).

Results Summary: Close correlations are found between PSI and OSI predicted values and actual program and outcome values. The indices provide a repeatable method for measuring sustainability, although they are sensitive to data measurement errors.

<table>
<thead>
<tr>
<th>Study Design/Setting: Indices were developed by Tsui and Knight (1997) by applying their original method to recent data. The indices help identify the directional path of program and outcome sustainability.</th>
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</thead>
<tbody>
<tr>
<td>Policy/Programmatic implications: The indices provide a policy tool for funding decisions, but should be used with other data sources to judge sustainability.</td>
</tr>
<tr>
<td>Source: MEASURE Evaluation.</td>
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</table>

<table>
<thead>
<tr>
<th>Study Design/Setting: Cross-sectional descriptive study in four regions.</th>
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<tr>
<td>Policy/Programmatic implications: MOH and RCH NGOs should increase access to and availability of IUCD services to RH clients and revive IUCD training for untrained providers.</td>
</tr>
<tr>
<td>Source: Tanzania Ministry of Health, Reproductive and Child Health Section.</td>
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<thead>
<tr>
<th>Study Design/Setting: Data obtained through a demographic surveillance system in Kisesa, Tanzania, and two large sero-surveys of all residents.</th>
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<tr>
<td>Policy/Programmatic implications: N/A</td>
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<thead>
<tr>
<th>Study Design/Setting: Data from four pooled Demographic and Health Surveys of Tanzania (1991, 1994 [KAP], 1996 and 1999).</th>
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<tr>
<td>Policy/Programmatic implications: All three components of the FP program are shown to have an impact on modern-method choice: (1) better logistical support for fixed facilities so that they would have a variety of contraceptive methods available, (2) improved training for FP providers and (3) a public information campaign that included FP radio dramas as an important component.</td>
</tr>
</tbody>
</table>
Larsen U et al., 2003: Women’s empowerment and fertility decline among the Pare of Kilimanjaro region, Northern Tanzania

**Study Objectives:** To explore the relationship between fertility outcomes and the status of women in a rural area of Kilimanjaro Region, Tanzania.

**Results Summary:** Findings in this population show that age at first birth increased and the progression from having one child to the next child declined. The factors associated with this phenomenon are those related to the status of women, particularly to gender equity within families.

**Study Design/Setting:** An ethnographic study, a community-based survey and in-depth interviews in two villages, Masumbeni and Kisanjuni, located in the Ugweno Division of Kilimanjaro Region in Tanzania.

**Policy/Programmatic implications:** The evidence suggests that the status of women is a key factor in fertility related behaviors.


Richey LA, 2003: Women’s reproductive health and population policy: Tanzania

**Study Objectives:** To use a case study from Tanzania to argue that the challenges of improving RH are unlikely to be met without a revitalization of public health care provision in African countries.

**Results Summary:** Tanzania’s donors and lenders promoted Neo-Malthusian types of population policies aimed primarily at reducing childbearing as a partial solution to the country’s economic crisis. In the mid-1990s, however, the international discourse on population shifted toward a new dependent variable of women’s reproductive health. The notion of RH reunites population and development issues in the context of basic health care provision.

**Study Design/Setting:** A case study from Tanzania.

**Policy/Programmatic implications:** Improving Tanzanian women’s RH will require more than simply providing effective contraceptives.

**Source:** Review of African Political Economy; 2003(96):273–92.


**Study Objectives:** To examine the factors that may have been responsible for the fertility decline in Tanzania and the absence of a decline in Uganda from the mid-1970s to the mid-1990s.

**Results Summary:** One reason that may help explain the different fertility trends in the two countries is that the change in the quantum and tempo of fertility among young women was greater in Tanzania. Women in Tanzania in the mid-1990s were stopping childbearing at lower parities, increasing the age at which they first give birth and spacing their subsequent births at longer intervals than they did in the past. A second and complementary reason for the different fertility patterns concerns the different educational attainment patterns among women in Tanzania and Uganda. Three other possibilities were considered to explain the different fertility patterns among young women in Tanzania and Uganda: economic conditions, political stability and mass education.

**Study Design/Setting:** The analysis was based on the 1996 Tanzania DHS and the 1995 Uganda DHS.

**Policy/Programmatic implications:** More resources should be directed at the primary-school level so that a larger percentage of girls can complete this important level of education and complete it in schools of an acceptable quality.

**Source:** Economic Development and Cultural Change 2003, 51(4):945–75.

Ayoub AS, 2004: Effects of women’s schooling on contraceptive use and fertility in Tanzania

**Study Objectives:** To explore the economic relationships between women’s schooling, fertility rates and contraceptive use in Tanzania.

**Results Summary:** The fertility model indicates that higher education levels are consistently associated with lower fertility rates. Likewise, the contraceptive use model indicates that more education is positively associated with contraceptive use. Both models show that the relations become stronger with higher levels of schooling.

**Study Design/Setting:** Tanzania DHS data of 1996.

**Policy/Programmatic implications:** This study suggests that investing in women’s education should be a practical priority.

Study Objectives: To examine the connection between contraception and those aspects of a woman’s position that are related to her marriage.

Results Summary: The determining factor for contraception and thus for fertility limitation in this society is the nature of the conjugal union. A marital union in which the interests of men and women converge and where the partners communicate about decisions facilitates the acceptance of fertility limitation.

Policy/Programmatic implications: The high prevalence of contraceptive use among the women in the *companionate* unions among the Pare may be an indication of what might be a first stage in a fertility transition in this society, at least in some groups.


Results Summary: Modern contraceptives function as the ultimate technologies of sex disciplining bodies through their life-giving powers of emancipating the modern subject (by freeing women and families from the burdens of children). Local women in this context of layered and unequal power relations and constructions of their own identity choose to accept or reject modern FP according to their own perceptions of need.

Policy/Programmatic implications: Interventions must become more accountable for the ways in which their content, priorities and assumptions serve to shift the balance of power toward some actors and away from others.


Results Summary: The case study of Tanzania exemplifies an RH paradox: fertility is declining, yet so is access to basic RH care. Given that Tanzania, like most post-adjustment countries, is heavily reliant on donor aid to finance health care, donor priorities are likely to have direct implications for Tanzanian clinics.

Policy/Programmatic implications: The RH paradox in post-adjustment health care as demonstrated by the realities of Tanzanian clinics provides important contextualization for understanding the results of reducing aid in the health sector, while increasing it in the population sector.


Results Summary: The most important determinants of using the methods were observed to be level of knowledge of the methods, religious affiliation and discussion of FP issues among partners.

Policy/Programmatic implications: It is imperative for RH programs to intensify efforts in improving women’s knowledge of modern FP methods and encourage partner communication in order to raise the contraceptive prevalence rate.

**Hotchkiss DR et al., 2005: Is maternal and child health service use a causal gateway to subsequent contraceptive use?: a multi-country study**

**Study Objectives:** To examine the relationship between MCH service use and contraceptive use.

**Results Summary:** The intensity of MCH service use is positively associated with subsequent contraceptive use among women, even after controlling for observed and unobserved factors at the individual and community levels.

**Study Design/Setting:** DHS data on women of reproductive age linked with data from service-availability surveys in five countries: Bolivia, Guatemala, Indonesia, Morocco and Tanzania.

**Policy/Programmatic implications:** Increasing investments in programs that are effective in increasing the use of MCH services can also be a viable strategy to increase the use of modern FP techniques.


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**Keele JJ et al., 2005: Hearing native voices: contraceptive use in Matemwe Village, East Africa**

**Study Objectives:** To identify cultural barriers to modern contraceptive use in Matemwe village, Zanzibar.

**Results Summary:** Despite free and easy access to contraceptives, only 2 percent of Matemwe women participated in the village’s FP program. Several factors were found to influence contraceptive use, including strong Muslim beliefs, male dominance over females (especially in polygynous relationships) and limited exposure to modern ideas via education and travel.

**Study Design/Setting:** More than 50 in-depth interviews with community leaders, health care workers and couples in Matemwe village, Zanzibar.

**Policy/Programmatic implications:** In order to lower fertility in Matemwe, cultural barriers to FP must be confronted.


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**Rasch V et al., 2005: Scaling up postabortion contraceptive service—results from a study conducted among women having unwanted pregnancies in urban and rural Tanzania**

**Study Objectives:** To describe the magnitude of the problem of unwanted pregnancies among women with incomplete abortions and evaluate the outcome of PAC interventions.

**Results Summary:** Sixty-seven percent of the women in urban Tanzania and 42 percent in rural Tanzania stated that their pregnancies were unwanted. Contraceptive acceptance among women with unwanted pregnancies was high: 93 percent in urban Tanzania and 71 percent in rural Tanzania left with a contraceptive method.

**Study Design/Setting:** Data were collected among 781 women admitted with incomplete abortions in the Dar es Salaam region (urban Tanzania) and 575 women in Kagera region (rural Tanzania).

**Policy/Programmatic implications:** The high proportion of women with unwanted pregnancies in urban and rural Tanzania underlines the need to scale up postabortion contraceptive service.

**Source:**

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**National Bureau of Statistics (NBS) [Tanzania] and ORC Macro, 2005: Tanzania 2004-05: results from the Demographic and Health Survey**

**Study Objectives:** To provide up-to-date information on fertility, FP, childhood mortality, nutrition, maternal and child health, domestic violence, malaria, adult mortality and HIV/AIDS-related knowledge and behavior.

**Results Summary:** The total fertility rate (TFR) is 5.7 children. Twenty-five percent of women between the ages of 15 and 19 have begun childbearing; 18 percent of births are mistimed; 5 percent of births are unwanted; 96 percent of women and 97 percent of men know at least one modern method; 26 percent of married women are currently using some method of contraception, including 20 percent who are using a modern method. Injectable contraceptives are the leading method, used by 8 percent of married women. 38 percent of contraceptive users discontinued use of a method within 12 months of starting its use. Among currently married nonusers who intend to use in the future, the preferred method is injectables (46 percent), followed by the pill (26 percent).
<table>
<thead>
<tr>
<th>Study Design/Setting: A nationally representative survey of 9,735 households selected from 475 sample points throughout Tanzania.</th>
<th>Policy/Programmatic implications: Almost one-third of women who are not using FP (31 percent) reported visiting a health facility, but not speaking with staff about FP during the visit. This is an indication of missed opportunities for increasing FP acceptance and use.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Source:</strong> National Bureau of Statistics and ORC Macro; Dar es Salaam, Tanzania.</td>
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</table>

**Krehbiel Keefe S, 2006: “Women do what they want”: Islam and permanent contraception in Northern Tanzania**

<table>
<thead>
<tr>
<th>Study Design/Setting: A combination of group discussions and individual interviews with women, men, local religious leaders and hospital workers in Ugweno Tanzania.</th>
<th>Policy/Programmatic implications: N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Results Summary:</strong></td>
<td>Perceptions of Islamic rules about FP are inconsistent. Individuals are able to define their own approach by manipulating the rules and resisting them. Aina put it best when she said, “Yes, many Muslim women use FP; they just do not talk about it at the mosque. Basically, people do what they want, they decide for themselves.”</td>
</tr>
</tbody>
</table>

**Pile JM et al., 2006: Tanzania case study: A successful program loses momentum. A repositioning family planning case study**

<table>
<thead>
<tr>
<th>Study Design/Setting: A combination of group discussions and individual interviews with key informants and a review of secondary program documents for the past 10 to 20 years in the region.</th>
<th>Policy/Programmatic implications: Consistent and meaningful commitment of national and local government (and donor) attention and resources over time is essential if a country is to avoid a loss of momentum like that seen in Tanzania.</th>
</tr>
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<tbody>
<tr>
<td><strong>Results Summary:</strong></td>
<td>A number of factors appeared to account for Tanzania’s loss of momentum in contraceptive use. These include: (1) the impact of decentralization, health-sector reform and other policies; (2) reduced advocacy by champions; (3) failure to sustain training and other program supports; (4) weakening of community-based programs; and (5) transition from key partnerships.</td>
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<tr>
<td><strong>Source:</strong> New York, New York, EngenderHealth, ACQUIRE Project, 2006 Dec.</td>
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**Borda M, 2007: Family planning needs during the extended postpartum period in Tanzania**

<table>
<thead>
<tr>
<th>Study Design/Setting: The analysis is based on the 2004–2005 DHS data from Tanzania.</th>
<th>Policy/Programmatic implications: This finding illustrates a critical period, beginning at approximately four to six months postpartum, in which women become vulnerable to a subsequent pregnancy.</th>
</tr>
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<tr>
<td><strong>Study Objectives:</strong></td>
<td>To summarize key findings related to birth spacing and postpartum FP during the extended postpartum period.</td>
</tr>
<tr>
<td><strong>Results Summary:</strong></td>
<td>Results demonstrate that Tanzanian women have a very high unmet need for FP during the first year postpartum. Approximately 16 percent of births in Tanzania occur within short intervals of less than 24 months, and another 41 percent occur between 24 and 35 months. Among women during their first year postpartum, 74 percent have an unmet need, but only 19 percent are using any FP method. Furthermore, among Tanzanian women, approximately 60 percent return to sexual activity during the four- to six-month period after giving birth, and menses returns for 20 percent during this same period.</td>
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<tr>
<td><strong>Source:</strong></td>
<td></td>
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<tr>
<td>Study Objective</td>
<td>Results Summary</td>
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</table>
| Montgomery CM et al., 2008: *The role of partnership dynamics in determining the acceptability of condoms and microbicides*  
*Study Objectives:* To investigate the processes of communication and decision making in gel and condom use, including constructions of risk and trust.  
*Results Summary:* Gel was found to be acceptable to individual couples on the basis of increased sexual pleasure, partner communication and sense of trust. Although gel was supposedly woman-controlled, men exercised considerable influence in determining whether and how it was used. Despite this, negotiations around its use were largely successful.  
*Policy/Programmatic implications:* It is important to foster an environment in which it is socially and culturally acceptable to use microbicides.  
| Garenne MM, 2008: *Fertility changes in sub-Saharan Africa*  
*Study Objectives:* To provide an overview of major fertility trends in sub-Saharan Africa in the second half of the 20th century. It also presents the proximate determinants and the socioeconomic correlates of these trends.  
*Results Summary:* On average, for the countries investigated, the total fertility rate at age 40 increased from 5.3 children per woman in 1950 to 6.2 in 1975, then declined to 4.9 in 2000. The decline in period fertility appeared to be due primarily to increasing contraceptive use and, to a lesser extent, the rising age at first marriage and increasing urbanization. The dynamics of the fertility decline were different in urban and rural areas.  
*Policy/Programmatic implications:* N/A  
| Richey LA, 2008: *Global knowledge/local bodies: Family planning service providers’ interpretations of contraceptive knowledge(s)*  
*Study Objectives:* To examine Tanzanian service providers’ perceptions of contraceptives to shed light on questions of local level dissemination of population knowledge(s) and shaping of identities.  
*Results Summary:* FP, as a series of practices embedded in global relations of competing and unequally funded development agendas, provides a mean by which service providers can distinguish themselves from their clients. FP service providers are marked or identified at the clinic level by their knowledge of modern methods. This differentiation subsequently shapes the implementation of the FP program.  
*Policy/Programmatic implications:* N/A  
| Ezeh AC et al., 2009: *Stall in fertility decline in Eastern African countries: regional analysis of patterns, determinants and implications*  
*Study Objectives:* To describe patterns of a stall in fertility decline in four Eastern African countries and identify unique and common factors associated with stalling or continuing fertility decline among subgroups within each country.  
*Results Summary:* In both Kenya and Tanzania (where fertility decline has stalled at the national level), fertility continued to decline among the most educated women. The results suggest that declines in contraceptive use, increases in unmet need for FP, increasing preferences for larger families and increases in adolescent fertility were consistently associated with stalls in subgroup fertility.  
*Policy/Programmatic implications:* There is a need to reinvigorate campaigns on contraceptive use and engage policy makers with evidence to increase budgetary allocation towards increasing contraceptive prevalence.  
| Study Objectives: To identify factors that account for the relative success of FP programs. |
| Results Summary: The study identified a number of programmatic emphases that, by their presence or absence, accounted for the relative success of FP programs in Ghana, Malawi, Senegal, Tanzania and Zambia. Foremost among these factors was an emphasis on increasing access to services across all dimensions, because “no access, no program.” These dimensions of access include geographic, cognitive, psychosocial/sociocultural and economic access, as well as factors related to the structure and function of the health care system. |
| Study Design/Setting: Data on FP parameters in Sub-Saharan Africa overall and in eight of its countries: Nigeria, Kenya, Uganda, Ghana, Tanzania, Malawi, Zambia and Senegal. |
| Policy/Programmatic implications: The following are helpful in guiding program efforts: (1) ensuring widespread stakeholder participation, partnership and ownership; (2) focusing on the fundamentals of service delivery: informed choice, medical safety and continuous quality improvement; (3) ensuring that no opportunities are missed (integrate FP services with postpartum, postabortion, HIV/AIDS and/or maternal and child healthcare services); (4) “going beyond the clinic walls”; and (5) addressing and promoting gender equity. |

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| Study Objectives: To analyze the relationship between a woman's preference to limit her family and her exposure to husbands and husbands' kin. |
| Results Summary: Despite wide differences in desired family sizes between men and women, the extent of sexual conflict in this population is restricted to husbands and wives, and affects not a woman's use or planned use of modern contraception, but her success in employing such methods effectively. |
| Study Design/Setting: Women's reproductive output between the initial FP survey in 1996 and the most recent demographic survey (2006) of Pimbwe along Rukwa Valley in Mpanda District, Tanzania. |
| Policy/Programmatic implications: N/A |

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| Study Objectives: To understand how microbicides fit into the broader context of women's and men's everyday lives. |
| Results Summary: Women highlighted the positive aspects of microbicide use relating to perceived good health, hygiene and well-being (including HIV-risk reduction), but also linked this to having a desirable vaginal environment, increased libido and sexual pleasure, support and communication in their relationships and improved home life. |
| Study Design/Setting: In-depth interviews with MDP301 Phase III microbicide trial female participants in South Africa, Zambia, Tanzania and Uganda. |
| Policy/Programmatic implications: This demonstrates the importance of understanding the context into which a new investigational product or intervention is introduced and the need to explore how researcher definitions fit with local meanings of sexual practices. |

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| Study Objectives: To gather information on the FP/RH situation in Tanzania, providing key areas of advocacy intervention for impact. |
| Results Summary: The report identifies the key FP stakeholders in Tanzania and assesses their role in advocacy. It further analyzes the policy environment and factors affecting provision of FP services. Resource flows/funding into FP programs and services are also presented. The assessment also identifies and presents issues that impede RH commodity security, while providing information on ongoing efforts to integrate FP/RH into HIV/AIDS programs and services. |
| Source: *John Hopkins School of Public Health, 2010: Tanzania Family Planning landscape assessment* |

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<table>
<thead>
<tr>
<th>Study Design/Setting: A review of FP/RH–related documents and interviews with key informants included senior officials in government ministries and departments, and international and local NGO staff.</th>
<th>Policy/Programmatic implications: N/A</th>
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<td>Source:</td>
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**Lavis JN et al., 2010: Bridging the gaps between research, policy and practice in low- and middle-income countries: a survey of researchers**

<table>
<thead>
<tr>
<th>Study Objectives: To investigate the efforts to bridge the gaps between research, policy and practice among researchers who conducted research in one of four clinical areas relevant to the Millennium Development Goals.</th>
<th>Results Summary: Engagement in a variety of promising bridging activities was reported by less than half of the surveyed researchers. In particular, targeted dissemination of research products and the development of the capacity of target audiences to find and use research were rarely undertaken.</th>
</tr>
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<tbody>
<tr>
<td>Study Design/Setting: Cross-sectional survey of 308 researchers who conducted research in one of four clinical areas relevant to the Millennium Development Goals (including the care of women seeking contraception) in 10 low- and middle-income countries, including Tanzania.</td>
<td>Policy/Programmatic implications: Future initiatives could focus on supporting those bridging strategies targeted at health care providers that have been found to be effective, and addressing factors that appear to increase the prospects for using research in policy making.</td>
</tr>
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</table>

**Winfrey B et al., 2010: Influence of postpartum behaviors on birth intervals in 17 countries**

<table>
<thead>
<tr>
<th>Study Objectives: To discuss the influence of postpartum behaviors on birth intervals.</th>
<th>Results Summary: Slower return to sexual activity and extended amenorrhea were associated with birth intervals longer than 18 months. Women whose menses has not returned tend not to use FP methods. Higher FP use was reported among women who have had adequate ANC and among women who delivered at a facility.</th>
</tr>
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<tbody>
<tr>
<td>Study Design/Setting: Data from 17 countries, including Tanzania.</td>
<td>Policy/Programmatic implications: Where postpartum abstinence is limited to a short period, ensure that postpartum women and couples are aware of pregnancy risk and have access to methods.</td>
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<tr>
<td>Source: Baltimore, Maryland, Jhpiego, ACCESS, Family Planning Initiative [ACCESS-FP], 2010 Jan.</td>
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**Tanzania National Bureau of Statistics, DHS ICFMM, 2010: Tanzania Demographic and Health Survey 2010**

<table>
<thead>
<tr>
<th>Study Objectives: To provide up-to-date information on fertility, FP, childhood mortality, nutrition, maternal and child health, domestic violence, malaria, adult mortality and HIV/AIDS-related knowledge and behavior.</th>
<th>Results Summary: The TFR was 5.4. The contraceptive prevalence rate had increased significantly, from 26 percent of married women in 2004-05 to 34 percent in 2010. 29 percent of all women, 34 percent of currently married women, and 51 percent of sexually active unmarried women between the ages of 15 and 49 are using a contraceptive method. A majority of women who are using a contraceptive method use a modern method (24 percent). The most commonly used methods are injectable contraceptives (8 percent), oral contraceptive pills (6 percent) and traditional methods (6 percent).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study Design/Setting: A nationally representative household cross-section survey of 10,300 households selected from 475 sample points throughout Tanzania.</td>
<td>Policy/Programmatic implications: N/A</td>
</tr>
</tbody>
</table>
Creanga AA et al., 2011: Low use of contraception among poor women in Africa: an equity issue

Study Objectives: To examine the use of contraception in 13 countries in sub-Saharan Africa.

Results Summary: Poorer women use contraception much less than wealthier women. When childbearing intentions are controlled for, women in the richest wealth quintile appear to be more likely than women in the poorest wealth quintile to use long-term contraception, which is more expensive than short-term contraception and usually provided at clinics.

Policy/Programmatic implications: Wealth-related inequalities for contraception are greater in the use of long-term methods; hence by making short-term methods more widely available or improving their distribution may not suffice to close the gap between the rich and the poor.


Shija AE et al., 2011: Maternal health in fifty years of Tanzania independence: challenges and opportunities of reducing maternal mortality

Study Objectives: To analyze the maternal mortality situation in Tanzania during the past 50 years (1961-2010) and to identify efforts, challenges and opportunities of reducing it.

Results Summary: From 1961 to 1990, the maternal mortality ratio in Tanzania had been on a downward trend, from 453 to 200 per 100,000 live births. From the 1990s, however, there has been an increasing trend to 578 per 100,000 live births. Current statistics indicate that maternal mortality ratio has dropped slightly in 2010 to 454 per 100,000 live births.

Policy/Programmatic implications: Maternal health care services should focus on ensuring there is a continuum of care through strengthening the health system.


Say L et al., 2011: Universal access to reproductive health. Accelerated actions to enhance progress on Millennium Development Goal 5 through advancing Target 5B

Study Objectives: To illustrate the application of a variety of strategies to improve access to SRH.

Results Summary: Lessons learned during implementation and results achieved helped identify a range of actions for accelerated progress in universal access.

Policy/Programmatic implications: The strategic actions taken in the countries outlined in this report help accelerate progress towards the attainment of MDG Target 5B within the wider context of the implementation of the WHO Global RH strategy.


Management Sciences for Health AS, 2011: The use of information and communication technology (ICT) in family planning, reproductive health, and other health programs: a review of trends and evidence

Study Objectives: To assess how new technology, particularly mobile technologies, has the capacity to improve access to FP and RH information and services.

Results Summary: ICT applications in FP and RH include using SMS and text messages to give information on FP methods to women mobile users, wireless solutions that update and connect rural health workers to web-based distance learning programs, mobile phones and PC solutions that help to manage health data, drug supplies, patients’ electronic medical records and the health workforce.

Policy/Programmatic implications: The use of ICT is breaking down barriers, enabling health service providers to work together more closely and reach out to local clients as well as communities far beyond their geographic borders.

Source: Cambridge, Massachusetts, MSH, AIDSTAR-Two, 2011.
### Johnson K et al., 2011: Changes in the direct and indirect determinants of fertility in sub-Saharan Africa

**Study Objectives:** To track changes in fertility and its determinants.

**Results Summary:** In some of these countries, notably Namibia, there has been a consistent downward trajectory in TFR. In most countries, however, there was little change from approximately 1995 to 1999 to approximately 2005 to 2009. This pattern is often described as a *stalled* fertility decline. In most countries, it is found that contraceptive use has been increasing, if only modestly, during the entire series of surveys. Fertility decline sometimes stalled, despite an increase in contraception, because of a countervailing trend in nonmarriage or postpartum infecundity, predominantly the latter.

**Study Design/Setting:** 13 sub-Saharan countries.

**Policy/Programmatic implications:** A description of the patterns within each country in this report helps to clarify how socioeconomic development may or may not translate easily into fertility decline.

**Source:** Calverton, Maryland, ICF Macro, MEASURE DHS; 2011.

### Diamond-Smith N et al., 2011: A woman cannot die from a pregnancy she does not have

**Study Objectives:** To highlight the role of fertility decline in reducing maternal deaths.

**Results Summary:** Reducing fertility disproportionately affected maternal mortality in the high-risk age groups (the youngest and oldest women). For example, the maternal mortality rate for the youngest women (15–19), who face a higher risk for adverse outcomes, fell by two-thirds (69 percent); but among the 20–29 age group (those at lower risk), the maternal mortality rate declined, but by less than half (46 percent).

**Study Design/Setting:** An exercise was conducted using historical data on fertility and maternal mortality from Sweden to create two hypothetical scenarios in order to estimate how reducing fertility affects the number of deaths.

**Policy/Programmatic implications:** Reducing barriers to FP may lessen the burden of maternal deaths in low-resource settings.

**Source:** Int Perspect Sex Reprod Health 2011, 37(3):155–58.

### Effron R et al., 2011: Use of hormonal contraceptives and risk of HIV-1 transmission: a prospective cohort study

**Study Objectives:** To assess the association between hormonal contraceptive use and risk of HIV-1 acquisition by women and HIV-1 transmission from HIV-1-infected women to their male partners.

**Results Summary:** Among 1,314 couples in which the HIV-1-seronegative partner was female (median follow-up 18·0 [IQR 12·6–24·2] months), rates of HIV-1 acquisition were 6·61 per 100 person-years in women who used hormonal contraception and 3·78 per 100 person-years in those who did not (adjusted hazard ratio 1·98, 95 percent CI 1·06–3·68, p=0·03). Among 2,476 couples in which the HIV-1-seronegative partner was male (median follow-up 18·7 [IQR 12·8–24·2] months), rates of HIV-1 transmission from women to men were 2·61 per 100 person-years in couples in which women used hormonal contraception and 1·51 per 100 person-years in couples in which women did not use hormonal contraception (adjusted hazard ratio 1·97, 95 percent CI 1·12–3·45, p=0·02).

**Study Design/Setting:** A prospective study of 3,790 heterosexual HIV-1-serodiscordant couples participating in two longitudinal studies of HIV-1 incidence in seven African countries, including Tanzania.

**Policy/Programmatic implications:** Women should be counseled about the potentially increased risk of HIV-1 acquisition and transmission with hormonal contraception, especially injectable methods, and about the importance of dual protection with condoms to decrease the risk of acquiring HIV-1.

### Bradley SE et al., 2011: The impact of contraceptive failure on unintended births and induced abortions: Estimates and strategies for reduction

**Study Objectives:** To analyze contraceptive failure rates and simulates levels of unintended births and induced abortions that could be achieved if current FP users adopted more effective contraceptive methods.

**Results Summary:** 34 percent of all pregnancies in the four-year period of observation ended in either an unintended live birth or an induced abortion. On average, one of every three unintended births resulted from contraceptive failure. In four countries, more than half of unintended births were conceived while the women were using contraception. The impact of contraceptive failure on levels of induced abortion is even greater.

**Policy/Programmatic implications:** Long-acting and permanent methods, if used in place of less-effective methods, can substantially reduce the number of unintended births and induced abortions, and can help families and countries achieve their health goals.

**Source:** Calverton, Maryland, ICF Macro, MEASURE DHS, 2011 Sep.

### FHI 360, 2011: m4RH: Mobile for Reproductive Health

**Study Objectives:** To provide the steps, processes and lessons learned in developing, implementing and evaluating an opt-in SMS-based health communication program called mobile for RH (m4RH).

**Results Summary:** While this program focuses on disseminating information about FP, the process and lessons learned are transferable to SMS-based programs within RH or other areas of international public health and development.

**Policy/Programmatic implications:** m4RH messages complement other FP information dissemination approaches (mass media, peer-to-peer, etc.) and can reach a broader audience than traditional FP services, including young people and men.

**Source:** Research Triangle Park, North Carolina, Family Health International [FHI 360], 2011.

### 2012: A Review of operational barriers to achieve family planning goals in Tanzania

**Study Objectives:** To generate a comprehensive description of the operational policies (including associated barriers) with which the health care system operates to implement programs and deliver FP services in Tanzania.

**Results Summary:** A total of 16 operational policy barriers were identified in the five strategic action areas of the National FP Costed Implementation Program, including the following: (1) lack of registered FP products in the essential drug list, (2) frequent stock-outs of contraceptives, drugs, and supplies, (3) lack of budget items for any other contraceptive commodities at the district level, (4) low outreach of FP services to men and youths, (5) Low coverage of outreach services, (6) shortage of health force, (7) lack of FP service coverage by insurance schemes and (8) limited capacity for quality assurance.

**Policy/Programmatic implications:** N/A

**Source:**

### Keogh SC et al., 2012: The impact of antenatal HIV diagnosis on postpartum childbearing desires in northern Tanzania: a mixed methods study

**Study Objectives:** To investigate the differences in childbearing desires between HIV-negative and HIV-positive women after antenatal HIV testing.

**Results Summary:** HIV diagnosis was associated with a long-term downward adjustment in childbearing desires, but not with changes in short-term postpartum desires. The qualitative interviews identified health concerns and nurses’ dissuasion as major factors discouraging childbearing post-diagnosis. At the same time, pro-natalist social norms appeared to pressure women to continue childbearing.
<table>
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<tr>
<th>Study Design/Setting: A baseline survey, follow-up survey and in-depth interviews on reproductive behavior among antenatal clients attending routine HIV testing in two districts of Mwanza region.</th>
<th>Policy/Programmatic implications: Given the potential for fertility desires to change following antenatal HIV diagnosis, contraceptive counseling should be provided on a continuum from antenatal through postpartum care, taking into account the conflicting pressures faced by HIV-positive women in relation to childbearing.</th>
<th>Source: Reprod Health Matters 2012, 20(39 Suppl):39–49.</th>
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<tbody>
<tr>
<td><strong>Oduotola A et al., 2012: Pregnancy and contraceptive use among women participating in an HIV prevention trial in Tanzania</strong></td>
<td>Study Objectives: To investigate the pregnancy rate, risk factors for pregnancy and determinants of contraceptive use in randomized controlled trials of herpes simplex virus (HSV)-suppressive therapy for HIV prevention.</td>
<td>Results Summary: The study demonstrated a high incidence of pregnancy in an HIV-prevention trial cohort and identified a number of factors that predict increased risk of pregnancy and use of effective modern contraceptives following study enrolment. Younger age, unmarried status, higher baseline parity and changes in contraceptive methods during follow-up were independently associated with pregnancy. Having paid sex and being HIV positive were associated with a lower risk of pregnancy.</td>
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<td><strong>Macky GA, 2012: Family planning and its implications</strong></td>
<td>Study Objectives: To review trends of FP practice in Sub-Saharan Africa from 1980 to 2010 among women of reproductive age in order to observe the relationship between FP use and fertility in Africa.</td>
<td>Results Summary: In two-thirds of the countries, there was evidence of fertility decline, with a particularly rapid decline in Kenya and Zimbabwe. Statistics from 2010 further showed the African total fertility rate to be standing at 4.7. These rates reflect the contraceptive prevalence of these specific regions. In all world regions, contraceptive use generally corresponds to fertility patterns.</td>
</tr>
<tr>
<td><strong>Fullerton JT et al., 2012: Global postabortion care desk review</strong></td>
<td>Study Objectives: To review activities conducted under the PAC Strategy.</td>
<td>Results Summary: The majority of the recommendations that emerged from the 2001 global review have been addressed in various program interventions conducted over the term of the five-year PAC Strategy. Integration of PAC into pre-service education was a notable exception. A positive feedback loop emerged in which each entity built upon the evidence and activities generated by others to implement programming that was designed to increase new populations’ access to proven strategies; to promote their quality improvement; and to disseminate information about successes, challenges and lessons learned.</td>
</tr>
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### Guttmacher institute, 2013: Unsafe abortion in Tanzania: a review of the evidence

**Study Objectives:** To summarize the current evidence on induced abortion in Tanzania, clarify existing law on the provision of abortion and identify key areas where government and program planners can take action to decrease unintended pregnancies and unsafe abortions.

**Results Summary:** According to the Tanzanian MOHSW, 16 percent of maternal deaths are due to complications from abortion. In eastern Africa, more than 600,000 women were estimated to be hospitalized for induced abortion complications in 2005. Although no recent costing studies have been conducted, it is clear that hospital admissions for abortion-related complications account for a disproportionate share of hospital expenditures.

**Study Design/Setting:**

**Policy/Programmatic implications:** National-level data on abortion incidence and abortion-related complications and assessments of the cost of unsafe abortions to the Tanzanian health system would help raise awareness of the issue and give policymakers a better understanding of the magnitude of the problem.

*Source: Guttmacher institute: In brief series 13. No. 1.*

### Exavery A et al., 2013: How mistimed and unwanted pregnancies affect timing of antenatal care initiation in three districts in Tanzania

**Study Objectives:** To assess the association between mistimed pregnancies and the timing of ANC initiation and the association between unwanted pregnancies and the timing of ANC initiation.

**Results Summary:** 50.7 percent of women became pregnant unintentionally. ANC initiation in the 2nd trimester was 1.68 and 2.00 times more likely for mistimed and unwanted pregnancies, respectively, compared to intended pregnancies. These estimates rose to 2.81 and 4.10, respectively, in the 3rd trimester.

**Study Design/Setting:** A cross-sectional survey among 910 women of reproductive age who had given birth in the past two years in the Rufiji, Kilombero and Ulanga districts in Tanzania.

**Policy/Programmatic implications:** Late ANC initiation is a significant maternal and child health consequence of mistimed and unwanted pregnancies in Tanzania.
