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Report

Rapid Assessment of Bottlenecks Inhibiting the Scale-up of Social Behaviour Communication for Family Planning in the United Republic of Tanzania

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LIST OF ABBREVIATIONS AND ACRONYMS

MNCH	MATERNAL, NEWBORN AND CHILD HEALTH
SBC	SOCIAL BEHAVIOUR CHANGE
PPFP	POST PARTUM FAMILY PLANNING
FP	FAMILY PLANNING
WHO	WORLD HEALTH ORGANIZATION
CGE	COMMUNITY GROUP ENGAGEMENT
HPO	HIGH IMPACT PRACTICES
CSO	CIVIL SOCIAL ORGANIZATIONS
KII	KEY INFORMANT INTERVIEW
IDI	IN-DEPTH INTERVIEW
NGO	NON-GOVERNMENT ORGANIZATION
CHW	COMMUNITY HEALTH WORKERS
CBO	COMMUNITY-BASED ORGANIZATIONS
HIV	HUMAN IMMUNODEFICIENCY VIRUS
TB	TUBERCULOSIS
YFCS	YOUTH-FRIENDLY CONTRACEPTIVE SERVICES
IUCD	INTRAUTERINE CONTRACEPTIVE DEVICE
URT	UNITED REPUBLIC OF TANZANIA
MoH	MINISTRY OF HEALTH
LAM	LACTATION AMENORRHEA
SBCC-CRC	SOCIAL AND BEHAVIOR CHANGE COMMUNICATION CONTENT REVIEW COMMITTEE
SBCC	SOCIAL AND BEHAVIOR CHANGE COMMUNICATION
NFPCIP	THE NATIONAL FAMILY PLANNING COSTED IMPLEMENTATION PROGRAM
TCDC	TANZANIA COMMUNICATION DEVELOPMENT CENTRE
MIYCN	MATERNAL, INFANT, AND YOUNG CHILD NUTRITION
PA	PUBLIC ANNOUNCEMENT
MCSP	THE MATERNAL AND CHILD SURVIVAL PROGRAM
USAID	UNITED STATE AGENCY OF INTERNATIONAL DEVELOPMENT
WASH	WATER SANITATION AND HYGIENE
TDHS	TANZANIA DEMOGRAPHIC HEALTH SURVEY
RMNCAH	REPRODUCTIVE MOTHER, NEWBORN, CHILD AND ADOLESCENT HEALTH
FTM	FEMALE-TO-MALE
EBF	EXPRESSED BREASTFEEDING
FTP	FIRST TIME PARENTS
HIP	HIGH IMPACT PRACTICES
c-RCT	CLUSTER RANDOMIZED CONTROLLED TRIAL
ANC	ANTI-NATAL CARE
WRA	WOMEN OF REPRODUCTIVE AGE
CHV	COMMUNITY HEALTH VOLUNTEERS

EXECUTIVE SUMMARY

Introduction: Investments in SBC interventions enhance those made in service delivery and policy and can be highly cost-effective. SBC interventions can be used to address a range of behavioral determinants influencing the uptake and continuation of modern contraceptive methods so that individuals and couples can achieve their reproductive intentions. In Tanzania, scaling up SBC for FP has been challenging due to various bottlenecks at the community and health system levels. **Objective:** The assessment was undertaken to gain a better understanding of the country's specific bottlenecks that hinder the scale-up of social behaviour communication for family planning in the United Republic of Tanzania. **Methods:** Using WHO tool, stakeholders' views on the current SBC for FP implementation status, and information on bottlenecks that hinder scale-up and sustainability of SBC for FP in the country were collected. Secondary data and key documents were reviewed, analysed and synthesized to determine what is known about social behaviour change for FP in the United Republic of Tanzania. In addition, up to three case studies about SBC for FP programs were identified and reviewed to document challenges and lessons learned. A consensus stakeholders' meeting will be organized with two aims: 1) to prioritize the most important bottlenecks and 2) co-develop strategies to address the gaps. Participants of the consensus meeting will come from Mara, Iringa, Arusha and Kilimanjaro (high FP uptake regions) and Ruvuma, Njombe, Mtwara, Pwani, Kaskazini Pemba and Kaskazini Unguja (low FP uptake regions). In addition, implementing partners of the selected case studies will be invited to the consensus meeting to share their insights on how these programs contributed to the observed SBC and/or PPFP achievements. **Findings:** There is limited awareness of integrated SBC for FP among service providers who are required to offer information and counselling to clients in various service delivery points. Healthcare providers' bias, attitudes and beliefs towards provision of FP contribute to low adoption and sustaining SBC for FP practice. The health system capacity for implementing SBC for FP at different service delivery points is low. Nevertheless, there is locally generated evidence which indicate that SBC for FP is effective in changing negative attitudes and beliefs that affect adoption, access, delivery and use of PPFP in the country. **Conclusion:** Despite the country's commitment and efforts to integrate SBC for FP into other community and health facility interventions, scale up and sustaining such high impact practice will continue to be a challenge if the country does not finalize, approval and operationalize the national SBC for FP strategy.

1.0 INTRODUCTION

1.1. Background

The Social Behaviour Change (SBC) is an evidence-driven approach to improve and sustain changes in individual behaviors, social norms, and the enabling environment. Evidence shows that SBC interventions are an essential component of high-quality family planning programs but remain underutilized. Investments in SBC interventions enhance those made in service delivery and policy and can be highly cost-effective. SBC interventions can be used to address a range of behavioral determinants influencing the uptake and continuation of modern contraceptive methods so that individuals and couples can achieve their reproductive intentions. These factors include social and gender roles and norms about family, sexuality, and fertility; couples' communication and other partner-related factors; perceived personal and social costs; method-specific barriers to use (e.g., myths and misconceptions and fear of side effects); perceived low risk of getting pregnant; weak, inconsistent, or ambivalent fertility preferences; and generic disapproval of preventing pregnancy. SBC interventions also play an important role in improving client-provider interaction, improving perceptions about good quality services and trust in the health system, and reinforcing linkages with other health areas and creating a supportive normative and structural environment for family planning. As such, SBC complements the areas of service delivery and the enabling environment to create a set of interconnected high impact practices (HIPs) that work together to strengthen family planning programs.[1] At the individual level, accurate knowledge about fertility and family planning is essential to informed choice. Other individual factors influencing someone's ability to reach their fertility intentions include beliefs, attitudes, and personal agency, including self-efficacy. At the interpersonal level, there are various forms of communication that influence family planning use, e.g., between peers; parent or trusted adult to adolescent; and provider to client. Couples' communication and joint decision making, which are influenced by gender roles and norms, are particularly important in the voluntary uptake of contraceptive methods. At the community level, social and gender norms or the perceived informal, mostly unwritten, rules that define acceptable, appropriate, and obligatory behaviors within a given community or group, including those based on gender influence an individual's or couple's desire for, and access to, family planning methods.

[1] https://www.fphighimpactpractices.org/briefs/sbc-overview/

SBC interventions to address behavioural determinants can use a variety of communication channels and other intervention approaches. Currently, there are three high impact practices (HIPs) that address specific communication channels for SBC: mass media, community group engagement (CGE), and digital technologies.[3]

SBC programs are most effective when they use a multi-channel approach, and there is consistent evidence that shows the greater the exposure to SBC campaigns through different channels, the greater the odds of behaviour change (known as a dose-response relationship).[2]

SBC approaches can support service delivery interventions before, during, and after a client-provider interaction. Before a client seeks out family planning and reproductive health services, SBC approaches are important to increase awareness of, and interest in, family planning; foster supportive social norms; and create a supportive enabling environment.

During service delivery, SBC approaches can be used to empower clients, improve provider behaviour, and build trust. After a client leaves a clinic, SBC can enhance follow-up, support behavioural maintenance, and reinforce health and cross-sectoral linkages. Specifically, SBC approaches can be used to support community health workers through job aids and counselling skills to help dispel rumours and address social barriers to family planning; promote postpartum and post abortion family planning by addressing myths and misconceptions around modern contraceptive methods; create behavioural-based job aids for pharmacies and drug shops, and contribute to effective social marketing through the design of communication messages to improve knowledge, attitudes, and use of family planning products.

SBC approaches are also an important tool in creating an enabling environment for family planning, including for adolescents and ensuring equitable access to high-quality family planning information and services. They can be used to help address social and economic factors, such as educating girls, by shaping social norms that support girls' education. SBC approaches can also be used to support high-performing institutions, better governance, and management of programs. For example, SBC programs are a helpful tool in promoting social accountability by bringing together community members with health workers and local officials to establish common goals. Lastly, SBC approaches can be leveraged to galvanize commitment and create supportive laws, policies, and financing for family planning.

In Tanzania, the government and national stakeholders have high level of understanding, awareness, and acceptance of these practices, but scaling them up has been challenging due to various bottlenecks at the community and health system levels. Thus, it is important to conduct

[2] https://www.fphighimpactpractices.org/briefs/sbc-overview/

an assessment to gain a better understanding of the country's specific bottlenecks that hinder the scale-up of postpartum family planning and social behaviour communication.

1.2.OBJECTIVES

1.2.1. Broad Objective

To identify bottlenecks that hinder the scale-up and sustainability of social behaviour communication for family planning in the United Republic of Tanzania.

1.2.2. Specific Objectives

1. To review and synthesize what is known about scale up and sustainability of SBC in URT including implementation status, alignment of guidance with national, regional, and international standards.
2. To document lesson learned from successful implemented SBC for FP programs in Tanzania.
3. To understand the perspective of key stakeholders (policy makers, programme managers, healthcare managers, service providers and CSO) on the various community and health system factors inhibiting scale-up of SBC for FP
4. To identify the most important bottlenecks and solutions to scale up SBC for FP

2.0 METHODOLOGY

I. Key Informant Interviews

Two adapted WHO KII tool for assessing SBC for FP was used to collect information from targeted stakeholders which included Directors, coordinators and implementers of SBC and/or health promotion Program/Department/Unit, decision and policy makers, and NGOs and CSOs working on or supporting SBC for FP. A link to the KII tool was shared to the targeted individuals which included SBC implementers, experts of health promotion and SBC at all levels, NGOs and CSOs involved in SBC for FP.

II. In-depth Interviews (IDIs)

We interviewed 26 key informants (Table 1) from 10 regions namely Arusha, Kilimanjaro, Iringa, Mara, Njombe, Pwani, Mtwara, Ruvuma, Kaskazini Unguja and Kaskazini Pemba. The informants were selected based on their positions or roles in SBC for family planning.

Table 1. Number of In-depth Interviews in Mainland and Zanzibar

Informant	Mainland	Zanzibar	All
Director Health Promotion	1	0	1
Social Welfare officers	1	1	2
Health Promotion/SBC expert	4	2	10
Community Health Workers	9	3	12
CSOs/CBOs/NGOs/CHWs	4	1	5
All	**19**	**7**	**24**

III. Desk Review

Documents were accessed through searching engines such as google scholar, pub med, SCI-Hub and other sources, and reviewed to assess their alignment with international or regional guidance. The WHO review guide helped to identify gaps in national and local SBC policies guidance.

Consensus Meeting

It is expected that stakeholders from regions with high PPFP uptake (Mara, Iringa, Arusha and Kilimanjaro) and low PPFP uptake (Ruvuma, Njombe, Mtwara, Pwani, Kaskazini Pemba and Kaskazini Unguja) will participate in the consensus meeting. Thus, directors, program managers, coordinators, implementers, and experts of SBC and health promotion will be invited to the consensus meeting.

3.0 FINDINGS

3.1. Policies Guidance on Social and Behavior Change Communication in Tanzania

National Standard Operating Procedures for Health Communication (2021) recognizes that SBCC is the strategy for promoting positive health outcomes by influencing changes in knowledge, attitudes and practices among specific audiences as well as changes in social norms. Multiple communication channels (interpersonal, community-based based and mass media) are used to influence the desired changes. The document highlights key elements in conducting SBC and factors that need to be considered in selecting channels for health communication. Complexity of the health issue, sensitivity of the issue, prevailing social norms, audience profiles, media habits and preferences of intended audiences, desired reach, and cost implication are considered when selecting channel(s) for health communication. Key element in conducting SBC interventions include: research driven and evidence based, participatory, integrated and comprehensive, foster behavioral outcomes (individual and societal level), use of multiple channels, target pretested specific products, monitoring and evaluation, and disseminate experiences gained to inform on-going and future interventions. Best practices are disseminated for the purpose of encouraging utilization of locally generated knowledge and experiences in solving local problems. However, as per guidelines issued by the Social and Behavior Change Communication Content Review Committee (SBCC-CRC)

which operate under the Health Promotion Section, re-use of radio/video spots, re-printing, customization or borrowing of approved materials require an approval of the Ministry of Health.

Currently, the country does not have SBC for FP policy, but there a number of national documents (National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child, and Adolescent Health in Tanzania (2016 - 2020); National Five Year Development Plan 2016/17 – 2020/21; National Standard Operating Procedures for Health Communication, 2021; NAWEZA strategy; NFPCIP 2019 – 2023; Zanzibar Health Sector Strategic Plan III 2013/14-2018/19; National Operational Guideline for Community-Based Health Services, 2021) that adhere to recommended and evidence-based principles for SBC. For example, the importance of SBC interventions in promoting male involvement is recognized in a number of FP guidance (National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child, and Adolescent Health in Tanzania (2016 - 2020); National Five Year Development Plan 2016/17 – 2020/21; National Standard Operating Procedures for Health Communication, 2021; NAWEZA strategy; NFPCIP 2019 – 2023; Zanzibar Health Sector Strategic Plan III 2013/14-2018/19; National Operational Guideline for Community-Based Health Services, 2021). However, absence of data to measure the impact of SBC on uptake of PPFP remains a challenge.

Two SBCC campaigns (Jiamini and the relaunch of the Green Star Campaign) were rolled out during the NFPCIP 2010–2015 to raise awareness about family planning options in Tanzania. In the past 6 years Tanzania Communication Development Centre (TCDC) has been working with 83 community-based organizations (CBOs) to promote positive health behaviour on water-borne diseases, malaria, HIV/AIDS, family planning, safe motherhood, TB, WASH and nutrition. Of course, new SBC strategies have been developed, reviewed, tested and evaluated. (Massenga et al, 2021, Prasad et al 2022). Tulonge Afya project, an integrated social behaviour change (SBC) strategy which is organized and delivered around the audience and not a health area or disease. The approach is in line with the national strategy for integrated health services. NAWEZA is a platform that enables messages spanning a range of health issues, including malaria, HIV, MNCH, FP, TB, and emerging infectious diseases, that target adults in two lifecycle groups, firstly pregnancy and childbirth and secondly caregiving of children under 5 to promote individual adoption of healthy behaviours and increase service utilization.[3] Jiongeze is encouraging and helping women to hold health providers accountable for delivering core services by raising awareness among pregnant women and mothers of the services available to them while they are pregnant and for after childbirth.

Despite the efforts made, community involvement and particularly male involvement remains low. This may be due to the fact that most demand generation interventions were not segmented to address the needs of various audiences (e.g., youth, male, female, urban, rural, educated, uneducated) at various points in the life cycle (e.g., unmarried, married with no children, postpartum). In addition, use of commercial marketing approaches is low. Thus, there is a need for developing a national SBC strategy, and dissemination of tailored communication materials using varied communication channels to reach different groups of individuals with FP information.

[3] https://pdf.usaid.gov/pdf_docs/PA00X91S.pdf Accessed 10th September, 2024

In efforts to increase the use and scale up of efficacious SBC interventions, the country is in the process of enhancing the environment conducive for delivering such interventions at health facility and community level. Such effort includes:

- Updating FP job aids (to include additional information related to PPFP and adolescent sexual and reproductive health) for both trainings and integrated service delivery purposes.
- Expanding pool of PPFP trainers to ensure that each region have at least four trainers from the public and private sector.
- Capacitating personnel stationed in labour and delivery, antenatal and postnatal care, including those who participate in immunisation services to provide PPFP service including FP counselling and referral for FP services.
- Identifying and training/retraining CHWs on updated content focused on PPFP and YFCS that emphasise free and informed choice.
- Revising operational guidelines and standards to ensure that at least one provider qualified to counsel on FP and offer short-acting methods accompanies each immunisation outreach activity.
- Updating the preservice curriculum for nurse-midwives to strengthen its FP content, particularly related to PPFP, youth-friendly contraceptive services (YFCS), and rights-based high-quality FP services.
- Sharing updated curriculum with private training institutions, including faith-based hospitals with nursing programs.

Interviews with key informants in Tanzania Mainland, revealed that the introduced interventions to reduce stigma around family planning (FP) services for adolescents have led to the establishment of education sessions which are provided to clients who seek youth-friendly services ("Huduma Rafiki"). These sessions are solely dedicated to both adolescent girls and boys. By providing a specific time and space for adolescents, these services aim to reduce the stigma that often discourages young people from seeking care.

> *"There are specific education and health provision sessions/rooms for adolescents who come for FP services. They are called "Huduma Rafiki" and aim to reduce the barrier of stigma experienced by adolescents when they seek FP services. In such sessions older women and men are excluded, and specific day and time are allocated for adolescents' session"* HP officer Mara.

Despite these initiatives, there is a clear need for more widespread education on family planning, especially in rural areas where knowledge remains limited. Urban populations tend to be more aware of FP options, but rural communities, particularly men, often continue to hold patriarchal views, which create barriers to the adoption of family planning methods.

> *"There is a need to provide more education. In urban areas, people understand, but in rural areas, they still do not. Especially men, as they tend to have a patriarchal mindset."* NGO Representative_ Mara.

Many women, facing opposition from their partners, choose to keep their family planning decisions secret for fear of being negatively judged or get into conflict. One NGO representative has this to share,

> *"In the context of family planning, many clients tend to hide their choices because they do not want their partners to know about these methods. This is because men differ in their views some do not want their wives to use family planning methods. A woman may say, 'I would rather keep it a secret than have many children while my husband does not help in raising them",* NGO Representative_ Mara

This highlight the challenges women face in accessing and utilizing FP services in environments where male approval is crucial. These cultural and gender dynamics underscore the need for ongoing education and culturally sensitive interventions to ensure that both men and women have the knowledge and support to make informed family planning choices.

In Zanzibar, there is a project called "Scale Up Family Planning," it focuses on health promotion in collaboration with the government. They provide FP methods, such as IUCD, organize FP service days, and raise awareness through health committees and peer groups, particularly among youth. In addition, the NGOs educate the community on the benefits of FP, which include child spacing which provide opportunity for mothers to restore and maintain their health. Despite the existence of various methods, many women in the community prefer short-term methods or traditional methods, such as using special sticks or ties, which they believe serve as a form of family planning.

> *"We as NGO have a project called scale up family planning, we do health promotion on FP. We work together with the government to provide training on all FP methods, including IUCD, creating awareness and promoting health behaviours"* (NGO representative-Kaskazini Unguja)

> *"As CHWs, we give education to the community on the benefits of using FP methods which include child spacing that help the mothers to maintain their health. Women mostly prefer tradition and short-term modern methods. There is a special stick they lick or tie on their body believing it will prevent unwanted pregnancy.*" (CHV_Kaskazini Pemba-Zanzibar)

Key informants in Zanzibar acknowledged the valuable assistance from USAID-Afya Yangu, which supported them in the outreach program on family planning. This enables them to reach and educate many communities members.

> *There is good governance, which attract funds from USAID- Afya yangu they supported us on doing outreach on FP* (HPO -Kaskazini Pemba-Zanzibar)

3.2. Access to FP information

Review of TDHS 2022 report revealed that 65.6% of FP users received full method information (informed of side effects, told what to do if experience side effects, informed of other methods of FP). However, it is not easy to determine how the provision of FP information varied with socio-demographics since the presented data was not disaggregated by age and rural-urban residence. Involvement of FP clients in decisions about their care during FP consultations varied across age groups. Compared to 86% of women aged 20 years and above, only 67% of those below 20 years are involved in decisions about their care during FP consultations. The most commonly channel used to disseminate FP messages is radio (50.2%). However, a significantly low proportion of women in rural areas (44.1%) and adolescent girls (38.7%) are reached through this channel. The second common source of FP information is outdoor sign/billboard (49.6%). Whereas almost half of urban women (60.1%) are exposed to FP messages via outdoor sign/billboard, only 43.7% of women are reached with FP messages through this channel (Annex II). While 77% of women own mobile phones, only 11.2% are exposed to FP messages through this channel (5.4% rural versus 17.7% urban).

Furthermore, respondents of in-depth interviews had similar views regarding access to FP information. The majority said that many individuals access the FP information through brochures, vehicle advertisements, or community health workers (CHWs). Additionally, posters which indicate provision and availability of FP services are strategically placed in public areas to further raise awareness. House-to-house outreach is another effective method used to spread information, ensuring that families, especially those in remote areas, are informed about available FP options. These diverse communication strategies aim to ensure that FP services are accessible and known to as many people as possible, helping to reduce barriers to care and increase service utilization.

> "*There are posters which show the availability of FP services. Information on FP also is spread through house-to-house outreach*". CHW Kilimanjaro

> "*For example, in a given month, most people receive information through brochures, vehicle advertisements, or CHWs*" HP Officer Ruvuma

In Zanzibar, there are no strict regulations limiting access to family planning services, as it is considered everyone's right, including youth, who benefit from a special program called the "Youth Friendly Program." However, participants shared their opinion on Zanzibar's culture, that men are often the primary decision-makers, and in some cases, women are threatened with divorce if they choose to use FP methods. For long-term methods, women are typically expected to seek permission from their husbands before proceeding.

> *There is no strict regulation in the provision of FP as we all believe it is every one's right to access these services, even to youth. There is a special program called youth friendly program this also insist on the use of FP. However, in our culture men is a decision maker and sometimes they threaten women if they use FP will get*

divorced. For long term methods they should seek permission. (NGO Representative -Zanzibar).

NGO representative from Zanzibar reported on the inadequate of FP information due to poor Monitoring and reporting. Many individuals fail to document well the FP information, including the number of people who receive services and education, making it difficult to track progress and impact.

> *"Monitoring of reports is a challenge as people fail to document how many people got the services and education on FP" (NGO Representative, Zanzibar)*

3.3. The perspective of key stakeholders on the various community and health system factors inhibiting the scale-up of SBC.

The majority of key informants over (80%) were health workers at the council and community levels (Table 2).

Table 2. Profile of Online Respondents (N = 464)

Institution/Organization	**Number**	**%**
Public	440	94.8
Other (Private, NGO)	24	5.2
Position		
Policy	6	1.3
Program Manager	20	4.3
Researcher/M&E	1	0.2
Health professional	414	89.2
Other	23	5.0
Working level		
National	4	0.9
Region	25	5.4
Council	211	45.5
Community	176	37.9
Other	48	10.3

Table 3. SBC for FP Mean Score (N = 464)

Item	Mean	Code	Bottleneck severity
Implementation status	1.35		Not a bottleneck
Leadership & commitment	1.50		Not a bottleneck
Accountability	1.50		Not a bottleneck
Regulation	1.59		Not a bottleneck
Guidance formulation	1.70		Not a bottleneck
Budgeting	2.32		Minor bottleneck

Donors	2.44		Minor bottleneck
Insurance	2.71		Minor bottleneck
Spending allocation	2.18		Minor bottleneck
Planning	1.89		Not a bottleneck
Equity	2.04		Minor bottleneck
Communication, knowledge & awareness	2.08		Minor bottleneck
Acceptability	1.86		Not a bottleneck
Consultation	1.92		Not a bottleneck
Coordination	1.86		Not a bottleneck
Networks	2.00		Minor bottleneck
Community engagement	1.84		Not a bottleneck
Reporting	1.81		Not a bottleneck
Data & HMIS	1.69		Not a bottleneck
Guidelines & tools	1.74		Not a bottleneck
Client SBC/IEC	1.82		Not a bottleneck
Health promotion	1.80		Not a bottleneck
Infrastructure	1.90		Not a bottleneck
Supplies	1.84		Not a bottleneck
Management	1.82		Not a bottleneck
Supervision	1.77		Not a bottleneck
Team work & coordination	1.45		Not a bottleneck
Service organization & scheduling	1.55		Not a bottleneck
Referral systems	1.81		Not a bottleneck
Fees	1.39		Not a bottleneck
Training & education	2.36		Minor bottleneck
Capacity	1.69		Not a bottleneck
Roles	1.68		Not a bottleneck
Skills and competencies	1.70		Not a bottleneck
Motivation	1.64		Not a bottleneck

Government expenditure on SBC does not matches the allocated budget, and hence no adequate budget and no sufficient donors' contribution for scale up of SBC for FP at all levels. Training

on SBC for FP is inadequate. Only a few key informants strongly agreed that SBC/IEC materials on PPFP are available for use in maternal and newborn health facilities. Reproductive Mother, Newborn, Child and Adolescent Health (RMNCAH) have inadequate skills and competencies to deliver PPFP (Table 3).

While at the national level, budgeting and planning were the important challenges, at the regional level budgeting, insurance, and training and education emerged as important challenges. For the community, the biggest outcry was insurance (Table 4).

Table 4. SBC for FP Mean Score by Working Station Level

	National	Region	Council	Community	Other	All
Implementation status	1.50	1.72	1.31	1.31	1.50	1.35
Leadership & commitment	1.50	1.72	1.43	1.52	1.63	1.50
Accountability	1.50	1.72	1.46	1.51	1.52	1.50
Regulation	1.75	1.84	1.56	1.57	1.67	1.59
Guidance formulation	1.50	1.88	1.67	1.69	1.79	1.70
Budgeting	2.00	3.00	2.23	2.25	2.65	2.32
Donors	1.75	2.48	2.38	2.46	2.60	2.44
Insurance	3.50	3.60	2.61	3.00	2.60	2.71
Spending allocation	2.75	2.76	2.15	2.06	2.44	2.18
Planning	3.00	2.40	1.92	1.76	1.81	1.89
Equity	2.00	2.56	2.06	1.91	2.17	2.04
Communication, knowledge and awareness	2.00	2.84	2.04	1.98	2.29	2.08
Acceptability	1.75	2.44	1.82	1.77	2.06	1.86
Consultation	2.00	2.52	1.89	1.81	2.15	1.92
Coordination	2.50	2.32	1.87	1.69	2.13	1.86
Networks	2.50	2.64	1.99	1.86	2.21	2.00
Community engagement	2.25	2.16	1.82	1.74	2.10	1.84
Reporting	2.25	2.28	1.82	1.65	2.06	1.81
Data & HMIS	2.50	2.44	1.64	1.55	1.92	1.69
Guidelines & tools	1.75	2.44	1.76	1.57	1.92	1.74
Client SBC/IEC	1.75	2.32	1.87	1.66	1.98	1.82
Health promotion	1.75	2.44	1.78	1.67	2.02	1.80
Infrastructure	2.25	2.40	1.88	1.77	2.17	1.90
Supplies	2.00	2.32	1.82	1.70	2.15	1.84
Management	1.50	2.16	1.81	1.72	2.10	1.82
Supervision	2.00	2.32	1.79	1.63	1.90	1.77
Team work & coordination	2.50	1.40	1.47	1.37	1.54	1.45
Service organization & scheduling	1.50	1.80	1.56	1.44	1.75	1.55
Referral systems	2.25	2.12	1.80	1.71	2.08	1.81
Fees	1.50	1.52	1.43	1.29	1.52	1.39
Training & education	2.50	3.08	2.32	2.24	2.60	2.36
Capacity	1.75	2.20	1.65	1.64	1.83	1.69
Roles	2.00	1.96	1.72	1.55	1.83	1.68
Skills & competencies	1.50	2.16	1.67	1.58	2.04	1.70
Motivation	2.25	2.17	1.65	1.50	1.75	1.64

On the Contrary qualitative respondents especially those from NGOs and CHWs said the budget for FP services is somehow assisted by the NGO. The NGO representatives said they provide financial support to the health providers they collaborate with. They are responsible for covering costs such as payments for nurses and doctors, as well as fuel for district vehicles if needed. However, challenges remain in ensuring that all involved personnel are adequately compensated. For instance, community health workers (CHWs) often face financial constraints, as there is no sufficient budget to cover their travel expenses. One CHW mentioned,

> "*Traveling to the inner islands is a challenge because I have to use my own personal fare." there is no adequate budget available to compensate the CHWs*" CHWs Mara

> "*The budget is for the providers we work with. The NGO, since it is our organization, provides support. The nurses we will have, the doctors if a vehicle is needed, they will cover the fuel costs for the district's vehicle. They provide financial support. They are the ones managing it; they will pay the nurses, and if a doctor is assigned by the district, they will also handle that."* NGO representative Mara

Furthermore, some individuals involved in the interview expressed uncertainty about the budgeting process, with one stating, *"I don't know about the budgeting*." (NGO Ruvuma). This highlights gaps in financial support for frontline workers, which may affect the efficiency and sustainability of family planning initiatives.

The same to Zanzibar, participants said they have not invested enough in Social and Behavior Change Communication (SBCC) efforts for FP, which is evident in the limited coverage and effectiveness of the approach reaching the wider society. This gap can be attributed to a lack of resources, hindering the ability to fully engage and educate the community.

> "*We haven't invested enough on SBCC for FP due to lack of resources*. (NGO Representative -Zanzibar*)*

Key informants also acknowledged the government FP initiatives, though the coverage remains low due to absence of mechanisms to sustain the initiatives or projects over the long term. Informants believes that the government should invest more to create bigger impact. However, there are stakeholders who support SBC for FP efforts by providing resources such as mobile vans, public announcements (PA), and family planning flyers. The following

Yes, they do invest, but cannot cover a large area and projects are not done for a long time. I think it's not enough (NGO representative -Zanzibar)

3.4. Acceptability

Acceptability of FP remains a challenge in the Zanzibar community, as most campaigns primarily target women, while men, who are the primary decision-makers, are often left out. To improve acceptance, there is a need to provide more education to men and other influential community members, empowering them to make informed decisions about family planning.

"Men involvement is still a challenge because most of the FP campaigns are for women but in our community, women are not the last decision makers, Men are the ones who make decisions. We should give more education to men and all influential people in the community. (HPO, Kaskazini Pemba, Zanzibar)

3.5. Documentation of lesson learned from successful implementation of SBC for FP programs in Tanzania.

Case Study I. Strengthening Postpartum Family Planning (PPFP) and Maternal, Infant and Young Child Nutrition (MIYCN) Outcomes in Mara and Kagera, Tanzania A Multi-Level Approach

Lactational Amenorrhea Method (LAM) is over 98% effective in preventing pregnancy when practiced correctly in the first six months post-delivery. Inclusion of LAM in the method mix expands women's postpartum contraceptive options and allows a woman time to consider her choice of another modern contraceptive method when one or more of the three LAM criteria no longer applies. In addition, counselling on LAM presents an opportunity to reinforce links between exclusive breastfeeding and postpartum return to fecundity. Thus, USAID's Maternal and Child Survival Program (MCSP) worked with regional and district-level teams in Kagera and Mara to improve the coverage, quality and sustainability of an integrated package of reproductive, maternal, newborn and child health interventions along the household to hospital continuum of care. Maternal and Child Survival Program (MCSP) re-envisioned the way PPFP information was communicated. The program examined use of services and then identified socio-cultural cues for birth spacing and most appropriate channels and approaches for communicating culturally appropriate information. Simplified FP messages were disseminated at the household, community and health facility levels. This included using radio and song, training community health workers through an e-Health platform, involving health workers at the dispensary level, and engaging breastfeeding support groups, local champions, and civil society organizations. Ultimate program aim was to advance the understanding of factors affecting timeliness and knowledge of postpartum contraceptive uptake and optimal MIYCN practices, recognizing that health systems considerations such as commodity availability are also critical for stimulating demand. Community Health Workers (CHWs) tracked women's

use of LAM and adherence to the three criteria in their catchment area. The tool used for tracking, facilitated CHWs to ask women about their breastfeeding and family planning practices, counsel women on maternal nutrition, monitor adherence to the LAM criteria on an ongoing basis, and provided a cue to action for providing an FP referral and advice on appropriate introduction of complementary foods before/when LAM criteria are no longer met. CHWs filled out the tracking forms during household visits. Women who chose to use LAM were given a self-monitoring tool by the CHW or facility provider. The tool helped women on a weekly basis, to track if the three LAM criteria were met. If not, this prompted woman to return to the health facility for counseling on other family planning options. The tool has low-literacy, visually dynamic information addressing criteria for exclusive breastfeeding and return of menses.

To make the criteria for LAM more memorable, a song was created to promote good maternal nutrition and reinforce the importance of *timely* transition. This song was aired on local radios (Bunda FM in Mara and Radio Kwizera in Kagera) and covered the implementation districts/catchment area. The airing of LAM song started in July 2017 to November 2018. The airing tracking mechanism was used to record hours and dates when the song was aired. Maternal and Child Survival Program (MCSP) developed a LAM/EBF job aid to guide counseling by family planning providers at the health facility and CHWs, complementing existing government RMNCH materials. The two-sided job aid featured key information about LAM on one side, addresses context-specific barriers to exclusive breastfeeding and emphasizes adequate maternal nutrition. All CHWs received the LAM job aid as part of the working tool, and each implementing facility received their own copies of the LAM job aid.

Facility service providers and CHWs were oriented on MIYCN and FP guide. The one-day training addressed guidance on LAM, strategies for addressing barriers to exclusive breastfeeding, postpartum return to fecundity and importance of timely postpartum contraceptive uptake and introduction of complementary foods. Monthly supportive supervision to health care providers and CHWs reinforces contraceptive choice and importance of counseling on the range of FP options. Regular monthly supervision meetings gave opportunities to discuss achievements, challenges and way forward as far as LAM and MIYCN is concerned. Action plans were documented and followed up on during follow-on supportive supervision visits.

The Maternal and Child Survival Program (MCSP) which applied gender, equity and health systems-focused approaches improved service availability, access, quality, demand and utilization of services including FP services in project regions. Research findings at formative stage contributed to the knowledge base on existing barriers and facilitators for optimal nutrition and family planning practices in the region. The research informed the development of a strategic approach for re-envisioning and revitalizing the promotion of the Lactational Amenorrhea Method as a contraceptive option within the context of integrated nutrition and family planning programming.

The majority of women (82.8%) were able to mention at least one family planning method and less than two-thirds (55.7%) had exposure to at least one media source. Prior approval from husband/partner to use family planning was required in 79% of women. Women who discussed family planning with husbands/partners, CHWs and facility health workers, and women who had received family planning counselling during ANC, were more likely to use postpartum family planning methods. Multiple counseling sessions during the course of a pregnancy contributed to higher postpartum family planning uptake. Overall lessons for success included emphasis on country-level and hospital-based leadership, on-the-job training, competency standards, prenatal counseling, and robust monitoring, evaluation, and feedback. Understanding barriers to PPFP uptake and tailoring programmatic approaches to address those barriers helped to improve uptake.

SBC for FP Case Study II: Leveraging large-scale projects to increase first-time parents' use of postpartum family planning and postnatal care (CONNECT Project)

The Connect Project is led by Save the Children in collaboration with the George Washington University (GWU) Milken Institute School of Public Health. EDI Global is the data collection partner in Tanzania. Drawing from formative work, CONNECT designed "program enhancements" additional activities layered onto the host projects' existing facility- and community-level approaches to address key barriers to increase first time parents' (FTPs') use of PPFP in Tanzania. Efforts were focused at the community level, leveraging Lishe Endelevu's community support groups (CSGs) and existing relationships with Community Health Workers (CHWs). Under Connect, FTPs were recruited into CSGs, receiving home visits and referrals from CHWs.

Beginning in 2019, Connect designed and tested the approaches in a pilot, and conducted a quasi-experimental evaluation (read more here). Lessons from the initial testing were integrated into a second roll-out of the approaches. Impact evaluation which employed a cluster randomized controlled trial (c-RCT) assessed the causal impact and cost-effectiveness of the project's community-level interventions on PPFP adoption and continuation among first time mothers (FTMs) aged 14-25. The project was implemented in Dodoma region of Tanzania. A total of 72 villages, within two largely rural districts of Dodoma region, were randomly assigned to treatment and control groups, stratified by district and urban, peri-urban, or rural status.

The baseline data reveals a key message: there is room for improvement in PPFP adoption and the timing of adoption. Almost all (97%) of respondents said they want to space births by 2 or more years. Since giving birth, 45.9% of FTMs had adopted a modern PPFP methods and at the time of data collection 34.2% were currently using them. Most FTMs who had adopted PPFP, did so 3-6 months after giving birth, this presents an opportunity for interventions to increase early adoption. Among the FTMs who adopted PPFP, most used Lactational Amenorrhea Method (LAM, 32.4%), male condoms (36.1%), and implants (37.9%). Fewer FTMs adopted oral contraceptive pills (6.3%) and intrauterine devices (IUDs, 1.8%). There was also a low intention (2%) to adopt IUDs of those who have not adopted any modern

PPFP. Only 50% of partnered FTMs have discussed family planning with their husband/partner.

FTMs had limited decision-making power; male partners and older female relatives make many decisions on their behalf, including decisions regarding fertility and PPFP; FTMs experienced judgmental treatment from health providers when accessing health services including PPFP, especially when they are younger or unmarried; FTMs and their families had key misinformation about FP in general, particularly that FP may limit their future fertility or result in malformations in babies, that male partners must accompany women and girls for FP services, and limited awareness that PPFP adopters can choose another method if they do not like the first method they try; Community health workers (CHWs) often overlooked FTMs in outreach activities, and FP was often not discussed when FTMs accessed other RMNH services.

In 2021, CONNECT and Lishe Endelevu introduced three community-level "enhancements" and developed one facility-level enhancement. The enhancements were selected based on the potential to address the identified barriers, complementarity with existing Lishe Endelevu activities, and the potential for scale in the Tanzanian context. At the community level, CONNECT enhanced Lishe Endelevu's existing nutrition-focused community support groups (CSGs) of pregnant and lactating mothers to integrate PPFP and to increase enrolment of FTMs in the community support groups. The Lishe Endelevu CSGs met twice per month over a six-month period. The CHWs who facilitated CSGs also conducted home visits to FTMs, using an integrated nutrition/PPFP job aid developed under CONNECT. During visits, CHWs engaged FTMs' male partners or older female relatives in counselling when possible, and provide short-acting PPFP methods and facility referrals for PPFP methods and other services. FTMs were enrolled in Lishe Endelevu's existing SMS platform and received nutrition and PPFP messages. Connect made several key decisions during the design phase to improve scalability and sustainability of the approaches by leveraging existing platforms (e.g., existing CSGs, the CHW cadre). In the Tanzanian context, no existing platform offered opportunities for deeper engagement with male partners or older female relatives that could be sustained beyond a time-bound donor-funded initiative. To address harsh and judgmental treatment from facility-based providers, CONNECT supported the Tanzanian Ministry of Health (MoH) to develop a 12-hour gender and respectful care on-the-job training (OJT). The OJT includes provider reflection to increase self-awareness on specific biases related to FTPs and PPFP. This streamlined approach builds off more extensive efforts to address provider bias by including opportunities for reflection and dialogue to help providers to understand their own biases, to increase the potential for institutionalization within the government health system. CONNECT's community-level enhancements were introduced in five wards of Kongwa district in Dodoma region in January 2021. Small-scale testing in thirteen villages of Kongwa District was conducted to assess the effectiveness, acceptability and feasibility of the enhancements, and to identify refinements needed to CONNECT's approaches and to inform scale-up plans. Connect formed 40 dedicated FTM CSGs, in two waves of 20 CSGs. Each CSG included 15 FTMs.

Rapid Surveys of FTMs Connect were conducted two rounds of a pre-post design survey with FTMs ages 15-24 years. The surveys aimed to: 1. Measure associations between enhancements and PPFP use among FTMs; 2. Explore FTMs' positive and negative experience with the program enhancements; 3. Identify areas for improvements needed before scale-up of tested enhancement materials; implementation approaches, and measurement; and 4. Explore socio-demographic and cultural characteristics of surveyed FTMs.

CONNECT convened three pause-and-reflect meetings with 20 CHWs to gather insights on progress through successes, challenges, how they overcome the challenges, and their recommendations for improvement. Connect conducted brief sessions with 77 FTMs in April/May and December 2021 to gather feedback about the interactions, experiences with activities, and suggestions for improvement. Connect convened separate group discussions with 25 older female relatives (mothers and grandmothers) and individual interviews with 12 male partners (husbands or partners in less formal unions with FTMs). These sessions explored the interactions and experiences that household influencers of FTMs had with the program enhancements, any concerns about the content, the level of their involvement and/or the involvement of FTMs, and their recommendations for improvements.

Postpartum Family Planning Uptake Use of modern PPFP among FTMs increased over time. Overall, survey findings identified a 48% increase in actual PPFP adoption and plans to adopt for both age groups. At Round 1, 42.4% of FTMs who had given birth had adopted a modern PPFP method; by Round 2, 64.0% of those who had given birth had adopted modern PPFP. FTMs ages 15-19 had lower PPFP uptake than FTMs ages 20-24, although both age groups saw similar increases in PPFP use between survey rounds. Part of the increase in PPFP use is simply related to FTMs' babies getting older and the timing of home visits occurring 3-6 months following delivery; the majority of FTMs who adopted PPFP (36.2%) adopted when their baby was between six and 12 months old. However, regression analyses identified associations between exposure to CONNECT's enhancements, and PPFP uptake.

Most of FTMs (68.3%) adopted implants, 29.3% adopted male condoms, 19.2% adopted injectables, 12.0% adopted pills, and 0.6% adopted IUDs. The method mix was similar across age groups and partnership status, with two distinctions. FTMs who did not have a partner were more likely to adopt implants than those who did have a partner (73.7% vs. 65.5%). FTMs ages 20-24 were more likely to adopt injectables than FTMs ages 15-19 (22.7% vs. 15.2%). In general, the method mix reflects FP use among girls ages 15- 19.

Some adopters of short-acting PPFP methods switched to other methods, but discontinuation was overall low. Many adopters of short-acting methods (condoms, pills, and injectables) were not using the same PPFP method ranging from 31%-67% of adopters at R2. More than one-quarter (26.7%) of adopters of short-acting methods switched to another modern method.

PPFP knowledge increased, but belief that male partner accompaniment is required to access FP remained high. We surveyed FTMs on knowledge barriers identified in Connect's formative work (FP causes infertility, male partner accompaniment is required to access FP services, FP

adopters cannot switch to another method, and FP can cause malformations in babies). Between survey rounds, we identified increases in the proportion of FTMs correctly reporting that each statement was false.

At Round 2, 95.5% of FTMs said that they wanted at least two years of spacing between the births of their children, a slight increase from 85.5% at Round 1. On average, FTMs wanted to have a total of 3.8 children, which is lower than the national average of 4.7 child wanted among all women. Overall, 46.9% of partnered FTMs said that their male partners wanted the same number of children. However, 39.3% said that they did not know their partner's preference.

Among partnered FTMs, couple communication around PPFP increased. At Round 2, the majority of partnered FTMs (83.7%) indicated discussing PPFP with their male partner, an increase from 69.9% at Round 1. PPFP discussion was more likely to happen once the child was older than six weeks, and even more likely after the child was six months old. FTMs ages 15-19 were less likely than FTMs ages 20-24 to report discussing PPFP with male partners.

Most FTMs shared nutrition or PPFP information from community support groups with others, most often with husbands or mothers. Over half (53.4%) of FTMs reported sharing any information from the CSGs with others. These findings provide insights into FTMs' social networks and relationships. Most frequently, FTMs shared information with their male partner, if they had one. Many FTMs shared with their mother (42.8%), female friend (33.7%), sister (12.3%), or mother-in-law (11.2%). FTMs ages 15-19, and those who did not have a partner, were more likely to share information with their mother (47.4% and 80%, respectively) than FTMs ages 20-24 and those who had a male partner. FTMs ages 20-24 and those who did not have a partner were more likely to share information with their sister (17.4% and 18.7%, respectively) than adolescent (ages 15-19) and partnered FTMs.

Exposure to enhancements was associated with improvements in most outcomes, including PPFP uptake. However, coverage was limited; many FTMs attended only one CSG meeting (out of as many as 12 offered over the six-month period), nearly one-quarter did not receive a home visit, and less than 10% received SMS. Given that exposure to the enhancements was associated with positive outcomes, efforts to improve enhancement coverage could be beneficial. However, low mobile phone ownership among FTMs will limit improved coverage of SMS.

Scalable efforts designed to enhance existing platforms with low-dosage engagement of FTMs (attending two or more CSG meetings, receiving two to three home visits from a CHW, receiving SMS) can effectively improve PPFP uptake and other key outcomes among both adolescent and older FTMs. While findings underscore the potential of light-touch approaches, they also point to several limitations and areas for improvement or deeper exploration.

Despite overall increases in PPFP uptake, decision-making power largely remained with male partners. The limited movement on the decision-making outcome suggests that shifting deeply-seated social norms underpinning decision-making may require deeper engagement than

feasible with light-touch engagement of male partners through scalable platforms. In addition, a large proportion of partnered FTMs did not know their partner's fertility preferences, which suggests a gap in couple communication. While deeper engagement to shift social norms and bolster couple communication skills could further accelerate PPFP uptake. The project did not identify existing platforms to engage the male partners of FTMs.

Case Study III: USAID Tulonge Afya Project[4]

Implemented by FHI 360 from 2017 to 2022, the **USAID Tulonge Afya project**—Kiswahili for "Let's Talk about Health"—was the USAID flagship SBC project in Tanzania, delivering integrated activities that addressed SBC needs across 6 core health areas: HIV; family planning and reproductive health; malaria; maternal, newborn, and child health; TB; and emerging infectious diseases. The project's goal was to catalyze opportunities for Tanzanians to improve their health status by transforming sociocultural norms and supporting the adoption of healthier behaviors. Through use of a participatory, evidence-based, and theory-informed approach, the project developed 2 integrated, branded SBC platforms: **Naweza (Kiswahili for "I Can") targeted** adults at key life stages (pregnancy and caregiving for a child aged younger than 5 years, with a focus on the first 1,000 days); **and Sitetereki ("Unshakeable")** engaged youth to increase uptake of positive sexual and reproductive health behaviors. These integrated platforms were supplemented by a long-running HIV-focused campaign, Furaha Yangu ("My Happiness"), which addressed the needs of priority populations at higher risk of HIV and people living with HIV. From 2019, the project implemented comprehensive packages of SBC activities under these platforms, including mass and social media at the national level; mid-media (e.g., community theater, radio, and events); community mobilization; and interpersonal communication activities (e.g., community health worker counseling and small group dialogues) in collaboration with local civil society organization (CSO) partners in 29 focal districts.

The Adult Strategy applied an ADDED approach. ADDED stands for Audience-driven Demand, Design, and Delivery which sought to understand what people demand – or desire – and to deliver activities that address this using a range of participatory methods. This ADDED approach was taken to segment audiences, address behavioural determinants, and produce and deliver solutions at individual, community, and system levels with and by our audience.

ADDED utilizes a socio-ecological model to address multiple levels of influence on behaviour, and applies specific SBC tactics based on where audiences fall on a spectrum of behaviour change to:

- Increase desire or demand for healthy behaviours, products, and services
- Move audiences from intention-to-action
- Support behavioural maintenance Facilitate individual and community advocacy for change

Two independent repeated cross-sectional household surveys were conducted in 19 focal regions approximately four years apart, during program implementation years 1 and 5. Districts in the study include: Ninety-one "non-enhanced" districts where standard programming (mass

[4] https://www.ghspjournal.org/content/11/Supplement_2/e2200215

media and technical assistance [TA] and tools for partner implementing organizations) were implemented in Twenty-nine "enhanced" districts where greater programming intensity were supported (mass media, community mobilization, and interpersonal communication [IPC] in addition to TA and tools for partner implementing organizations). At baseline, less than half (44.4%) of women with a live birth <12 months ago reported using contraceptives to delay the next pregnancy for 12 months, less than a quarter (23%) reported seeking information on contraception in the past six months. Furthermore, only slightly more than a third (39%) of the study population had positive attitudes toward FP. And, only 6% of the study population ages 15-49 years reported discussing contraceptive use with a partner in the past six months

GOT staff and the CSOs implementing SBCC activities on the ground reported that USAID Tulonge Afya contributed to SBCC data systems strengthening. They noted that before USAID Tulonge Afya, systems did not exist to capture various data on implemented SBCC activities. USAID Tulonge Afya developed output indicators (i.e., number trained, number exposed to messages), implemented an electronic SBCC data system (up to the CSO level), and trained CSOs and CVs on SBCC data reporting. CSOs reported that their CVs collect data (on implemented SBCC activities) on paper and CSO staff enter the paper forms into the electronic system that is directly accessed by USAID Tulonge Afya, IPs, and GOT staff with access to the database

Despite many governments officials' knowledge of what integrated SBCC means, some still found it hard to understand its implementation in practice. For example, one of the SBCC coordinators for a specific health program thought that the integrated SBCC approach required him to start supporting SBCC activities in other health areas in which he was not competent.

USAID Tulonge Afya supported the HPS to develop National Health Communication Policy Guidelines, a National Communication Strategy, and SOPs to operationalize the policy and strategy. Unfortunately, the documents have not been signed. This limits their use to guide integrated SBCC implementation.

As per evaluation report, there is still a lack of clarity on roles and responsibilities of SBCC staff of vertical programs compared to the HP coordinators of the integrated SBCC program who work under the HPS. HP coordinators working at the regional and district levels do not collaborate with coordinators of vertical programs at the national level as planned. The lack of collaboration caused confusion regarding their role as coordinators of vertical programs at sub-national levels, who previously worked with sub-national HP coordinators. Some staff of the vertical programs felt left out and expressed a concern that USAID Tulonge Afya focuses too much on the HP unit. On the other hand, the HPS stated that they felt that USAID Tulonge Afya and vertical programs were implementing various SBCC activities without involving them. Additionally, the HPS expressed a concern that since they have a mandate for coordinating SBCC activities under all the health areas (approximately 12 different health areas), they faced challenges because USAID Tulonge Afya only supports five different health areas. As different HP coordinators were not included in certain integrated activities or meetings, this affected the comprehensiveness reported by HP coordinators in integrated SBCC, some of whom were reported as not capturing SBCC activities supported by SBCC coordinators of specific health programs under other partners.

USAID Tulonge Afya was successful in generating buy-in for an integrated SBC strategy and approach in Tanzania, including the Government of Tanzania's ownership of integrated SBC

platforms and strong leadership and engagement from national, regional, and district-level stakeholders in the development, implementation, and oversight of integrated campaigns. To build on these successes, continued investment and advocacy are needed to ensure systems and structures facilitate integrated SBC programming.

Furthermore, during in-depth interviews it was revealed that a program "Waache Wasome" have been introduced in Mara to support girls and adolescents who require educational assistance after giving birth. Community health workers (CHWs) play an essential role in identifying young girls who were unable to complete their education due to teenage pregnancies and have settled in the mining areas, helping to bring them back to school. In addition, health clubs in schools collaborate with CHWs to provide family planning (FP) education to students, ensuring that adolescents are informed about their reproductive health options. Education for women and adolescents is prioritized, and often funded by donors. To increase access to health education, CHWs take proactive steps by reaching out to the groups in needs to ensure they are well-informed about available FP services.

> *"Programs like "Waache Wasome" is implemented in Mara to aid girls/adolescents who need educational support after giving birth and CHWs look for young girls who were not able to finish school because of teenage pregnancies and settled in the mines, bringing them back to school"* CHW representative Mara

> "*Education to women and adolescents is a priority and is given by donor, when access is limited to acquiring health education, we go to them to make sure they have knowledge on FP services as well'*. HP Officer Iringa

Overall, there are efforts to educate community health volunteers (CHVs) through the provision of guidelines after training in the form of posters that they can use to educate women of reproductive age (WRAs). However, the guidelines are known by only few CHVs who have been trained.

> *"General training on guidelines is being provided which the help of CHVs to perform their job. Guidelines [family planning guidelines] are given after training in the form of posters. They used to educate WRAs but few CHW knows about the guidelines. CHW, Kaskazini Unguja -Zanzibar*

> *"SBC/IEC are good but they need improvement because the world is changing and advancing and we need to advance with it". (Health Promotion Officer, Kaskazini Pembe, Zanzibar)*

4.0 BARRIERS TO SCALING UP SBC FOR PPFP

4.1. Cultural and Religious Beliefs

Key informants declared that, cultural and religious beliefs significantly influence attitudes toward family planning, with some women facing societal pressure to have many children

and others, particularly born-again Christians, viewing family planning as both religiously prohibited and harmful."

> "*There is culture which a woman is not allowed to use FP and is supposed to get as much children as they can.* " (CHW-Iringa)

> "*For those who are born-again Christians, it is often a challenge for them to use family planning. Their religion does not allow it, and they see it as harmful."* (CHW-Iringa)

Furthermore, in communities with a significant Roman Catholic population, there is often resistance to discussions about FP, as some individuals do not support the use of FP methods due to religious beliefs. As a result, clinics located in areas with high Catholic populations tend to see lower uptake of FP services, reflecting the influence of these religious views on health-seeking behaviours.

> *"Roman Catholics do not want to hear anything about FP turn up to the clinic to places where there is a lot of catholic the uptake of FP will be low*". NGO representative Kilimanjaro

However, the majority of participants in Tanzania mainland said, there are no laws or regulations that explicitly prevent individuals from accessing FP services. However, cultural and religious beliefs can create barriers. For instance, some respondents said Muslim communities in their society have strong preferences for having children without a significant age gap and may resist using FP methods, citing religious restrictions. Additionally, certain women may not feel empowered to seek FP services without first obtaining permission from their partners. While there are no legal restrictions for individuals over the age of 21, these social and cultural factors still pose challenges to the widespread adoption of family planning practices. The following quote illustrates

> *"There are no regulations that stop any person from getting FP but in the case of religion Muslims tend to have kids without an age gap when you tell them they say the religion doesn't allow them to use FP."* CHW Iringa

> *"Some women can't use FP until they get permission from their partner."* NGO representative Kilimanjaro

> *"There are no any regulations which hinders someone to get FP services if someone is from 21 years and above."* CHW Iringa

4.2. Parents' Misconception of FP

According to CHWs, despite FP education being provided in the community, some parents still prevent their children from discussing FP, believing it is not appropriate for youths. In some communities, parents lack understanding of FP and actively discourage their children from discussing it. There is a prevalent misconception about FP services, with many people believing that promoting FP use among adolescents encourages risky behaviour, such as engaging in early sexual relationships. This negative belief surrounding FP services can create significant

barriers for young people who may otherwise benefit from access to reproductive health education and services.

> *"Some parents have no understanding on FP so they forbid their children to even speak about it. Most people have bad belief on FP services they believe it's a go-ahead to adolescents to start bad manners and have partners in the early stage*" CHW in Iringa

4.3. Inadequate trainings for CHWs.

There is a notable inadequate training for community health workers (CHWs). Some CHWs receive only instructions from the nurses they work with, without formal training. For example, a CHW from Ruvuma shared, "I have never received any training." Additionally, a CHW from Iringa said, "We haven't had training on family planning since 2017." This highlights a gap in ongoing FP trainings for CHWs.

4.4. Low motivation

Interviewed CHWs said that there is no compensation from the government, so they rely on the mercy of the donors or NGOs they work with such as Marie Stopes, for support. One respondent emphasized, "Financial motivation is very important, especially for CHWs." This lack of financial support has led to low motivation and may hinder the effectiveness of CHWs' work.

> *"More motivation in terms of pay is needed especially for CHWs as they are not compensated by the government only by Donors like Marie Stopes*" NGO Repr. Njombe

Similarly, participants from Zanzibar complained of low motivation among VHWs. Because they are volunteering, they often not paid anything and have to cover their travel expenses when performing outreach duties.

> "*Motivation is essential and any financial aid will enable Community Health Volunteers (CHVs)to perform well. Aid is needed more for travel expenses and water during work related trips.* (CHV- Kaskazini Unguja-Zanzibar)
>
> *This is our job and our passion, and that's where we draw our motivation from; other forms of motivation, like financial incentives, are just the cherry on top.* (CHV- Kaskazini Pemba-Zanzibar)

4.5. Inadequate Supplies of SBC for FP Materials

The provided SBC for FP materials is limited, consisting mainly of posters, phones, and cards that are used for health promotion and dissemination of information on FP/PPFP. To scale up SBC we need to have these supplies available. The following quote illustrates;

Not much supplies are given except for the poster, the phone and the card that aids in health promotion and disseminating information on FP/PPF. Supplies are limited and are used effectively; they need improvement for ease of use. (HPO-Kaskazini Unguja-Zanzibar)

5.0. SOLUTION FOR SCALING UP SBC FOR FP

5.1. Community Education

Various strategies are employed to provide FP education and services to adolescents and communities. Peer groups for adolescents are formed, and FP services are offered on weekends, alongside educational sessions at reproductive and child health (RCH) clinics. Additionally, FP education is delivered to adolescent girls through small business groups and village meetings. Community outreach extends to local churches, including Seventh-Day Adventist (SDA) and Pentecostal congregations, where FP information is shared. To further spread awareness, loudspeakers are used to announce community meetings, and collaboration with local government and cultural leaders enhances the reach and impact of these outreach efforts.

"We have peer group (adolescent) for them we give them FP service on weekends. Education on RCH clinics, small business groups (adolescent girls) we go to give them FP educations, in village meetings also we give FP education. We give FP education on churches like SDA and Pentecostal". CHW Ruvuma

"*The community is involved we start from local government leaders, religious leaders, influential people then we go to community members".* CHW Iringa

Furthermore, in Zanzibar education on guidelines is provided to support community health volunteers (CHVs) in their work. They also inform that after training, these guidelines were given to CHVs in the form of posters '*bango kitita'* that they can easily understand and use to educate women of reproductive age (WRAs). However, these guidelines are not widely known. Additionally, some guidelines help create Social and Behavior Change (SBC) and Health Promotion (HP) materials which are used to scale up SBC.

"*General education on guidelines is provided to aid CHVs in doing their job. These are given after training in the form of posters 'bango kitita', they can use to educate Women of Reproductive Age. Guidelines are not well known to all of us. There are guidelines that aid in the creation of SBC and HP materials* (HPO Kaskazini Unguja Zanzibar)

Furthermore, in carrying out their work effectively, CHVs follow a guideline called "Bango Kitita." However, this guideline was not available in the Health Promotion offices they can only be seen available only at the Reproductive and Child Health (RCH) unit in hospitals.

> *"I have guideline called" bango kitita" which direct me how to do my work*" (CHV-Kaskazini Unguja- Zanzibar)

> "I have never seen that guideline here at HP office, maybe at RCH unit in hospitals. (HPO-Pemba-Zanzibar)

5.2. Community Outreach

Community outreach plays a crucial role in educating the public about family planning (FP) and ensuring that information is widely disseminated. Additionally, outreach efforts are directed towards health centres experiencing staff shortages, where extra support is provided to help ensure that women can access FP services promptly.

> "*We do outreach to those health centres with shortage of staff to add workforce in helping women to access FP services. on time*". NGO Representative Kilimanjaro

> "*There is community outreach where we get a chance to educate and give education on FP*" CHW Kilimanjaro

5.3. Community Engagement

Community engagement has played a crucial role in promoting family planning (FP) and postpartum family planning (PPFP). This is achieved through health facilities and clinic visits, where women attending the clinics are gathered and provided with information on FP/PPFP as a group. Most of the community engagement efforts are carried out by community health volunteers (CHVs), who actively go into communities to speak with women of reproductive age (WRAs) and spread valuable information and knowledge about FP/PPFP.

> *"Community engagement has been an essential part of promoting FP/PPFP. This is done through health facilities and clinic visits, gathering the women who come for clinic visits and speaking to them as a whole about FP/PPFP"* (CHV- Kaskazini Unguja-Zanzibar)

"Community engagement is done mostly by CHVs, they are the ones that go to the communities and speak to WRAs and spread information and knowledge about FP/PPFP" (HPO- Kaskazini Pemba-Zanzibar)

5.4. Use of Data

The use of data was said to increase the uptake of FP services. In some communities they said to use tablets which have been distributed to RCH centres to input data while providing services, ensuring accurate and efficient record-keeping. Additionally, some participants said to have data quality assessments conducted in their facilities. The collected data is used to guide outreach programs, helping to tailor services to the needs of the community and improve overall service delivery.

"*There are the tablets which were distributed to input data at RCH when giving out all services*" CHW Ruvuma

"*And we also conduct data quality assessments for all the facilities we visit."* HP Officer Pwani

Also in Zanzibar, data is very important, they said to conduct quality data assessments based on information they received from clinics regarding FP services. This data helps to track the progress of FP efforts. However, documenting SBC activities remains a challenge, although verbal reports are often available.

"*We do quality data assessment which we get from the clinics about FP services".* (NGO Representative-Zanzibar)

"There is a challenge to document SBC activities but monthly reports are available" (HPO-Kaskazini Pemba-Zanzibar)

5.5. Supportive Supervision

In order to increase PPFP service provision, supportive supervision from health care workers was said to be very important. Participants said to conduct joint supportive supervision between Health Workers and NGOs in order to monitor all reproductive and child health (RCH) family planning activities. This ensures that government healthcare providers, who are well-trained, can deliver services effectively. Additionally, our NGO supports on-the-job training and

provides continuous supervision for nurses working at RCH centres, fostering ongoing improvements in service delivery and quality.

> *"We do joint supportive supervision with coordinators all the RCH FP activities to government health care giver who are well trained to make sure they provide services perfectly*. NGO Kilimanjaro

> "*There is on job training and supervision to Nurses working at RCH from our NGO. We also get supervision from the health centre"* NGO Ruvuma

> *"There is supervision and the FP service providers and CHWs are taught how to counsel and promote FP health services before they start working*" NGO Representative Njome

From Zanzibar, supportive supervision is conducted by the facility in-charges, with all CHVs reporting directly to them, this helps to facilitate the scale up of SBC in the community.

> *"Supervision is done by the facility in-charge and all CHVs report to the facility in-charg*e directly (CHV Kaskazini Unguja- Zanzibar)

5.6. Team works and Coordination

Teamwork plays a vital role in the successful delivery of family planning services. Staff collaborate closely with health centre teams, working together five days a week, each day at a different centre, to build each other's capacity, provide guidance, and plan activities collectively. The in-charges of health facilities are also involved, attending ward council and community development meetings where they share information about the availability of services. This collaborative approach helps ensure that vital information is disseminated effectively and in a timely manner, with community health workers (CHWs) supporting and coordinating efforts to aid each other and work together seamlessly.

> "*You go to the health centres and work with the staff there. Five days a week, each day you go to a specific centre where we work together, build each other's capacity, provide guidance, plan together, and hold meetings together*." NGO representative Njombe

> *"Teamwork is very important we observed the coordination between the CHWs, and NGOs, they aid each other and work together Therefore, they help us in disseminating this information*." NGO representative Mara

There is a strong sense of **teamwork and coordination** among community health volunteers (CHVs) and other healthcare workers (HCWs), as CHVs serve as the bridge between HCWs and clients or women of reproductive age (WRAs). Teamwork is essential to ensure that the work is carried out effectively and to the highest standards.

> *There is a lot of teamwork and coordination among CHVs and other HCWs as they are the bridge between HCWs and clients or WRAs.* (CHV-Kaskazini Unguja-Zanzibar)

> *Team work is important to make sure the work is done at its best.* (HPO-Kaskazini Pemba- Zanzibar)

The majority of respondents in Zanzibar said, teamwork and coordination play a crucial role in delivering FP education. Community Health Volunteers said they work closely with community leaders such as the sheha, shekhe, and traditional birth attendants. The strong teamwork extends the partnership with service providers and Community Health Workers (CHWs), to foster a coordinated effort to effectively promote FP services and education across the community.

> *In delivering these FP educations we go to the community with sheha, shekhe and traditional birth attendant*. (CHV-Pemba-Zanzibar)

> *There is good team work as we work together with service providers and CHWs (*HPO Kaskazini Pemba-Zanzibar)

5.7. Referral System

There is a well-established referral system in place from the community to health centres for clients seeking long-term family planning methods. When clients choose their preferred method, referral books are used to document and provide them with the necessary referral to the same health centre for further assistance and service provision.

There is referral system from community to the health centre as to clients who want long term FP methods" CHW Kilimanjaro

Referrals are made, but there isn't a formal system in place; they are primarily done through word of mouth and the connections established among healthcare workers (HCWs).

"*Referral is done but there isn't a system in place, it is mostly through word of mouth and the connections made among HCVs"* (CHV-Kaskazini Unguja-Zanzibar)

5.8. Skills and Competencies

This is another component to scale up SBC, Community health volunteers (CHVs) are competent in the tasks they perform and are well-versed in disseminating information on family planning (FP). They attribute their competence to the training they received and the knowledge they gained during their schooling.

CHVs are competent in the tasks they perform and they are well versed in the dissemination of information on FP" (HPO-Kaskazini Unguja- Zanzibar)

*"We are competent because we are trained and we have learned these things from when we were in school (*HPO-Kaskazini Pemba- Zanzibar)

5.9. On-Job Training

On-job training is regularly provided to service providers, particularly on postpartum family planning (PPFP), to ensure they have the skills and competence to deliver high-quality services. For those who lack the necessary expertise, ENGENDER NGO conducts specialized training to CHWs. Additionally, training is provided by trained trainers (TOTs) on the insertion of implants and overall family planning service delivery. Service providers also receive education and knowledge from doctors and nurses, with comprehensive training on family planning having been conducted in 2021.

"*We provide training every month and on job supervision to service providers on PPFP. To those who don't have skills and competence to deliver FP services well we as ENGENDER NGO train them. On-job trainings also are done by TOTs on*

the insertion of implants and all FP service delivery". NGO representative Kilimanjaro

"We get education and knowledge from doctors and nurses. But we also received training in 2021 on family planning in general." CHW Iringa

Report of Stakeholders' Consultative Workshop

During stakeholders' consultative workshop, participants scored, ranked and prioritized the most important challenges, and developed action plan. Of the assessed bottlenecks of SBC for FP, 8.8% were rated as very important bottlenecks, 44.1% were important bottlenecks, 44.1% were minor bottlenecks and 2.9% were not bottlenecks. Mismatching of government budget allocation, insurance and budgeting emerged as very important bottlenecks. Participants discussed and agreed that low motivation was an important bottleneck of SBC for FP (Table 5).

Table 5. Ranked Mean Score for Assessed SBC for FP Bottlenecks

Bottleneck	Ranked Mean Score	Rating
Spending allocation	**4.40**	Very important bottleneck
Budgeting	**4.20**	Very important bottleneck
Insurance	**4.20**	Very important bottleneck
Motivation	**3.80**	Important bottleneck
Planning	**3.60**	Important bottleneck
Equity	**3.60**	Important bottleneck
Community engagement	**3.60**	Important bottleneck
Guidelines and tools	**3.60**	Important bottleneck
Networks	**3.40**	Important bottleneck
Accountability	**3.20**	Important bottleneck
Communication, knowledge and awareness	**3.20**	Important bottleneck
Acceptability	**3.20**	Important bottleneck
Client SBC/IEC	**3.20**	Important bottleneck
Health promotion	**3.20**	Important bottleneck

Consultation	**3.00**	Important bottleneck
Coordination	**3.00**	Important bottleneck
Service organization and scheduling	**3.00**	Important bottleneck
Training and education	**3.00**	Important bottleneck
Roles	**2.80**	Minor bottleneck
Guidance formulation	**2.60**	Minor bottleneck
Donors	**2.60**	Minor bottleneck
Reporting	**2.60**	Minor bottleneck
Referral systems	**2.60**	Minor bottleneck
Capacity	**2.60**	Minor bottleneck
Skills and competencies	**2.60**	Minor bottleneck
Leadership and commitment	**2.40**	Minor bottleneck
Management	**2.40**	Minor bottleneck
Team work & coordination	**2.40**	Minor bottleneck
Fee	**2.40**	Minor bottleneck
Regulation	**2.20**	Minor bottleneck
Data and HMIS	**2.20**	Minor bottleneck
Infrastructure	**2.20**	Minor bottleneck
Innovation	**2.20**	Minor bottleneck
Supplies	**1.80**	Not a bottleneck

After participants agreed on the important root causes, solutions of the prioritized SBC for FP bottlenecks were identified and action plan developed (Table 6).

Table 6. Actions to Address SBC for FP Bottlenecks

Problem description	**Action description**	**Responsible organization/person**
Inadequate budget for scale-up of SBC for FP at all levels	Incorporate costed implementation plan for scale-up of SBC for FP into national FP costed implementation plan III	MOH-DRMCH, sub TWG FP

	Include SBC for FP in the Global Financing Facility (GFF) Investment Case.	MOH-DRMCH, sub TWG FP
	Include SBC in the national FP Investment Case	MOH-DRMCH, sub TWG FP
	Advocate for inclusion of adequate funds SBC for FP in national and regional budgets	MOH-HPS and DMRCH
Outdated guidance on SBC for FP and NOT widely used (Mainland Tanzania)	Update and disseminate guidance on SBC for FP (SBC guidance not yet approved)	MOH-HPS
Updated guidance in NOT wisely used (Zanzibar)	Disseminate the updated guidance in user friendly format	MOH
No financing mechanisms and policy actions in place to ensure equitable scale-up of SBC	Advocate for budget allocation in areas where rates of FP use are low and unmet needs for FP are high	MOH-HPS
	Ensure SBC programmes address the needs of adolescents, other marginalized women including women living with HIV and women with disability through regular review data to ensure equitable allocation of budget.	MOH-HPS and IPs
Inadequate accountability for SBC for FP across institutions and among policy makers and programme managers	Ensure SBC and health promotion experts at different levels are accountable in coordination, developing, and implementation of effective SBC interventions for FP	MOH-HPS
Inadequate SBC/IEC materials to support SBC for FP	Routinely distribute SBC/IEC materials/apps on FP provision to health facilities and community outreach work, and clients/for client takeaway.	MOH-HPS and IPs
Inadequate capacity of health facility and community to implement SBC for FP	Regularly assess training needs for CHW and health facilities to implement SBC for FP.	MOH-HPS
	Orient facility and community based health promotion teams on effective SBC approaches	MOH-HPS
Staff working on FP across the health system have limited capacity to deliver SBC for FP	Train staff in national, regional and district health teams working on FP to promote the use of SBC for FP	MOH-HPS

Inadequate capacity of health facility and community to implement SBC for FP	Assess training needs for CHW and health facilities to implement SBC for FP regularly	MOH-HPS and IPs
	Orient facility and community based health promotion teams on effective SBC approaches	MOH-HPS
Staff working on FP across the health system have limited capacity to deliver SBC for FP	Train staff in national, regional and district health teams working on FP to promote the use of SBC for FP	MOH-HPS
Limited knowledge and awareness of recommended SBC policies and practices	Disseminate relevant policies and guidance.	MOH-HPS
	Orient policymakers and programme managers at the national and regional levels, health promotion/communication teams to fully understand and know recommended principles and practices for SBC for FP	MOH-HPS
	Strengthening the use of existing communication channels and platforms to ensure that stakeholders remain engaged and informed about SBC activities and progress.	MOH-HPS

6.0. CONCLUSIONS

In URT of there is a conducive policy environment for implementation of SBC for FP. Efforts to scale up SBC for FP services in Tanzania Mainland and Zanzibar have yielded notable progress. Initiatives such as "Huduma Rafiki," youth-friendly services, and community outreach have proven effective in reducing stigma and improving access to FP services. CHWs have played a key role in bridging the gap between healthcare providers and communities, ensuring that FP information reaches women of reproductive age, adolescents, and men. The use of tools like the guidelines and data management systems, including tablets for accurate record-keeping, has further improved service delivery.

However, challenges such as patriarchal cultural norms, particularly among men, and widespread misconceptions about family planning still hinder the broader adoption of FP

methods, especially in rural areas. Despite positive outcomes from collaborations between the government and NGOs, issues such as governance, limited resources, and inadequate financial support for CHWs remain. There is also a need for improved monitoring, documentation, and evaluation of SBC activities to assess the effectiveness of these programs and refine strategies.

7.0. RECOMMENDATIONS

I. Tanzania government through MOH to invest in FP education programs, especially in rural areas, targeting both men and women. These programs should focus on challenging patriarchal views and promoting shared decision-making in family planning.

II. The government in collaboration with responsible ministry to Improve access to FP information by using diverse communication channels like radio, mobile technology, and community outreach, particularly in rural areas and for adolescents who may lack access to mainstream media. Increase the use of local media, such as vehicle advertisements and the involvement of community health workers (CHWs), to raise FP awareness and encourage wider service use.

III. Governments through MOH and other stakeholders should prioritize funding for FP programs, focusing on education and outreach efforts, while maximizing donor support for scalability.

IV. The MOH in collaboration with the Ministry of Education to integrate FP education into school curricula, focusing on areas with high adolescent pregnancy rates, ensuring culturally sensitive content that resonates with local communities.

V. The MOH in collaboration with other stakeholders to train local staff on the use of electronic data systems to improve data collection, transparency, and accountability.

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