Sources of Family Planning

Tanzania

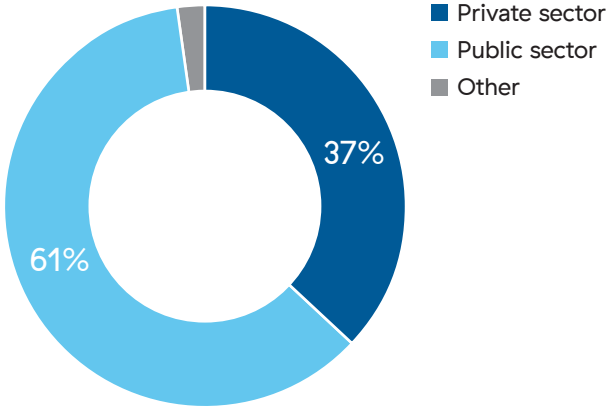
Photo: Jane Miller/DFID

Understanding where women acquire their family planning methods is important to increase access to modern contraception and catalyze efforts to meet Tanzania's Health Sector Strategic Plan (HSSP IV) goals and Family Planning 2020 commitments. This brief presents a secondary analysis of the 2015–16 Tanzania Demographic and Health Survey. It describes where modern contraceptive users obtain their method and examines the contribution of the private sector to family planning in Tanzania.

Key Findings

- More than one-third (37%) of modern contraceptive users rely on the private sector for their method.
- Most private sector users (67%) rely on pharmacies, accredited drug dispensing outlets, or shops for their contraception.
- Short-acting method users rely equally on the public and private sectors.
- More than 2 in 10 of the poorest users go to the private sector for family planning.
- Approximately one-half of the wealthiest contraceptive users rely on public sector sources.

Source of modern contraceptives



This is one in a series of briefs that examines sources of family planning methods in USAID priority countries. View the data at **PrivateSectorCounts.org**.

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Modern contraceptive prevalence rate and method mix

Tanzania's modern contraceptive prevalence rate (mCPR) among all women of reproductive age is 27 percent. Among married women, the mCPR is 32 percent. This brief focuses on all women, married and unmarried, to accurately portray contraceptive sources among all users. Injectables are the most popular method in Tanzania (10 percent). Use of implants, the second most popular method, more than tripled from 2 percent in 2010 to 6 percent in 2015-16. More Tanzanian women rely on short-acting methods (SAMs, 18 percent) compared to long-acting reversible contraceptives and permanent methods (LARCs and PMs, 9 percent).[1]

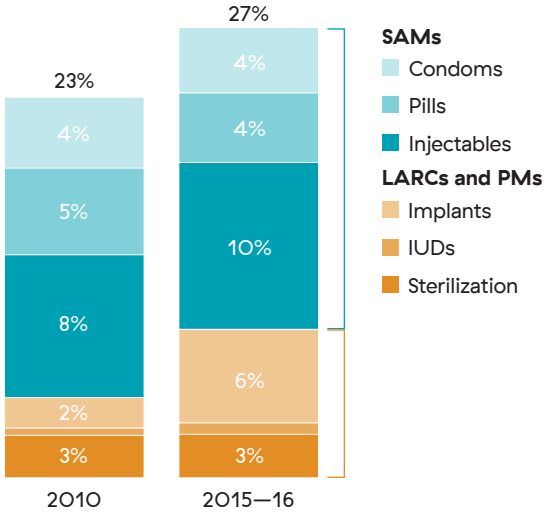
Sources for family planning methods

The public sector is the primary source of modern contraceptives in Tanzania (61 percent). More than one-third of users (37 percent) rely on the private sector, which represents an increase from 31 percent in 2010. Two percent of users rely on other sources.[2] As a result of Tanzania's population growth and mCPR increase, the public and private sectors combined served approximately 930,000 additional women from 2010 to 2015-16.

Private sector's contribution to method mix

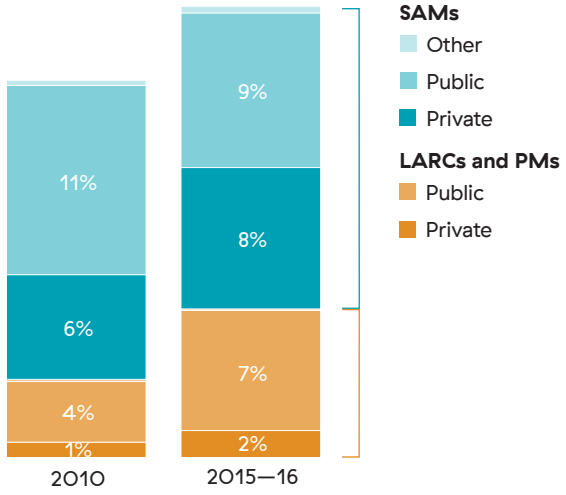
More women in Tanzania rely on the private sector to obtain SAMs (8 percent) than LARCs and PMs (2 percent). Use of SAMs did not change between 2010 and 2015-16, but the public sector now serves a slightly smaller share of SAM users (from 11 to 9 percent) and the private sector a slightly larger share (from 6 to 8 percent). SAM users now rely on public and private sources in nearly equal proportions (9 and 8 percent, respectively). This does not hold true for LARCs and PMs—public sector supply of these methods has increased since 2010 (from 4 to 7 percent), while the private sector's increase in LARC and PM distribution has been more modest (1 to 2 percent). Among injectable users, two-thirds use public sources and one-third go to private sources. Among implant users, 88 percent use public sources and 11 percent use private sources.

Use of implants in Tanzania tripled between 2010 and 2015–16



Note: Numbers may not add due to rounding.

SAM users rely equally on public and private sources to obtain their method



[1] SAMs include injectables, contraceptive pills, male condoms, female condoms, and fertility-awareness methods. LARCs and PMs include IUDs, implants, and male and female sterilization. The lactational amenorrhea method and "other modern" methods are excluded from this analysis, as the Demographic and Health Surveys do not systematically ask women about sources for these methods. This analysis shows which methods women use. It does not reflect which methods women might choose if they had access to all methods.

[2] Public sector sources include hospitals, health centers, clinics, and dispensaries. Private sector sources include hospitals, health centers, and clinics; faith-based and non-profit organizations including religious/voluntary hospitals, health centers, clinics, and dispensaries; and pharmacies, dispensaries, accredited drug dispensing outlets (ADDOs), shops, kiosks, bars, and guest houses. Other sources include friends, relatives, neighbors, and women who did not know or report the source. This analysis shows where women obtained their most recent method. It does not reflect where women might choose to go if they had access to all sources of care.

Private sector sources

Among private sector users, more than half (57 percent) obtain their method from a pharmacy or accredited drug dispensing outlet (ADDO), and 10 percent go to a shop. Nearly one-fourth (22 percent) go to a nongovernmental or faith-based organization, and 11 percent go to a private clinic or hospital. The two methods most commonly sought from the private sector are injectables and condoms. Most private sector injectable users (58 percent) and private sector condom users (68 percent) go to pharmacies or ADDOs.

Rural and urban areas

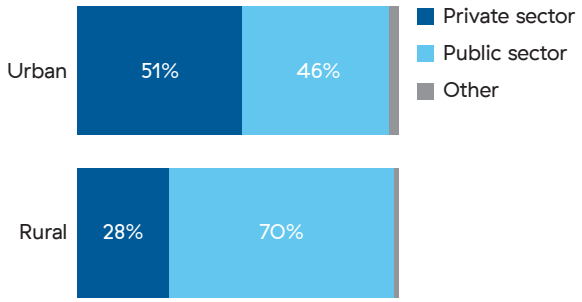
The mCPR is slightly higher in urban (29 percent) than in rural (26 percent) areas. Urban users are nearly twice as likely to purchase their method from the private sector (51 percent) compared to rural users (28 percent). Less than half of urban users rely on the public sector to obtain their method (46 percent) compared with more than two-thirds (70 percent) of rural users.

Contraceptive source by marital status and age

Nearly half (48 percent) of unmarried contraceptive users rely on private sector sources compared with one-third of married users. Unmarried users are somewhat more likely to use SAMs than married users (72 versus 65 percent).

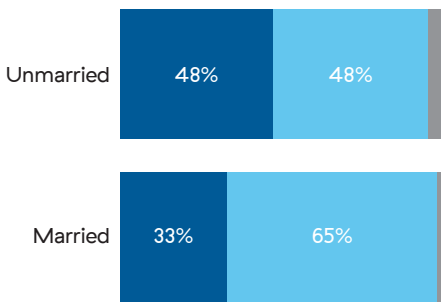
Contraceptive users ages 15-24 are slightly more likely than users ages 25-49 to use private sector sources (42 versus 35 percent, respectively). Across age groups in Tanzania, SAMs are more popular than LARCs and PMs. However, condoms are more common among young contraceptive users (under age 25, 24 percent) than among older users (over 25, 11 percent), while pills are more popular among older users (17 percent) than younger users (11 percent).

Urban users are almost twice as likely to use the private sector as rural users



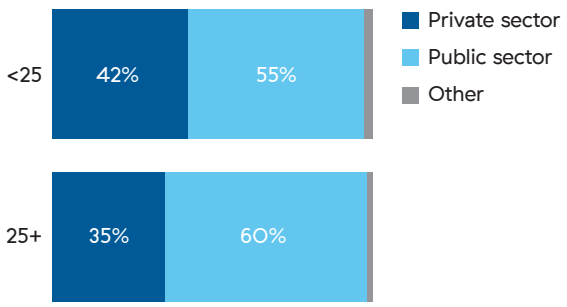
Percent of urban and rural users who obtain method from each source

Nearly half of unmarried users obtain their method from the private sector



Percent of married and unmarried users who obtain method from each source

Younger users are somewhat more likely than older users to go to the private sector



Percent of younger and older users who obtain method from each source

Contraceptive source by socioeconomic status

The mCPR is lower among the poorest women than it is among the wealthiest women (22 versus 29 percent, respectively).[3] Among the poorest users, 23 percent rely on the private sector, indicating that private sources may offer benefits to these women that outweigh financial costs. The poorest rural users are slightly more likely to go to a private sector source (23 percent) than the poorest urban users (18 percent). Almost half (48 percent) of the wealthiest contraceptive users obtain their method from the public sector, demonstrating a possible need for improved targeting of public resources. The wealthiest contraceptive users rely on the private sector more for SAMs (58 percent) than they do for LARCs and PMs (23 percent), suggesting that the private sector is underused for LARCs.

More than 2 in 10 of the poorest contraceptive users in Tanzania rely on the private sector

Nearly half of the wealthiest contraceptive users in Tanzania rely on the public sector

Implications

Tanzania's private sector is an important source for all population segments and represents a critical opportunity to increase contraceptive access and choice. Private pharmacies, ADDOs, and shops are relied on heavily among SAM users. ADDOs have received substantial investments, and support should continue to expand the range of family planning methods that ADDOs can supply. In addition, many community pharmacies staffed by nurses may offer an opportunity to expand access to injectables—the most popular method. Private sector interventions that increase provision of implants could also help more women achieve their reproductive intentions. In line with the Tanzanian government's efforts to implement a total market approach for contraceptive services, this analysis highlights opportunities to better target service provision efforts (FP2020 2017, MOHSW 2010). Redirecting limited government resources away from wealthier population segments—half of which currently rely on the public sector—and toward services targeted to poorer populations will foster a more efficient market and provide greater opportunity for the private sector to serve those segments of the population with the ability to pay. This approach may also help the government sustain LARC growth and reduce inequities by having more resources to focus on underserved populations.

References

FP2020. 2017. "Family Planning 2020 Commitment: Govt. of Tanzania."

The United Republic of Tanzania Ministry of Health and Social Welfare (MOHSW). 2010. *National Family Planning Costed Implementation Program 2010–2015.*

[3] The poorest and wealthiest women are those in the lowest and highest two wealth quintiles, respectively, as defined by the Demographic and Health Survey's asset-based wealth index.

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Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is a five-year cooperative agreement (AID-OAA-A-15-00067) funded by the United States Agency for International Development (USAID). The project strategically engages the private sector to improve health outcomes in family planning, HIV, maternal and child health, and other health areas. Abt Associates implements SHOPS Plus in collaboration with the American College of Nurse-Midwives, Avenir Health, Broad Branch Associates, Banyan Global, Insight Health Advisors, Iris Group, Population Services International, and the William Davidson Institute at the University of Michigan. This brief is made possible by the generous support of the American people through USAID. The contents are the responsibility of Abt Associates and do not necessarily reflect the views of USAID or the United States government.

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