INTRODUCTION

Through the Expand Family Planning (ExpandFP) project, EngenderHealth is working to increase access to and use of quality family planning (FP) services in three countries in Sub-Saharan Africa: the Democratic Republic of the Congo (DRC), Uganda, and Tanzania. The project promotes clients’ full, free, and informed choice of contraceptive method, with a focus on expanding the availability and use of long-acting reversible methods of contraception, particularly hormonal implants and intrauterine devices (IUDs). Funded by the Bill & Melinda Gates Foundation, ExpandFP actively supports the partnership between the donor community and pharmaceutical companies to reduce the price of contraceptives as part of the global FP2020 commitment to support the provision of FP services to an additional 120 million women and girls in the world’s poorest countries by 2020.

Designed to the specific contexts and needs within each country, the ExpandFP project aims to:

- Create, expand, and support FP service delivery by increasing the number of trained providers—especially for implants and IUDs—as well as FP counselors, supervisors, managers, and support personnel
- Integrate quality assurance, quality improvement, and facilitative supervision into all activities
• Ensure accurate reporting and use of data for decision making, particularly for contraceptive security

• Build an enabling environment that supports wide access to FP by offering a full method mix of short-acting, long-acting reversible, and permanent methods of contraception, while prioritizing clients' rights and choice, medical follow-up care, and access to implant and IUD removal services on demand

• Create demand for and awareness of FP services through dissemination of information, education, and communication materials, client mobilization using community health workers and volunteers, and engagement of key community members

EXPANDFP IN TANZANIA

Both the overall contraceptive prevalence rate (CPR) and reliance on modern FP methods have increased steadily in Tanzania. Data from the two most recent Demographic and Health Surveys there indicate that use of modern methods increased from 20% among married women in 2004–2005 to 27% in 2010, while the overall CPR rose from 26% to 34% over the same period. Injectables (11%) were the most commonly used contraceptive method (NBS & ICF Macro, 2011). Nevertheless, in 2010, 25% of married women were found to have an unmet need for FP—i.e., they wanted to space their next birth or stop childbearing entirely but were not using contraception. In response, efforts were intensified to realize the goal of the National Family Planning Costed Implementation Program 2010–2015 to raise the CPR to 60% (MOHSW, 2013).

Through its RESPOND Tanzania Project (RTP), EngenderHealth operates in all 26 regions of the country to improve access to FP, build capacity for FP services, and advance the reproductive rights of Tanzanian women and their families. In partnership with the Ministry of Health and Social Welfare (MOHSW), local government authorities, health facilities, and communities, RTP works to strengthen health systems by standardizing training for health providers, ensuring the availability of multiple contraceptive methods, especially long-acting reversible contraceptives (LARCs) and permanent methods (PMs), and improving integration of FP with other reproductive health services. To complement its nationwide FP activities, EngenderHealth implemented the ExpandFP Project from October 2013 to September 2015 in selected areas of Tanzania where RTP was not active.

PROJECT SCOPE AND PRINCIPAL ACTIVITIES

In collaboration with the MOHSW and members of local Council Health Management Teams (CHMTs), 21 facilities in six districts of six regions (Table 1) were selected for ExpandFP support based on a set of criteria, including notable unmet need for spacing and limiting births; gaps in the numbers of trained medical staff, especially for LARCs; the sites' suitability to provide quality clinical care; the availability of EngenderHealth medical personnel to undertake training, coaching, and follow-up; and minimal external international support (to avoid duplication of efforts).

These 21 “Category 1” facilities received a full package of support, including:

• Training, technical assistance, and mentoring of health care staff in FP clinical and counseling skills to provide clients with the full range of contraceptive methods, with a focus on LARCs/PMs

• Procurement of minor essential equipment, such as examination tables, infection prevention equipment, and IUD and implant instruments and expendable supplies

• Supportive supervision and data quality assurance visits (Supervision visits were routinely carried out by the CHMTs, as well as by Regional/District Reproductive and Child Health Coordinators [RRCHCos/DRCHCos] using the MOHSW Supportive Supervision Checklist. Supervision teams were often joined by ExpandFP staff.)

An additional 82 lower-level (Category 2) facilities in catchment areas surrounding the 21 facilities received targeted assistance, including training at least one provider at each facility in LARCs, infection prevention, or other areas, while an additional 204 Category 3 facilities received support for service delivery events, such as mobile outreach services.

Table 1: Baseline data on the project districts

<table>
<thead>
<tr>
<th>District</th>
<th>Region</th>
<th>Population in 2012 Census</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same</td>
<td>Kilimanjaro</td>
<td>269,807</td>
</tr>
<tr>
<td>Chamwino</td>
<td>Dodoma</td>
<td>330,543</td>
</tr>
<tr>
<td>Lushoto</td>
<td>Tanga</td>
<td>492,441</td>
</tr>
<tr>
<td>Chunya</td>
<td>Mbeya</td>
<td>290,478</td>
</tr>
<tr>
<td>Sumbawanga</td>
<td>Rukwa</td>
<td>305,846</td>
</tr>
<tr>
<td>Namtumbo</td>
<td>Ruvuma</td>
<td>201,639</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>1,890,754</strong></td>
</tr>
</tbody>
</table>

| Est. % of women of reproductive age (15–49 years), 2012 census | 47.2% |
| Est. no. of women aged 15–49 in project districts | 892,436 |

Sources: NBS & OCGS, 2013a; NBS & OCGS, 2013b
MODALITIES OF SERVICE DELIVERY

ExpandFP supported three main modalities of service delivery:

1. Routine static services at the 21 core facilities
2. Special FP days (i.e., one-day events outside the normal operating hours or schedule at the static sites, such as on weekends or public holidays)
3. Mobile outreach service events (i.e., supplementary service delivery events typically implemented at lower-level facilities in more remote or underserved areas of the project districts)

Starting in October 2014, in response to high levels of client demand, ExpandFP introduced “FP weeks” with special support for LARCs/PMs. This approach engaged up to four teams to conduct outreach events simultaneously within a district, thus reaching more facilities in a given period of time. In some districts, FP weeks reached up to 20 facilities over a five-day period. All FP weeks were coordinated from the office of the district medical officer, with technical support from EngenderHealth. Medical teams typically included a surgeon, a nurse, and a medical attendant from a district hospital.

To raise awareness and encourage demand, ExpandFP supported local community mobilizers to announce dates and locations of upcoming special FP days and mobile outreach events, usually traveling on foot or bicycle throughout nearby villages, where they delivered messages over a loudspeaker. While these individuals did not provide FP counseling, they were an effective link between the facility and prospective clients. Health talks were also routinely conducted at all health facilities during the week before and on the day of implementation of the special FP day or mobile outreach event, to inform clients of service availability, discuss myths/misconceptions, and address questions. These health talks often drew clients attending the facility for other services and helped pique the interest of and engage male bystanders.

PROJECT ACHIEVEMENTS

Clinical and Counseling Capacity

ExpandFP increased and strengthened clinical and counseling capacity to deliver routine FP services and conduct special FP days at the 21 static health facilities and trained a pool of providers to carry out mobile outreach at lower-level facilities. In total, ExpandFP supported MOHSW trainers to train 183 medical personnel in project districts and neighboring districts to provide implants. Of these personnel, 158 were serving in a nursing function, with the remaining 25 holding positions as clinical/medical officers, assistant medical officers, or maternal and child health aides. One hundred thirty-five staff also received clinical training in the insertion and removal of the Copper-T 380A® IUD, and 44 staff were trained in counseling based on the 2010 MOHSW curriculum and EngenderHealth’s REDI Counseling Framework.1

In May 2015, a training-of-trainers workshop on LARCs was held for 20 MOHSW providers from three project districts (Same, Lushoto, and Chamwino) and four neighboring districts. Participants learned how to counsel clients, provide methods, and manage side effects for the Jadelle® and Implanon® implants, as well as for the Copper-T 380A® IUD. The curriculum included guidance on infection prevention and on adult learning techniques. These 20 certified trainers are expected to be key human resources to conduct future clinical training and contribute to mobile outreach events and special FP days in their respective districts.

In addition, in June 2015, acting on requests from district medical officers in three project districts, ExpandFP (in collaboration with RTP) conducted an intensive clinical training course on minilaparotomy—a safe, permanent method of female contraception—for nine personnel.

Based on facility audits carried out in September 2015 at the 21 supported facilities, attrition of trained staff was limited. Of the 129 staff trained at those sites, 114 were followed up, and among those, only nine were no longer providing FP services (five had transferred to other facilities, two had returned to study/training, and two had died). At the close of the project, all 21 static facilities had at least two providers trained in LARCs (both implants and IUDs), up from six facilities in January 2014.

Access to FP Services

FP service delivery in the six participating districts was significantly expanded over the project period. As shown in Table 2 (page 4), a total of 160,378 FP client services2 were provided between January 2014 and September 20153 (on average, approximately 23,000 clients per quarter), compared with a total of 25,138 clients in the preintervention baseline period between January and December 2013 (on average, approximately 6,300 clients per quarter).

By service modality, 57% of clients were served during mobile outreach, 39% during routine services at static facilities, and 4% during special FP days at the static facilities. The lower percentage of clients served during special FP days was mainly due to the small

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1 REDI stands for Rapport building, Exploration of options, Decision-making support, and Implementing the decision to use a particular method. This framework for counseling is a client-centered approach to help clients choose the best contraceptive with which to achieve their reproductive intentions.

2 Data collected represented the total number of services and do not represent unique users. Women using short-acting methods may have been served several times by the same facilities over the project period.

3 The funding period for the ExpandFP initiative in Tanzania was for two years, from October 2013 to September 2015. However, the effective intervention period commenced in January 2014. For the purpose of assessing changes in service delivery, baseline data for the 12-month period from January to December 2013 (four quarters) are compared with the 21-month project period, from January 2014 to September 2015 (seven quarters).
number of special FP days held during the intervention period.

In total, 60 special FP days were undertaken, compared with 682
individual outreach events.

While the majority of clients served during the intervention period
received their methods through outreach events, ExpandFP also
worked to sustainably upgrade routine FP services at the static
sites. Client loads for routine services at the 21 supported facilities
increased from around 6,200 clients per quarter during the
baseline period to just under 9,000 clients during the intervention,
representing a 44% increase in clients served per quarter.

Changes in the method mix were also striking. The proportion of FP
clients choosing LARCs increased over six-fold, from 10% (implant,
8.4%; IUD, 1.6%) during the baseline period to 62% (implant,
49.5%; IUD, 12.9%) in the intervention period (Figure 1). A sizable
increase in adoption of female sterilization was also seen, from fewer
than 1% of clients to 12%. These changes were accompanied by
major declines in the relative share of short-acting methods, with the
proportion of women choosing injectables falling from 74% to 19% of
adopters and the proportion choosing the pill from 15% to 7%.

<table>
<thead>
<tr>
<th>Method</th>
<th>Static facilities</th>
<th>Special FP days</th>
<th>Mobile outreach (including FP weeks)</th>
<th>All service modalities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline (21 sites)</td>
<td>Project (21 sites)</td>
<td>Baseline (21 sites)</td>
<td>Project (21 sites)</td>
</tr>
<tr>
<td></td>
<td>Total no. of clients adopting a method</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Baseline</td>
<td>Project</td>
<td>Baseline</td>
<td>Project</td>
</tr>
<tr>
<td>Permanent methods</td>
<td>193</td>
<td>3,709</td>
<td>0</td>
<td>578</td>
</tr>
<tr>
<td>Female ster.</td>
<td>189</td>
<td>3,681</td>
<td>0</td>
<td>576</td>
</tr>
<tr>
<td>Male ster.</td>
<td>4</td>
<td>28</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>LARCs</td>
<td>2,358</td>
<td>27,501</td>
<td>0</td>
<td>4,235</td>
</tr>
<tr>
<td>Implant</td>
<td>1,978</td>
<td>22,523</td>
<td>0</td>
<td>3,532</td>
</tr>
<tr>
<td>Jadelle®</td>
<td>67</td>
<td>1,268</td>
<td>0</td>
<td>1,428</td>
</tr>
<tr>
<td>Implanon®</td>
<td>1,902</td>
<td>9,523</td>
<td>0</td>
<td>2,104</td>
</tr>
<tr>
<td>Sino-implant (I)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unspecified</td>
<td>9</td>
<td>11,732</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>IUD</td>
<td>380</td>
<td>4,978</td>
<td>0</td>
<td>703</td>
</tr>
<tr>
<td>Short-acting methods</td>
<td>21,934</td>
<td>29,825</td>
<td>0</td>
<td>1,558</td>
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<tr>
<td>Injectable</td>
<td>18,140</td>
<td>22,833</td>
<td>0</td>
<td>1,025</td>
</tr>
<tr>
<td>Pill</td>
<td>3,794</td>
<td>6,992</td>
<td>0</td>
<td>533</td>
</tr>
<tr>
<td>Total no. of clients adopting a method</td>
<td>24,485</td>
<td>61,035</td>
<td>0</td>
<td>6,371</td>
</tr>
<tr>
<td>Removals</td>
<td>445</td>
<td>1,817</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Implant</td>
<td>434</td>
<td>1,465</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>IUD</td>
<td>11</td>
<td>352</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total no. of clients</td>
<td>24,930</td>
<td>62,852</td>
<td>0</td>
<td>6,372</td>
</tr>
</tbody>
</table>
Service delivery data indicate considerably higher adoption of LARCs and PMs during mobile outreach and special FP days compared with routine health services in static facilities (see Figure 2). Among FP clients who adopted a method during mobile outreach, 90% chose LARCs and PMs. The corresponding data for special FP days and routine services at static facilities were 76% and 51%, respectively.

**Quality of Services**

Throughout the intervention period, ExpandFP supported routine facilitative supervision and data quality assurance visits. Supportive supervision was conducted by CHMT members as part of their routine work, using updated techniques and supervisory tools to improve their work. During the visits, the supervision teams used the MOHSW Supportive Supervision Checklist, which assesses key indicators for quality service delivery, such as infection prevention practices, stockouts of consumables/contraceptives, commodity storage, and client confidentiality.

Typically, these visits coincided with mobile outreach events and special FP days, so that CHMT members could mentor and coach health care workers at the local facilities. Informal training was conducted throughout outreach days to improve staff skills in: managing client flow, counseling, and clinical practices.

Over the life of the project, 83 supervision visits were conducted across the 21 static facilities. In addition, 72 providers, CHMT members, and health managers/supervisors and administrators were
Assuring Clients’ Rights while Scaling Up LARCs: Results from the ExpandFP Client Study in Tanzania

Between April and July 2015, ExpandFP conducted a client study in Tanzania on client perceptions of quality and choice, to examine if women were able to make full, free, and informed choices about contraception and to investigate if quality care was provided across all service modalities. (Similar studies were conducted in the Democratic Republic of the Congo and Uganda.) In Tanzania, interviews were conducted with 200 FP clients attending 13 health facilities in three out of the six project districts. The facilities were purposively sampled to represent geographic reach and type of facility, and clients were systematically sampled at the facility level during mobile outreach and routine service delivery at the static sites. Among other things, clients were asked about their perceptions of the quality of FP counseling provided and their level of satisfaction with respect to specific FP service items, as well as their satisfaction overall, using a four-point Likert scale.

Ninety-nine percent of clients across all modalities in Tanzania were satisfied with project-supported services. Clients’ level of satisfaction exceeded 90% for all items examined, with the lowest level of satisfaction (93%) reported for the item “Opportunity to ask questions.” However, responses with respect to the quality of counseling indicated room for improvement. Among the 185 women who selected a method during their visit, 81% reported being counseled on the benefits of their chosen method, but only 65% reported being counseled on the method’s possible side effects.

Almost three-quarters (74%) of the women interviewed in Tanzania also reported receiving “too much” information, while an overlapping 81% of women stated they wanted information about additional FP methods, suggesting that providers’ assessment of reproductive intentions needed improvement, so that counseling could be better tailored for each client. Fewer than 10% of clients reported receiving “too little” information.

LESSED LEARNED

Building the capacity of districts and individual facilities to deliver quality FP services was the cornerstone of ExpandFP’s approach in Tanzania. The intervention aimed to make comprehensive FP services an integral part of service planning and delivery and a normal aspect of community health. The following are important lessons learned during the intervention in expanding FP service capacity, access, quality, and use.

Capacity

- The shortage of FP providers is a major obstacle to service delivery. In almost all of the supported facilities, a shortage of trained providers—particularly in reproductive and child health and FP units—was cited at the start of the project as the main obstacle to FP service delivery. Once this shortage was alleviated, adoption of FP methods climbed.

Oriented on COPE©, a comprehensive yet easily implemented quality improvement approach that enables service providers and other facility staff to assess the services they provide, identify problems and their root causes, and develop action plans with practical solutions. This approach has been further adapted in Tanzania to include a module on contraceptive security for facilities and district supervisors. Importantly, the COPE© for Contraceptive Security approach was incorporated into the MOHSW’s national supervisory system.

As part of project close-out, facilities evaluated progress made on their COPE action plans. Evaluation of the plans indicated persistent though less-frequent issues across facilities, such as fewer periodic stockouts of contraceptives and consumables and shortages of client data forms. In addition, ExpandFP held district-level dissemination meetings in the six project districts with representation from all 21 supported sites. Facility teams analyzed the data to develop “facility report cards” to clearly show each facility’s standing in providing quality services. This highly participatory approach used self-assessment of performance to strengthen clinic staff ownership of the process, results, and areas for future improvement.

The report cards showed that 20 of the 21 facilities had at least two providers trained in LARCs (both implants and IUDs) at the close of the project. Results also showed marked improvement in contraceptive security. At baseline, almost all facilities reported stockouts of IUDs and/or injectables in the two months prior to the assessment. At endline, only nine of the 21 sites reported stockouts of these contraceptives in the preceding two months, and for only a single method in each instance (stockouts were reported for Jadelle® at four sites, Implanon® at three sites, and the Copper T IUD at two sites). Only one facility had neither type of implant available at endline. The reason commonly cited for the stockouts was that these contraceptives were not available from the Medical Stores Department.
• New and follow-up/refresher trainings of health care providers enable districts and facilities to serve more FP clients with a variety of methods, especially LARCs. Tanzanian government regulations permit nurses to provide implant and IUD services in accordance with national standards, yet many lacked the competence to do so. ExpandFP implemented a comprehensive clinical and counseling training program to enable providers to offer the full range of methods available.

• Provider training must be backed by an enabling facility environment. Providers must not only be trained to competence to deliver FP services; they must be placed in enabling facility or mobile environments. Stockouts of contraceptives and consumables erode both providers’ capacity (regardless of their clinical competence) and the community’s confidence in FP services. When FP providers are supported and methods are offered in an environment of quality and choice, with solid counseling tied to reproductive intentions, clients’ contraceptive needs are met.

Access and Choice

• Community engagement is an essential part of success. Community mobilizers, FP talks, and appropriate information posted in the community and in clinics helped normalize FP use in the project districts and ensured that communities knew where and when they could get FP services. The project also found that with appropriate sensitization, influential community members (including religious leaders) often came out in support of FP services in their communities.

• Various service delivery approaches are needed to meet client demand. The provision of on-demand FP services on a daily basis at static sites ensures access to contraception without “waiting” for special events. In this way, FP services are institutionalized and normalized, which reinforces community acceptance and use. In addition, the experience of ExpandFP confirms that mobile outreach is an essential service delivery approach for closing the gap in unmet need, especially in underserved or resource-poor areas, and particularly for LARCs and PMs. Well-planned and well-publicized outreach events give prospective clients confidence that sufficient numbers of trained providers will be present and that all methods and materials will be on hand. Project results support the concept that when all of the elements of contraceptive security for LARCs and PMs are in place (i.e., trained providers, contraceptives, and related supplies), many clients will opt for LARCs and PMs.

Quality

• Clients’ rights can be assured when LARC provision is scaled up. Every FP client has the right to information, access to services, informed choice, safety, privacy, dignity and comfort, and continuity of care. The experience of ExpandFP in Tanzania and the positive findings from the client study (see box, page 6) demonstrate that these rights can be assured even while the provision of LARCs is being scaled up.

• Accurate reporting and use of data for decision making are vital to ensuring the sustainability and quality of services. Complete and reliable facility- and district-level data are essential for assessing progress and performance in providing FP services and for informing health planning, budgeting, human resource needs, and contraceptive security. However, data quality assurance visits found that documentation was at times incomplete and that facilities periodically encountered shortages or stockouts of client record forms, which are an essential part of client registration.

Contraceptive Use

• When long-acting and permanent methods of contraception are available, women will freely choose them. Though our findings are not directly comparable to the results of the nationally representative 2010 DHS, the high level of adoption of LARCs, particularly implants, during ExpandFP-supported activities parallels DHS results and suggests the potential for a dramatic shift in contraceptive use in Tanzania if implants become more readily and widely accessible. On average, across all service modalities, 50% of women who adopted a method chose an implant, 13% chose an IUD, and a further 12% opted for minilaparotomy.

Through the expansion of both routine and mobile outreach services, more method choices were available in more places for more women. Access and use of implants increased dramatically from baseline to endline, increasing from 8% of all FP adopters to about 50%. The percentage of women served receiving Implanon (27%) was nearly twice the percentage choosing Jadelle (15%); this difference was most likely due to the relatively limited availability of Jadelle rather than to clients selecting between the two brands. There was also a healthy increase in the number of IUD adopters, with the proportion of new users growing from 1.6% at baseline to 12.9% at endline. All of the above findings indicate that when LARCs and PMs are offered in an environment of quality and choice, many women will adopt these methods, thus reducing unmet need with highly effective methods.
RECOMMENDATIONS AND NEXT STEPS

In terms of numbers of clients reached and personnel trained to provide LARCs, ExpandFP made a significant impact in reaching women with an expanded method mix in the supported districts. The project dramatically improved the contraceptive options available and the ways in which they could be accessed. However, continued strengthening of FP service delivery will be required to sustain and expand project gains.

Long-term, coordinated solutions across all levels of the health care system are needed to overcome chronic shortages of health personnel and improve logistics and supply chain management to ensure contraceptive security. The EngenderHealth/Tanzania Country Office continues to address contraceptive supply through national and regional contraceptive security meetings in Tanzania. However, ongoing advocacy will be required at the national, regional, and district levels for increased funding for health services in general and FP services in particular, so that district-level work plans and budgets include funds for additional staffing, regular training, support and supervision, all contraceptives, LARC and PM equipment, instruments and supplies, and transportation for outreach. CHMTs will necessarily play a central role in planning and delivering FP services. Supplies and services will be sustainable only if financing for FP is routinely incorporated into Comprehensive Council Health Plans and decentralized structures are committed to following up issues limiting access to FP at district- and lower-level facilities. RTP is engaged in advocacy with CHMTs and district political authorities nationwide. It will be important to continue these efforts.

At the facility level, providers will need ongoing mentoring, support, and supervision to ensure that each client receives the best information and FP services available. Crucially, the COPE for Contraceptive Security methodology used for quality improvement and facilitative supervision is grounded in promoting clients’ rights and addressing providers’ needs. The REDI Counseling Framework is also client-focused, as it does not “inundate” the client with information but rather seeks to tailor information to the client’s reproductive intentions and health concerns during each encounter. However, results from the client study indicate that additional mentoring and training of providers in FP counseling would be beneficial.

Lastly, to institutionalize evidence-based decision making, it is important to have a designated staff member at the facility level who is responsible for ensuring data quality prior to submission. New or refresher trainings on Tanzania’s health management information system (known as MTUHA) tools will be needed periodically to update providers on changes to reporting requirements and to correct mistakes in completing FP registers and client forms. Similarly, at the district level, a designated staff member should be responsible for reviewing submissions for accuracy and completeness, establishing protocols to address late, incomplete, inaccurate, and missing reports, and providing feedback to all service points.

REFERENCES


