Putting Reproductive Health Back on the Map in Tanzania: A Demand-Driven Approach to Increase Funding for Family Planning is a Tides Foundation-funded Pathfinder International project in Tanzania running from 2010 to 2014. Working in five districts in the Shinyanga region (Shinyanga District Council and Kahama District Council), and Dar es Salaam (Ilala, Temeke, and Kinondoni Municipal Councils), the project works to: increase prioritization of and funding for family planning at national and district levels, promote a quality service delivery system, increase modern contraceptive prevalence, and improve reproductive health indicators in Tanzania.
In 2010, as part of a larger effort to improve maternal and child health and meet MDG 5 targets, the government of Tanzania established a target of achieving a 60 percent contraceptive prevalence rate (CPR), and increasing contraceptive users in the country from 2.1 million to 4.2 million by 2015.1 Nationally, unmet need for contraception in Tanzania is 25 percent,2 with rural women facing a disproportionate burden at 27 percent as compared to 20 percent in urban areas.3 With the majority of the Tanzanian population residing in rural areas—where the total fertility rate is 6.1 births,4 contraceptive options are limited, and stock-outs of essential supplies are common—district-level leadership to secure contraceptive access in these areas will be critical to the country’s pursuit of its targets.

Recognizing the critical role that planning and budgeting plays in realizing family planning (FP) access at the community level, from April 2011 through April 2013 Pathfinder International’s Putting Reproductive Health Back on the Map project undertook an assessment to better understand the processes by which districts plan and budget for health and FP. Partnering with the Ifakara Health Institute (IHI), the project’s assessment analyzed select districts’ prioritization of FP, budgeting, and resource allocation, identifying critical barriers to and opportunities for advancing logistical and governance efficiencies in support of improved FP and, by extension, maternal and child health outcomes. This update summarizes key findings and provides recommendations.

Methods

The IHI assessment included respondents from regional- and district-level health management teams, health facility governing committees, council health service boards, and community members. Focused on district health plans in five districts, the assessment included the Shinyanga region (Shinyanga District Council and Kahama District Council), and Dar es Salaam (Ilala, Temeke and Kinondoni Municipal Councils).

The assessment was conducted in three parts. In part one, a baseline assessment was implemented to determine the current district prioritization, budgeting, and resource allocation for FP, identify decision-making processes, compare budgeting against FP need, and to track changes over time. Data collection methods included: a document review; key informant interviews with government, civil society, and community stakeholders; focus group discussions; and budget and expenditure analysis.

In part two, the project followed up on the district planning and budgeting process for FP after the baseline assessment results were shared. Data collection methods included additional document review, informal interviews, budget and expenditure re-analysis, an advocacy workshop, and lobbying activities.

Part three comprised a review of the district health plans from the five study districts to observe prioritization and fund allocation for contraception in comparison to previous years, and to determine whether FP had been separated in the district health plans into specific FP-related activities per the categories outlined in Tanzania’s National FP Costed Implementation Program. These categories include advocacy—defined as generating increased visibility and support for FP among local stakeholders—as well as demand generation, health systems management, monitoring and evaluation, commodity security and logistics, strengthened service delivery systems, and capacity building.

Assessment Findings

Findings across the three phases of the assessment showed that community health priorities were not often included in district health plans due to ineffective linkages and incompatibility of planning tools between the community and district levels, as well as the precedence of competing national and donor health priorities. The reduced focus on community FP needs, in combination with all FP-related activities being relegated to a single budget item, led to a reduction in expenditures on FP overall. Inadequate budgeting for FP contributed to contraceptive commodity stock-outs and a near halt of community awareness and education activities around FP. As a result, women had difficulty reliably accessing preferred long-acting contraception methods and there was a decline in community awareness of FP.5 These findings are grouped by common themes below.

Broken Linkages between Community and District Health Planning

During the baseline assessment, it was found that structural barriers and decision-making processes on health priorities impede bottom-up health planning. District health planners consider community-level health prioritization and health planning costly and time consuming, and community-based facilitators, guidelines, and budget for carrying out participatory community planning are often absent.

Facility Health Committees act as community representatives in the health planning process. The Facility Health Committees offer a promising structure for enabling dialogue between communities and districts on health priorities, however, most of these groups do not function at present and their members have little knowledge of FP health issues or the health planning process. To support a more decentralized planning process, community participatory structures will require back-end investment in the capacity of community members to meaningfully engage in the health planning process. Community members and the Facility Health Committees need support to understand FP issues, identify community health needs in a systematic manner, and voice community needs in a way that enables integration into district health plans.

Incompatibility of planning tools presents additional barriers to linking community- and district-level health planning. To identify and prioritize community health needs, community facilitators use a different planning tool than the one used in district-level planning, and the two tools are not aligned. The data on community health priorities generated by the community-level planning tool requires additional extrapolation before it can be incorporated into the district-level planning tool used in developing district health plans. Community- and district-level planning should be coordinated to facilitate easier integration of community health
priorities in district health plans, beginning with planning tools themselves.

The necessity of district-level health planners to comply with top-down national planning guidelines, the National Essential Health Interventions Package, and donor requirements often overrides community-level planning. Though Facility Health Committees have the potential to address this through Incorporation of local priorities in planning, this process is undermined by the compounded barriers of committees’ relative dysfunction, and the incompatibility of existing district- and community-level planning tools noted above. As a result, district health plans are less likely to reflect local priorities, and do not reflect local epidemiological or logistical contexts related to FP. Strengthening linkages between the community and district levels and supporting a decentralized approach to health planning may support improved integration of community priorities into district health plans. When communities are provided with the technical assistance and resources to engage with health systems and hold leadership accountable for their needs, districts will gain a sustained counterbalance to the strong national and donor influences in health planning that are now inhibiting alignment.

**Effect of Inadequate FP Budgeting on Community Awareness and Contraception Access**

The baseline assessment found that low prioritization of FP in district health plans led to inadequate budgeting and a failure to disaggregate individual activities related to FP service delivery into separate budget items. As a result, inadequate budgeting for FP service delivery and commodities is common. The reduced prioritization and budgeting for FP has led to fewer community awareness campaigns and community education activities. Respondents reported that there has been a decline in community perception and acceptance of contraception in recent years. Negative community perceptions of contraception will present barriers to the government’s goal of increasing CPR and the number of contraception users.

Adequate budgeting and investment is needed for community health education around FP, to increase community knowledge about the full range of contraceptive methods available to address unmet need, reduce barriers to increased CPR, and support community members to understand FP issues during the health planning process.

“[Depo-Provera and implants] are easy to hide from the husbands who, according to Sukuma culture and customs, don’t want to hear about FP methods.” – FP client from Shinyanga rural district

Interviews conducted with antenatal care clients confirmed that in cases where health education does occur, there is a notable improvement in awareness and uptake of contraceptive methods. Among this group, long-acting methods were found to be preferred because their use can be hidden from male partners. Long-acting methods were difficult to obtain though, in part due to stock-outs. Reliable availability of preferred methods is critical to improving contraceptive uptake, but improvements are needed in budgeting for FP commodities based on community contraceptive method preferences. Though advocacy can help to fill funding gaps that drive stock-outs of preferred methods, embedding such commodities-related planning in budget
planning tools may provide a long-term solution to this gap in the future.

**Follow-up**

To promote a comprehensive approach to FP and budgeting, the project successfully petitioned the Ministry of Health during part three of the assessment to incorporate additional specific FP–related activity categories into the latest version of the PlanRep planning tool that districts are required to use when developing district health plans and budgets. The specific contraception-related activity categories identified and incorporated into the planning tool are in line with the categories in the National FP Costed Implementation Program: 1) advocacy and demand generation, 2) health systems management, monitoring, and evaluation, 3) commodity security and logistics, 4) strengthened service delivery systems, and 5) capacity development.

Beginning in the 2014 Tanzanian government budget cycle, health plans in the more than 150 districts will include planning and budgeting for FP at the district level. Planning fully for FP services will enable district governments to better determine areas for prioritization, gaps in services, and put in place programs to address those gaps. Community-level planning tools will be brought into alignment with the newly revised district-level planning tool to further reduce barriers and administrative burden in integrating community priorities into district health plans.

**Recommendations**

The IHI assessment findings have highlighted key areas for attention in advancement of contraceptive uptake for improved maternal and child health outcomes. While gains have been made at the district level in improving integration of comprehensive contraceptive planning, findings reflect that further investments must be made to support a decentralized, participatory approach to health planning and strengthen linkages and alignment between community- and district-level planning. Strong community Facility Health Committees can act as “watchdog” groups, advocating for community interests and priorities and helping to hold health systems accountable for response to contraceptive need. Meaningful linkages like these require intentional investment in the capacity of community representatives to understand and meaningfully participate in the health planning process. Community health education initiatives and capacity building of community Facility Health Committees require prior planning and adequate budgeting for such activities at the district level. District and community planning tools should align to facilitate easier integration of community health priorities into district health plans. Community preferences for contraceptive methods should also influence the level of budgeting for FP commodities to support the accessibility of preferred contraceptive methods and increased CPR.

Ifakara Health Institute is continuously tracking the FP budget by assessing the district-level health plans to gauge uptake and utilization of the revised planning tool (PlanRep) and its influence on FP budgeting at the district level. The Putting Reproductive Health Back on the Map project will continue to distill and disseminate key lessons from this experience as they develop.

**Endnotes**

4 Ibid.
5 For the full findings, see “Tracking Planning and Budgeting Processes for Family Planning in Dar es Salaam and Shinyanga Regions: Final Report,” available at www.pathfinder.org.