TANZANIA

PAC-FP COUNTRY BRIEF

Postabortion care (PAC) provides a comprehensive approach to preventing morbidity and mortality caused by abortion complications (PAC Consortium, 2014). As per the U.S. Agency for International Development (USAID) PAC model, a critical component of PAC is providing access to family planning (FP) counseling and services. Providing these services helps meet the reproductive intentions of women who most clearly demonstrate an unmet need for FP, reduces unintended pregnancies, and prevents repeat abortions, thus reducing maternal deaths (Curtis, Huber, and Moss-Knight, 2010). The information below highlights the United Republic of Tanzania's investment in providing PAC and FP services to women in need.

POLICIES, LEADERSHIP, AND GOVERNANCE

The United Republic of Tanzania's national family planning (FP) and reproductive health (RH) policy is outlined in a number of documents, including the National Family Planning Costed Implementation Plan 2010–2015 (updated in 2013) and the National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child, and Adolescent Health in Tanzania: One Plan II 2016–2020 (2016). Among many objectives, the country's strategic plan aims to scale up and strengthen FP services (especially long-acting methods and community-based distribution of contraceptive commodities) and to integrate FP services into other RH and child health delivery points in order to minimize missed opportunities for women to access quality care (Ministry of Health, Community Development, Gender, Elderly, and Children [MoHCDGEC], 2015). The National Package of Essential Reproductive and Child Health Interventions includes postabortion care (PAC) as an essential service, in addition to other RH and child health services, emergency obstetric and postpartum care, and FP (Wanjiro et al., 2007).

Legal Status of Abortion

Tanzania's Penal Code (2002) authorizes abortion to save a woman's life. (Center for Reproductive Rights, 2012).

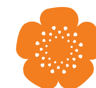
PAC TRAINING AND STANDARDS

In 2000, the MoHCDGEC added comprehensive PAC (referred to as cPAC) to its list of essential RH and child health interventions. cPAC includes the emergency treatment of complications of abortion as well as postabortion FP counseling and voluntary service delivery (Mwanga et al., 2013).

EngenderHealth's Access, Quality and Use in Reproductive Health Project (ACQUIRE) trained service providers in an effort to understand how to incorporate PAC into national health systems service delivery. Training included clinical management of incomplete abortions using manual vacuum aspiration (MVA), screening and management of sexually transmitted infections (STIs), STI and HIV counseling, FP, infection prevention, and community education (Wanjiro et al., 2007). As a result of ACQUIRE's efforts, the government adopted MVA as a first-line treatment for first-trimester incomplete abortions, which enabled mid-level providers (nurses and midwives) to deliver PAC at all levels of the health system. Misoprostol is widely used for this purpose in Zanzibar, a semi-autonomous region with its own ministry of health, despite the absence of clear guidelines in its use for PAC.

PAC·FP THE POSTABORTION CARE FAMILY PLANNING PROJECT
Expanding contraceptive methods and informed choice to PAC clients

USAID FROM THE AMERICAN PEOPLE


EngenderHealth for a better life

To support health systems strengthening objectives in PAC and FP, Tanzania developed a five-day community-based FP refresher training to update community health workers' skills (FP 2020, 2016). The postabortion FP training package, which integrates uterine evacuation with FP counseling and voluntary method provision—including the insertion of postabortion intrauterine devices and implants and use of MVA—was developed and approved by the Ministry in 2016 (FP 2020, 2016).

STRENGTHENING SERVICE DELIVERY

In 2007, the MOHCDGEC began expanding PAC to lower-level facilities in order to increase access throughout the country (Keogh et al., 2015). This brought PAC and FP service provision closer to women by enabling on-site provision of FP services prior to discharge from the facility. Task shifting of PAC (such as MVA to nurses and midwives) through decentralization further promotes women's access to these services.

BARRIERS TO DEMAND AND ACCESS TO PAC

Women in Tanzania face multiple barriers to accessing PAC and FP services. Poor location of facilities—often compounded by lack of reliable transportation—is a primary barrier to PAC. Women who are able access a facility for the required care often encounter facilities with incomplete and inadequate medical supplies (USAID, 2008). In a study of health facilities in three districts of Tanzania, only a quarter had MVA kits in stock (Venture Strategies Innovations, forthcoming). The high cost of user fees also proves difficult for many women.

In addition to challenges accessing PAC, the quality of PAC is often inadequate. Provider biases and client experiences demonstrate the need for more training on FP counseling. FP counseling frequently lacks information on method side effects, leaving women unable to make informed decisions (Venture Strategies Innovations, forthcoming). Inadequate awareness of PAC also prohibits access to these lifesaving services. In Zanzibar, only 52% of women were aware of PAC, and 15% of those women thought PAC services were illegal (Riwa et al., 2013).

FINANCING MECHANISMS

The Government of Tanzania has made a commitment to universal health coverage under the Third Health Sector Strategic Plan (2009–2015) through social health insurance (West-Slevin and Dutta, 2015). While the current National Health Insurance Fund covers PAC and FP costs, only a quarter of the population is covered by the fund. Nonetheless, progress has occurred in Tanzania: in 2016–2017, the government reported increasing its allocation for FP to TZS five billion (approximately USD 2,171,650), and subnational governments have regularly acknowledged the role of FP in their development plans.

TANZANIA		Year	Source
Demographic/background indicators			
Country population	57,310,019	2017	World Bank[1]
Total fertility rate	5.0	2016	World Bank[1]
Age at first birth	19.7	2015–16	Demographic and Health Survey, 2015–16
Maternal mortality per 100,000 live births	556	2015–16	Demographic and Health Survey, 2015–16
Newborn mortality per 1,000 live births	25	2015–16	Demographic and Health Survey, 2015–16
Infant mortality per 1,000 live births	43	2015–16	Demographic and Health Survey, 2015–16
Under-five child mortality per 1,000 live births	67	2015–16	Demographic and Health Survey, 2015–16
Facility-based deliveries	63.0%	2015–16	Demographic and Health Survey, 2015–16
Proportion of women who attended at least one antenatal care visit	98.0%	2015–16	Demographic and Health Survey, 2015–16
Proportion of women who received a postnatal check within two days of delivery	34.0%	2015–16	Demographic and Health Survey, 2015–16
Abortion and FP-related indicators			
Number of abortions	405,000	2013	Guttmacher Institute, 2016
Abortions per 1,000 women	36	2013	Guttmacher Institute, 2016
Number of unintended pregnancies	1,181,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Proportion of maternal deaths attributable to abortion complications	16%	2015	Guttmacher Institute, 2016
Number of unintended pregnancies averted due to use of modern contraceptive methods	1,604,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of unsafe abortions averted due to use of modern contraceptive methods	353,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of maternal deaths averted due to use of modern contraceptive methods	4,700	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Modern method contraceptive prevalence rate, all women of reproductive age (WRA)	31.2%	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Knowledge of FP, all WRA	99%	2015–16	Demographic and Health Survey, 2015–16
Contraceptive use by type		2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Long-acting and permanent methods		2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Sterilization (female)	9.3%	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Sterilization (male)	0.0%	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Intrauterine device	2.6%	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Implant	20.7%	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Short-acting methods		2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Injection (intramuscular and subcutaneous)	49.8%	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Pill	3.8%	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Condom (male)	5.8%	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Condom (female)	0.0%	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Other modern methods (e.g., cycle beads, and lactational amenorrhea method)	0.4%	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Unmet need for FP[2] (2018)	23.0%	2015–16	Demographic and Health Survey, 2015–16
Unmet need for spacing	16.0%	2015–16	Demographic and Health Survey, 2015–16
Unmet need for limiting	7.0%	2015–16	Demographic and Health Survey, 2015–16
Percentage of all women who received FP information during their last visit with a health service provider	21.4%	2015–16	Demographic and Health Survey, 2015–16

1 https://databank.worldbank.org/data/reports.aspx?source=2&country=TZA

2 Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior.

REFERENCES

Center for Reproductive Rights, 2012. *Briefing Paper: A Technical Guide to Understanding the Legal and Policy Framework on Termination of Pregnancy in Mainland Tanzania*. New York, NY: Center for Reproductive Rights. www.reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_TZ_Briefing_Paper.PDF.

Curtis, C. 2008. "Decentralization of Postabortion Care in Senegal and Tanzania." *Global Health Technical Briefs*. Washington, DC: U.S. Agency for International Development. https://www.k4health.org/sites/default/files/Decentralization%20of%20PAC%20-%20Senegal%20and%20Tanzania.pdf.

Curtis, C., Huber, D., and Moss-Knight, T. 2010. "Postabortion Family Planning: Addressing the Cycle of Repeat Unintended Pregnancy and Abortion." *International Perspectives on Sexual and Reproductive Health* 36(1): 44–48. doi: 10.1363/ipsrh.36.044.10.

FP 2020. 2016. *Tanzania: Commitment Maker Since 2012*. http://www.familyplanning2020.org/entities/143.

FP2020. *Tanzania: FP2020 Core Indicator Summary Sheet: 2017–18 Annual Progress Report*. https://www.familyplanning2020.org/sites/default/files/Tanzania%202018%20CI%20Handout.pdf.

Keogh, S. C., Kimaro, G., Muganyizi, P., Philbin, J., Kahwa, A., Ngadaya, E., and Bankole, A. 2015. "Incidence of Induced Abortion and Postabortion Care in Tanzania." *PLoS One* 10(9): e0133933. doi: 10.1371/journal.pone.0133933.

Ministry of Health, Community Development, Gender, Elderly, and Children (MoHCDGEC). 2016. *The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child, and Adolescent Health in Tanzania (2016–2020)*. Dar es Salaam, Tanzania. http://globalfinancingfacility.org/sites/gff_new/files/documents/Tanzania_One_Plan_II.pdf.

MoHCDGEC, Ministry of Health, National Bureau of Statistics, Office of the Chief Government Statistician, and ICF. 2016. *Tanzania Demographic and Health Survey and Malaria Indicator Survey, 2015–16*. Dar es Salaam, Tanzania, and Rockville, MD: MoHCDGEC, Ministry of Health, National Bureau of Statistics, Office of the Chief Government Statistician, and ICF.

Mwanga, F., Rimoy, M., Killian, R., et al. 2013. *Increasing Access to and Use of Comprehensive Post-Abortion Care Services: Evidence from Tanzania*. Presentation from the 2013 National Family Planning Conference. Dar es Salaam, Tanzania. http://www.rchs.go.tz/index.php/en/fppresentation/day-3/engaging-communities/80-feddy-cpac-commpac/file.html.

Postabortion Care (PAC) Consortium. 2014. *Misoprostol for Postabortion Care: Expanding PAC Service Delivery and Access with a Highly Effective Treatment for Incomplete Abortion*. PAC Consortium.

Riwa, J., Augustino, I., Phillipo, E., et al. 2013. *Postabortion Care for Young Women in Zanzibar: Opportunities and Barriers*. Presentation from the 2013 National Family Planning Conference. Dar es Salaam, Tanzania. http://www.rchs.go.tz/index.php/en/fppresentation/day-2/young-people/73-mboya-festo-saaf-ppp-dar/file.html.

Venture Strategies Innovations. Forthcoming. *Assessing Availability of Uterotonics in Tanzania: Results From a Survey of Maternal Health Providers*. Anaheim, CA.

Wanjiro, M., Askew, I., Munguti, N., RamaRao, S., Homan, R., Kahando, R., and Pile, J. 2007. *Assessing the Feasibility, Acceptability, and Cost of Introducing Postabortion Care in Health Centres and Dispensaries in Rural Tanzania: Final Report*. Washington, DC: ACQUIRE Project and FRONTIERS Program. http://www.acquireproject.org/archive/files/6.0_integrate_fp-lapms/6.2_resources/6.2.2_studies/tanzania_PAC.pdf.

West-Slevin, K. and Dutta, A. 2015. *Prospects for Sustainable Health Financing in Tanzania*. Washington, DC: Futures Group. http://www.healthpolicyproject.com/pubs/804_TanzaniaHealthFinancingBriefupdateFINAL.pdf.

Woog, V. and Pembe, A. 2013. "Unsafe Abortion in Tanzania: A Review of the Evidence." *In Brief (1)* New York, NY: Guttmacher Institute. https://www.guttmacher.org/sites/default/files/report_pdf/ib_unsafe-abortion-tanzania.pdf.

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