HP+ POLICY *Brief*
November 2021

Achieving Equitable Access to Family Planning Services Through Sustainable Financing in Tanzania: Options for Consideration

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Introduction

Tanzania has made important strides within the last decade in improving family planning outcomes, including an increase in the modern contraceptive prevalence rate (mCPR) among all women, from 25 percent in 2012 to about 32 percent in 2020 (FP2020, n.d.). Such improvements and their financial sustainability have been priorities for Tanzania, as demonstrated by the inclusion of family planning in key national plans. The *National Family Planning Costed Implementation Plan 2019–2023* (NFPCIP) serves as a roadmap to enable women, youth, and couples to achieve access to high-quality family planning services and augments the national One Plan III, which aims to provide services for reproductive, maternal, newborn, child, and adolescent health that are affordable, equitable, and sustainable (United Republic of Tanzania, 2019).

Since the 1970s, Tanzania has operated under a "free-for-all" policy whereby women receive family planning products free of charge, regardless of their ability to pay (Pile and Simbakalia, 2006). This policy relies on the availability of supply-side financing, mainly from external donor resources, for critical program inputs including contraceptive commodities. However, external family planning funding is expected to decline, particularly from the U.S. Agency for International Development (USAID), the largest donor. Therefore, the current "free-for-all" policy may not be financially sustainable. In Tanzania, the government funding allocation level in 2019, if fully dispersed, would cover only 36 percent of the required procurement budget for commodities (Lasway and Mujaya, 2019). In addition to commodities, the NFPCIP estimates Tanzania needs US$18.3 million per year to implement complementary priority interventions (i.e., demand creation, service delivery, commodity security, and enabling environment) to reach its mCPR goal of 43 percent uptake among married women by 2023 (United Republic of Tanzania, 2019).

For many low- and middle-income countries, reliance on donor funding for family planning is high—in Tanzania, for example, 91 percent of its commodities were supported by development partners in 2019 (USAID, 2020). The government of Tanzania envisions that by 2025 the country will have graduated from lower-middle-income to middle-income status, according to the World Bank classification, which will affect its eligibility for some donor funding and may lead to reductions in health funding (Lasway and Mujaya, 2019; Battaile, 2020). Reports from other countries transitioning from lower- to middle-income status have illustrated challenges in fully funding family planning programs and highlighted the importance of sustainable domestic financing. For example, a notable portion of the government of Ghana's health budget is funded by donors (about 20 percent per year). Donor funding is expected to decline in the coming years, with family planning experiencing the most rapid decline (15 percent per annum), placing the program at risk (Pharos Global Health Advisors, 2019). Similarly, in Kenya, donors contributed nearly 75 percent of family planning funding from 2014–2016. Donor funding has since decreased, with an estimated US$27.2 million commodity funding gap in fiscal years 2019/20 to 2020/21 (Pharos Global Health Advisors, 2019).

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For Tanzania to be able to fund the family planning program outlined in its NFPCIP, the government will need to increase resources, especially to serve those most in need (United Republic of Tanzania, 2019). This idea is supported by the fact that in 2015 unmet need for family planning decreased as wealth quintile increased: 23 percent of women in the lowest quintile had an unmet need for family planning compared to 17 percent in the highest quintile (United Republic of Tanzania, 2019).

Study Objectives

This brief explores two possible financing options to replace the "free-for-all" family planning policy, both of which free up public funds to meet the need for poorer families as those with an ability to pay obtain their family planning through either the private sector or through health insurance schemes. This is done through two analyses conducted by the USAID-funded Health Policy Plus (HP+) project to compare the financing opportunities for improved long-term sustainable domestic financing for the family planning program: (1) application of a total market approach (TMA) and (2) inclusion of family planning services in government and private insurance schemes. Using the results of these analyses, the government of Tanzania can redefine the "free-for-all" policy and optimize public sector resources by reserving subsidies and free products for those with the greatest financial need.

Total Market Approach

Purpose

The HP+ TMA Projection Tool, developed in 2019, allows policymakers to understand shifts in market share among public, social marketing, and commercial players, and estimates the health equity and financial impacts of a larger commercial market (Klein et al., 2019).[1] When wealthier women purchase family planning services through the commercial sector, instead of receiving products for free or for a subsidized amount, public and donor resources are saved and can be reallocated to underserved populations. HP+ consulted with Tanzanian stakeholders, including representatives from the Ministry of Health, civil society organizations, and the government to review model inputs, assumptions, and results. Tables 1 and 2 describe the TMA model's outputs and how different stakeholders can use these results.

Table 1. TMA Model Outputs

Outputs
• Number of women using family planning • Number of women served and products sold through the commercial sector • Percent of women obtaining family planning by source or distribution point • Savings to public sector and donors through increased use of commercial sources • Equitable redistribution of family planning resources

Source: Klein et al., 2019

Table 2. TMA Model Stakeholders and Use of Outputs

Stakeholder	Use of Outputs
Government	• Data to support alternate resource allocation decisions • Impetus to engage commercial sector and improve regulatory environment
Donors & Implementing Partners	• Evidence to support coordination and targeting of social marketing and other subsidized or market development activities
Commercial Sector	• Insight into potential commercial market size • Intelligence on appropriate methods for market entry

Source: Klein et al., 2019

[1] *Social marketing* combines demand-creation with the provision of health products and services to lower-income and targeted people in need of such services. It is available in the commercial sector but typically funded—at least in part—by donor organizations (PSI, 2021).

Scenarios

The TMA model compares two scenarios over nine years, from 2021 to 2030: the status quo and the TMA scenario. In the status quo scenario, current means of receiving family planning products remain—with the "free-for-all" policy in effect and all women receiving services and products for free. In the TMA scenario, wealthier women who currently access family planning services from the public sector shift to purchasing through the commercial sector (i.e., private clinics and pharmacies). Based on the Health Sector Strategic Plan IV and input from stakeholders, HP+ estimated an increase in mCPR to 53 percent by 2030 (United Republic of Tanzania, 2021). To apply the model, HP+ used Demographic and Health Survey (DHS) population-based demographic data (including for wealth quintile, geography, and family planning method source), World Bank poverty headcounts, and United Nations population estimates.

TOTAL MARKET APPROACH

Status-Quo Scenario: Family planning remains "free-for-all."

TMA Scenario: A proportion of wealthier women who currently access family planning products and services from public and social marketing sources shift to the commercial sector.

Family Planning Products and Program Costs to Reach Poorer Populations

HP+ used costs and prices for each family planning commodity across the public, social marketing, and commercial sectors (Mann Global Health, unpublished). The public sector and social marketing costs were used to estimate the savings realized when a woman switches from a free public provider to a commercial product. HP+ also estimated the cost of using mobile outreach services to reach one long-acting permanent method acceptor in a difficult-to-reach rural area and used this cost to estimate how many additional hard-to-reach women could be reached with the public funds saved (Vance and Bratt, 2013).

Family Planning Product Utilization Rates and Commercial Share Shifts

Using historical trends from DHS data and in consultation with country stakeholders, HP+ projected the percentage of wealthier women of reproductive age who might feasibly switch from using public sector products to commercial sector products by 2030 (see Table 3). The model disaggregates switch rates by the top two wealth quintiles, by geography, and by product. The share of family

Table 3. Percentage of Women Switching from Public/Donor Sources to Commercial Sources by 2030 by Geography, Wealth Quintile, and Method

Method Type	Wealthiest (Quintile 1)		Wealthier (Quintile 2)	
	Urban	Rural	Urban	Rural
Pill	28%	72%	34%	37%
IUD	15%	10%	15%	10%
Injectable	25%	37%	55%	83%
Implant	20%	15%	20%	15%
Condom	49%	56%	59%	70%

Source: 2010 and 2015 DHS trends

planning products accessed from commercial sources not funded by donors is expected to increase as government and donor resources are prioritized more for women who are less able to pay. Through discussions with country stakeholders, HP+ determined that all family planning products considered in this analysis (i.e., intrauterine device [IUD], implant, injectable, pill, and male condom) can be made available through the commercial sector and HP+ further estimated the percentage of products that would be accessed only from commercial sources (i.e., not accessed through social marketing) over the time period (2021 to 2030).

Results

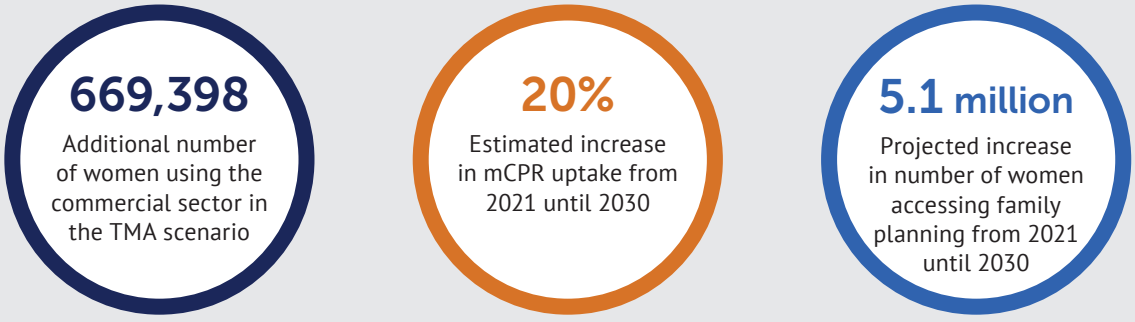
Using DHS data from 2010 and 2015 to estimate method and source mix, HP+ extended historical trends until 2030, with consultation and validation from local stakeholders. The second column in Table 3 shows the percent of the wealthiest urban women who are expected to switch from the public/donor sector to the commercial sector to acquire their family planning products by 2030.

Also shown in Table 3, the greatest proportion of wealthy urban women switching from the public/donor sector to the commercial sector are purchasers of male condoms (49%), whereas those who switch from the public/donor sector to the commercial sector is only 15 percent for IUD purchases. Stakeholders suggested the generally larger switch rate among women in rural areas from both quintiles is because these areas are heavily subsidized through public/donor funding and so the number of women who switch to commercial sources could be greater.

The TMA model also took note of the number of women who would access family planning by 2030 and projected an increase of 5.1 million in the total number of family planning users compared to 2021, based on population growth, an increasing mCPR, and family planning scale-up in the commercial sector. It also predicts an increase in the numbers of women (669,398) who will use the commercial sector by 2030 for their family planning commodities (see Figure 1).

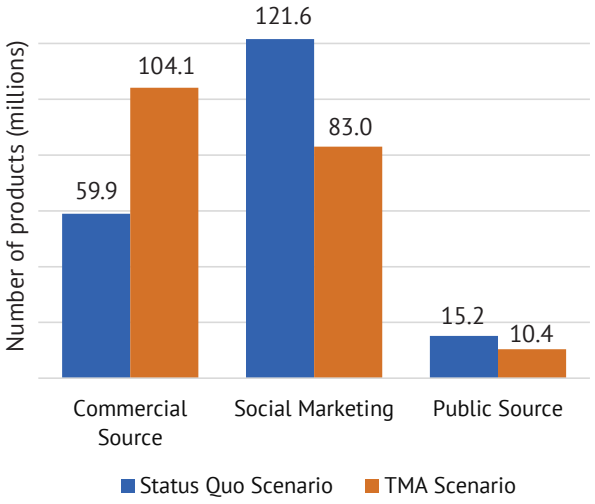
By 2030, the number of women expected to be served by the commercial sector in the TMA scenario is 1.6 million, a 79% increase (or 669,398 women) compared to the status quo scenario, which assumes no changes in the current source mix. The TMA scenario predicts that when wealthier women choose to source family planning products through the commercial sector, donors and the public sector will have a total of US$5.9 million saved from 2021–2030 that can be reallocated to address unmet need

Figure 1. Select TMA Model Outputs



and that would reach an additional 352,422 rural or poorer women. Retargeting of public family planning resources for these women allows for a more equitable distribution of family planning products and a larger, more sustainable mix of public and commercial providers.

Figure 2. Estimated Number of Contraceptive Products Accessed by Source/Distribution Point



Introducing a total market approach leads to 104.1 million family planning products sold by the private sector, a 74 percent increase (or 44.2 million products) from a 2021–2030 status quo scenario (see Figure 2). Of these products, an estimated 4.7 million products will be used by women who are new contraceptive users. Figure 2 shows the shift in accessing each product source from 2021 to 2030, highlighting a slight decrease in products distributed by both public and social marketing sources as a result of the 74 percent increase in private market share.

HP+ also estimated the number of users served by the commercial sector by 2030 by method and scenario. Pills and condoms purchased by users through the commercial sector (two methods with commercial presence in 2021) would increase by 76 percent and 73 percent, respectively, by 2030. IUDs, injectables, and implants are not currently sold through the commercial sector, but would be expected by 2030 to increase slightly, serving 1,602 users for IUDs, 35,153 for injectables, and 8,550 for implants.

Inclusion of Family Planning Services in Insurance

Purpose

HP+ applied a second model to calculate the number of additional women using health insurance to purchase family planning products and the potential cost savings to the family planning program of Tanzania. Through insurance integration, family planning is available to all enrollees and costs are spread over a risk pool (USAID, n.d.). Currently, the family planning program of Tanzania is responsible for ensuring family planning information, commodities, and services are available. When family planning is included in health insurance schemes, costs are shifted from the public sector to the insurance schemes and the public resources used for family planning commodities and services can be reallocated to the women with less means who seek public services.

This analysis projected the same mCPR scale-up as in the TMA model and considered family planning inclusion into three main health insurance schemes: the National Health Insurance Fund (NHIF), Improved Community Health Fund (ICHF), and private health insurance. NHIF currently enrolls about 4.5 million people (7.8 percent of the total population), mostly formal sector beneficiaries, while ICHF enrolls about 3 million (5.2 percent of the population), mostly from the informal sector and rural households. Private health insurance coverage currently reaches about half a million people (1 percent) (UNICEF, n.d.). Together, the three insurance schemes in Tanzania cover approximately 8.1 million people, representing 14 percent of the population in 2021.

Scenarios

HP+ projected the percentage of the general population enrolled in health insurance schemes, family planning coverage, and women of reproductive age using contraception from 2021 to 2030. In both scenarios, the mCPR scale-up is the same. In the status quo scenario, HP+ estimated that 15 percent of women of reproductive age using contraception have access to family planning services through each insurance scheme each year until 2030. In the insurance integration scenario, family planning coverage begins at 15 percent in 2021 and increases by 20 percent each year for each scheme. This is an increased estimate from the trend described by a large private insurer, Assemble Company Limited. By 2030, HP+ estimates that coverage for family planning by insurance is 77 percent.

INSURANCE INTEGRATION

Status Quo Scenario: 15% coverage each year from 2021–2030.

Insurance Integration Scenario: 15% coverage in 2021, then increases by 20% of previous year each year until 2030.

Over time, any rise in family planning coverage decreases reliance on the public sector, thus allowing for reallocation of those saved costs for commodities that Tanzania's family planning program currently provides. HP+ also projected shifts in the method mix from predominantly short-acting methods to an increase in users for long-acting methods—both by geography and source through 2030. This estimate is based on consultation with stakeholders in Tanzania and NFPCIP trends.

Family Planning Commodity Unit Price

HP+ used NFPCIP unit commodity prices and estimated the number of units per year to determine total direct commodity costs per woman from 2021 to 2030. These total direct commodity costs are then mitigated by integrating services into insurance and thus provide potential savings for Tanzania's family planning program.

Results

Among the insurance schemes, in 2021, NHIF had the highest enrollment at 7.8 percent, followed by ICHF at 5.2 percent, and private health insurance at 1 percent. HP+ estimates that by 2030 ICHF will have the largest enrollment numbers (26 percent), followed by private health insurance (19 percent), and NHIF (9.3 percent) (see Table 4). Enrollment numbers affect the percentage of women of reproductive age likely to have access to and utilize health insurance for family planning.

Figures 3 and 4 show the percent of women using contraception across urban and rural landscapes and by select sources in 2021 and 2030. Methods without significant shift in usage between 2021–2030 are not included in the figures. In urban settings (see Figure 3), pills and male condoms are more accessed from private sources than from public sources. However, public access of pills goes down from 2021 to 2030. Access from public sources for implants see an increase from 2021 to 2030.

Table 4. Estimated Insurance Coverage

Insurance Type	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
NHIF Insurance Coverage	7.8%	8.2%	8.4%	8.6%	8.7%	8.8%	9.0%	9.1%	9.2%	9.3%
ICHF Insurance Coverage	5.2%	19%	20%	21%	22%	23%	24%	24%	25%	26%
Private Health Insurance Coverage	1%	5%	5%	7%	9%	11%	13%	15%	17%	19%

Figure 3. Urban Method Mix from Public and Private Sources in 2021 and 2030, Select Methods

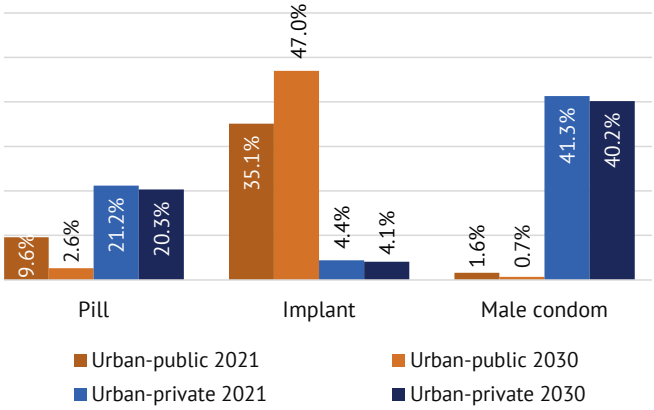
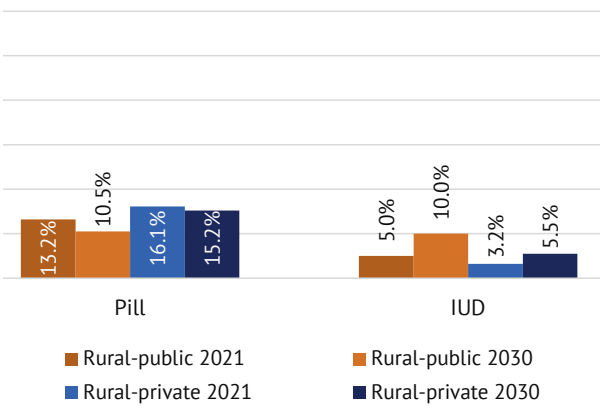


Figure 4. Rural Method Mix from Public and Private Sources in 2021 and 2030, Select Methods

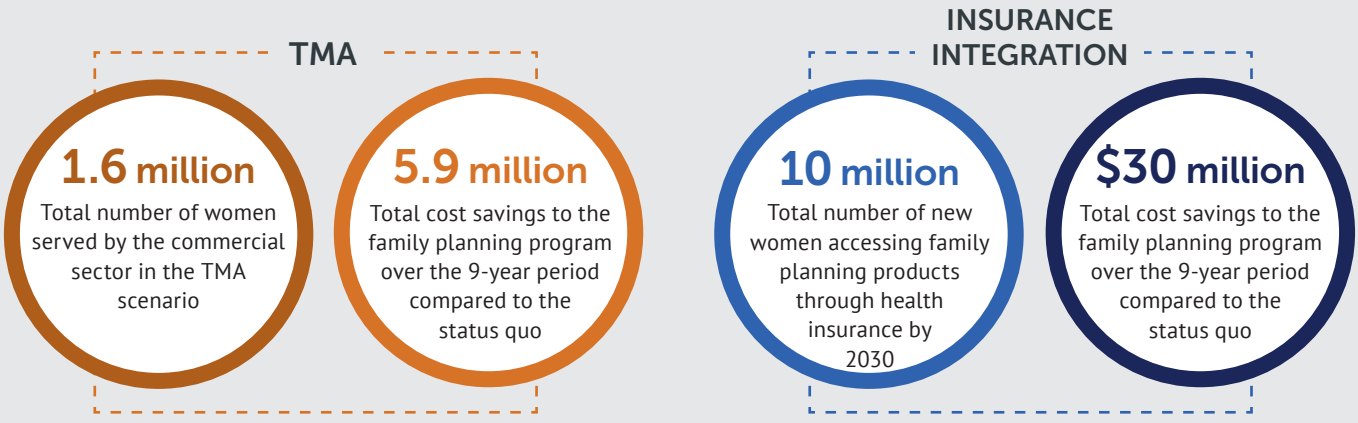


Source: Author projections based on stakeholder consultations

In rural settings (see Figure 4), pills are most often accessed through the private sector. In 2030, IUDs are estimated to show slight growth in the both the private and public sectors. The method mix from this model helps estimate the family planning program cost savings, as the number of products sourced through health insurance will no longer need to be provided for free by the government.

As family planning is integrated in health insurance schemes and coverage and mCPR increases, the number of new users receiving family planning products through insurance increases over what is seen in the status quo scenario. From 2021 to 2030, an additional 10.3 million women are predicted to obtain family planning through insurance, with 5.2 million women obtaining family planning through ICHF, 3.2 million through a private health insurance scheme, and 1.9 million through NHIF. This additional number of women using insurance for family planning by scenario translates into a total of US$30.2 million in cost savings to the public family planning program: US$15 million saved from ICHF users, US$9.6 million from private insurance users, and US$5.6 million from NHIF users. Most (73 percent) of these cost savings are savings through the use of short-term methods (i.e., pills, condoms, and injections), given projected utilization rates and method mix until 2030. HP+ projects that the highest cost savings will occur due to increased enrollment in the ICHF scheme, which is expected to have the highest projected enrollment percentages by 2030. Figure 5 describes the overall financial and family planning outcomes for each approach.

Figure 5. Financial and Family Planning Outcomes



Discussion and Key Findings

A total market approach and insurance integration are two compelling approaches toward sustainable financing as Tanzania aims to reduce donor reliance for family planning services and program interventions. The TMA model estimates the potential for a substantial increase in the number of women accessing family planning through the private sector, based on ability to pay. Shifts to the private sector among women in rural areas and among those with the ability to pay, and increases in the commercial market ability to offer products, particularly IUDs, implants, and injectables, will lead to an increase in the total market value for family planning.

This analysis demonstrates that if women in quintiles 1 and 2 are transitioned to the commercial sector, then the public sector will have an estimated additional US$5.9 million between 2021–2030 that it can use to reach more women who are currently not accessing family planning services or that it can use to alter the method mix and promote long-acting methods. On average, this means that the government of Tanzania can expect to have approximately US$650,000 per year in additional funds, which is about 2.2 percent of Tanzania's 2017 domestic family planning expenditure (US$29.5 million), adjusted for 2021 inflation (see Table 5). These annual expenditures include commodity purchases, demand-creation campaigns, investments in training and research, and service delivery (FP2020, 2020). Alternatively, these additional funds could match 0.7 percent of donor funding (US$87.7 million) from fiscal year 2016/17, adjusted for 2021 inflation (Lasway and Mujaya, 2019). Hence, incorporating a total market approach allows for a slight reduction in dependency on external funding and for substantial growth within the commercial market. Assessing and catalyzing political and stakeholder interest is the first step toward implementing a total market approach, according to a 2016 planning guide (Brady et al., 2016). In fact, local organizations and stakeholders have expressed strong interest in a TMA strategy and have developed a TMA working group through SHOPS Plus (Abt Associates, 2020; SHOPS Plus, n.d.). Additional analyses will be needed to gather further evidence, build capacity and coordination, and implement a monitoring and evaluation plan.

Table 5. Additional Funds as Percent of Family Planning Expenditure, by Approach

Approach	Domestic Expenditure	Donor Funding
TMA	2.2%	0.7%
Insurance Integration	11.4%	3.8%

Tanzania is currently progressing toward universal health insurance coverage as a means to improve equity in insurance coverage, increase resources for health, and gain efficiencies in health spending (Prabhakaran and Dutta, 2017). HP+ modelled integration of family planning services into the current available three insurance schemes, projecting a total of US$30.3 million cost savings for Tanzania's family planning program. These savings would allow the government and donors to reallocate the funds for other commodity purchases to fulfill unmet needs for hard-to-reach or other women with unmet need. As shown in Table 5, on average, the government of Tanzania can expect almost US$3.4 million in savings annually, representing about 11.4 percent of Tanzania's 2017 domestic family planning expenditure or 3.8 percent of donor funding from fiscal year 2016/17, adjusted for 2021 inflation. As Tanzania progresses toward universal health coverage, additional analyses will be needed to understand the financial sustainability of family planning integration, and to estimate the cost of that

integration to insurance companies. Further advocacy will also be needed to engage the nation's health insurance providers and ensure their sustained commitment to improve access to family planning for the underserved.

Tanzania should redefine the current "free-for-all" policy. There is evidence to support increased engagement with the private sector and re-targeting of subsidized or free products, which will reduce the burden for the public sector and increase access to family planning products to those most in need.

There are compelling strategies to reallocate, retarget, and redefine health priorities in Tanzania. TMA and insurance integration are not mutually exclusive, as both approaches involve a greater role for the commercial sector. In fact, the two strategies can be implemented in parallel with due consideration to align implementation, particularly regarding developing and rolling out means-testing to determine who should be eligible for government services and to ensure that those who are eligible have appropriate access to services and products. If TMA and insurance integration were to be implemented jointly, additional analyses should consider the potential effects of wealthier women accessing products through both insurance and a total market approach.

To receive these financial and health gains, the government should redefine the "free-for-all" policy to target those who cannot afford to pay. Shifting women who can afford to pay to either the commercial sector and/or a health insurance plan for family planning services will allow the family planning program in Tanzania to reallocate and redistribute resources to areas and people most in need and, thus, sooner reach national family planning goals.

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Health Policy Plus (HP+) is a seven-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-15-00051, beginning August 28, 2015. HP+ is implemented by Palladium, in collaboration with Avenir Health, Futures Group Global Outreach, Plan International USA, Population Reference Bureau, RTI International, ThinkWell, and the White Ribbon Alliance for Safe Motherhood.

This publication was produced for review by the U.S. Agency for International Development. It was prepared by HP+. The information provided in this document is not official U.S. Government information and does not necessarily reflect the views or positions of the U.S. Agency for International Development or the U.S. Government.

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