

# implementation story:



## “One Stop Shop” Mobile Family Planning Outreach and Service Integration in Southern Tanzania



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### ORGANIZATION

EngenderHealth Tanzania  
(USAID Boresha Afya Southern Zone)

### PARTNERS

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Deloitte Consulting Limited

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FHI 360

Management and Development for Health



### BACKGROUND AND CONTEXT

As HIV becomes a manageable chronic disease, meeting the family planning (FP) needs of women living with HIV is increasingly important (Rourke, Farley, & Atkinson, 2017). Particularly in a country such as Tanzania where the HIV prevalence is high—estimated at 6.3 percent (NBS, 2018) among women—evidence suggests that integrating FP in a variety of health care settings can increase access and uptake.

Following the Evidence for Contraceptive Options and HIV Outcomes Trial, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) issued guidance to ensure that young people have access to more contraceptive choices in all types of settings and that people accessing contraception receive integrated testing, prevention, and treatment for HIV and sexually transmitted infections (STIs) (WHO, 2020a). In a systematic review of behavior interventions to increase contraceptive services among women living with HIV, women receiving integrated FP services in the same setting were more likely to use non-condom contraception, had lower incidence of unintended pregnancies, and reported being less likely to have unprotected sex in the past two weeks compared with those who were referred to a facility for care (Rourke et al., 2017).



“I decided to use long-acting contraception after bearing many children at an early age. I chose a five-year implant to help me recover and stabilize my health. I wish I knew earlier; I would have spaced my children better and remain healthier.”

Tatu Michael, family planning client,  
Malinyi Morogoro  
Improve Health Program

Tanzania is committed to increasing its modern contraceptive prevalence rate (CPR) from 36 percent in 2019 to 40 percent among all women and 47 percent among married women by 2023 (FP2020 Tanzania, 2014; MOHCDEGC, 2019). From 2010 to 2015 the country's modern CPR improved from 27 percent to 32 percent. There is, however, notable variance among regions and unmet need for FP has remained high at 22 percent (MoHCDGEC, 2016).

Similar to other lower-income countries, Tanzania faces a shortage and inequitable distribution of human resources for health, resulting from a low absorptive capacity of new graduates to employment and lack of incentives to attract health care providers to rural areas (Barker & Dutta, 2015). Human resource shortages and financial constraints pose challenges to delivering care to women, especially those living in remote areas. Mobile outreach and service integration have been recognized for maximizing human resources for health, increasing staff retention, strengthening provider capacity, and bridging service gaps created by shortages (Dudley & Garner, 2011; de Roodenbeke, Lucas, Rouzaut, & Bana, 2011; Sonalkara, Modyb, & Gaffield, 2014; USAID, 2015b). Furthermore, care via mobile outreach and FP and immunization integration during the postpartum period (up to one year after childbirth) have been found to increase contraceptive uptake and improve birth spacing (Jarvis, Wickstrom, & Shannon, 2018; Ngo, Nuccio, Pereira, Footman, & Reiss, 2017; Sonalkara, et. al, 2014; USAID, 2015b).

Through the USAID Boresha Afya ("Improve Health") – Southern Zone five-year program, Deloitte Consulting Limited leads a comprehensive health delivery program in six regions in southern Tanzania, with its technical partners FHI 360, EngenderHealth, and Management and Development for Health. The project works to control the HIV epidemic and integrate FP; tuberculosis (TB); maternal, newborn, and child health; malaria; and nutrition services through innovative approaches at all levels and opportunities.

The regions covered in the program have CPRs similar to or higher than the national average of 32 percent, ranging from 32 percent in Iringa Region to 52 percent in Lindi Region (MoHCDGEC, 2016). Despite a high CPR, these regions have a limited FP method mix dominated by short-term methods, and frequent commodity stock out (MOHCDEGC, 2019). In addition, these regions have the highest HIV prevalence—Iringa and Njombe regions have an HIV prevalence higher than the national average of 4.9 percent at 11.3 percent and 11.4 percent, respectively (NBS, 2018).

## THE HIGH IMPACT PRACTICE

"Initially we could only support one provider for immunization outreach; it was impossible to offer integrated services. She would offer vaccination and those in need of family planning would be referred, but as you know, rarely would women complete those [referrals]." —Hadija Omar, district immunization and vaccination officer, Morogoro Municipal

Through the USAID Boresha Afya – Southern Zone program, the [Mobile Outreach Services](#) high impact practice (HIP) (USAID, 2015b) was integrated into three existing outreach programs in the Morogoro, Iringa, Njombe, Mtwara, and Lindi regions of Tanzania: (1) HIV and TB screening days, (2) immunization days, and (3) HIV antiretroviral refill days. The aim was to increase FP access, strengthen FP commodity management, expand the method mix (to include long-acting reversible contraception [LARCs] and bilateral tubal ligation), expand FP uptake, and increase TB notification and HIV identification.



Provider Coaching peers on Counselling for Informed choice at Likombe Health Centre, Mtwara

As part of HIV and TB screening days, FP mobile outreach was integrated at select sites based on the availability of trained providers, their capacity to routinely provide a wide range of FP care, and the catchment population size served by the facility. Integrated care was offered five days per quarter in 35 councils of the supported regions, including all FP methods. HIV and TB screening, testing, and referrals were also provided to FP clients.

Immunization outreach programs integrated FP days into some of the catchment areas previously identified for immunization services. Every month, two providers from five facilities in each council offered integrated FP immunization outreach. Due to regulations limiting the provision of intrauterine contraceptive devices and bilateral tubal ligation at the community level, clients who opted for these methods were referred to a facility.

At HIV care and treatment clinics that offered high-volume HIV antiretroviral refills, additional support staff were integrated for FP days. The additional human resources ensured that women who requested contraception could receive it at the same visit, except for bilateral tubal ligation, which was offered only through facility referrals.

All outreach days were coordinated by the local government and implemented by public health facility staff. Whenever available, community health workers (CHWs) conducted home visits to inform community members about the upcoming outreach days, and public service announcements were issued several days in advance. Before community-based immunization days, village leaders were involved to secure outreach sites and to display posters at their offices showing the immunization outreach schedule. Implementation details of these outreach days are presented in the following table.



“INITIALLY WE COULD ONLY SUPPORT ONE PROVIDER FOR IMMUNIZATION OUTREACH; IT WAS IMPOSSIBLE TO OFFER INTEGRATED SERVICES. SHE WOULD OFFER VACCINATION AND THOSE IN NEED OF FAMILY PLANNING WOULD BE REFERRED, BUT AS YOU KNOW, RARELY WOULD WOMEN COMPLETE THOSE [REFERRALS].”

Hadija Omar, district immunization and vaccination officer, Morogoro Municipal

**Table. Details of Outreach Implementation**

|                                     | OUTREACH TYPE   |   |   |
|-------------------------------------|---|---|---|
|                                     | FP, HIV, AND TB OUTREACH  | FP AND IMMUNIZATION OUTREACH  | FP AND HIV ANTIRETROVIRAL REFILL OUTREACH                                     |
| <b>Entry point service</b>          | FP care   | Immunization services   | HIV antiretroviral refills  |
| <b>Where services are provided</b>  | Facility  | Community   | HIV care and treatment sites  |
| <b>Targeted clients</b>             | All women and men of reproductive age   | Postpartum women  | Women and adolescents living with HIV   |
| <b>FP method provided</b>           | All methods including LARCs/PM  | Short-acting methods and implants. Escorted referral to nearby facility for intrauterine contraceptive devices; planned referral for bilateral tubal ligation | Short-acting methods and LARCS; planned referral for bilateral tubal ligation |
| <b>Integrated services</b>          | HIV screening, testing, and linkages; TB screening  | Immunization services   | Cervical cancer screening   |
| <b>Team formation</b>               | Five team members, including a surgeon and their assistant, two health care providers (HCPs) and one HCP managing client flow, commodities, and sterilization | Team of two to three HCPs—one for immunization and one for FP; and one CHW for client mobilization  | One or two HCPs for FP and cervical cancer screening                          |
| <b>Frequency</b>                    | Quarterly   | Monthly   | Monthly   |
| <b>Client mobilization strategy</b> | Public announcement using public address system and CHW home visits   | CHW and village leaders   | Targeted HIV care and treatment clinic days; CHW                              |

Abbreviations: CHW, community health worker; FP, family planning; HCP, health care provider; LARC, long-acting reversible contraception; TB, tuberculosis.

## Implementation Story

Design and implementation of the USAID Boresha Afya – Southern Zone program was guided extensively by HIP evidence. FP mobile outreach is a common practice in Tanzania (Jarvis et al., 2018; Ngo et al., 2017). However, to effectively implement integrated outreach, the program drew from the [FP and Immunization Integration](#) HIP (USAID, 2013), in addition to a wealth of implementation experience brought by the consortium partners.



PHOTO CREDIT: Rehema George, EngenderHealth

Tatu Michael (20 yrs) a family planning client smiling as provider went to visit her home for follow up in Malinyi Morogoro.

Provider training was conducted through both in-class and on-the-job training outlined by a comprehensive 12-day family planning clinical training curriculum. This curriculum was supplemented by provider mentorship during clinical practice exposure and supportive supervision.

To further support integration, integrated services were offered free of charge and supportive policies were established for referrals when providers were uncertain. In addition, good data collection mechanisms were established to ensure outreach data were collected and reported through the government District Health Information Software (DHIS 2).

As recommended by the [Mobile Outreach Services](#) HIP (USAID, 2015b), host facility providers were an integral part of the outreach team and routinely worked with the government's reproductive and child health division in the Ministry of Health. Host providers prepared the site prior to outreach days to ensure commodities were available and infection prevention measures were in place, including a functioning autoclave. As familiar faces in the community, host providers also assured community members during outreach days and, in addition to offering contraceptive care, ensured data integrity for monthly reporting.

As recommended by the [Community Health Workers](#) HIP (USAID, 2015a), the program used both male and female CHWs to assist clients navigating the system. Male CHWs offered positive male engagement in FP and served as positive links between the community and providers beyond mobilization and outreach days.

### THE IMPACT

"I was trained, but I was also mentored, and through mentorship and coaching I have increased my knowledge on minor side effects and implant removals. I used to remove the implant just because of bleeding, without understanding that these were just minor side effects. But now I don't do that anymore." —Nurse, Lugala Hospital, Malinyi Morogoro

The program supported FP care at 1,184 health facilities and 618 HIV care and treatment clinics. Between October 2018 and March 2020, a total of 341,503 clients were reached through mobile outreach—including 174,115 through integrated FP/HIV/TB services, 77,599 through FP/immunization outreach, and 87,758 through HIV care and treatment clinics.

The method mix varied according to outreach type. Overall, implants were the most selected method (116,136; 36 percent), followed by condoms (102,880;



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Nurse, Lugala Hospital, Malinyi Morogoro

31 percent), injectables (55,150; 15 percent), and intrauterine contraceptive devices (31,813; 9 percent). In addition, 7,040 bilateral tubal ligation procedures and six vasectomies were conducted, generating 685,260 couple-years of protection. Figure 1 shows the method mix by outreach type.

In addition to increasing FP access and use, 31,914 clients were screened for HIV and 21,518 were screened for TB. Clients diagnosed as HIV positive (194) were linked to care, and clients with presumptive TB (325) were referred for further diagnosis.

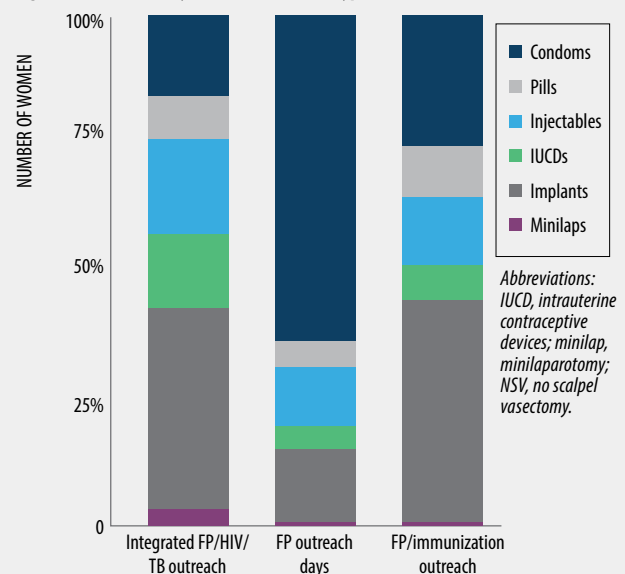
## CHALLENGES

Some providers initially perceived the addition of new services as extra work and were reluctant to provide integrated care. This resistance was overcome by showing practical examples of how staff could easily integrate care within the same consultation room, such as integrating HIV counseling during post insertion counselling of intrauterine contraceptive devices, followed by screening and testing. Experienced providers, for example, shadowed outreach staff when providing care to ensure mastering of skills. In addition, providers received the clinical rationale for integration and related national government policies and guidelines (physical or electric). Routine supervision and mentorship by council health management team supervisors, national trainers, and competent peer providers helped ensure a meaningful FP method mix.

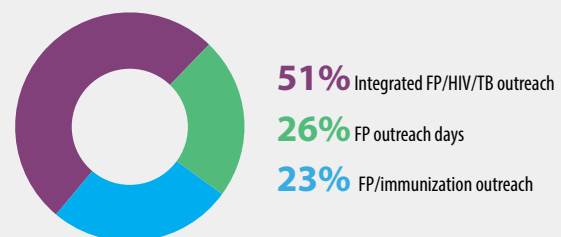
When counseled, most people agreed to be tested for HIV and screened for TB. However, less than 1 percent of clients tested were diagnosed to be HIV positive or presumptive TB, particularly in regions with lower HIV prevalence rates, raising concerns about the effective use of resources, such as rapid test kits. These concerns were addressed by assessing risk prior to testing, which was then limited to eligible clients.

In 2018, the Ministry of Health, Community Development, Elderly, Gender and Children revised its outreach guidelines to restrict bilateral tubal ligation in facilities without a functioning surgical theater (operating room). The program adapted to offer transportation to care for women seeking permanent methods during outreach days, but some women were reluctant to move out of their villages. The program continues to strengthen the routine availability of permanent methods by expanding surgical theater facilities in all councils.

**Figure 1. Method Mix by FP Mobile Outreach Type**



**Figure 2. Clients Served by Outreach Type**



CHW facilitating a discussion on family planning during community based FP outreach at Wang'ingombe- Njombe, Tanzania



## LESSONS LEARNED

Training outreach teams to multitask and provide a “one-stop shop” model via mobile outreach was essential. Before implementation, the initial integrated team included an FP surgeon and assistant surgeon for permanent methods, two FP providers for counseling and care, one HIV counselor and tester, and an additional provider for TB screening. Clients began with one provider for FP counseling, and then moved to receive FP care. After receiving FP care, they visited another provider for HIV counseling and testing, and finished with TB screening. This approach was resource-intensive and required the client to see many providers. The inclusion of HIV and TB testing also discouraged some FP clients who feared testing. By streamlining the model in our program, FP providers were trained to offer HIV counseling, testing, and referral, and TB screening and referrals, simplifying the process and reassuring clients that HIV testing would not affect their access to FP care or their method of choice.

Even when providers were trained and equipment was available, host facilities depended on outreach to mobilize clients for LARC/permanent method care. It was important to carefully select dispensaries—community-level health facilities—for FP days and balance the outreach frequency once a facility achieved the desired competency.

Designing integrated delivery through programs like Boresha Afya nurtures client-centered care, which is particularly important in an environment where FP, HIV, TB, and malaria programs are vertically funded and have distinct management structures within the Ministry of Health. This integration fosters collaboration and ownership by the partners and supervisors for successful implementation and sustainability.

## recommendations

**01 FP care should be integrated with services that are already established and accepted.** Immunization coverage, for example, was already high and the government funded and implemented immunization outreach services. Previously, clients were offered short-term contraception (i.e., pills, injectables, or condoms) during outreach days, so adding LARCs and permanent methods was easily accepted. The majority of clients living with HIV attend on their appointment days, so integrating much-needed FP care through mobile outreach was feasible and complementary.

**02 Mobile outreach should also be built into system strengthening activities.** This includes strengthening the capacity of host facility providers through formal training to ensure they can provide a wide range of methods, manage side effects, and offer LARC removal services when needed. Further quality assurance and mentorship can be provided by experienced staff during outreach days by ensuring they observe insertion and removal services by a host provider.

**03 Ensure the facility has a sufficient supply of commodities and can sustain care beyond the outreach day.** In light of budget constraints at most health facilities, programs should consider procuring equipment for insertion and removal of LARCs to ensure that supported facilities can continue care and maintain provider competency in the long term. This will reduce dependency, ensure method continuation, and support clients' continuum of care.

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Gladness Kweka instructing mentee how to use Family Planning Medical Eligibility Criteria table.

PHOTO CREDIT: Rehema George, EgenderHealth



Sikujua Gabriel Luvanda (39) contends it was the efforts of Program supported Community Health Workers (CHWs) that finally convinced her to use Family Planning services.

PHOTO CREDIT: USAID Boresha Aya – Southern Zone/S. Whango