UNCOVERING THE HIDDEN

The most in need, but missing Family Planning in Tanzania

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A: FAMILY PLANNING COUNTRY CONTEXT

Over the years, Tanzania has made tremendous efforts in increasing family planning uptake whereby contraceptive prevalence rates increased from 20% in 2004-05 to 27% in 2010 and 32% in 2015-164. Modern contraceptives play a significant role in achieving desired family size and optimal child spacing, reduces unwanted pregnancies and teenage pregnancies which is currently 27% nationally5, reducing Total Fertility Rate. TFR has declined over the past decade, from 5.7 children in the 2004-05 TDHS to the current TFR of 5.2 children in 2015-16. Studies shows that FP further plays a significant role in reducing Maternal Mortality Rate up to a one third6.

Access to health services is a human right that has yet to be realized in Tanzania. Like many other health services, family planning is everyone’s right for individuals who want to determine the number of children and space between them. According to the Tanzania Demographic and Health Survey 22% are not currently using family planning (unmet need), putting them at risk for unintended pregnancies. The 22% of unmet need for family planning affects more the poor, the rural based and people with disability.

B: THE HIDDEN GROUPS POOR, UNEDUCATED AND RURAL WOMEN

While good progress has been made for instance on TFR with an average of 5.2 nationally, Figure 1 below shows that TFR is highest among poorest quantile (7.5), those not educated (6.9) and rural (6). This data calls for community based and health facility-based programs to specifically target

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4 TDHS (2015/16)
5 Ibid
This trend is not only seen among all women, but also in teenage pregnancy exhibiting the similar trend. For example, national average for teenage pregnancy is 27% among 15-19 girls, translating to an estimate of 1.2million out of 4.5million 15-19 teenage female. Among uneducated girls of similar age bracket teenage pregnancy is 52%, compared to 10% educated cohort. Among poorest quantile teenager pregnancy is 42% compared to 13% among wealthiest quantile. According to National Costed Implementation Plan II, teenage pregnancy is 1.7 higher in rural areas than in urban areas.

Although there is no clear data in the health surveys on the need of FP services to people with disabilities, there is a possibility that people with disabilities (PWD) are facing similar challenges in accessing family planning services that needs to be addressed. PWD have unique needs of family planning but due to self-stigma, community stigma, often provider stigma, physical inaccessibility, they are likely to be denied family planning services. As shown in figure 2 western and lake zone has highest TFR.

**C: ARE HIDDEN GROUP PRIORITIZED?**

Based on two graphs above, we can conclude that women from rural areas, non-educated, poor and living in western or lake zones have less access to FP and therefore needs to be prioritized. The hidden groups have yet to be prioritized as shown in figure 2, the TFR in western zone, lake zone and eastern zone is higher than that of southern zone. Given the socioeconomic and geographic discrepancies in CPR and the documented limited availability of long-term contraceptive, there is need for concerted efforts to improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania and to generate demand for and improve access to a full range of FP services.\(^2\)

In reducing these disparities, segmentation of RMNCAH services per socio-economic factors will merit consideration. Strengthening community-based provision of FP services that can reach these groups that seems not to be reached by general interventions.

**D: POLICY RECOMMENDATIONS**

We have provided evidence that poorest, rural and uneducated girls and women are likely to miss family Planning services. This is likely to cause myriad of vicious misfortune to their children in accessing economic opportunities, education etc. This is likely to lead them to be dependent

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\(^1\) 2012 Tanzania’s Census
\(^2\) One Plan II (2016-2020)
and unable to contribute to national and personal development. We put forward policy and programmatic recommendations.

- Government to commit to Family planning client segmentation that identifies who is not being reached (as summarized above) and propose how best they can be reached.
- Government, donors and partners should ensure access to age-appropriate sexual and reproductive health information and services prioritizing girls from poorest families, rural and non-educated and with disability.
- The Government to initiate programmes of sign language trainings to medical staff to facilitate communications with PWD as they often require special program to conveniently access appropriate health services.

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