Partnering to Scale up Inclusive Sexual and Reproductive Health Services in Tanzania
Welcome and Introductions
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Remarks from Ministry Representatives from Mainland Tanzania and Zanzibar
Remarks from the Foreign, Commonwealth, and Development Office
Scaling Up Family Planning Programme: Achievements and Lessons Learned
  - Strengthening Health Systems
  - Reaching Adolescents and Youth
  - Utilizing a Disability-Inclusive Lens
  - Integrating Gender-Based Violence Care into Sexual and Reproductive Health Services
  - Exploring Key Indicators and Results
Questions and Answers
Closing
Partner Welcome
Speaker Introductions

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Ministry of Health Mainland Tanzania:
- Gerald Kihwele

Ministry of Health, Zanzibar:
- Farhat Jowhar Khalid

EngenderHealth:
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- Lilian Lukumai
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- Deus Ngerangera
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Comprehensive Community Based Rehabilitation in Tanzania:
- Fredrick Msigallah

Pathfinder International:
- Shahada Kinyaga
Remarks from the Ministries of Health (Mainland Tanzania and Zanzibar)
Remarks from the Foreign, Commonwealth, and Development Office
Scaling Up Family Planning Programme: Achievements and Lessons Learned
SuFP Service Delivery Models

- Routine Services
- Postpartum Family Planning Services
- Outreach Services
  - Family Planning (FP) Weeks
  - Service Days
  - Integrated Community Outreach
Strengthening Health Systems
## Approaches and Achievements

<table>
<thead>
<tr>
<th>Approach</th>
<th>Achievement</th>
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<tbody>
<tr>
<td>Improve healthcare provider and community health worker (CHW) skills</td>
<td>1,346 healthcare providers and 235 CHWs trained and/or mentored</td>
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<tr>
<td>Ensure health facilities maintain adequate stock of sexual and reproductive health (SRH) supplies and equipment</td>
<td>450 health facilities received postpartum FP supplies, 312 facilities received permanent methods supplies, 545 facilities received postabortion care equipment, and 544 facilities received personal protective equipment for COVID-19 prevention</td>
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<tr>
<td>Strengthen quality improvement structures via training and mentoring</td>
<td>&gt; 8 regional health management teams and their council health management teams completed orientation on the national quality improvement framework</td>
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<td></td>
<td>&gt; 600 health facilities received quality improvement mentoring support</td>
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<tr>
<td>Strengthen SRH service delivery via supportive supervision</td>
<td>600 health facilities received supportive supervision</td>
</tr>
<tr>
<td>Support collection and use of high-quality data for decision-making</td>
<td>600 health facilities participated in data quality assurance audits and received related mentoring support</td>
</tr>
<tr>
<td>Support service integration (including COVID-19 vaccination)</td>
<td>All outreach services integrated COVID-19 vaccination services</td>
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The Programme in Action
Lessons Learned

- Joint supportive supervision provides an avenue to support health facilities and has a potential for sustainability.

- Quality improvement trainings can help regional and council health management teams establish quality improvement structures.

- Supply chain strengthening can assist in identification of stock gaps and timely redistribution.

- Mentorship and coaching are vital to ensuring high-quality service provision.

- Facilities need support to provide a comprehensive FP method mix.
Challenges

- Critical shortage of service providers across all levels of health facilities
- Periodic health facility and ministry staff reorganization, affecting skills for service delivery and oversight
- Inadequate financial resources to support SRH services and infrastructure improvement
- Lack of skills and tools to ensure capture and report key data
Reaching Adolescents and Youth
Approaches

- Integrate youth-friendly services orientation across all trainings
- Orient CHWs to mobilize young people for outreach services
- Conduct adolescent and youth outreach services in facilities that offer youth-friendly services
- Conduct outreach on weekends to attract adolescents and youth
- Strengthen linkages between schools, health facilities, and CHWs
The programme reached a total of 899,142 clients.

- 115,700 (13%) of all clients were adolescents (ages 10 to 19)
- 672,696 (75%) of all clients were reached via outreach services
  - 95,400 (14%) of outreach clients were adolescents
  - 91,314 (96%) of outreach clients were adolescent girls
  - 33,226 (36%) of outreach clients had not been pregnant previously
FP Method Mix among Adolescents, February 2020 to December 2021

- Implants: 63.7%
- Condoms: 11.2%
- Injectable: 10.7%
- Oral Contraceptive Pills: 9.3%
- Intrauterine Devices: 4.7%
- Emergency Contraception: 0.4%
- Permanent Methods: 0.0%
Lessons Learned

- There is a need to advocate for increased health systems investments in adolescent-focused health services.
- Strengthening linkages between schools and nearby health facilities can increase health service uptake among adolescents.
- Strengthening systemic structures for reaching adolescents is vital for sustainability.
- Adolescents have unique needs and service providers need training to provide appropriate care.
Challenges

- Pervasive negative attitudes about FP by gatekeepers—including parents, teachers, community leaders, and religious leaders

- Health facilities lack the necessary infrastructure to support adolescent- and youth-friendly services

- Healthcare providers lack training in youth-friendly service provision

- Limited health system investments in adolescent- and youth-friendly services
Utilizing a Disability-Inclusive Lens
Approaches and Achievements

The programme employed six strategies to reach people with disabilities (PWD).

- Engage with PWD-oriented organizations
- Orient CHWs to mobilize PWD for outreach services
- Develop a screening tool to identify PWD clients
- Participate in PWD-focused events
- Train healthcare providers to deliver inclusive services
- Develop a monitoring tool to aggregate PWD data

6,174 PWD clients reached through outreach services
Methods Mix among PWD, January to March 2022

- Implants: 78.6%
- Injectables: 9.1%
- Intrauterine Devices: 6.3%
- Oral Contraceptive Pills: 3.5%
- Condoms: 2.0%
- Permanent Methods: 0.5%
- Emergency Contraceptives: 0.1%
Lessons Learned

- Capacity building on disability and disability-inclusive services can help to achieve the program goals.

- Coordinating with PWD-focused organizations and training CHWs to provide PWD with information and services can improve demand and uptake.

- Strengthening outreach services can reduce access barriers to SRH services, especially in remote and distant areas.

- Including a section on PWD-specific service provision in the National FP Guidelines and Standards could strengthen PWD service delivery.
Challenges

- Few service providers trained to provide PWD-inclusive services
- Health information and education materials are not available in formats accessible to PWD clients
- Health facilities lack appropriate infrastructure for PWD clients
- The current health information management system (HMIS) does not capture data on disability
Integrating Gender-Based Violence Care into SRH Services
Approaches

- Train, orient, mentor, and coach healthcare providers and CHWs on gender-based violence (GBV), including violence against children
- Advocate for use of GBV tools at service delivery points
- Analyze and share GBV data to inform timely interventions
- Provide safeguarding orientation for all staff and partners
- Engage regional and district nursing officers in supportive supervisions
- Engage men and boys via targeted activities
Achievements

2,224,689 clients were reached through programme-supported services (before attribution)

> 285,028 of all clients were screened for GBV

> 70,565 GBV cases were identified through all screenings

> 1,597 referrals to GBV care and support services were provided

672,696 of all clients were reached via outreach services

> 247,044 of outreach clients were screened for GBV

> 9,520 GBV cases were identified through outreach screenings
Lessons Learned

- Engaging regional and district nursing officers in supportive supervision can help ensure service providers offer high-quality GBV care.

- Using a standard package to orient all programme staff and trainers on GBV care can help improve providers’ knowledge and skills.

- Adhering strictly to national GBV screening standards can help identify GBV incidents.

- A strong commitment from the ministry’s GBV focal person is key.
Challenges

- Pervasive sociocultural tolerance of GBV
- Providers view GBV services as a supplementary intervention and lack necessary training to provide GBV care
- Service providers and supervisors lack skills and experience with national GBV screening tools
- Insufficient availability of GBV in HMIS tools at the facility level
Exploring Key Indicators and Results
FP Uptake, by Service Delivery Model

FP Clients Reached via Programme-Supported Activities
899,142

Routine Services
182,146 (20%)

Postpartum FP Services
44,300 (5%)

Outreach Services
672,696 (75%)

FP Weeks
497,829 (74%)

Service Days
129,109 (19%)

Integrated Community Outreach
45,758 (7%)
## Overall Achievements
### February 2020 to December 2021

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Achievement</th>
<th>Milestone</th>
<th>% Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td># of clients reached</td>
<td>899,142</td>
<td>662,713</td>
<td>135.7%</td>
</tr>
<tr>
<td># of couple years of protection generated</td>
<td>1,627,889</td>
<td>1,552,030</td>
<td>104.9%</td>
</tr>
<tr>
<td># of unintended pregnancies averted (est.)</td>
<td>650,601</td>
<td>304,617</td>
<td>213.6%</td>
</tr>
<tr>
<td># of unsafe abortions averted (est.)</td>
<td>161,858</td>
<td>68,433</td>
<td>236.5%</td>
</tr>
<tr>
<td># of maternal deaths averted (est.)</td>
<td>1,136</td>
<td>566</td>
<td>200.7%</td>
</tr>
<tr>
<td># of additional FP users reached</td>
<td>554,417</td>
<td>120,619</td>
<td>459.6%</td>
</tr>
<tr>
<td># of clients who received comprehensive postabortion care</td>
<td>20,596</td>
<td>18,921</td>
<td>108.9%</td>
</tr>
</tbody>
</table>
Methods Mix among All Clients, February 2020 to December 2021

- Implants: 54.8%
- Injectable: 16.0%
- Intrauterine Devices: 10.2%
- Oral Contraceptive Pills: 9.3%
- Condoms: 7.4%
- Female Sterilization: 2.1%
- Emergency Contraception: 0.2%
- Vasectomy: 0.0%
## Annual Client Exit Survey Results, Percent of Respondents

<table>
<thead>
<tr>
<th>Client Characteristics</th>
<th>December 2020: Percent of Respondents</th>
<th>December 2021: Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseled according to FP2020</td>
<td>88%</td>
<td>95%</td>
</tr>
<tr>
<td>Level of poverty (lowest 2 quintiles)</td>
<td>36%</td>
<td>42%</td>
</tr>
<tr>
<td>Clients satisfied with services</td>
<td>79%</td>
<td>92%</td>
</tr>
</tbody>
</table>

## Factors Associated with Client Satisfaction, AOR (95% CI)

<table>
<thead>
<tr>
<th>Client Characteristics</th>
<th>December 2020 AOR (95% CI)</th>
<th>December 2021 AOR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseled according to FP20202</td>
<td>14.20 (98.23–24.6)**</td>
<td>86.20 (40.86–183.20)**</td>
</tr>
<tr>
<td>Level of poverty (lowest 2 quintiles vs. highest 3)</td>
<td>0.81 (0.50–1.30)</td>
<td>1.27 (0.75–2.04)</td>
</tr>
<tr>
<td>Age (adolescents vs. older)</td>
<td>0.99 (0.94–1.04)</td>
<td>1.81 (0.91–3.59)</td>
</tr>
<tr>
<td>Residence (urban vs. rural)</td>
<td>1.02 (0.62–1.66)</td>
<td>0.86 (0.53–1.39)</td>
</tr>
<tr>
<td>Level of education (primary or less vs. above primary)</td>
<td>0.81 (0.50–1.34)</td>
<td>1.87 (1.07–3.28)*</td>
</tr>
<tr>
<td>Level of health facility (hospital vs. lower level)</td>
<td>0.86 (0.66–1.14)</td>
<td>0.89 (0.52–1.53)</td>
</tr>
</tbody>
</table>

* = P < 0.05, ** = P < 0.01
Lessons Learned

- Routine services serve more clients overall; however, with attribution the overall contribution appears low.
- FP weeks are the main driver of outreach clients served, including for adolescents and youth.
- Commodity redistribution is critical to uninterrupted service provision.
- Commitment of central government officials, regional and council health management teams, and health facility staff is critical.
Challenges

- Low uptake of permanent methods
- Inadequate systemic financial resources to sustain FP services
- Insufficient availability of HMIS tools in health facilities
- Periodic reorganization of trained service providers
Questions and Answers
Thank you!

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