

*"A population is said to have stabilized when the number of births has come into balance with the number of deaths, thus attaining replacement level fertility, immigration notwithstanding - a situation where couples have just the number of children needed to replace themselves in the population". This paper examines the population policies and strategies to be taken in order to achieve population stabilization in Tanzania. The paper was prepared in 2014 with support from Population Communication Inc., California, USA".*

## POPULATION STABILIZATION IN TANZANIA



## Table of Contents

<b>List of Figures</b> .....	<b>3</b>
<b>List of Tables</b> .....	<b>3</b>
<b>Acronyms</b> .....	<b>4</b>
<b>Glossary</b> .....	<b>5</b>
<b>Acknowledgement</b> .....	<b>7</b>
<b>SECTION 1.0: INTRODUCTION</b> .....	<b>8</b>
1.1 Background .....	8
Political and socioeconomic environment .....	8
<b>SECTION 2.0: POPULATION SITUATION ANALYSIS</b> .....	<b>9</b>
2.1 Population Growth .....	10
2.2 Population Age-Sex Structure .....	11
2.3 Population Policies .....	11
<b>Section 3.0: Impact of Population Growth on Socio-Economic Factors</b> .....	<b>13</b>
3.1 <i>Women's development</i> .....	13
3.2 <i>Education</i> .....	13
3.3 <i>Agriculture</i> .....	14
3.4 <i>Urbanization</i> .....	15
3.5 <i>Population and Environment</i> .....	16
3.6 <i>Development of community institutions</i> .....	16
<b>SECTION 4: REPRODUCTIVE HEALTH</b> .....	<b>16</b>
4.1 <i>Access to health services</i> .....	17
4.2 <i>Safe motherhood</i> .....	17
4.3 <i>Maternal Mortality</i> .....	18
4.4 <i>Child Survival</i> .....	19
<b>SECTION 5.0: FERTILITY AND POPULATION</b> .....	<b>19</b>
5.1 <i>Fertility levels and trends in Tanzania</i> .....	20
5.2 <i>Fertility stagnation: dynamics and implications</i> .....	20
5.3 <i>Teenage pregnancy and early child bearing</i> .....	21
5.4 <i>Population Projections using fertility assumptions</i> Fertility .....	22
<b>SECTION 6.0: THE STORY OF FAMILY PLANNING IN TANZANIA</b> .....	<b>23</b>
6.1 <i>Current program performance and prospect for change</i> .....	24
6.2 <i>Trend in Contraceptive Use</i> .....	25
6.3 <i>Contraceptive method mix and its implication for fertility:</i> .....	26
6.4 <i>Demand factors, unmet needs</i> .....	27

<b>SECTION 7.0: TOWARDS POPULATION STABILIZATION IN TANZANIA.....</b>	<b>28</b>
7.1 Expanding family planning services.....	29
7.1.1 Family Planning Method specific actions .....	29
Bring family planning to the door steps.....	29
Revitalize use of IUDs .....	30
Expand sterilization services .....	31
Task Shifting .....	31
Expand access to emergency contraception .....	32
<b>7.1.2 Focus on the basics .....</b>	<b>32</b>
Skills training of service providers.....	32
Expanding access—Community programs and social marketing .....	32
Ensure availability of commodity supplies .....	33
Increase Funding for family planning to ensure sustainability .....	34
Strengthening of private service outlets .....	34
Improving quality of care .....	35
Address FP access problems through research .....	35
7.2 Integrating gender in health related services.....	36
7.3 Delayed start of child bearing.....	36
7.4 Regional Parity .....	36
7.5 Provision of integrated FP Services.....	37
<b>SECTION 8.0: Conclusion .....</b>	<b>37</b>
<b>REFERENCES.....</b>	<b>38</b>

**List of Figures**

Figure 1: Tanzania Population Trend in Million: 1967 - 2012 Censuses .....	10
Figure 2: Population Growth Trends 1978-2012 .....	11
Figure 3: Population Pyramid (Five-Year Age Groups) – Tanzania, 2012 Census .....	11
Figure 4: Proportion of girls and boys secondary school enrolment 2008-2012.....	14
Figure 5: Urbanization in Tanzania .....	15
Figure 6: MMR per 100,000 live births by year by Tanzania DHS reports .....	18
Figure 7: Child Mortality Ratio: Figure 1: Trends in Child Mortality .....	19
Figure 8: Fertility Trend <sup>1</sup> 1960- 2010 .....	20
Figure 9: Age at First Marriage and Age at First Sexual Intercourse - Women.....	21
Figure 10: Age at First Marriage and Age at First Sexual Intercourse - Men .....	22
Figure 11: Tanzania Population Projections with various TFR assumptions 2010 - 2060 .....	23
Figure 12: Trends in CPR and TFR – 1991 – 2010.....	25
Figure 13: Trends in contraception Use, Tanzania (percentage of current married women using any method) .	26
Figure 14: Meeting Family Planning unmet need with method mix .....	26
Figure 15: Increasing Demand and constantly high unmet needs for family planning .....	28

**List of Tables**

Table 1: Contraceptive Prevalence Rate Projection –Past trend from 2010 DHS continue .....	12
Table 2: Family Planning LARPM Acceptors by method .....	24
Table 3: Projected FP users in Tanzania if the country has to reach 60% CPR by 2015 .....	28
Table 4: Unmet needs for contraceptive services, 1991/2 to 2010.....	28

<sup>1</sup> 1960 to 1985 is data from United Nations, Department of Economic and Social Affairs Population Division [http://esa.un.org/unpd/wpp/unpp/panel\\_population.htm](http://esa.un.org/unpd/wpp/unpp/panel_population.htm) and 1992 to 2010 DHS surveys

**Acronyms**

AIDS	Acquired Immuno-Deficiency Syndrome
ATP	AQUIRE Tanzania Project
CBD	Community Based Distribution
CHA	Community Health Agents
CPR	Contraceptive Prevalence Rate
DFID	Department for International Development
EAC	East African Countries
FBO	Faith Based Organization
GDP	Gross Domestic Product
GER	Gross enrolment ratio
HIV	Human Immunodeficiency Virus
IMR	Infant Mortality Ratio
IUD	Intrauterine Device
ITN	Insecticide Treated Nets
LARC/PM	Long Acting Reversible Contraception and Permanent Methods
MCC	Millennium Challenge Compact
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MOHSW	Ministry of Health and Social Welfare
NER	Net Enrolment Ratio
NFPP	National Family Planning Program
NSV	No-Scalpel Vasectomy
PATH	Program for Appropriate Technology in Health
PSSS	Policy and Service Satisfaction Survey
RHCS	Reproductive Health Commodity Security
RTP	RESPOND Tanzania Project
SMI	Safe Motherhood Initiative
TDHS	Tanzanian Demographic and Health Survey
TFR	Total Fertility Rate
WRA	Women of Reproductive Age
UMATI	Chama Cha Uzazi na Malezi Bora Tanzania
UN	United Nations
UNFPA	United Nations Population Fund
URT	United Republic Of Tanzania
USAID	United States Aid for International Development
WHO	World Health Organization
WRA	Women of reproductive age

## GLOSSARY

**Child Dependency Ratio:** The child dependency ratio is the number of child dependents under the age of 15 for every 100 adults in the working ages.

**Contraceptive Prevalence:** Contraceptive prevalence is the number of married women (or all women) in their reproductive years, ages 15 to 49, using a contraceptive method divided by the total number of married women (or all women) ages 15 to 49.

**Demographic and Health Survey (DHS):** The DHS is a large national survey that generates information on key demographic and health issues, including HIV and AIDS. Tanzania now has results from four in-depth Demographic and Health Surveys in 1991–1992, 1996, 2004–2005 and 2010 and from the Reproductive and Child Health Survey, in 1999.

**Early marriage:** Marriage under the age of legal consent—most commonly for girls. Sexual intercourse in such relationships constitutes statutory rape under Tanzania laws, as the girls are not legally competent to agree to such unions. Early marriages are associated with negative health consequences to the mother and the child that include among others, complicated labor, disabilities, and maternal and neonatal deaths.

**Fertility Rate or Total Fertility Rate (TFR):** The TFR is the average number of children that would be born alive to a woman during her lifetime if she were to bear children conforming to the age-specific fertility rates of a given year. It is a measure often used to describe the average number of children per woman.

**Gross Enrolment Ratio (GER):** Gross enrolment ratio in this document refers to the number of primary students of all ages divided by the total number of children aged 7–13 years old.

**Infant Mortality Rate (IMR):** The IMR is the number of deaths of infants under age 1 per 1,000 live births in a given year.

**Kilimo Kwanza:** The Kilimo Kwanza (KK) declaration is a pronouncement of the Government of Tanzania on ways and means of speeding up the existing strategies and programs regarding the modernization of agriculture.

**Maternal Mortality Ratio (MMR):** The MMR is the number of women who die as a result of complications of pregnancy or childbearing in a given year per 100,000 live births in that year.

**Modern Contraceptive Prevalence:** Modern contraceptive prevalence includes just those women using a modern method of contraception in the numerator of the prevalence calculation.

**MKUKUTA:** The *National Strategy for Growth and Reduction of Poverty* in Kiswahili.

**Net Enrolment Ratio (NER):** The NER is the number of primary students age 7–13 divided by the total number of 7–13 year-olds.

**Replacement Level Fertility:** Replacement level fertility is the situation where couples have just the number of children needed to replace themselves in the population. If the TFR stays constant at replacement level, a country's population will eventually stop growing because births and deaths will reach equilibrium.

**Population Momentum:** Population momentum describes the tendency for population growth to continue beyond achievement of replacement level fertility because of the relatively high concentration of people in the childbearing years.

**Population Stabilization:** Is a condition of demographic balance where the number of people in a specified population neither grows nor declines.

**Unmet Need:** According to the basic definition used in the TDHS, married women of reproductive age who are able to bear children have an unmet need if they report that they do not want to have any more children (limiters) or that they want to wait two or more years before having another child (spacers) but are not using contraception.

**Zero Growth:** Is the maintenance of a population at a constant level by limiting the number of live births to that needed to replace the existing population.

DRAFT

## Acknowledgement

The successful completion of the *Population Stabilization in Tanzania Report* was made possible by the joint efforts of a number of individuals, whose participation we would like to acknowledge with gratitude. We are particularly thankful to Population Communication for supporting the initiative to prepare a report on population stabilization for future programmatic interventions and direction in Tanzania. The report examines the programs and policies that would accelerate progress towards population stabilization in Tanzania and proposes recommendations that will help in achieving the replacement level fertility. We would especially like to thank Dr. Robert Gillespie for his support, guidance and inputs in finalizing this report.

Special thanks go to Dr. Neema Rusibamayila, the acting Director of Preventive Services (DPS) for approving the Scope of Work for this documentation and for reviewing and providing overall guidance and leadership.

We are particularly grateful to Dr. Mehjabeen Alarakhia, from UNFPA Tanzania; Mr. Richard Killian from EngenderHealth Tanzania; Dr. Eric Van Praag from FHI 360, Dr. Georgina Msemo, from RCHS/MOHSW; Ms. Halima Shariff, from Advance Family Planning/Johns Hopkins, Tanzania and Ms. Mariam Alli, from the Policy and Planning Directorate of the MOHSW, for reviewing and critiquing this report. Special thanks also go to Mr. Jumanne Mbilao of EngenderHealth for reviewing tables and figures included in this report.

We also acknowledge the special contributions and hard work of several other individuals in the development of this document whose names we are not able to mention individually.



## SECTION 1.0: INTRODUCTION

A population is said to have stabilized when the number of births has come into balance with the number of deaths thus attaining replacement level fertility, immigration notwithstanding. "A situation where couples have just the number of children needed to replace themselves in the population". If the TFR stays constant at replacement level, a country's population will eventually stop growing because births and deaths will reach equilibrium. In countries with high infant and child mortality rates, slightly larger completed family sizes are needed for replacement than in nations with lower death rates. For instance, in the developed world, replacement reproduction is an average completed family size of 2.1, while in developing nations, where infant deaths are still high, replacement would be about 2.3<sup>2</sup>.

The purpose of this report is to carry out a situation analysis and identify future directions for population stabilization in Tanzania through examining the programs and policies that would achieve population stabilization. The report describes the status of the population policies and the role of family planning programs in accelerating progress towards population stabilization. It has largely relied upon various secondary sources including government reports, local and global policy papers related to health and population policy programs; literature review and desk research. Information was also gathered about health, population and reproductive health scenario in Tanzania through discussions with different stakeholders like Government officials, local and International health NGOs. The report provides a population and development profile of Tanzania. It discusses key reproductive health issues and reviews family planning status in terms of current use and unmet need. This is followed by a discussion of possible programmatic strategies to accelerate progress towards achieving replacement fertility and subsequent population stabilization and their implementation requirements. In conclusion, based upon recent improvement trends in socio-economic development and family planning program performance over the past decades, and depending on strong continuing political will and leadership and strategies put in place to continue to address challenges in reproductive health programs implementation, we can cautiously be optimistic that Tanzania can achieve replacement fertility within 20- 25 years (URT 2006)).

### 1.1 Background

#### ***Political and socioeconomic environment***

The United Republic of Tanzania is a union between Tanganyika and Zanzibar, which was formed in 1964 after attaining independence in 1961. It is the largest country in East Africa, occupying an area of about 945,087 square kilometers - 60,000 of which are inland water. Tanzania lies south of the equator and shares common borders with eight neighboring countries: Kenya and Uganda to the north; Rwanda, Burundi and Democratic Republic of Congo to the west, Zambia, Malawi to the South West, Mozambique to the South and the Indian Ocean to the East. The Islands of Zanzibar are situated 30 kilometers from Tanzania mainland and in the Indian Ocean. Administratively, Tanzania is divided into 30 regions, of which 25 are on the mainland and five are on Zanzibar Islands; and is further divided into 169 districts. Tanzania's estimated population of 44.9 million (2012 Census) is growing at the rate of 2.7%, and has a population density of 52.33 per square kilometer (2011)<sup>3</sup>.

Tanzania is rated number 14 among the top 50 world's poorest countries (worldwidewebblog 2012) in terms of per capita income. This is partly attributed to population growth exhibiting a youthful age cohort whose numbers are still expanding. This has profound implications for development and quality of life for the people of Tanzania. Changes in population growth, age structure and composition have direct and indirect impact on national development and poverty reduction, as well as the general well-being of the population.

In 2012, Tanzania's estimated per capita income stood at 483.48 US dollars (Trading Economics), equivalent to 4 percent of the world's average<sup>4</sup>. From 1988 until 2012, Tanzania GDP per capita averaged 341.7 USD reaching

---

2

<sup>3</sup> World bank indicators – Tanzania density and urbanization - 2011

<sup>4</sup> World's per capita average

an all-time high of 483.5 USD in December 2012 and a record low of 278.4 USD in December 1994. The level of poverty, therefore, remains high with about 12.3 million Tanzania Mainland citizens living in poverty (*Household Budget Survey 2013*). Women's income levels are estimated to be 50% lower than those of men. One of the underlying reasons for high level of poverty is the slow growth in the agricultural sector, on which the majority of the poor depends for a living. Agricultural growth, at around 4.5 per cent per annum, is not high enough to raise the standard of living of the poor above the poverty line given the high population growth in rural areas.

The mining of diamonds, gold, nickel and natural gas is increasing as a result of foreign direct investment and is becoming an important part of the economy. Tourism also contributes significantly to government revenues. Tanzania's active economy has led to strong economic growth in recent years (between 5-7% per annum) as well as macro-economic stability. However global economic crisis and internal power shortages pushed inflation to a double digit of 19.7 by early 2012. Inflation Rate in Tanzania however averaged at 7.64 Percent from 1999 until 2014, reaching an all-time high of 19.80 Percent in December 2011 and a record low of 3.40 Percent in January 2003<sup>5</sup>.

As a result, Tanzania has made major strides in converting to a market economy, institutionalizing reforms that are controlling inflation and deficit spending, attracting increased investment, privatizing public enterprises, and sustaining an average of 6.9% annual economic growth rates from 2001 to 2012 that are among the best in Sub-Saharan Africa.

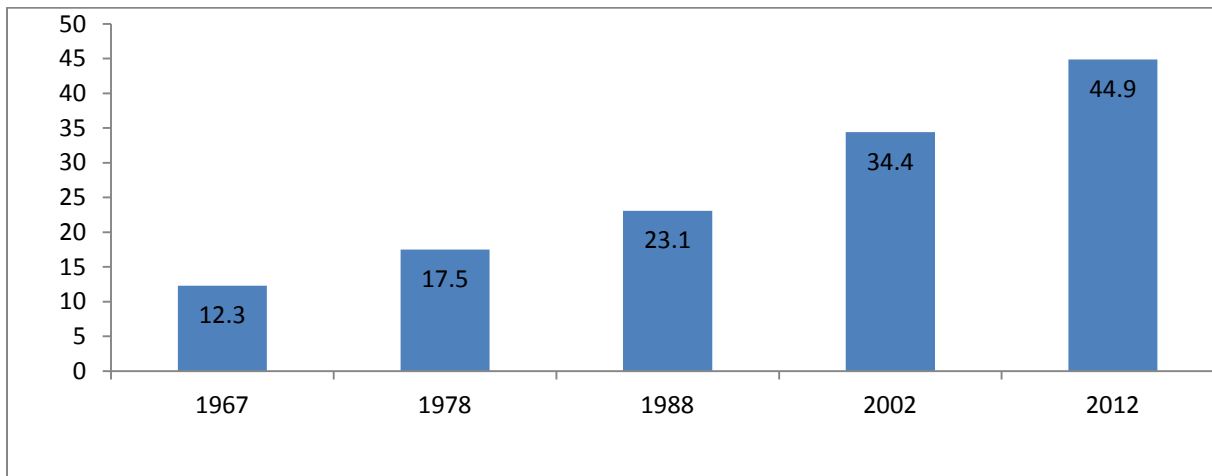
Additionally, Tanzania has experienced a high degree of political stability since its independence in 1961 and has stood out as one of the few stable countries in Eastern and Southern Africa. However, Tanzania's geographic location, bordering eight other countries within Eastern and Southern Africa, makes it very exposed to various migration flows to, from and through its territory. Due to its political stability, Tanzania has, for many years, hosted a large refugee population from neighboring countries. Although the situation has improved as neighboring countries gain political stability, cross boarder immigration placed heavy population burden on its resources over the past decades.

## **SECTION 2.0: POPULATION SITUATION ANALYSIS**

Like many developing countries, Tanzania has one of the fastest growing populations despite the desire of many Tanzanian women and men for better spaced and smaller families (*TDHS, 2010*). The population of Tanzania has more than tripled from 12.3 million in 1967 to 44.9 million in 2012. The population is primarily rural (76.9%) with 43.6 million living on Tanzania mainland while 1.3 million in Zanzibar. About 66% of the population is below the age of 25 years (*Youth in Tanzania: 2013*). It is important to note that, Tanzanian population is going to be considerably larger in the future than it is today no matter what happens to birth rates. In recognition of this fact, Tanzania has put in place a very ambitious vision to provide high quality of life for all the people and to develop a strong and competitive economy. Public policy measures taken to influence future population size, growth, structure and distribution of the population form a major integral part of the country's population policies.

---

<sup>5</sup> National Bureau of Statistics (NBS) - Tanzania.

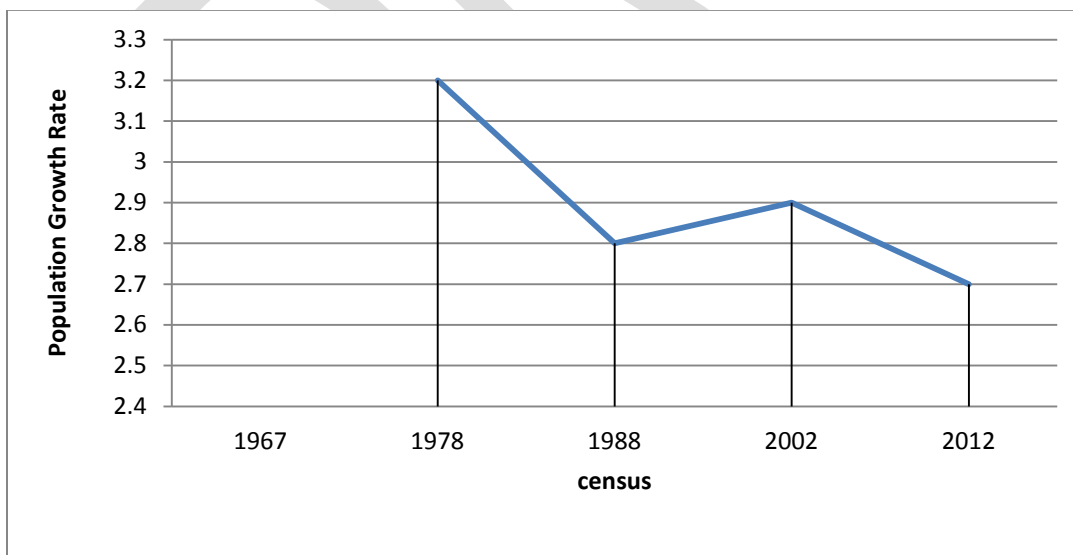
**Figure 1: Tanzania Population Trend in Million: 1967 - 2012 Censuses**

Source: Population and Housing Censuses 1967, 1978, 1988, 2002 and 2012

### 2.1 Population Growth

On the whole, Tanzania's population growth rate declined from 3.3 percent in 1967 to 2.7 percent in 2012. However, while the population growth declined from 3.2 percent in 1967 to 2.7 percent in 2012 on the mainland, in Zanzibar, the growth rate increased from 2.7 percent in 1967 to 3.1 in 2002 and then declined to 2.7 percent in 2012.

Rapid population growth due to high fertility levels, regional disparity in population indicators, rapid urbanization, skewed population distribution and high family planning unmet need still remain key population concerns for Tanzania in its efforts to population stabilization now and in the future. At the current growth rate of 2.7 percent, the population of Tanzania is likely to double again in the next 25 years if not checked. (*National Bureau of Statistics, Population Distribution by Administrative Units, Key Findings. 2013*)

**Figure 2: Population Growth Trends 1978-2012**

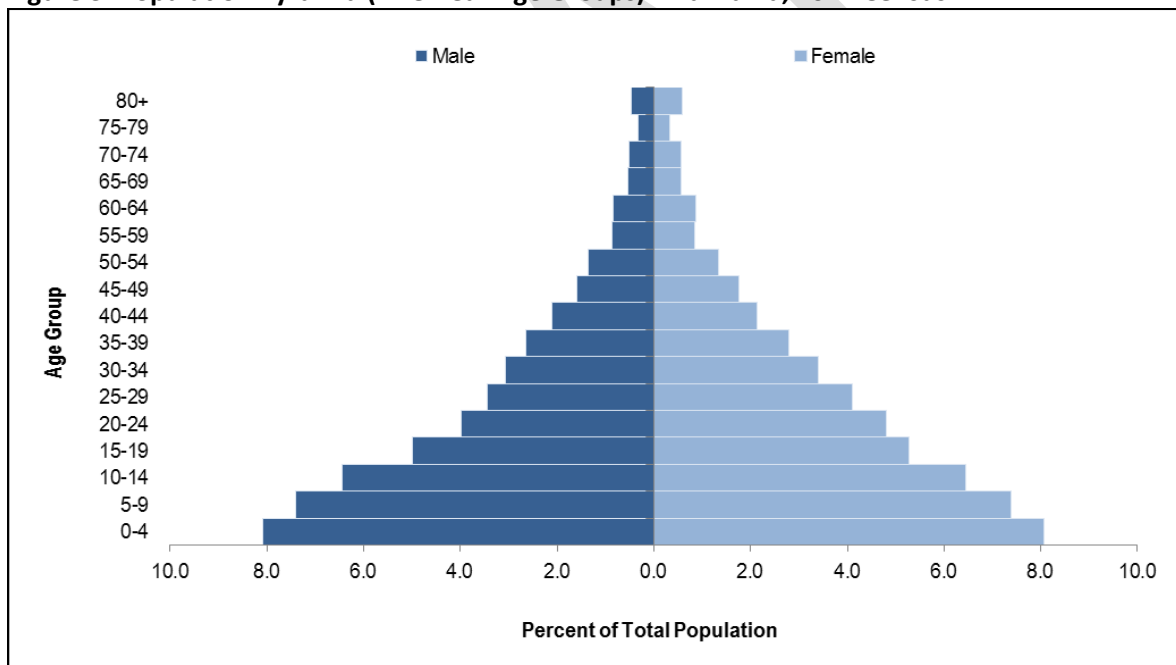
Source: URT (1967, 1978, 1988, 2002, 2012)

## 2.2 Population Age-Sex Structure

The rapid population growth over the past decades in Tanzania has created a youthful age cohort whose numbers are still expanding and which has an in-built momentum for rapid population growth. The 2012 census reports that about 44 percent of Tanzania's population is under the age of 15. The young age structure has important population and development implications. It creates a high child dependency ratio<sup>6</sup> (85%) that places a heavy burden on the working age population and constrains the provision of basic needs and social services. The young population also means that there is an in-built population momentum for future growth. Today's children will soon grow into their reproductive years. Because there will be so many couples having children, even if each woman had only about 2 children (*global replacement fertility level*) the population would continue to grow, although moderately.

As in countries all over the world, Tanzania's demographic processes play a vital role in other development indicators. Changes in population growth, age structure and composition have direct and indirect impact on national development and poverty reduction, as well as the general well-being of the population. As the population continues to grow rapidly, it becomes imperative for the education sector to plan for more students, teachers and schools; the health sector has to anticipate a higher need for more health facilities, doctors, nurses and supplies; likewise, the agricultural sector has to plan for better use of arable land and greater food production. Larger population creates greater pressures on the land, the forests and other natural resources. The cities inevitably grow creating higher needs for housing, water, transport, sanitation and other urban services.

**Figure 3: Population Pyramid (Five-Year Age Groups) – Tanzania, 2012 Census**



Source: Population Distribution by Age and Sex, National Bureau of Statistics Ministry of Finance, September, 2013

## 2.3 Population Policies

Since its independence in 1961, development policies in Tanzania have taken into cognizance the pressing need to reduce population growth rate in order to ease mounting pressure on its resources though the country had not yet developed explicit population policy till 1992 when the first population policy was developed. Though,

<sup>6</sup> The ratio of the population 0-14 to the population ages 15 – 64. Population Reference Bureau

*the Tanzania Development Vision 2025* did set the national development agenda, including population issues. The major aims of the Vision 2025 are to achieve a high-quality livelihood for the people, attain good governance through the rule of law and develop a strong and competitive economy. To attain this vision, Tanzania adopted the following goals in the area of **High-quality livelihood**: Food self-sufficiency and food security; Universal primary education; Gender equality; Quality primary health care for all; Quality reproductive health services; Reductions in infant and maternal mortality; Universal access to safe water; and increase in life expectancy.

Tanzania's population policy is also determined to accelerate the use of family planning in the country as a means to stabilize its population growth<sup>7</sup>. Informed by this reality, the Ministry of Health and Social Welfare with support from family planning partners convened the first National Family Planning Conference in October 2013 to rally different stakeholders behind the national efforts to promote family planning and contribute to national development. The conference gathered momentum from the July 2012 London Summit on Family Planning at which the President of the United Republic of Tanzania, His Excellency Dr. Jakaya Mrisho Kikwete, made commitments that will see Tanzania double the number of family planning users to 4.3 million thus reaching a target CPR of 60 percent by 2015 (the NFPCIP- 2010-25). However, if the past trend performance of family planning between 2005 and 2010 demographic and health surveys continues, the country can only reach a CPR of 42.2 percent in 2015 (All methods)-achieving its intended target of 60 percent by the year 2025<sup>8</sup> (Table 1 ). This would certainly have an effect on the country's fertility and population growth.

**Table 1: Contraceptive Prevalence Rate Projection –Past trend from 2010 DHS continue**

Year	WRA	Any modern method users	CPR	Any Method Users	CPR
2010	10,363,173	2,829,146	27.3	3,554,568	34.3
2011	10,663,705	3,066,882	28.8	3,826,137	35.9
2012	10,905,117	3,295,526	30.2	4,085,057	37.5
2013	11,199,555	3,548,019	31.7	4,372,306	39.0
2014	11,501,943	3,811,744	33.1	4,672,089	40.6
2015	11,812,496	4,087,123	34.6	4,984,873	42.2
2016	12,131,433	4,374,595	36.1	5,311,141	43.8
2017	12,458,982	4,674,610	37.5	5,651,394	45.4
2018	12,795,374	4,987,637	39.0	6,006,149	46.9
2019	13,140,849	5,314,159	40.4	6,375,940	48.5
2020	13,495,652	5,654,678	41.9	6,761,322	50.1
2021	13,860,035	6,009,711	43.4	7,162,866	51.7
2022	14,234,256	6,379,793	44.8	7,581,165	53.3
2023	14,618,581	6,765,479	46.3	8,016,830	54.8
2024	15,013,282	7,167,341	47.7	8,470,494	56.4
2025	15,418,641	7,585,971	49.2	8,942,812	58.0

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat – World Population Prospects: 2012 Revision

<sup>7</sup> Tanzania population policy 2006

<sup>8</sup> Projections made using EngenderHealth Reality Check (v) tool

### Section 3.0: Impact of Population Growth on Socio-Economic Factors

Population stabilization and sustainable development are critical determinants of human development and improvement in the quality of life. Resources to support high population growth in terms of education, health, housing, jobs, water and food security, do not match the population growth in Tanzania. During the national family planning conference held in Dar es Salaam in October 2013, stakeholders emphasized the need for accountability on the part of every stakeholder, in order to realize the much desired demographic transition from high fertility, high mortality, and rapid population growth to low fertility, low mortality, and stable population size. (*National FP Conference report, October 2013*).

Socioeconomic development was seen as a “key driver of fertility decline” during the early demographic transition in the developed world in the past centuries (*Bongaarts 2008*). However, more recent experience with fertility transition in many developing countries has shown that certain social indicators, such as women’s development, education, organized community efforts and legal reforms, can be advanced independent of broader economic progress, which in turn can influence fertility without any significant economic development. Notwithstanding the need for economic progress, selective policy actions in social sector issues – many seen as important on their own merit – should therefore be pursued more vigorously. Most important among them in population context are discussed below:

#### 3.1 Women’s development

Improved status of women in the family and society is an important determinant in fertility decline process. Women’s economic and social roles – especially those requiring out-of-home activities – provide the motive, knowledge and power to prevent unwanted pregnancy and also positively contribute to economic progress. The UN Forum acknowledges that: “ensuring gender equity and equality and empowerment of women depends in part on overcoming cultural, social and economic constraints that limit women’s access to education, as well as providing universal access to reproductive health services that allow them to control their fertility” (*U.N. 2002*).

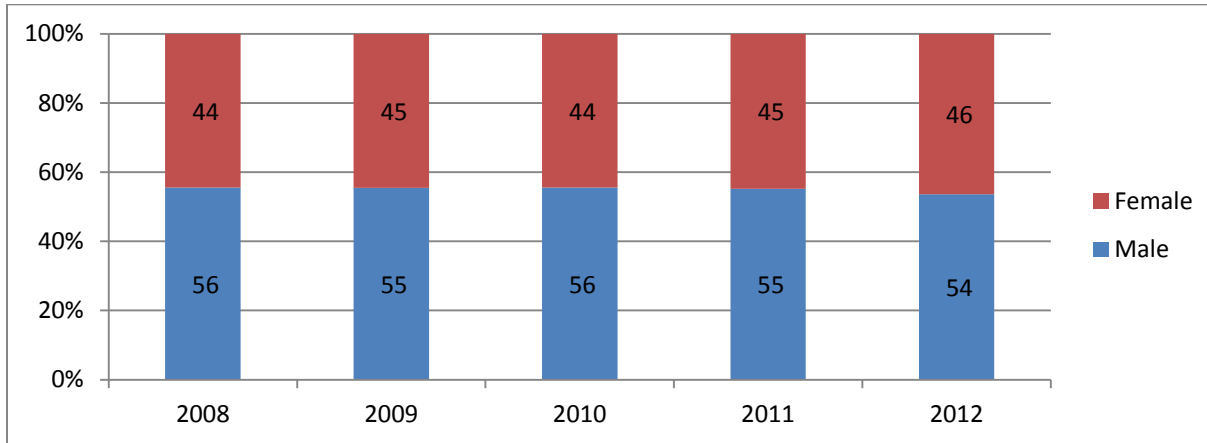
Recognizing this interrelationship, the government of Tanzania has shown commitment to women’s development as reflected in its development policies and program actions in all relevant sectors. More recently, legal reforms are being considered for equal rights of women to inherit property and there has been a noticeable increase in the political involvement of women. The above actions and reforms have heavily contributed to women’s participation in social and economic activities with visible transformation in women’s status especially in urban areas. However, rural women living in a conservative social environment still remain subjected to discrimination. Traditional rural society, together with widespread ignorance and deep-rooted cultural and religious beliefs, still remain limiting factors for women to contribute fully to development in rural Tanzania. Efforts should continue to (a) foster social support in favor of women’s education, and an enhanced role in social, political and economic activities, (b) adopt further social and legal measures to prevent violence against women, (c) dispel cultural and religious misconceptions and (d) enforce legal provisions to prevent and redress discrimination against women.

#### 3.2 Education

Education, especially for women, is an important factor to successful development. Tanzania, like most other developing countries, has recognized the importance of education and adopted a goal of universal primary education. In recent years, Tanzania has made significant progress towards ‘Achieving Universal Primary Education’ (*Millennium Development Goal 2*). According to the *September 2013 “New Global Partnership report” by United Nations*, Tanzania has succeeded in students’ enrolment rate for both primary and secondary schools by 90 percent. Recent studies also show that girls age 7-13 are slightly more likely than boys to attend primary school (81 and 78 percent, respectively), while 88 percent of children in urban areas are more likely to attend primary school, compared with 78 percent in rural areas. Despite the progress made to date, there are still

challenges such as regional disparities in primary education access. The proportion of 7-13 years enrolment ranges from 91 percent in Kilimanjaro to 66 percent in Tabora<sup>9</sup> (*UNICEF 2010*). On the other hand, while primary school enrolment ratios for girls and boys are near equal, in secondary schools, girl's enrolment as a proportion of total enrolment dropped to 46% in 2010 -an increase of 2% from 2008<sup>10</sup>. There is high coloration between regions with low enrolment, particularly for girls, low CPR and high fertility level.

**Figure 4: Proportion of girls and boys secondary school enrolment 2008-2012**



Source: URT BEST 2012

In spite of this significant increase in school enrollment for girls, socio-cultural and economic barriers still pose as major hindrance in retention of girl children in school. Tanzania continue to initiate basic innovative policies, such as provision of lunch, books and supplies, boarding facilities, parental education and community mobilization, to improve retention of girls in schools, particularly in those regions exhibiting low enrollment levels. It is important to retain girl children in schools until they gain physical and emotional maturity to understand the implications of early marriage and early child bearing. Suitably designed population subjects should be integrated in education curricula, and reviewed on a regular basis to ensure that these are in conformity with correct knowledge. Education reduces superstition, ignorance and misgivings, particularly those biased against family planning and population growth and create aspirations and opportunities in life, generate further demand for and promote family planning.

### 3.3 Agriculture

Agriculture is the key economic sector in many developing countries including Tanzania, since it provides a significant proportion of the economy's employment, food, and export earnings. 85 percent of the population in Tanzania depends on agriculture as a source of income. Agricultural value added grew by 4 per cent a year during the last decade. With the high annual rate of population growth (nearly 3 per cent in many rural regions, as high as 4 per cent in others) one cannot expect agriculture to help reduce poverty at this rate of growth as the value added would be sufficient only to cover the increased population. Consequently, there will not be any significant improvement in the incomes of the people. Rapid population growth may also make it difficult to adopt new technologies that are required to keep up with rising demand for food, water, and other socio amenities. In addition, as the intensity of cultivation increases, environmental problems may arise from the clearing of new lands for cultivation, from heavy fertilizer use, and from intensive irrigation.

Despite the abundance of unutilized land, Tanzanian agriculture is dominated by small-scale subsistence farming. It is estimated that the average per capita arable land holding is approximately 0.12 hectares.

<sup>9</sup> ([www.unicef.org/tanzania/SITAN\\_Mainland\\_report.pdf](http://www.unicef.org/tanzania/SITAN_Mainland_report.pdf)).

<sup>10</sup> URT BEST 2012



Approximately 85 percent of the arable land is used by smallholders who operate between 0.2 and 2.0 hectares and traditional agro-pastoralists who keep an average of 50 head of cattle. In recognition of this challenge, Tanzania initiated the “Kilimo Kwanza”<sup>11</sup> ideology, - a declaration, of the Government of Tanzania to speed up the existing strategies and programs to modernize agriculture<sup>12</sup>. The goal of ‘Kilimo kwanza’ is to raise agricultural growth from the current 4 percent to 10 percent within the time frame of the Tanzania Development Vision (2025) by addressing and resolving key challenges besetting agriculture<sup>13</sup>.

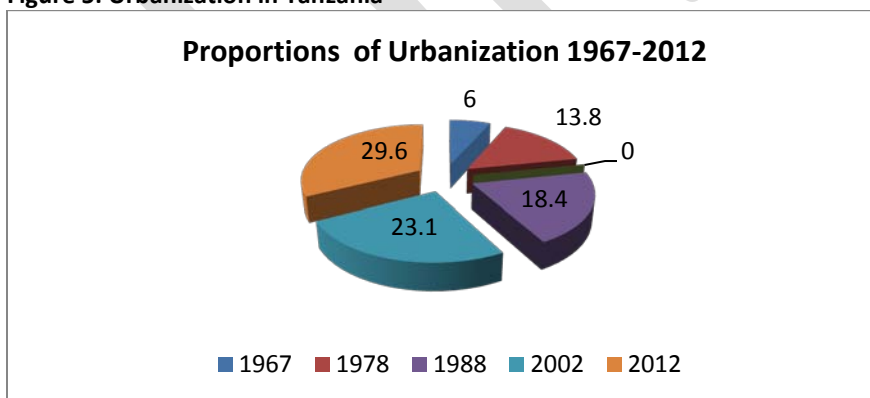
### 3.4 Urbanization

Urbanization is defined as an increase in population in cities and towns verses rural areas. Urbanization is said to have begun during the industrial revolution when workers moved towards manufacturing hubs in cities to obtain better paying jobs in factories as agricultural jobs became less common<sup>14</sup>. As a country develops, it generally makes a transition from being largely rural to having a significant proportion of its population living in urban areas. Urbanization can be particularly rapid in countries that combine a high rate of natural population growth with high rates of rural-to-urban migration, among which Tanzania falls. This is so because urbanization attracts, in the main, the age cohorts of the population which are the most active in production and reproduction.

In some instances, urbanization does offer some benefits, for example it can create the critical mass required for other development factors such as industries and labor for factories, mining companies and large scale agricultural companies. However, if urbanization takes place too rapidly, it can have a negative effect to the country by creating pressure and high demands for other basic needs such as housing, clean water, electricity, transport and sanitation. Experience has shown that rapid growth of urban population in developing countries, Tanzania included, has generally led to significant proportion of urban dwellers living in sub-standard conditions.

The rural-urban migration in Tanzania is high. According to the 1967 census, 6 per cent of Tanzanians lived in urban areas. The number rose to 13.8 per cent in 1978, 18.4 percent in 1988, 23.1 percent in 2002, and 29.6 percent in 2012. Today, approximately 13 million Tanzanians live in urban areas and it is estimated that by 2025 more than half of the population in Tanzania will be living in urban areas. The poor are the most vulnerable since they are obliged to reside in the most marginal areas of cities and towns.

**Figure 5: Urbanization in Tanzania**



Source: URT (1967, 1978, 1988, 2002, 2012)

<sup>11</sup>Kilimo Kwanza is a translation of “Agriculture first” which is a pronouncement of the Government of Tanzania on ways and means of speeding up the existing strategies and programs to modernize agriculture

<sup>12</sup>Used in the wide sense to include both crop and livestock production at small, medium and large scales

<sup>13</sup> Land – Pillar No. 5 of Kilimo Kwanza (Clearing the Ground to Success), Furaha N. Lugoe, Dar Es Salaam Institute of Land Administration and Policy Studies, September 2010. [www.dilaps.or.tz](http://www.dilaps.or.tz)

<sup>14</sup> <http://www.businessdictionary.com/definition/.htm>.



### 3.5 Population and Environment

There has been a debate on influence of population growth on environment. One extreme focuses on the *Malthusian view*, which suggests that population growth is a root cause of environmental degradation, as it exerts great pressure on environmental resources. On the other hand population growth is viewed as a driving source of increased efficiency, economies of scale and technological efficiency that expands the earth-carrying capacity<sup>15</sup>. Empirical evidence in Tanzania has shown that population growth and human livelihood activities have resulted into degradation of environment, deforestation and reduction of farm lands on fallow systems and land conflicts have been manifested in some parts of the country. The number of people, where they live, and how they live, all affect the condition of the environment. People alter the environment by clearing land for development, using natural resources, and producing wastes. Changes in environmental conditions, in turn, affect human health and well-being. Rural poverty, a high population growth rate, deforestation, and fresh water scarcity, for example, all pose challenges for policymakers in Tanzania and elsewhere in Africa<sup>16</sup>.

The 1984 International Conference on Population and Development held in Mexico City recommended that national and international development plans should take into account approaches which integrate population, resources and development<sup>17</sup>. Tanzania Vision 2025 aspires to transform Tanzania from one of the least-developed countries to a middle-income country by 2025. Vision 2025 further recognizes that fast economic growth will be pursued while reversing the current degradation of Tanzania's forests, fisheries, fresh water, soils, and biodiversity, and the accumulation of hazardous substances in the nation's air and water. This can only be achieved if these plans go hand in hand with appropriate population planning.

### 3.6 Development of community institutions

Sector-wide policies and programs may benefit from institution of a structure of community organization that would generate community consensus in favor of policies and programs. For such purposes, community facilities should be in place to hold meetings, promote exposure to media through provision of newspapers, books, radios and television and cultural events. Once instituted, communities can be involved in vetting policies and programs including those on population. Such organized community efforts can be a powerful legitimizing force for raising literacy and education, girl's education, women's role in society, addressing maternal health needs, access of adolescents to reproductive health knowledge and services, and awareness about health and social implications of early marriage and early child bearing. Based on its 'Ujamaa ideology'<sup>18</sup>, Tanzania has well established community structures down to household level which form a basis for community development.

## SECTION 4: REPRODUCTIVE HEALTH

A fundamental goal of *The Tanzania Development Vision 2025* is "access to primary health care for all." This vision acknowledges the relationship between population, health, and the development of the country. Population and reproductive health also plays a crucial role in the social and economic development of Tanzania, a country that continues to have one of the fastest growing populations in the world. Even though this paper primarily focuses on population and family planning, other reproductive health issues are so closely related to and interlinked with family planning and population that effective population policies cannot be conceived in isolation of relevant reproductive health issues. These are therefore briefly discussed in the subsequent paragraphs with due attention to the prospect for mutual integration of services that would make family planning more widely acceptable and effective.

<sup>15</sup> *Earth carrying capacity: For a given region, carrying capacity is the maximum number of individuals of a given species that an area's resources can sustain indefinitely without significantly depleting or degrading those resources*

<sup>16</sup> *Melisa Thaxton. Integrating Population, Health and Environment in Tanzania*

<sup>17</sup> *United Republic of Tanzania (2003). Integration of population variables in development planning. Demographic Training Unit. University of Dar es Salaam*

<sup>18</sup> *Ujamaa, The Swahili term for 'familyhood' is the social and economic policy developed by Julius Kambarage Nyerere, president of Tanzania from 1964 to 1985. Centered on collective agriculture, under a process called villagilization, and an increased level of self-reliance at both individual and national level*

#### 4.1 Access to health services

The need for health facilities in Tanzania will continue to increase with the continued rapid growth of the population and better health-seeking behavior. The MOHSW summary analysis report of the comprehensive council health plans 2013/2014 indicate that Tanzania benefits from a strong network of 6,270 registered health facilities, of which 4,739 are owned by the government while 1,531 are owned by voluntary Faith-based Organizations (FBOs), private entities, and parastatals. With the current population growth, and high fertility it is projected that the country would need approximately 10,740 health facilities and 17,310 by 2025 and 2035 respectively. On the contrast, with declining fertility scenario approximately 9,540 health facilities would be needed in 2025 and 13,200 in 2035<sup>19</sup>.

Expanding access to the formal health care sector is a primary goal for the Republic of Tanzania. While the mean distance to primary health facilities has decreased in the last decade, nearly a half million households remain more than 20 km from the nearest health facility<sup>20</sup>. Distance, poor roads, and the lack of suitable transport have continuously been cited among key obstacles to health care in Tanzania. According to a summary of the Tanzania Service Availability Mapping report, 80% of Tanzanians have access to health services, while about 90% of the population lives within 10 kilometers of a health care facility.<sup>21</sup> Yet the assumption underlying this priority—that access to the formal health care system improves health particularly of rural populations remains untested. Given that the quality of care at lower level public health facilities is often considered inadequate, improved access requires improvements of other meaningful health determinants such as infrastructure development, supply chain improvements, and investment in human capital.

Additionally, Tanzania has some of the lowest health personnel coverage per population in the world. For example, there are 0.4 physicians and 2.8 nurses and midwives per 10,000 people<sup>22</sup>. This is well below the corresponding average figures of 2.8 physicians and 6.7 nursing and midwifery personnel for all of the world's low income countries and is a challenge for the expanded delivery of health services. Based on the World Health Organization minimum standard of 23 health workers per 10,000 people, Tanzania is approximately 84,000 health workers short of meeting the most basic health needs. Over the next ten years, if the population continues to grow at the same pace, this gap is expected to grow to 104,000<sup>23</sup>.

#### 4.2 Safe motherhood

Safe Motherhood Initiative (SMI) is a global effort to reducing the number of morbidity and mortality associated with pregnancy and child birth. In Tanzania, the program aims to improve maternal and new-born outcomes in pregnancy, child birth and in post-partum period. Significant progress has been made in recent years in proportion of childbirths attended by medically trained personnel. According to the 2010 TDHS, 96 percent of all women who gave birth in the five years preceding the survey received antenatal care (ANC) from a health professional at least once; though only 50 percent of births occurred in health facilities (2010 TDHS) compared with 44 percent in 1999 (TRCHS<sup>24</sup>). In spite of this progress, more than two-thirds of child births still occur without a skilled attendant. The country loses 24 women every day, which makes an average of 8,000 deaths per annum, resulting from delivery complications. A skilled attendant at birth with the proper equipment and environment can reduce the incidence and severity of obstetric and newborn complications. Continued efforts are therefore needed to train midwives and other medical personnel and equip facilities to improve safe motherhood. Since pregnancy complications can occur unpredictably an increase in the

<sup>19</sup> Tanzania Service Availability Mapping 2005-2006: MOHSW

<sup>20</sup> Tanzania Service Availability Mapping 2005-2006: MOHSW

<sup>21</sup> Tanzania Service Availability Mapping 2005-2006: MOHSW

<sup>22</sup> Touch Foundation and McKinsey & Company, March 2009

<sup>23</sup> Touch Foundation and McKinsey & Company, March 2009

<sup>24</sup> 1999 Tanzania Reproductive Child Health Survey (TRCHS)

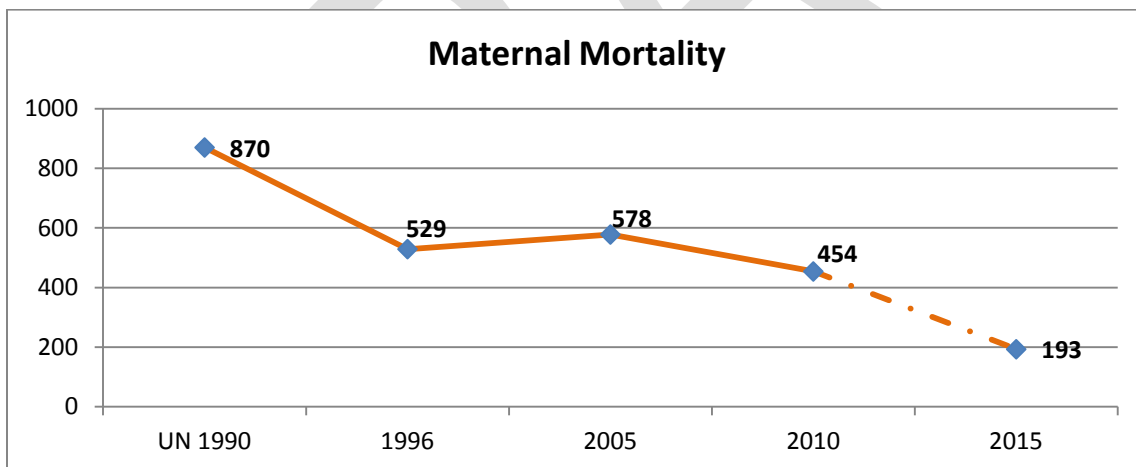
availability of basic emergency obstetric and newborn care (BEmONC)<sup>25</sup> services at dispensaries and health centers, and scaling up of rural health centers to perform caesarean sections and blood transfusions (comprehensive obstetric and newborn care (CEmONC)<sup>26</sup>, can save lives<sup>27</sup>.

### 4.3 Maternal Mortality

The estimate of the maternal mortality ratio (*MMR*) in Tanzania is 454 maternal deaths per 100,000 live births (*TDHS 2010*), one of the highest in sub-Saharan Africa, and is projected to reduce to 193<sup>28</sup> maternal deaths per 100,000 live births by 2015 (*MDG 5 target*). The facility delivery rate has improved over the past decade and a half after dropping in the 1990s – 1992 (52%), 1996 (47%), 1999 (44%), 2005 (47%) and 2010 (50%)<sup>29</sup>. Tanzania has however, made insufficient progress in maternal survival between 1990 and 2010. Approximately 7,900 women still die each year from complications of pregnancy and childbirth. In other words, for every 1,000 live births in Tanzania, about four to five women die of pregnancy-related causes. According to the Tanzania Demographic Health Surveys (*TDHS 2010*), *MMR* is slowly decreasing from 578 per 100,000 live births in 2005 to 454 in 2010. This shows a slow progress towards the attainment of the MKUKUTA target (*MMR 265 by 2010*). Given that the average percentage decline in *MMR* per year between 2005 and 2010 was 4.3%, it is likely to take 19 years up to 2029 for Tanzania to reach its MDG5 target if the current rate of decline continues. In order to achieve MDG5, the average decline rate should be escalated to 11.5% per year (*MTR-AR 2013*).

Direct causes of maternal mortality include lack of Essential Emergency Obstetric care facilities at all levels from District to National Hospitals - only 40% of facilities offer BEmONC services, and lack of skilled health providers at delivery units. Indirect causes include low CPR 34.8%, all methods (*TDHS 2010*), illiteracy – low education for women, and inappropriate health seeking behavior - 40% of women who attended ANC deliver at home under care of untrained birth attendants. Increased access to family planning reduces *MMR*.

**Figure 6: MMR per 100,000 live births by year by Tanzania DHS reports**



Source: UN, (*TDHS 2005, 2010*), *NBS projections*

<sup>25</sup> BEmONC: **Basic Emergency Obstetric and Newborn Care facilities:** Peripheral health facilities with maternity services that regularly practice the seven basic signal functions: parenteral administration of antibiotics, anticonvulsants, oxytocics, manual removal of placenta, manual vacuum aspiration for retained products, assisted instrumental delivery by vacuum extractor, newborn resuscitation with mask. The functions include stabilization of mothers and newborns with complications before and during transfer to hospital.

<sup>26</sup> **Comprehensive Emergency Obstetric and Newborn Care facilities** –Health facilities with maternity services that regularly practice the seven BEmONC signal functions listed above *plus* two additional signal functions: emergency surgery (caesarean section) and safe blood transfusion (can also include advanced newborn resuscitation).

<sup>27</sup> *One Plan Midterm Review report, October 2013.*

<sup>28</sup> Tanzania MDG 5 targets

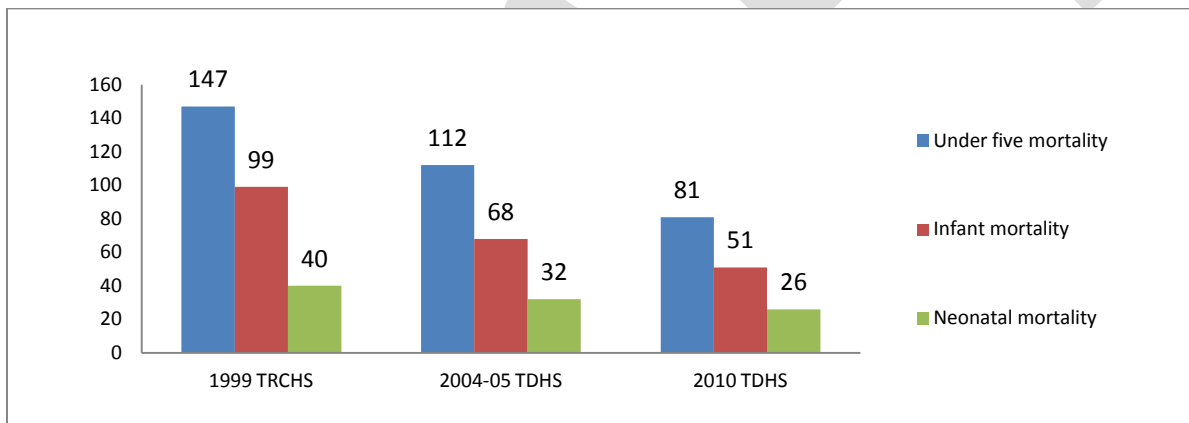
<sup>29</sup> Data are from DHS in respective years with exception to 2005, data source is Tanzania Ministry of Health and Social Welfare, National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008-2015

#### 4.4 Child Survival

Contrary to popular belief, accelerated child survival strategies, when combined with family planning, result in slower population growth, thereby making a stable and lower total population attainable. The effects of major improvements in child survival on population growth are often misunderstood. One assumption is that any reduction in child mortality rates automatically adds to population and population growth rates and that any reduction in the number of children dying each year would increase total population, now and in the future.

In fact, studies have shown that the opposite is the case. Actions which extend child and maternal health services and expand educational opportunities for girls and women help to both increase child survival and reduce fertility, making for lower population growth rates in the longer run. When combined with direct family planning efforts, actions to accelerate child survival are likely to lead to slower population growth and, therefore, the earlier attainment of a stable and lower population than would be the case if family planning or child survival measures were taken independently of each other. This interactive relationship is the essential logic for stressing the complementarity of vigorously pursuing child survival and family planning as key elements of maternal and child health and human advancement. In this respect, improved child survival in recent years in Tanzania is seen as a positive result of population policies and programs. Innovative communication strategies may help to enhance parental confidence, while continued efforts are needed for further improvement in infant and child health.

**Figure 7: Child Mortality Ratio: Figure 1: Trends in Child Mortality**



Source: Tanzania Demographic and Health Survey (TDHS) 2010

In 1990 child mortality stood at 141.5 deaths per 1000 live births; in 2004 it had reduced to 83.2 deaths per 1000 live births. Between 1999 and 2004 there was notable improvements in Tanzania's health system, including increased public expenditure on health; decentralization and sector-wide basket funding; and increased coverage of key child-survival interventions, such as integrated management of childhood illness, insecticide-treated nets, vitamin A supplementation, immunization, and exclusive breastfeeding. These interventions have seen a further decrease in the under-5 mortality rate to 81 and infant mortality to 51 per 1,000 live births in 2010 (TDHS 2010). Evidence shows that child spacing for the recommended 2 years reduces child mortality.

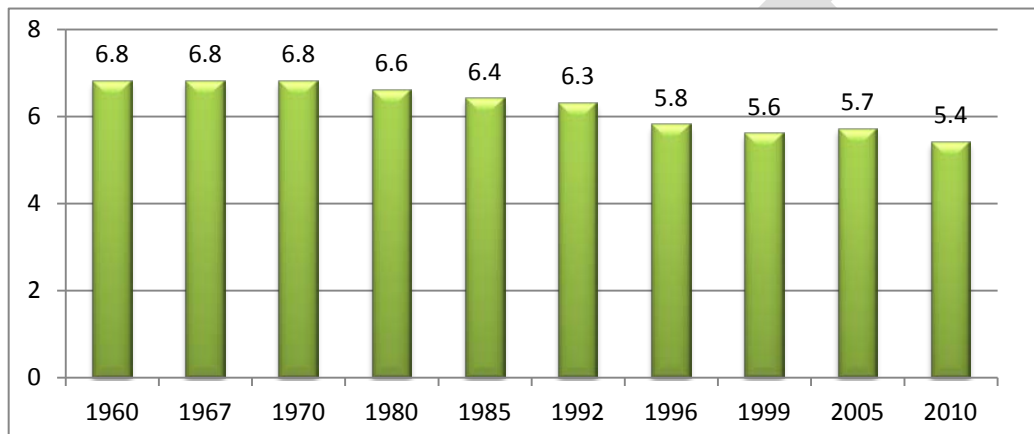
#### SECTION 5.0: FERTILITY AND POPULATION

Population stabilization and sustainable development are critical determinants of human development and improvement in the quality of life. Slowing population growth depends on simultaneously creating the social conditions for fertility decline and filling the family planning gap. Tanzania's rapid population growth rate, for the most part, is driven by high fertility rates, short birth intervals, early onset of sexual activity and related high adolescent fertility/teenage pregnancies.

## 5.1 Fertility levels and trends in Tanzania

Since independence the country embarked on policies for improvement of people's wellbeing by fighting three obstacles to development: ignorance, diseases and poverty. To realize this goal, the country initiated health programs in the early years which included family planning programs. During the 1960 – 1970 Tanzania's fertility level seem to stagnate at 6.8. However, the family planning program in early 1980s marked a downward trend in the fertility level. In spite of a seemingly unfavorable socio-economic environment, family planning programs in Tanzania achieved a remarkable success in promoting family planning practices and lowering fertility, with total fertility rate (TFR) declining from 6.3 in 1991/92 to 5.4 in 2010 as contraceptive prevalence rose from 20 percent to 27 percent (modern methods) during the same period. Despite the declining trend, Tanzania still has a high fertility level - 5.4<sup>30</sup>, above global replacement level (TFR 2.1 to 2.33).

**Figure 8: Fertility Trend<sup>31</sup> 1960- 2010**



Source: UN Department of Economic and Social Affairs Population Division, DHS 1992 to 2010 surveys

For Tanzania to attain stable population which take into account the available resources and state of technology, it has to strive for a fertility replacement close to the global rate of 2.3<sup>32</sup> taking into consideration the survival rates of girls and young women.

## 5.2 Fertility stagnation: dynamics and implications

Even though fertility decline process has again accelerated, the mid-transition fertility stagnation during the 1990s delayed the timeframe for achieving demographic goals including population stabilization. It therefore seems sensible to review the dynamics involved and future implications. Such phenomenon of stall or near-stall in 1960s and 1980s was also observed in several other countries mainly in sub-Saharan Africa, where two factors played major roles. First, socio-economic variables, including "poorly performing economy and rising mortality" were among plausible causes in many sub-Saharan Africa. Secondly, "lower priority assigned to family planning programs", particularly in rural areas, appeared distinctly relevant to and consistent with affiliated program performance in Tanzania. Several program trends in Tanzania which provide consistent clues to the above hypothesis were: (i) a shift in contraceptive method mix toward less effective methods, (ii) a significant decline in new acceptance of effective methods, (iii) an inert role of public sector in contraceptive service delivery, (iv) a simultaneous increase in unmet needs during the period of fertility stagnation, (v) the institution of the Global Gag Rule by the then US Administration effectively defunded IPPF affiliates, which

<sup>30</sup> 2010 TDHS

<sup>31</sup> 1960 to 1985 is data from United Nations, Department of Economic and Social Affairs Population Division [http://esa.un.org/unpd/wpp/unpp/panel\\_population.htm](http://esa.un.org/unpd/wpp/unpp/panel_population.htm) and 1992 to 2010 DHS surveys

<sup>32</sup>

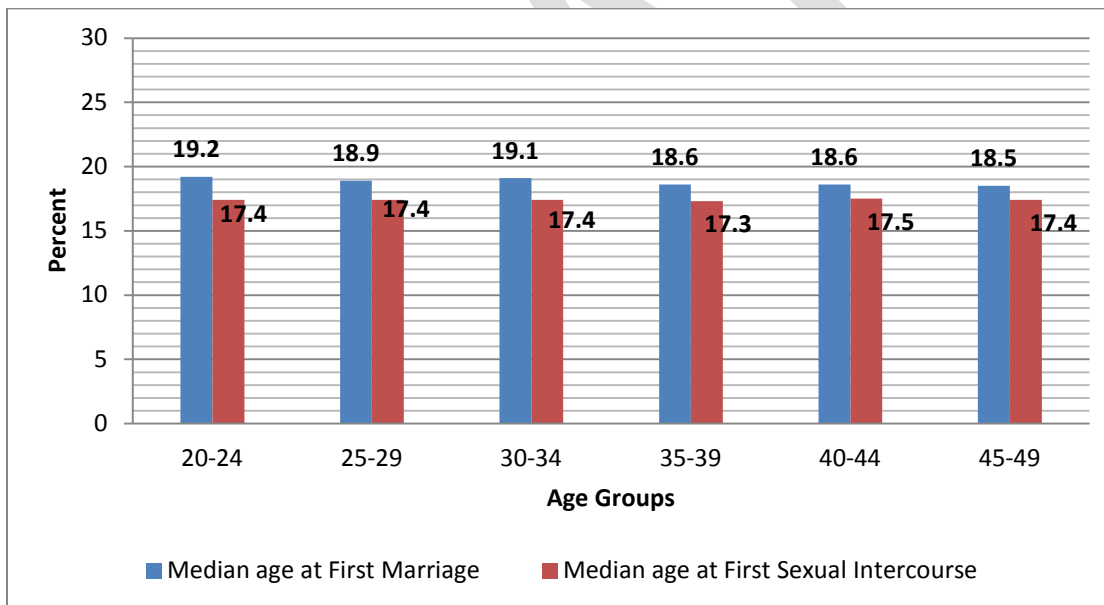
affected not only CBD services, but other services provided by those affiliates, and (vi) discontinuation of funding to the Community Based Distribution (CBD) program by USAID.

### 5.3 Teenage pregnancy and early child bearing

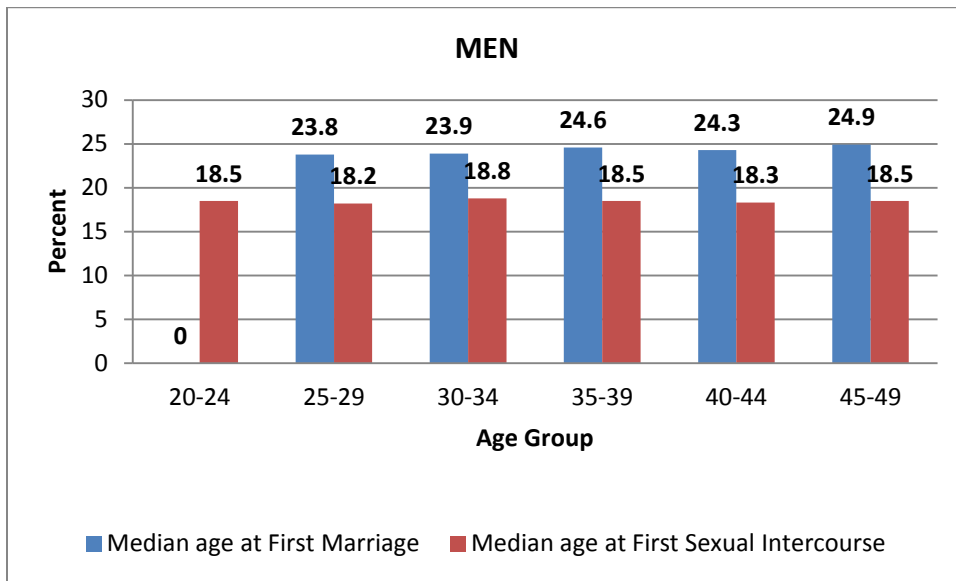
The age at which childbearing commences is an important determinant of the overall level of fertility as well as the health and welfare of the mother and the child. Although age at first marriage is often used as a proxy for first exposure to intercourse, the two events do not necessarily occur at the same time. According to the 2010 DHS, the median age at first intercourse for women age 25-49 is 17.4 years compared to 18.2 percent for men in the same age bracket. Fifteen percent of women age 25-49 have had sex by age 15, and almost 6 in 10 have had sex by age 18. The median age at first birth was around 18.8 years, representing a slight increase from the median reported in the 2004-05 TDHS (18.6 years). In this scenario, by around 25 years, women have 2 children, and they still have about 25 years remaining of reproductive life span. Postponement of first births due to an increase in age at marriage has contributed to overall fertility decline in many countries.

One of the constraints in fertility control effort in Tanzania is therefore that of early child bearing practices which have shown only small change during the past decades. Twenty-three percent of women age 15-19 have begun childbearing: 17 percent are already mothers while 6% are pregnant with first child. Although the percent of women age 15-19 that have begun childbearing has declined from that of 2004/05 TDHS (26%), the high rate of early childbearing is still a concern to population growth in Tanzania.

**Figure 9: Age at First Marriage and Age at First Sexual Intercourse - Women**





**Figure 10: Age at First Marriage and Age at First Sexual Intercourse - Men**

Source: URT (2010)

There is also a strong inverse relationship between early childbearing and education; teenagers with less education are more likely to start childbearing earlier than better-educated women. The 2010 DHS indicate that, 52 percent of teenagers who had no education had begun childbearing compared with only 6 percent of women who attended secondary education. Likewise, women in the lowest wealth quintile are also more than twice as likely to start childbearing early compared with women in the highest wealth quintile, 28 percent and 13 percent, respectively (*TDHS 2010*).

The high teen-age fertility partly arises from early marriage. The median age at first marriage for women aged 20-24 in Tanzania is 19.2, compared to 19.8 percent in Kenya (*DHS 2009*), 19.1 percent in Uganda (*UDHS*), and 20.7 percent in Rwanda (*RDHS*). The increase of age at first marriage from 18.5 years among women age 45-49 to 19.2 years among women age 20-24 indicates a shift towards later marriage (*TDHS 2010*). However, legally in Tanzania, girls can marry as young as fourteen under the Law of Marriage Act, 3; as young as puberty under customary law, 4 and as young as nine under the Islamic Restatement Act.5.<sup>33</sup> It is worth noting that the age at first marriage in countries where replacement fertility has been achieved is much higher. Consequently, the need to protect a longer reproductive life span, arising from low age at marriage and early child bearing practices, underscores the need for adequate resources for family planning and importance of use of more effective methods.

#### 5.4 Population Projections using fertility assumptions Fertility

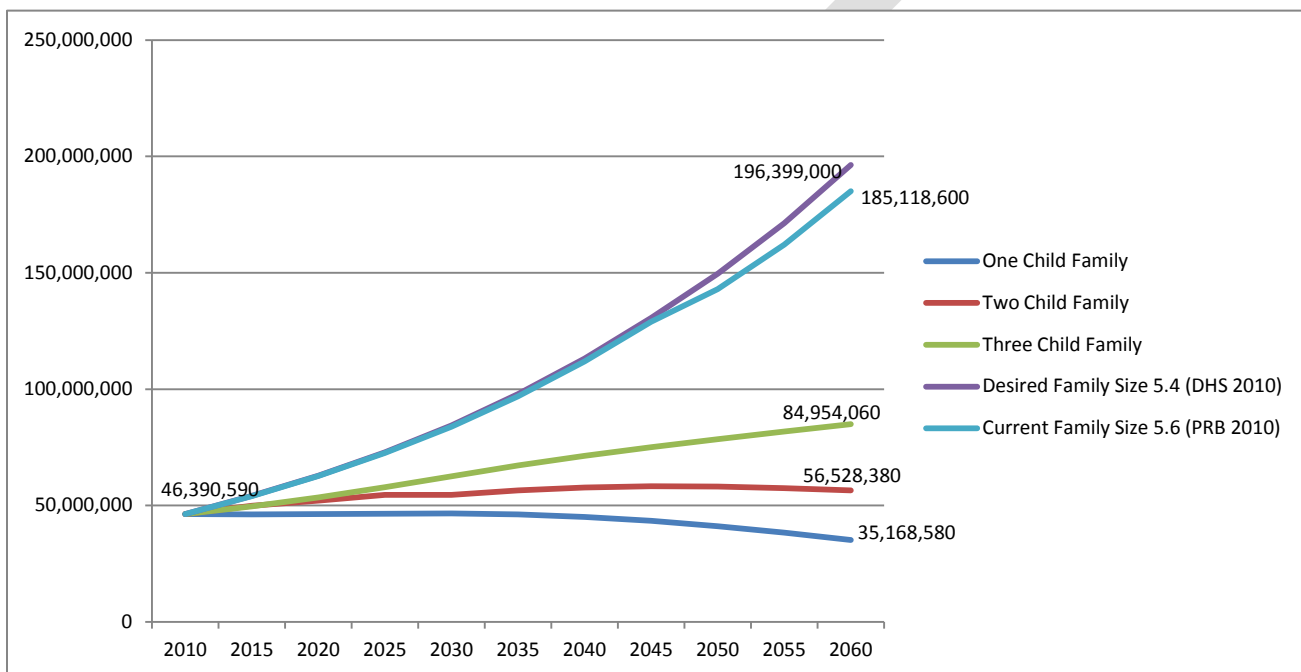
The term total fertility rate is used to describe the total number of children an average a woman in a population is likely to have based on current birth rates throughout her life. The high level of fertility and rapid rate of population growth impede poverty reduction efforts, while at the same time, poverty hinders efforts to reduce the fertility rate. Tanzania's average family size is 5.4 persons, with the average household size being lower on the Mainland (4.9) than in Zanzibar (5.6). Over 55 percent of households in Tanzania have a household size of 3 to 6 members. On the Mainland urban, 26 percent of households have 6 or more members compared with 39 percent in Mainland rural and 49 percent in Zanzibar (*2010 TDHS*). Data also shows regional variance in

<sup>33</sup> *Child Marriage and Guardianship in Tanzania : Robbing Girls of their Childhood and infantilizing Women: Tamar Aparna Polavarapu and Tina Tolentino Ezer, Kate Kerr, Kara Major, Aparna Polavarapu and Tina Tolentino*

population, with Dar es Salaam region leading with a population of 4,364,541, followed by Mwanza and Mbeya with a population of 2, 727, 509 and 2,707,410 respectively (2012 Census).

This means that the population of Tanzania is going to keep growing for most of the coming decades due to its youthful population structure -even if birth rates start to come down now. Research also shows that future population growth of any country is largely determined by what happens to its fertility. If the current fertility level of 5.4 children per woman is maintained, the country's population is estimated to almost triple to almost 150 million people by 2050. This would place a heavy burden on the provision of basic services such as water, health, electricity and education.

**Figure 11: Tanzania Population Projections with various TFR assumptions 2010 - 2060**



Source: projection of population growth in Tanzania based on 2010 DHS

## SECTION 6.0: THE STORY OF FAMILY PLANNING IN TANZANIA

Family planning programs have had a major impact on fertility rates in many countries. Research shows that in some countries with strong family planning programs, fertility fell from very high levels to replacement level within one generation. It is also noted that in the absence of family planning policies and programs fertility decline would have been slower than it actually did in those countries. An important step in stabilizing population in any country is to remove the physical and social barriers that prevent women from using family planning services. John Bongaarts of the Population Council reports that 42 percent of all pregnancies in the developing world are unintended. Of these, 23 percent end in abortion. Bongaarts concludes that one third of projected world population growth is due to unintended pregnancies. It is, for example, estimated that 13 percent of global maternal deaths are due to unsafe abortion while about 60 percent of abortion-related deaths occur in Africa (Shah and Åhman 2010; United Nations 2010).

Tanzania's IPPF affiliate (UMATI) introduced family planning services in urban Tanzania clinics in 1959. However, it was not until the 1970s that the Government of Tanzania became actively involved in family planning service provision. Through the 1970s and 1980s, levels of contraceptive use remained unchanged, as there were few trained providers, limited contraceptive supplies, and a weak logistics system.



A 1988 speech by former President Julius Nyerere was pivotal to placing family planning on the national agenda. In 1989, the Government of Tanzania designed a national population policy and launched the National Family Planning Program (NFPP). Government and mission/faith-based organizations joined together to comprise the national program, with UMATI mandated to provide supervision and quality assurance in the public sector. USAID, DFID, Germany and other donors provided significant support to family planning, and the 1990s were the “golden days” of family planning in Tanzania.<sup>34</sup> In the 1990s, along with Malawi, Tanzania posted the largest annual increase in contraceptive prevalence rate in the East Africa region—two percentage points per annum. Modern method prevalence increased from 6.6% in 1992 to 13.3% in 1999. Over the same period, use of any method increased from 10.2% to 25.4%.

Tanzania is a signatory to the 1994 International Conference on Population and Development (ICPD) Declaration signed by 185 countries and which called for universal access to family planning and reproductive health services by 2015. The United Nations MDG target 5(b) also calls for universal access to reproductive health care and seeks to reduce the maternal mortality rate by three-quarters for the period between 1990 and 2015. While notable progress has been made in expanding antenatal care in Tanzania, many women still lack access to family planning services and information as evidenced by 25 percent unmet need for family planning (2010 TDHS).

### 6.1 Current program performance and prospect for change

After about a decade of low performance, there appears to be a turnaround in the numbers of new acceptors of family planning, in particular, long acting/reversible and permanent methods (LARPM). Users of LARPM, which was lowest in the 1990s, rose steadily, with acceptors rising from 25,055 to 220,550 (780% increase) from 2004/5 to 2010 while acceptors of sterilization rose from 15,701 to 73,984 (371% increase) during the same period (EngenderHealth 2013).

**Table 2: Family Planning LARPM Acceptors by method**

Year	Sterilization		IUD	Implants	TOTAL
	Minilap	Vasectomy			
2004-2005 <sup>35</sup>	13,449	81	2,129	9,396	25,055
2005-2006 <sup>36</sup>	15,701	142	2,773	15,369	33,985
2006-2007	55,550	153	20,230	53,957	128,857
2007-2008	61,752	239	16,429	78,687	157,107
2008-2009	67,430	245	34,310	100,360	202,345
2009-2010	73,984	347	46,698	99,521	220,550
2010-2011	75,194	275	67,792	166,768	310,929
2011-2012	64,226	260	85,461	207,089	357,036
2012-2013	84,991	419	100,997	258,209	444,616

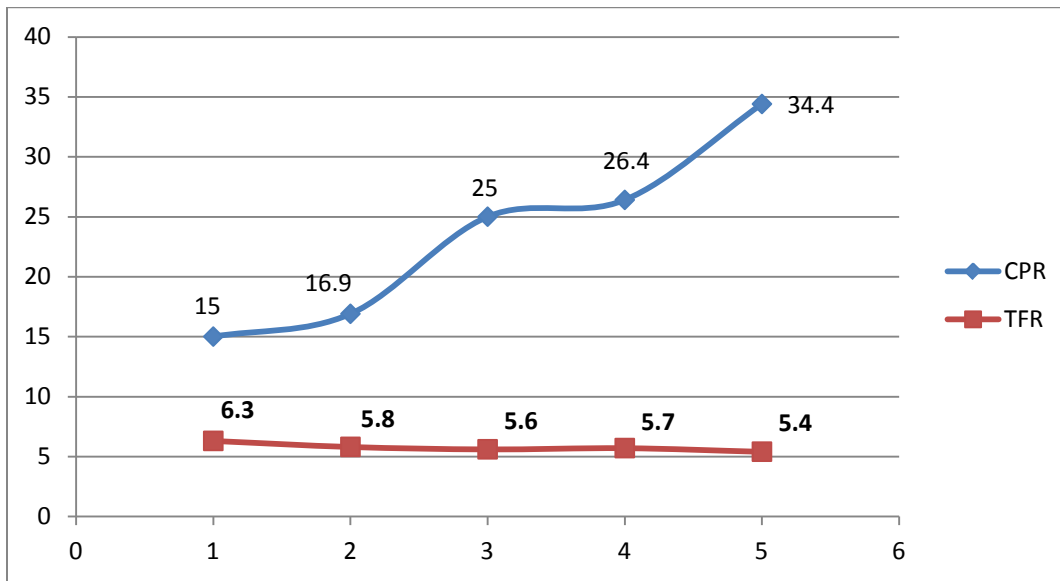
Source: HMIS Program statistics compiled by EngenderHealth, Tanzania

This performance trend may also explain the decline in fertility between 2004/05 and 2010. Since LARPM have a cumulative effect, further impact would be expected in future, especially if this trend continues.

<sup>34</sup>Tanzania Case Study: A Successful Program Loses Momentum A Repositioning Family Planning Case Study December 2006,

<sup>35</sup>Data collected from 128 supported sites

<sup>36</sup>Data collected from 406 supported sites

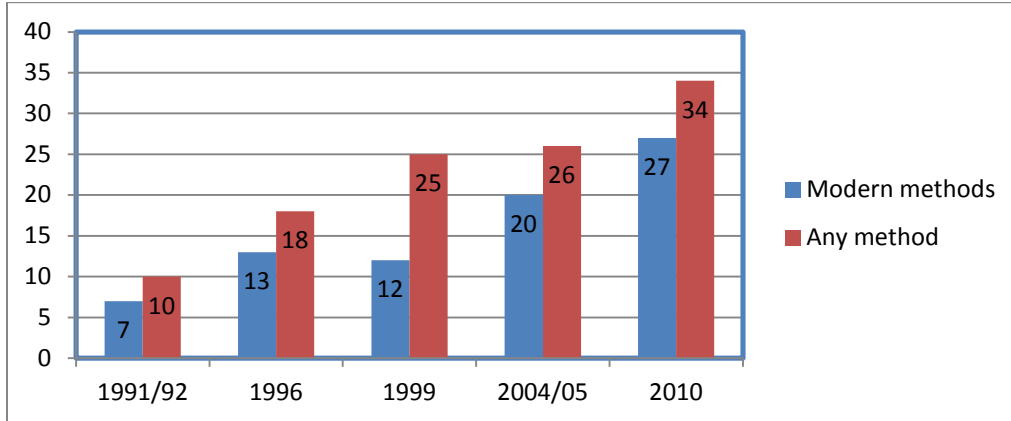
**Figure 12: Trends in CPR and TFR – 1991 – 2010**

Source: Making sense of Tanzania's fertility (LSERO).pdf-Adobe Reader

## 6.2 Trend in Contraceptive Use

Contraceptive use has been identified as one of the primary factors contributing to fertility decline, however, the link between contraception use and fertility is weak and less understood in most sub-Saharan Africa countries. For example, despite a large increase in the contraceptive prevalence rate (CPR) in Tanzania since the early 1990s, its total fertility rate (TFR) has remained high. There has been little research on the impact of method mix in this relationship. An understanding of the dynamics of the relationship between contraceptive use, method mix and fertility would provide important evidence to advocate and plan for future scale-up of and investment in family planning programs.

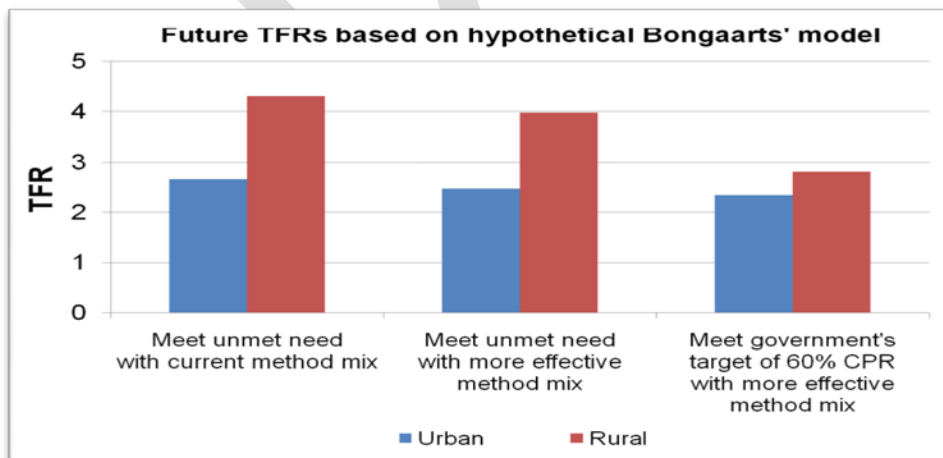
During the last 20 years, there has been a gradual and steady increase of contraceptive use among currently married women. However, the use of modern methods of contraception remains low, despite high contraceptive knowledge (74 percent for all women in the 1991-92 to 96 percent in 2010) and substantial unmet need for spacing and limiting of pregnancies which stands at 25 percent (DHS 2010). Use of any method increased from 26 percent of married women in 2004- 05 to 34 percent in 2010 while use of modern methods increased from 20 to 27 percent of married women during the same time period frame. The most commonly used modern method is injectables, used by 10.6 percent of married women, followed by the pill (6.7 percent), female sterilization (3.5), implants and IUD (2.3) and (0.6) respectively.

**Figure 13: Trends in contraception Use, Tanzania (percentage of current married women using any method) TDHS**

Source: DHS (1999, 2005, 2010)

### 6.3 Contraceptive method mix and its implication for fertility:

The most notable change in the mix of modern methods used by married women has been a gradual increase with the majority using injectables (less than 1 percent in 1991-92 compared to 6 percent in 1999 and 11 percent in 2010). There are significant variations in contraceptive use by background characteristics as well. Married women in urban areas are much more likely than their rural counterparts to use a family planning method. Between 1991 and 2010, five national surveys have measured contraceptive use among currently married women in Tanzania. Over the two decades, there has been a gradual and steady increase of contraceptive use among married women, from 10 percent in 1991-92 to 34 percent in 2010 TDHS). Likewise, modern methods of contraception increased by 20 percentage points, from 7 percent in 1991-92 to 27 percent in 2010. By specific method, use of injectables has continued to increase —from 3 percent of married women in 1992 to 11 percent in 2010. Regrettably, during the decade of the 1990s, contraceptive practice trends took a turn towards use of less effective methods. For example, use of sterilization declined to 1.4 in 1999 from 1.6 percent in 1992 to 1.5 percent in 2005 and improving to 3.5 percent in 2010. While use of IUDs showed a minimal increase: 0.4 percent in 1992, dropping to 0.3 in 1999 with significant increase from 0.2 percent in 2005 to 0.6 percent in 2010. Likewise implant increased from 0.5 percent in 2005 to 2.3 percent in 2010, this is over three fold increase in uptake of implants in the same period. Evidence shows that improved programing coupled with training of service providers, improved commodity security and improved method mix can result into high family planning uptake, increased national CPR and consequently reduced fertility.

**Figure 14: Meeting Family Planning unmet need with method mix**

Source: Making sense of Tanzania's fertility (LSERO).pdf-Adobe Reader

In order for Tanzania to double its CPR to 60 percent from 34 percent (all methods TDHS 2010) by 2015, the country will need to increase the total number of users (all methods) to approximately 7,093,404 from the current 3,554,568<sup>37</sup>. The assumption made is to increase family planning uptake in 2014 to 6,314,567 users, which will almost double each method specific CPR (Table 3). The MOHSW in partnership with other stakeholders therefore need to intensify use of such interventions like outreach, social marketing of pills and injectables, and conducting family planning camps in hard-to-reach areas focusing on regions with low family planning uptake, particularly to provide LAPM services.

**Table 3: Projected FP users in Tanzania if the country has to reach 60% CPR by 2015**

CPR	CPR 2010	CPR 2014	CPR 2015	Users 2010	Users 2014	Users 2015
Pill	6.7	13	14.58	694,333	1,495,253	1,721,671
Injection - three-month	10.6	16.7	18.23	1,098,496	1,920,825	2,152,827
Condom	2.3	4.1	4.55	238,353	471,580	537,469
LAM	1.3	1.3	1.30	134,721	149,525	153,562
Any Traditional Method	7	7	7.00	725,422	805,136	826,875
Implant	2.3	4.6	5.18	238,353	529,089	611,297
IUD	0.6	1.2	1.35	62,179	138,023	159,469
Female Sterilization	3.5	7	7.88	362,711	805,136	930,234
Any method	34	54	60	3,554,568	6,314,567	7,093,404
Any modern method	27	47	53	2,829,146	5,509,431	6,266,529
All LAPM methods	6	12	14	663,243	1,472,249	1,700,999

Source: DHS 2010, projected WRA for 2010, WRA 2012 census

#### 6.4 Demand factors, unmet needs

Unmet need for fertility regulation is defined as “fecund women who are currently married and say that they either do not want any more children or that they want to wait two or more years before having another child, but are not using contraception”. Unmet need in Tanzania fell steadily from 27.9 percent in 1991-2 to 21.8 in 2004/05 implying that unmet need was being partially met by services offered by the program<sup>38</sup>. Subsequently however, unmet need increased considerably from 21.8 percent in 2004/05 to 25 percent of currently married women having an unmet need for family planning in 2010: 16 percent for spacing, and 9 percent for limiting.

**Table 4. Unmet needs for contraceptive services, 1991/2 to 2010<sup>39</sup>**

Year	1991/02	1994	1996	1999	2004/05	2010
Unmet need, non-users (A)	27.8	27.2	23.9	21.8	21.8	25.4
Expressed limiters	9	9.7	8.5	8	6.7	9.5
Expressed spacers	18.8	17.5	15.4	13.8	15.1	15.9
Met need, users of modern methods (B)	10.4	12.2	18.4	25.4	26.4	34.3
Total Demand for FP: (A+B)	38.2	39.4	42.3	47.2	48.2	59.7

Source: : Tanzania DHS and United Nations Statistics Division; 2012 updated for MDG database [www.unpopulation.org](http://www.unpopulation.org)

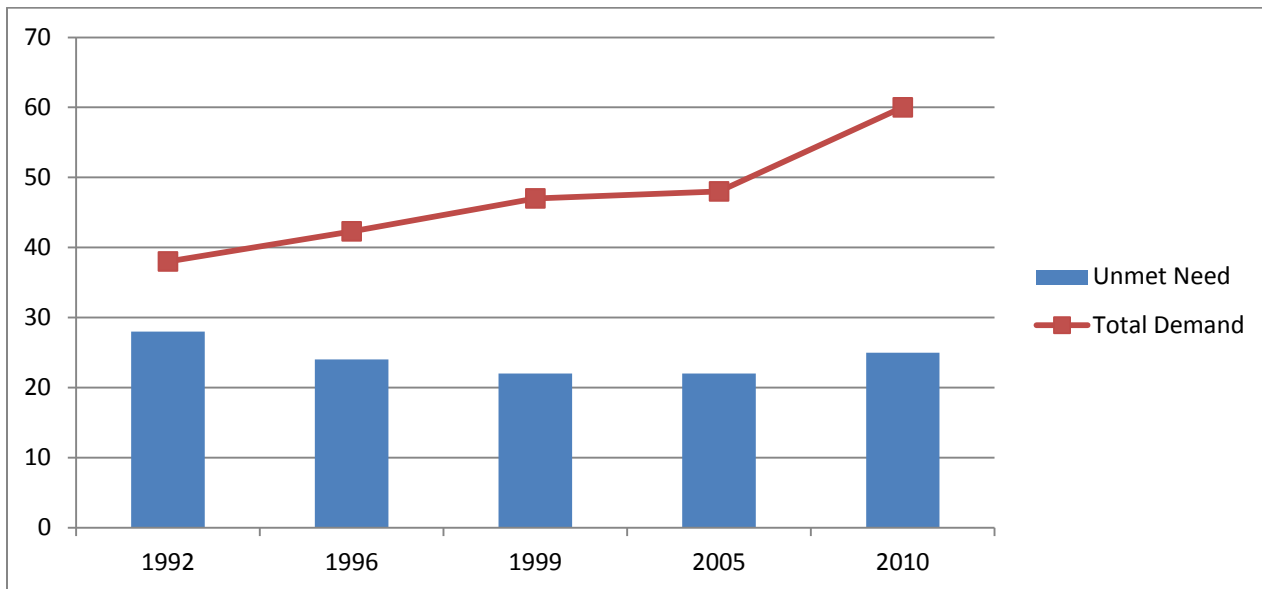
<sup>37</sup> 2013 – DHS data projections using Engenderhealth Reality Check tool (V)

<sup>38</sup> United Nations Statistics Division

<sup>39</sup> Met and unmet need for 1999-2010 are from respective years DHS

While most births in Tanzania are wanted at the time of pregnancy (74 percent), 22 percent are mistimed and 4 percent are unwanted (TDHS 2010). This explains the high total demand for family planning among currently married women which stands at 54 percent. This consistently high unmet need and demand can, to a large extent be attributed to constant commodity stock-outs experienced over years, and limited access to services due to shortage of skilled staff particularly in the lower level health facilities (health centers and dispensaries) where majority of women go for their family planning services. A dramatic increase in the use of long acting (IUD and Implants) and permanent methods (female and male sterilization) can change this scenario.

**Figure 15: Increasing Demand and constantly high unmet needs for family planning**



**Source:** Tanzania DHS and United Nations Statistics Division; 2012 updated for MDG database [www.unpopulation.org](http://www.unpopulation.org)

## SECTION 7.0: TOWARDS POPULATION STABILIZATION IN TANZANIA

Demographic transition occurs in four phases; of these the first three phases are characterized by population growth. In the first phase there is a fall in death rate and improvement in longevity; this leads to population growth. In the second phase there is a fall in birth rate but the fall is less steep than the fall in death rates and consequently there is population growth. In the third phase death rates plateau and the population growth continues because of the large size of population in reproductive age group. The fourth phase is characterized by fall in birth rate to below replacement level and reduction in the proportion of the population in reproductive age group; as a result of these changes population growth ceases and population stabilizes. From this analysis, Tanzania's case may fall under phase two or three and more work needs to be done to attain fertility stabilization.

The government of Tanzania has realized the value of investing in family planning as a means of reducing the high maternal mortality (MDG 5) and its fertility rate. Tanzania has a strong political will and commitment. In his speech at the launch of the accelerated One Plan on 28 April 2014, President Dr. Jakaya Mrisho Kikwete, said that "delay in taking the right decision at home, delay in reaching the health facility and delay in receiving care at the facility account for many women losing their lives". During the London Summit in July 2012, the President also said that "My government is committed to doubling family planning users from the current 2.1 to 4.2 million towards achieving the national contraceptive prevalence rate target of 60 percent by 2015". This is strong evidence that there exists a strong political will at the national level for family planning upon which implementers should build to improve family planning uptake in the country.

The existing unmet need for contraception justifies making family planning services as the most priority focus in reproductive health programs and future population policies in Tanzania. Policies should aim at, first, expanding access to safe, effective and affordable contraceptive services; second, improving reproductive health; and third, implementing social and economic measures that would generate further demand for fertility regulation. If family planning is revitalized and all births are planned and desired, the total fertility rate in Tanzania would reach replacement level or below replacement level within the coming 25 years. This can be achieved by:

### 7.1 Expanding family planning services

Developing countries that have established strong family planning programs and have successfully slowed rapid population growth have fared much better economically than countries that have neglected the population issue. The Asian economic "tigers" — South Korea, Thailand, Malaysia and Taiwan — had a history of supporting family planning and achieved an average of about 2 children per family in approximately 30 years. This benefitted the health of their people both by fostering economic development and establishing a healthy pattern of reproduction.<sup>40</sup>

In 1994, demographer John Bongaarts disaggregated the sources of future population growth in developing countries into 3 categories: 49 percent will come from momentum caused by the population's young age structure (the result of previous high fertility), 33 percent will come from unwanted fertility (i.e., births to those who wish to stop child-bearing but who are not using contraception), and only 18 percent will come from high desired family size. Meeting the family planning needs of the 25 percent of women in reproductive age in Tanzania who lack access to adequate information and services would drastically lower the TFR from the current 5.4 and move the country towards population stabilization.

Opportunities exist in Tanzania to build onto the strong political will to improve program performance by expanding access, improving quality of care, creating awareness of benefits of newer generation of methods, through communication support and making special efforts in low performing areas. These are briefly discussed below.

#### 7.1.1 Family Planning Method specific actions

Expanded availability and choice of safe, effective, acceptable and affordable contraceptive methods within the broader principle of informed choice, giving special emphasis on more effective methods is crucial. The ICPD recommended policies that ensure: "...*informed choices and making available a full range of **safe and effective methods***" (UN 1995). For many years in Tanzania preference has been skewed toward injectables and pills. Over the past decades, UMATI, EngenderHealth, Marie Stopes Tanzania, and more recently PSI have supported revitalization of LARPM, and available data shows that if *programs for LARPM are given renewed priority this would improve the effectiveness of the method mix,*" resulting in higher CPR and consequently lower TFR. It is important to also note that wide availability of **effective** methods through the public and private sector, as part of the government's public private partnership (PPP) approach is required to achieve high levels of broader and effective method mix and increased access to family planning services. Method-specific strategies are therefore recommended to reach an effective and desirable method mix for the country. To achieve this, family planning programs should endeavor to do the following:

##### i) **Bring family planning to the door steps**

Providing effective family planning services which address the needs of the community is essential. Therefore, service delivery strategies need to be tailored to reach populations in different locations, such as urban slums, rural towns, villages and hard to reach areas. The most common **family planning service delivery** approaches in

<sup>40</sup> [Htt://www.cmaj.ca/content/163/5/551.short#re-48,49,50](http://www.cmaj.ca/content/163/5/551.short#re-48,49,50)

Tanzania are static health facilities, social marketing, community-based distribution, pharmacies, ADDOs, and workplace distribution.

In the 1980s, Tanzania had a robust community based distribution program and records show that the CPR increased during this period. In countries where strong community-based family planning has been used, for example Ethiopia, Bangladesh and India, CPR increased and fertility reduced within a decade. In Ethiopia, **A door-to-door service** providing family planning packages at household level is carried out by Community Health Care Workers (Health Extension Practitioners) who provide family planning education, counselling and the provision of contraceptive methods, such as oral pills, condoms and injectables. This approach has been known to be cost-effective and reach majority of people in their homes.

Injectable is the most preferred family planning method in Tanzania. There has been an increase in injectable use rate, from 9.7 percent in 2004/05 to 11.2 percent in 2010, irregular supplies and major stock-outs notwithstanding. The TDHS 2010 data on intended future use shows 54.4 percent of non-users expressing interest to use family planning in future – of which 21.2 percent indicate their preference for injectables. This unmet need can be addressed if the country includes injectables in the community-based family planning package.

Furthermore, comparison of Tanzania's CPR and method mix with other countries in the region that have higher CPR shows that most of the higher CPR in other countries is attributable to provision of injectables by community-based workers. Studies in Uganda, Malawi and Ethiopia, also indicate that community-based health workers (CBDs) after training are able to provide injectables with low failure rates. Recently developed Depo-SubQ Provera (DepoSQ), which has been specially reformulated for administration by subcutaneous route, can be provided by community based workers (*Landey and Richey 2009*).

#### ii) Revitalize use of IUDs:

Modern IUDs, such as copper T 380A and hormonal IUDs, are significantly more effective and safer as compared to the older generations. "Misperceptions about safety of the IUD and inadequate trained service providers help explain low rates of use in Tanzania"<sup>41</sup>. Misperception about IUDs originated from earlier generations of IUDs in the 1960s and 1970s. The new IUDs are almost as effective as sterilization with an added advantage of being reversible. WHO-sponsored multi-centered studies found a failure rate of copper T 380A at 0.4 percent, which is comparable to that of sterilization (UNDP et al. 1997). In Tanzania, IUDs are underutilized and, if appropriate capacity building and promotional actions are taken, IUDs can play a major role in attaining replacement fertility. IUDs would likely be more acceptable if only facts are known widely. Notably, recent changes to *WHO guidelines now allow women with STIs other than gonorrhoea, Chlamydia or purulent cervicitis to have IUDs inserted* (WHO 2004). Minor RTIs such as bacterial vaginosis, trichomoniasis, moniliasis and non-specific cervicitis do not constitute a contraindication for IUD insertion.

To popularize IUDs it is essential to (a) implement well-designed, innovative strategies to communicate above facts and to create a new image of IUDs; (b) strengthen counselling efforts to dispel doubts and remove misperceptions about IUDs; (c) improve quality of clinical services, especially that for aseptic precaution, proper screening for contraindications and use of correct insertion techniques; (d) revise clinical indication to IUD use in conformity with recent WHO's eligibility criteria and, thereby, (e) create a cadre of satisfied users to act as peers to inform others.

<sup>41</sup> IUCD underutilized potential,



### iii) Expand sterilization services:

In recent years, acceptance of female sterilization has been on the rise in most regions of Tanzania. A positive note is that there is a rise in male sterilization - no-scalpel vasectomy (NSV), as well, although the numbers remain low. In view of high unmet need, especially for limiters (6 percent – TDHS 2010), easy access to quality services should increase acceptance of sterilization further. A key challenge to expanding use of sterilization is that of shortage of trained and trainable service providers: the current government policy only allows doctors (MDs and AMOs) to perform surgical services under which Minilaparotomy under local anesthesia is categorized.

Wider involvement of doctors, in both private and public sector, in sterilization services is also necessary if population stabilization is to be achieved. Due to other competing priorities for doctors' time, provision of surgical family planning during outreach and family planning service days, approaches introduced by EngenderHealth, should be scaled up and institutionalized by all districts. Doctors from public health facilities should be encouraged to provide family planning services during their spare time, weekends and holidays when they are not at work and extra duty allowance paid in accordance with the government policy.

### iv) Task Shifting:

Task-shifting, otherwise known as task sharing, to less specialized service providers, is not a new idea. Task-shifting initiatives have been undertaken in Bangladesh, Malawi, Mozambique, Kenya, Uganda, Ethiopia and Thailand, with nurses and clinical officers in these countries (after receiving extra training in surgery) providing specialized family planning services with rates of success similar to those of their higher level counterparts. This suggests that in the Tanzanian context, Clinical Officers can perform ML/LA with rates of success similar to those of doctors and Assistant Medical Officers (AMOs)<sup>42</sup>.

Findings from the task sharing research, conducted by Marie Stopes International (MSI), in Uganda<sup>43</sup> suggests that clinical officers, if trained, perform Minilaparotomy just as well as doctors. The overall major complication in this study showed a rate of 1.5%: at days three and seven, of training, major complication rates were 1.9% and 0.2%, respectively. At day 45, there were no major complications.

In Tanzania, COs comprise more than 70% of the providers capable of performing minor surgeries, yet they have no training to provide permanent contraception to women (i.e., through minilaparotomy). Preliminary findings of task sharing studies conducted by EngenderHealth 2010, further indicate that, Task-shifting minilaparotomy services to Clinic Officers, if approved in Tanzania, would increase access, address unmet need, and help approximately 44,000 women aged 30-49 with need for limiting choose female sterilization annually by 2015<sup>44</sup> — a 143% increase over 2005 uptake. Based on these findings, it is imperative that the MOHSW expedite policy change to enable Clinical Officers to provide female sterilization and conduct in-service training for those Clinical Officers working in hospitals and health centers, if the targeted CPR of 60 percent is to be realized by 2015.

As part of task shifting, there is also need to *promote effective use of injectable by de-medicalizing injectable provision*. Consideration for policy change to allow trained community-based family planning providers (CBFPWs) to administer injectables should seriously be considered. This would drastically ease the large client load at facility level and high discontinuation rates due to long waiting time. Comparison of Tanzania's CPR and method mix with other countries in the region that have higher CPR shows that most of the higher CPR in other countries is attributable to provision of injectables by community-based workers, reinforcing the importance of

<sup>42</sup> Fenton, Whitty, & Reynolds, 2003; Kruk et al., 2007; Cumbi et al., 2007; Satyapan et al., 1983; and Ghorbani, 1979) and EngenderHealth feasibility study and technical brief done in 2009-10.

<sup>43</sup> *Task sharing: Safety and acceptability of tubal ligation provision by trained clinical officers in rural Uganda - Research brief series 2013 / 007*

<sup>44</sup>



considering a policy change. Recently developed Depo-SubQ Provera (DepoSQ), which has been specially reformulated for administration by subcutaneous route, can be provided by community based workers (*Landey and Richey 2009*). Studies in Uganda, Malawi and Ethiopia, also indicate that community-based health workers (CBDs) after training are able to provide injectables with low failure rates. The challenge with this new technology now is also cost, as it is more expensive than current injectables.

Ifakara Health Institute in Tanzania is piloting a cadre of community health workers called “Community Health Agents” (CHAs). CHAs are trained for nine months on an integrated package for maternal neonatal and child health (MNCH) services at household and community level. CHAs visit all households for health problem identification, health promotion, case management for common under five illnesses, distributing condoms and family planning pills and refer clients to health facilities. This cadre, if trained, could comfortably administer injectables.

**v) Expand access to emergency contraception:**

Use of emergency contraceptives (ECs) after unprotected sexual exposure can prevent unwanted pregnancy. However, since ECs must be used within 3-5 days after an unprotected sexual exposure, without prior knowledge of the method, the likelihood of use may be very low. 2010 TDHS shows that knowledge on emergency contraception is higher among women aged 19 – 25 and much lower in higher age groups. To promote use, information on ECs must be widely disseminated, including on availability, sources for supplies and use instructions. Family planning service providers training should include how standard dose oral pills can be used as ECs. Another possible option to widen access to EC would be to strengthen service provision of the pill through social marketing channels.

**7.1.2 Focus on the basics**

*i) Skills training of service providers*

Prior to 1990, a great deal of family planning “training” had been going on in Tanzania, but very little was competency-based. Further, providers who received training in methods such as IUD insertion would go back to their health facilities without insertion equipment (IUD kits), expendable supplies, or even IUDs. There was no national strategy, nor were there guidelines or standards for service provision. From 1991, USAID worked closely with UNFPA and the MOHSW to develop a more rational system of clinic-based family planning training. The MOHSW has since developed several training guidelines including on the-job-training and with support from other partners such as EngenderHealth, Marie Stopes Tanzania, PSI, and Pathfinder International, Trainers of Trainers (TOTs) have been trained and in-turn cascaded the in-service training down to over 9,094 service providers in LARPM (*ACQUIRE Tanzania Project 2013*). The government and other stakeholders should intensify skills training, particularly using the on-the-job (OJT) approach to ensure continuous skills improvement of service providers at all levels.

It is also critical to make competency-based skills training a requirement in all pre-service training curricula as appropriate for the cadre. This will reduce the need for more costly in-service training, which, when conducted off-site, also removes providers from their duty posts for two weeks or more per training.

*ii) Expanding access—Community programs and social marketing*

Tanzania has a long history of community involvement in development, both in traditional tribal structures and later from the “*Uhuru*”<sup>45</sup> movement during the socialism years. German aid, the Seventh Day Adventists, the Evangelical Lutheran Church in Tanzania, UMATI, Marie Stopes Tanzania, Pathfinder International and many other NGOs and FBOs are recognized as having had community-based health workers involved in family

<sup>45</sup> “Uhuru” is Kiswahili word meaning independence

planning in the 1980s and early 1990s. The MOHSW wisely decided to build on this history and experience, and in 1993 launched the MOH National CBD Program in four regions (Dodoma, Tabora, Iringa, and Coast). It developed National CBD Guidelines and trained approximately 300 trainers and supervisors. With assistance from NGOs, FBOs, and donors, the government was able to scale up this program almost nationally by the end of the 1990s. This had a positive contribution to increased uptake of the pills and consequently to an increase in CPR in the 1990s.

Strengthening of community level services including community Outreach will increase access of family planning services, particularly, in hard to reach and rural areas, where family planning demand is highest. Importance of bringing services close to people is underscored by a finding in *Bangladesh* that couples were two and a half times less likely to use contraception if obtaining a method would require a travel time of 30 minutes or more from home (*Levin et al. 2000*). In the recent past, organizations such as Marie Stopes, EngenderHealth, Pathfinder International and PSI have developed and implemented community outreach programs in Tanzania with remarkable success. Priority attention is therefore needed to make the existing community –based programs function at an optimum level of their projected capacity. Donors and MOHSW should consider supporting the CBD program as part of the re-launch of the “Green Star”. Recruitment and training of a new generation of CBDs is crucial and besides bringing services nearer to the door-step, the CBDs are likely to increase public sector involvement in contraceptive services. These approaches should be reinforced and scaled up to reach all communities in the country particularly the rural areas. In countries such as Bangladesh and Ethiopia, where the door-to-door approach was introduced and used by community health workers, CPR increased and lower fertility attained. Donors should be encouraged to support these approaches, especially the community-based family planning program (commonly known as ‘CBD’).

Additionally, USAID has supported the social marketing of products in Tanzania since 1993. The social marketing program made great strides in increasing the awareness and utilization of reproductive health and HIV/AIDS prevention products, particularly the condom. The name of the socially marketed brand, *Salama* (Safe), has become the generic word for condom in Tanzania, and since 2000, revenue from *Salama* sales has underwritten the cost of condom procurement. The female condom, *Care*, was launched in 1998, and the oral contraceptive, *SafePlan*, was introduced in 2001. Brand promotion has been primarily through mass media (television and radio spots), with rural outreach consisting of road shows and mobile video units. Continuation of this strategy will sustain the high user rates for oral contraceptives and condoms.

**iii) Ensure availability of commodity supplies:**

Tanzania is heavily dependent on donors to fund procurement of FP commodities and in providing technical support in forecasting and quantification. Funding for contraceptive commodities varies from year to year and affects stock levels of numerous methods of contraception. Currently, JSI/DELIVER Project with funding from USAID has supported Medical Stores Department and MOHSW to forecast contraceptive needs annually. This includes the total funding needed for the full amount of each commodity. Commodity procurement responsibility for methods is divided among development partners and MOHSW, however if inadequate budget amounts are committed by either party, delays in procurement occur. Although government contributions to the family planning commodity budget have been limited and unsteady, this is gradually improving. However, donors and partners will still need to purchase the bulk share of family planning commodities for years to come as they work with the government to increase its budget allocation for family planning commodities.

The high method discontinuation is known to be at least partly due to inadequate or irregular supplies and temporary stock-outs. To ensure regular supplies at all service points and to avoid small pockets of temporary unavailability, it may be useful to establish a reproductive health commodity supply (RHCS) monitoring cell under the logistics system that will keep a watch on stock levels at peripheral points.

Current efforts should be directed at strengthening the local capacity in the Integrated Logistics System (ILS) and ILS Gateway to ensure that adequate skilled personnel including service providers are available at regional and district level, and at the Medical Stores Department (MSD). This would improve timely supply, access of FP commodities and product expiration. In this respect, sustained advocacy is needed to ensure adequate availability of FP commodities in the country to meet the unmet need.

**iv) Increase Funding for family planning to ensure sustainability**

Since the 1960s, alongside efforts to increase educational opportunity and improve health conditions, the main policy response to concern about rapid population growth has been the implementation of voluntary family planning programs<sup>46</sup>. Studies show that the choice of voluntary family planning programs as the principal policy instrument to reduce fertility has been based largely on the documentation of a substantial level of unwanted childbearing and an unsatisfied demand for contraception.<sup>47</sup> However, family planning programs provide a win-win solution: the welfare of individual women and children is improved, and the national economy and environment benefit. The international consensus on this issue is reflected in the Millennium Development Goals, specifically in Target 5.b.—to provide universal access to reproductive health by 2015 and to reduce the unmet need for family planning (*Guttmacher*).<sup>48</sup> Despite this long-standing and widely accepted rationale for voluntary family planning programs, global funding for these programs declined in the mid-1990s<sup>49</sup>. Unfortunately, Tanzania which depends heavily on donor funds for its family planning programs was among those countries affected. A number of reasons have been cited, including donor fatigue; persistent opposition from conservative governments and institutions (in particular the Bush administration and the Vatican); and the need for resources to address other pressing problems, such as the AIDS epidemic.

Due to limitation and inadequate funds, Tanzania continues to face erratic supply of contraceptive commodities that results into frequent stock outs and inadequate method mix at service delivery points. The government's 'own' budgeted funding for FP increased from Tsh.0.5 billion in 2010-11 to Tsh.1.2 billion in 2011-12. The government has also included a specific FP target (CPR growth) in the Medium Term Expenditure Framework. At the council level, revision of the comprehensive council health plan (CCHP) guidelines to include family planning has also increased resource allocation. However, this funding is far from meeting the high demand for family planning and considering that budgeted funds more often differ from funds disbursed. Radical fundraising efforts for family planning commodities such as reaching out to multinational companies including pharmaceuticals, communication companies, banks, breweries, etc., should be considered by the MOHSW in collaboration with other stakeholders. Such funding would supplement current government's funding.

**v) Strengthening of private service outlets**

In Tanzania approximately 40% of all registered health facilities are owned by private-for-profit organizations and FBOs. The current RCHS policy dictates that RCH services, family planning inclusive, should be provided free of charge. As a result very few private facilities provide family planning services. Some FBO facilities that benefit from public sector support, particularly those under Catholic control do not provide family planning services on the basis of their religious beliefs. In view of the overstretched public facilities and the growing potential of private facilities for contraceptive services, calls are needed for strategic efforts to strengthen the involvement of the private sector in the provision of integrated RCH/family planning services. This will however require building of technical capacity of these facilities and ensuring that they have access to commodities. If

<sup>46</sup> <http://www.guttmacher.org/pubs/journals/3503909.html>

<sup>47</sup> <http://www.guttmacher.org/pubs/journals/3503909.html>

<sup>48</sup> <http://www.guttmacher.org/pubs/journals/3503909.html>

<sup>49</sup> <http://www.guttmacher.org/pubs/journals/3503909.html>

some FBO facilities will not offer FP services, then convenient referral linkages need to be put in place to meet clients' needs for FP services.

New acceptors are especially vulnerable to insufficient information and misinformation, and therefore remain unprepared to deal with side effects. For this purpose, provision should be made for better, updated information and advice on use instruction in case of methods. These efforts should be in conformity and coordinated with the national technical support system. Adequate provision is needed for instructional materials and technical manuals to the private sector including pharmacies and retailers. Pharmacist training curricula in the universities should be reviewed and updated to include newer generation contraceptives and new scientific evidences influencing user instructions. Such policy updates should be undertaken periodically on regular basis and as warranted by new developments. Supervision by the relevant arm of the government should be undertaken to ensure quality services are provided and data is collected and submitted timely to the Ministry Of Health and Social Welfare (MOHSW).

**vi) Improving quality of care**

Improvement of quality of care is essential to reduce method discontinuation and frequent switching of methods, thereby, promoting effective use. Improvement of quality of care remains a major priority if further gains in contraceptive prevalence are to be achieved. Two strategies are important. First, improved provider skills in counselling can effectively address issues such as appropriate choice of methods, knowledge to deal with side effects and encourage continuity, and facilitate referrals as when necessary. Secondly, improved technical skills, especially for aseptic precaution, screening for contraindication and clinical procedures can reduce side effects and complications and, thereby, promote acceptor satisfaction, method continuation and effectiveness. Given the method mix trend, efforts should focus on "raising the awareness and availability of under-utilized methods, overcoming provider biases for and against certain methods, and strengthening provider's counselling skills" (UNFPA/PATH 2008). An often neglected aspect of quality of care is provision of unbiased information including expected side effects and possible complications. Effective implementation of quality of care strategies necessitates that institutions are part of a technically competent support system that can monitor clinical procedures, aseptic precautions, counselling practices, follow-up arrangements, and availability of equipment and supplies on a regular basis.

**vii) Address FP access problems through research:**

Contraceptive use has been identified as one of the primary factors contributing to fertility decline; however, the link between contraception use and fertility is weak and less understood. For example, despite a large increase in the contraceptive prevalence rate (CPR) in Tanzania since the early 1990s, total fertility rate (TFR) has remained high. There has been little research on the impact of method mix in this relationship. An understanding of the dynamics of the relationship between contraceptive use, method mix and fertility would provide important evidence to advocate and plan for future scale-up of and investment in family planning programs.

Besides actions proposed above, scientific efforts, including operations research on quality of care and acceptability, studies are needed to identify method-specific issues and problems. Clinical studies are needed to define the incidence and pattern of contraindications and gaps in clinical practices and technical competence. For example, a useful study can be undertaken by using interdisciplinary approach in methodology to define current practices in clinical procedures in IUD insertion, which would greatly contribute to improved increased method use. Studies to access the possible task sharing such as Clinical Officers performing sterilization and community health workers/community based distributors (CHW/CBDs) administering injectables should continue.

## **7.2 Integrating Gender in health related services**

Reproductive health matters have traditionally been the domain of women, although various mass media and community level programs are now in place to encourage men to participate in reproductive health. Women are also encouraged to take leading roles in matters related to their health status. Surveys show that there is positive correlation between involvement of men in decision making and desired family size. Women who are involved in decisions at household level prefer an average of 5.1 children whereas those not involved in decision at all prefer an average of 5.6, which is above the national fertility rate (DHS 2010). The government is committed to involving men in reproductive health services and improving gender equity and equality and these efforts should be strengthened.

## **7.3 Delayed start of child bearing**

Tanzania's population is a bottom-based pyramid with many children at the bottom, and the youth population (15-24) constituting 20% of total population (*URT 2012*). Of the young women aged 15-19 reported to have already started child bearing, 17% are mothers and 6 % are pregnant with their first child. Postponement of child bearing would be an option to decrease TFR. The country should strengthen youth programs on family planning. There is need for MOHSW to work with other ministries such as Education and Gender and Children Affairs to ensure compulsory secondary education that would promote postponement of early child bearing.

Advocating for youth friendly services is an area whereby various decision makers can be engaged to ensure that investments are made in establishing and sustaining these services for young people aged 15-24, some of whom have already begun child-bearing. Young people are the most marginalized, and arguably a very important group with regard to access to sexual and reproductive health services. Family planning unmet need among 15-19 year olds is 16% and among 19-24 year olds is 24%, which means the total unmet need for youth 15-24 is approximately 40% - according to the National Adolescent Reproductive Health Strategy (2008) and DHS 2010. Targeting adolescent and young people would greatly increase the number of users and contribute to the attainment of some of the national set targets by 2015. Evidence shows that targeting higher learning institutions with youth friendly services has been met with high acceptance of family planning (*EngenderHealth/UMATI 2012*) and should be scaled up.

Technology is attractive to youth. The growing use of mobile phones and text messaging in Tanzania provides innovative opportunities to use this technology to improve family planning services. Pilot initiatives to use this technology to improve family planning were presented during the recent family planning conference in Dar es Salaam. These included: (i) using mobile technology to improve the availability and use of family planning data in the Manyara region; (ii) the promise of mobile technology to transform community-based family planning services in low-resource settings; (iii) the use of mobile phones to provide real-time stock status of commodities for family planning; and (iv) using short message service (SMS) systems to deliver information on family planning methods and tips on pregnancy and newborn care. These innovations should go beyond information into distribution and be scaled up specifically to reach both urban and rural youth.

## **7.4 Regional Parity:**

During the launch of the National Family Planning Costed Implementation Plan (NFPCIP) in 2010, the MOHSW/RCHS emphasized the need to prioritize seven regions, where family planning uptake remains very low while TFR and maternal mortality are unacceptably high. These regions include Mwanza, Mara, Kigoma, Shinyanga, Tabora, Simiyu and Geita. The Lake and Western regions are in a zone where public and leadership perceptions have not been favorable to family planning even though the situation is gradually changing based on a number of partner activities, as well as voices of those who have seen the benefits of family planning. Low participation of and resistance by men to accept and utilize FP services has been noted as among the limiting factors. It is imperative that interventions target regional and district leaders of these regions in line with the country's FP2020 strategy. It is anticipated that intensification of programmatic efforts in these regions would



increase access to family planning services, especially to the underserved young people and women in rural areas.

### **7.5 Provision of integrated FP Services:**

There is great potential for success for instance by targeting post-partum women whose contraceptive demand is up to 74%. Other groups of sexually active young people, those needing post-abortion care, or women who need cancer screening justify the need for targeted and tailor-made interventions for these groups. The MoHSW supports integration of services and has recently released the National Operational Guidelines for Integration of Maternal, Newborn, Child Health, and HIV/AIDS Services in Tanzania (2013) to facilitate scaling-up of these services. Integrating family planning in other health services will increase access and uptake of modern contraception methods.

## **SECTION 8.0: Conclusion**

As noted earlier, even after fertility declines to replacement level, the population in Tanzania will continue to grow due to effects of “population momentum” – which is an inevitable consequence of the very large young age group below 25 years of age. On a longer term perspective, it is critically important for the government to seek policy options that would minimize the impact of population. From the accumulated evidence, we conclude that the stabilization of Tanzania’s population would contribute significantly to the nation’s ability to solve its problems. It is evident that moving toward stabilization would provide an opportunity to devote resources to problems and needs relating to the quality of life rather than its quantity.

It is also important for the government of Tanzania to recognize that the demographic implications of most of recommended policies concerning childbearing must be consistent with a goal of population stabilization. In this sense, achievement of population stabilization would be primarily the result of measures aimed at creating conditions in which individuals, regardless of sex, age, and cultural beliefs must be sensitized to demographic effects. Why does this matter? Women and children continue to suffer and die as a consequence of unwanted and unintended childbearing. Beyond that are renewed concerns about a variety of environmental issues and about the security and stability of the nation, as well as worries about food security and pervasive poverty. High fertility and rapid population growth remain real problems that merit the attention of every Tanzanian.

This also underscores the importance of policy actions to raise the legal age of female marriage and delay child bearing by ensuring all girls are enrolled and retained in school for a longer period. Some moderate changes in patterns of marriage and childbearing are necessary for any move toward stabilization. It is for the government to put in place clear policies on school dropouts due to pregnancy and ensure teenage pregnant girls complete their schooling after delivery. It is necessary to designate a focal point to carry these policy intents forward and, because of multi-disciplinary nature of possible activities, such policy options may be best addressed under an inter-ministerial consortium or under the office of the President or the Prime Minister’s Office.

Tanzania’s population policy is determined to accelerate the use of family planning in the country as a means to stabilize its population growth. However, its high population growth (2.7%) can be regarded as a constraint to growth and economic development, considering the current pyramid population structure. The very large proportion of young people under the age of 24 constitutes a threat to social stability because of the constraints it places on unemployment, education, health and other social welfare amenities. Theoretically speaking, the future impact of population momentum can be minimized if fertility could be reduced more sharply to below replacement level, which should not be rejected as an unlikely prospect if recent trends in program performance can further be stimulated and effective policies on political, cultural and legal fronts are adopted. Based upon recent improvement trends in socio-economic development, continued national political will and family planning program performance over the past decades, we can be cautiously optimistic that Tanzania can achieve replacement fertility within 20- 25 years.

**REFERENCES**

1. Abel, Ed (1999). *RAPID: Computer Programs for Examining the Socioeconomic Impacts of Population Growth (Version 4)*. Washington: The Futures Group International, POLICY Project. ([www.policyproject.com](http://www.policyproject.com).)
2. Corinne Dietiker, Cristin Gordon-Maclean, Lois K. Nantayi, Heidi Quinn, Thoai D. Ngoii. Task sharing: Safety and acceptability of tubal ligation provision by trained clinical officers in rural Uganda, Research brief series 2013 / 007
3. East Africa Community (EAC) 2012, *East African Community Facts and Figures*. Arusha Tanzania
4. EngenderHealth Tanzania. The ACQUIRE Tanzania project, Final Report 2013
5. EngenderHealth. Family Planning Partners Annual Outreach Reports (Engenderhealth, MST, PSI) for the Semi-Annual FP Implementing Partners meetings.
6. EngenderHealth. *Increasing access to family planning: The Case for Task-Shifting Female Surgical Contraceptive Services*, ATP Brief No. 1 / May 2010
7. Melisa Thaxton (2007), *Integrating Population, Health and Environment in Tanzania*. Population reference bureau 1875, Connecticut Ave, NW Suite 520, Washington, DC 20009 USA
8. Ministry of Health and Social Welfare (1990). *National Health Policy*.
9. Ministry of Health (2003). *National Health Policy*.
10. Ministry of Health (1992). *The Food and Nutrition Policy for Tanzania*.
11. Ministry of Health and Social Welfare: National Family Planning Costed Implementation Program (2010-2015).
12. National Bureau of Statistics (Tanzania). *2002 National Population and Housing Census*. <http://www.tanzania.go.tz/census/>.
13. National Bureau of Statistics (Tanzania) and Macro International Inc. (2000). *Tanzania Reproductive and Child Health Survey, 1999*. Calverton, Maryland: National Bureau of Statistics and Macro International Inc.
14. National Bureau of Statistics and Ministry of Labour, Youth Development and Sports (2003). *Integrated Labour Force Survey, 2000/01 – Analytical Report*.
15. National Bureau of Statistics (Tanzania) and ORC Macro (2005). *Tanzania Demographic and Health Survey, 2004–05*. Dar es Salaam, Tanzania: National Bureau of Statistics and ORC Macro.
16. National Bureau of Statistics (Tanzania). *Tanzania Demographic and Health Survey, 2010*. Dar es Salaam
17. The Planning Commission (1992). *National Population Policy*.

18. President's Office, The Planning Commission (1999). The Tanzania Development Vision 2025. President's Office – Planning and Privatization (2005).
19. The Economic Survey, 2004. President's Office – Planning and Privatization (2005). *Macroeconomic Policy Framework for the Plan/ Budget, 2005/06–2007/08*.
20. Shah I. and E. Åhman. 2010. "Unsafe abortion in 2008: global and regional levels and trends." *Reproductive Health Matters* 18(36): 90-101.
21. UNICEF (2010), *Children and Women in Tanzania Volume 1. Mainland*
22. United Nations Population Fund (UNFPA) (2002). *State of World Population 2002. People, Poverty and Possibilities*. New York: United Nations Population Fund.
23. United Nations. 2010. *Millennium Development Goal Report 2010: Trends in Maternal Mortality: 1999-2008*. New York: United Nations.
24. United Nations Population Fund (UNFPA) (2004). *State of World Population 2004. The Cairo Consensus at Ten: Population, Reproductive Health and the Global Effort to End Poverty*. New York: United Nations Population Fund.
25. United Republic of Tanzania, *The National Road Map Strategic Plan to Accelerate Maternal, Newborn and Child Deaths in Tanzania, 2008 – 2015, Sharpened One Plan*, April 2014
26. United Republic of Tanzania, Population distribution by age, 2012 National census
27. United Republic of Tanzania. The Demographic and Health Survey (2010)
28. United Republic of Tanzania. *Population, Reproductive Health and Development. December 2006*
29. National Bureau of Statistics, Ministry of Finance, June, 2013. *Tanzania in Figures (2012)*, <http://www.nbs.go.tz>