Validating *FP Goals*: A Model to Assess the Impact of Family Planning Interventions on Contraceptive Prevalence

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Abstract
As countries seek to increase their contraceptive prevalence rates, it is important to allocate scarce resources towards the most effective programs. Accordingly, the *FP Goals Model* (developed by Avenir Health with support from the Gates Foundation) enables practitioners and governments to project the impact of introducing or scaling up particular interventions on the modern contraceptive prevalence rate (mCPR). In order to assess the accuracy of the model, we inputted baseline data from Ethiopia in 2005 and Tanzania in 2010. We then compared the model's predictions to actual outcomes in 2011 and 2015, respectively. These validity checks demonstrated that the *FP Goals Model* performs well across countries, during different timeframes, and in varied family planning environments, predicting the mCPR in the endline year within one percentage point in both countries. We thus recommend developing country governments and development partners continue to rely on the model as they design family planning programs.

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Introduction

FP Goals is a new model designed by Avenir Health with funding from the Bill and Melinda Gates Foundation to help decision-makers set realistic goals and prioritize investments across varying family planning interventions. It is based on the *Goals* model, which focuses on HIV efforts (Bollinger et al. 2004; Bollinger 2008). By combining demographic data, family planning program information, and evidence of the effectiveness of diverse interventions, this model allows governments to make better informed strategic goals related to family planning.

This paper explores the results of a validity check of the *FP Goals Model*, to assess how well predictions made using historical data matched the actual recorded change in contraceptive use. For this validity check, we used the *FP Goals Model* to forward project the modern contraceptive prevalence rate (mCPR) in Ethiopia and Tanzania using Demographic and Health Survey (DHS) data. According to the DHS, modern methods include male and female sterilization, oral contraceptives, intrauterine devices (IUDs), injectables, implants, diaphragms, male and female condoms, and any use of emergency contraceptives. Traditional methods such as withdrawal and periodic abstinence are not considered modern methods (DHS, 2017). The base and endline years utilized in this analysis were determined by the most recently available DHS data. For Ethiopia, the baseline was 2005 and the endline was 2011; for Tanzania, the baseline was 2010 and the endline 2015.

The countries of Ethiopia and Tanzania have vastly different family planning stories, even though both put substantial effort towards increased contraceptive prevalence. While Ethiopia's mCPR increased by nine percent between 2005 and 2011 (ending at 18.7%), Tanzania's only increased by 3.5 percent between 2010 and 2015, although ending at the higher rate of 27.1%.

The rest of the paper is organized as follows. First, we present basic background on the history of family planning interventions in Ethiopia and Tanzania. We then present findings on the accuracy of the *FP Goals Model*, and describe the interventions that most contributed to the growth in mCPR. We conclude with a brief discussion of limitations and suggestions for how to improve the model.

Literature Review

Ethiopia

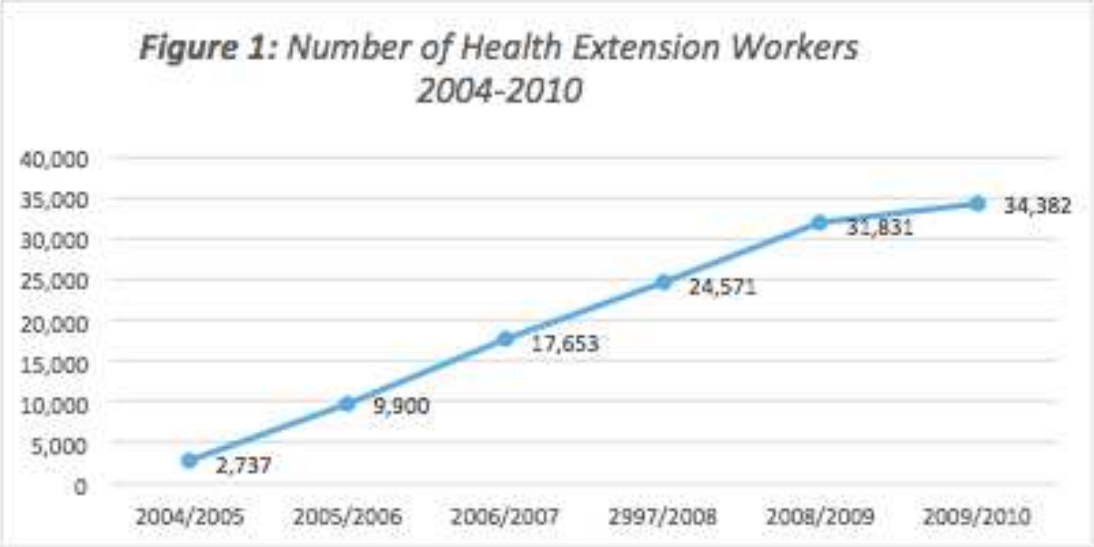
Ethiopia is often referred to as a family planning success story, thanks to a nine fold increase in mCPR between 1990 and 2011 (Olsen & Pillar, 2013). The rapid rise in the mCPR and drop in the total fertility rate (TFR) show what is possible when the government and donors work together to achieve a common goal.

With a population of 100 million (as of 2017), Ethiopia is the twelfth most populous country in the world. In the 1980's, rapid population growth of 3.5 percent per year contributed to resource shortages and famine (Olsen & Pillar, 2013). The increase in population led to resource shortages and convinced the Ethiopian government that population growth can be a challenge to poverty reduction, as well as maternal and child mortality (Olsen & Pillar, 2013).

The Ethiopian Ministry of Health officially incorporated family planning as part of the national health care program in 1982. Demographic surveys have been conducted regularly since 1990, and in 1993 the government adopted its first national population policy (Olsen & Pillar, 2013). Despite these efforts, in 2000, Ethiopia's mCPR (all women) was still only 4.7 percent—lower than any other country in Eastern and Southern Africa (with the exception of Eritrea).

It wasn't until the Ministry of Health started its incredibly successful Health Extension Program in 2003 that the mCPR started to rapidly increase: to 9.7 percent by 2005, and to 18.7 percent by 2011 (DHS). Similarly, the total fertility rate decreased from 5.5 to 4.8 between 2005 and 2011, leaving Ethiopia slightly below the average of 5.1 for Eastern African and sub-Saharan African countries in 2011 (Olsen & Pillar, 2013).

The Health Extension Program was aimed at rural areas of the country lacking health facilities and workers. The Ministry of Health initially trained a network of roughly 3,000 frontline health extension workers, which grew to 35,000 in 2011 (see Figure 1). Health extension workers are salaried, full-time, female health workers, trained for at least a year and stationed at 17,000 health posts, each of which serves approximately 5000 people. 85 percent of health extension workers can provide contraceptive services (Bilal, Nejmudin et al, 2011).



Source: HSDP Annual Performance Report 2009/2010

Since 2009, the Ministry of Health has prioritized long-acting reversible contraceptives (LARCs), and invested in the scale-up of implant services distributed through 22,000 of the health extension workers. In 2014, the Ministry of Health started a scale-up of IUDs (MOH, 2014).

The strong government support of family planning initiatives in Ethiopia encouraged huge donor investments. International donors, such as USAID and DFID, supported the government's efforts with US $172.8 million of funding between 2000 and 2010—more than any other country in the region. USAID's DELIVER project worked with the Ministry of Health on a country-level strategy to revise the contraceptives supply chain management systems through warehouse improvement and inventory management starting in 2003 (USAID, 2007). Nongovernmental organizations (NGOs) offered innovations such as mobile clinics (e.g. Marie Stopes International) and social franchising (e.g. Pathfinder International) as additional means of increasing access to modern contraceptives (Olsen & Pillar, 2013).

Ethiopia's success resulted from the combination of a government that prioritized family planning, external donor support, and the flagship Health Extension Program, all of which increased contraceptive access particularly in rural areas.

Tanzania

Since the introduction of family planning services in Tanzania, modern contraceptive use has

steadily increased. Between 1991-92 and 2015-16, modern contraceptive use by currently married women increased from 6.6 percent to 32 percent (DHS). However, despite this advancement in the use of modern contraceptives, fertility decline has stalled (MOHSW, 2013). In 2015-16, the total fertility rate was 5.2 children per woman, compared to 6.2 children per woman in 1991-92 (DHS).

In 1959, The International Planned Parenthood Federation (IPPF) partnered with the Family Planning Association of Tanzania (UMATI) to initiate the use of family planning services (MoHSW, n.d.). By 1974, the Government authorized the involvement of public sector maternal and child health clinics in UMATI's family planning efforts (MoHSW, n.d.). The Government's commitment to family planning was then solidified through the launch of the first National Family Planning program in 1989. This program aided in increasing the percentage of women using modern contraceptives from 6.6 percent to 13.3 percent by 1996 (MoHSW, n.d.).

Following the 1992 adoption of a national population policy, the second President of Tanzania, Ali Hassan Mwinyi, launched the National Family Planning "Green Star" campaign in 1993. The Green Star logo was used at health facilities to indicate that family planning services were available at that location. After the launch of the campaign, community awareness of family planning and the demand for family planning services increased. The campaign lost momentum, however, between 1999 and 2007, as focus shifted to the HIV/AIDS epidemic (MoHSW, n.d.).

After recognizing that family planning slowed down between 1999 and 2007, the Ministry of Health and Social Welfare developed the National Family Planning Costed Implementation Plan for 2010-2015 to reposition family planning in Tanzania. The Plan aimed to improve access to quality family planning services by strengthening service delivery systems, ensuring contraceptive security, and reinforcing the capacity of the Ministry of Health at all levels (MoHSW, 2010).

The Ministry of Health also committed to re-launching the National Family Planning "Green Star" campaign, in order to contribute towards meeting the national target of a 60 percent contraceptive prevalence rate. This revitalized campaign primarily targeted women with unmet need for contraception, seeking to brand 2.5 million private and public service delivery points that provide family planning services with the Green Star logo (MoHSW, 2010).

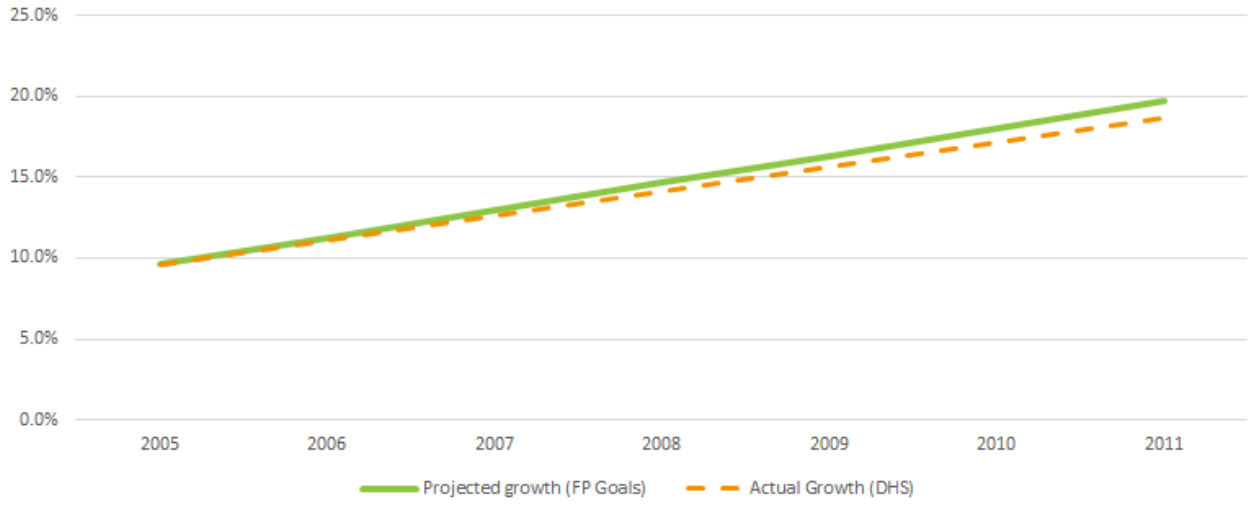
Findings

Accuracy of Model in Ethiopia

Between 2005 and 2011, the *FP Goals Model* came within one percentage point of predicting the actual national mCPR. As seen in Figure 2, the *FP Goals Model* predicted that the national mCPR would increase from 9.7 percent in 2005 to 19.7 percent in 2011, whereas the DHS indicated that the mCPR actually only increased to 18.7 percent. The data sources used to populate the FP Goals Model for Ethiopia are listed in Appendix C.1.

In addition to predicting the national growth of the mCPR in Ethiopia, the model also closely forecast the actual growth in mCPR for both urban and rural areas (see Figure 3). The model more accurately projected the urban mCPR, predicting that the 19 percent baseline in 2005 would grow to 24.6 percent. This prediction came within just 0.9 percent of the actual mCPR for urban areas, to 25.5 percent in 2011. In rural areas, the mCPR actually went from 7.6 percent in 2005 to 16.5 percent in 2011. The *FP Goals Model* had projected the growth to reach 18.2 percent by 2011, which overshot the actual growth in rural areas by 1.7 percent.

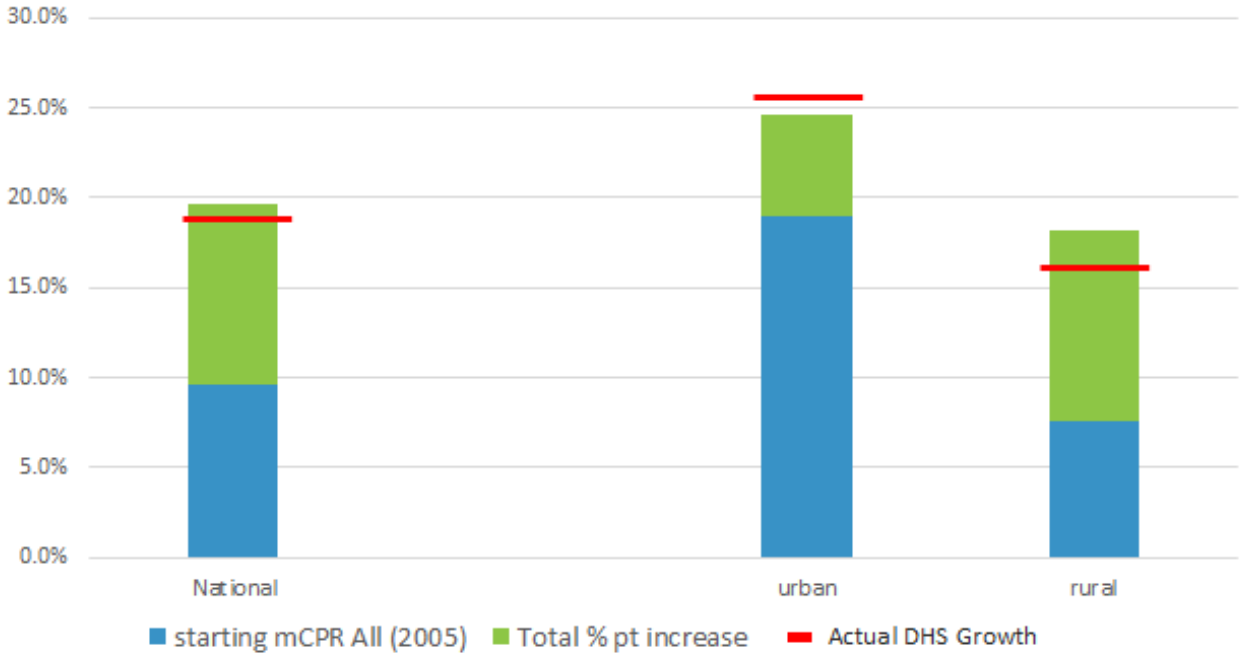
***Figure 2**: Growth in National Modern Contraceptive Prevalence Rate (mCPR) in Ethiopia*



The model also indicated no demand-based limits on the increase of mCPR during this time frame. A demand-based limitation refers to the relationship with overall demand for family planning resources and modern contraception in a country. If the demand for these resources is low, then the model limits the extent to which investments in increasing access to modern

contraceptives can impact the growth in mCPR, implying that further mCPR growth will require increased demand for these services.

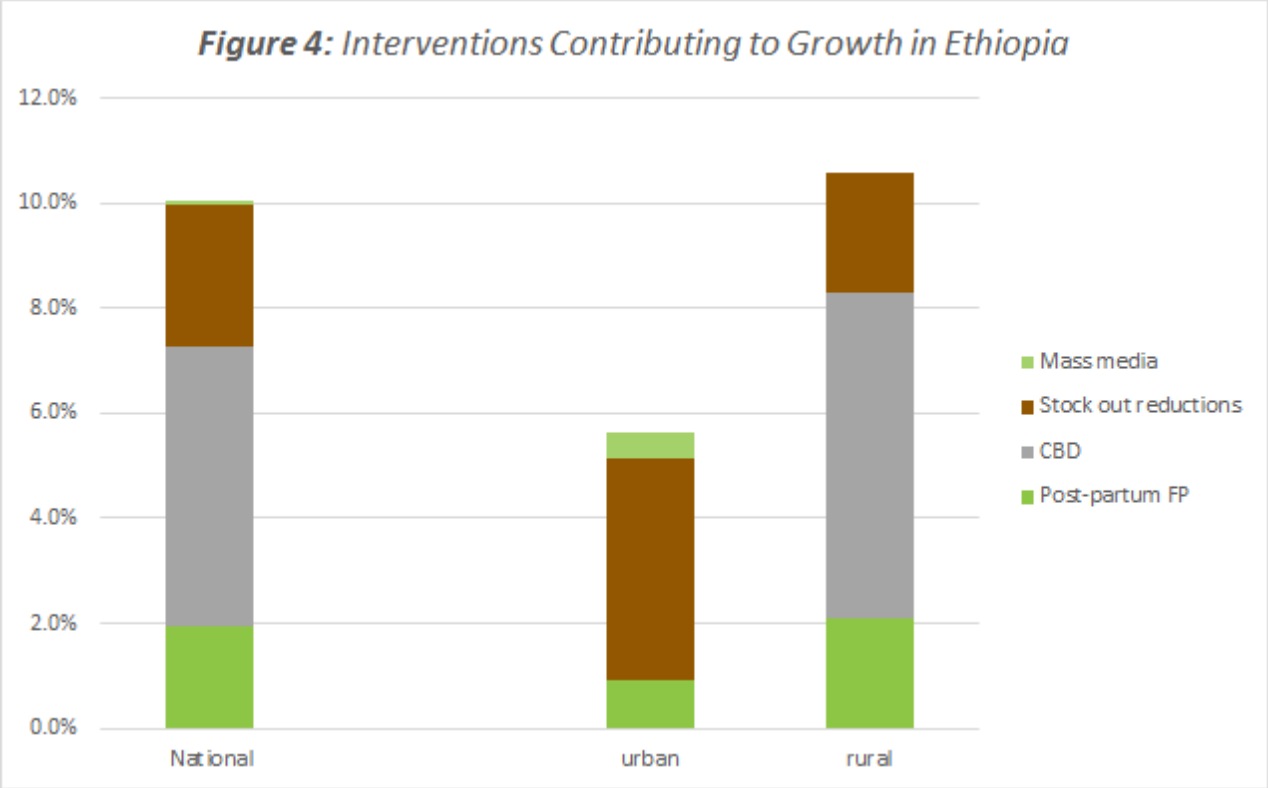
Figure 3: *Growth in National, Urban and Rural mCPR in Ethiopia*



(See Appendix A.1 for complete details)

Factors Significantly Impacting mCPR Growth in Ethiopia

According to the *FP Goals Model*, infrastructure improvements and increased access in rural areas were the underlying factors that led to Ethiopia's family planning success. As seen in Figure 4, the specific factors which contributed most to the growth were, in order of impact: the Health Extension Program (53 percent of mCPR growth), stock-out reductions (26.8 percent), and better postpartum family planning (19.4 percent).



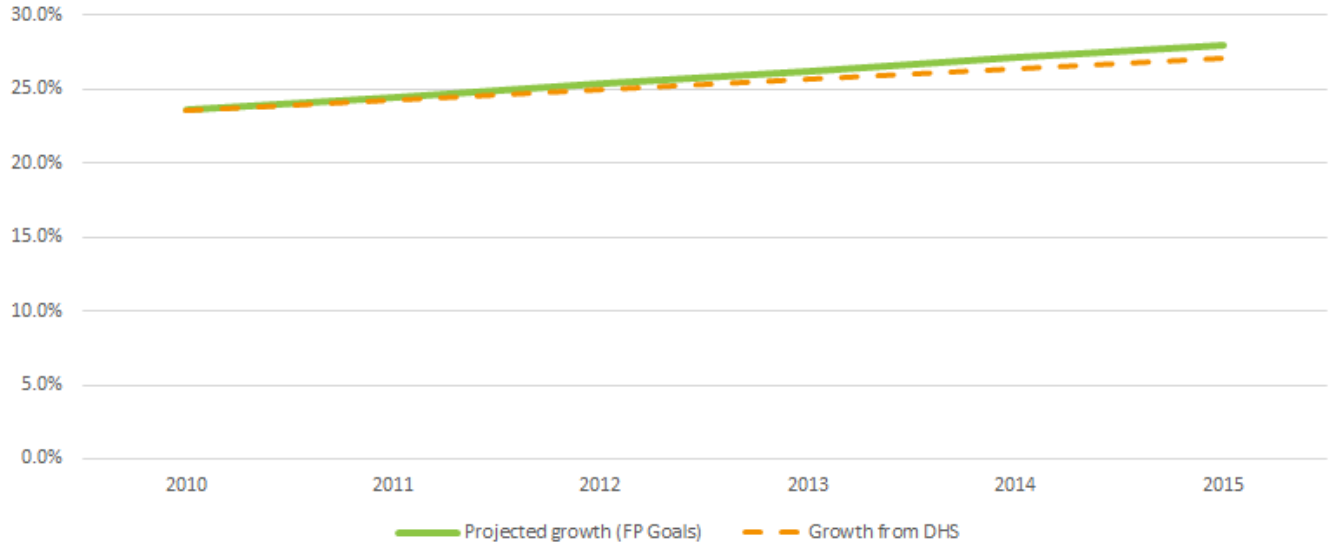
(See Appendix B.1 for complete details)

These findings are consistent with the Ministry of Health's efforts to increase access in rural areas with the Health Extension Program. Additionally, the reductions in stock-outs are also consistent with the supply-chain and inventory improvements funded by USAID.

Accuracy of Model in Tanzania

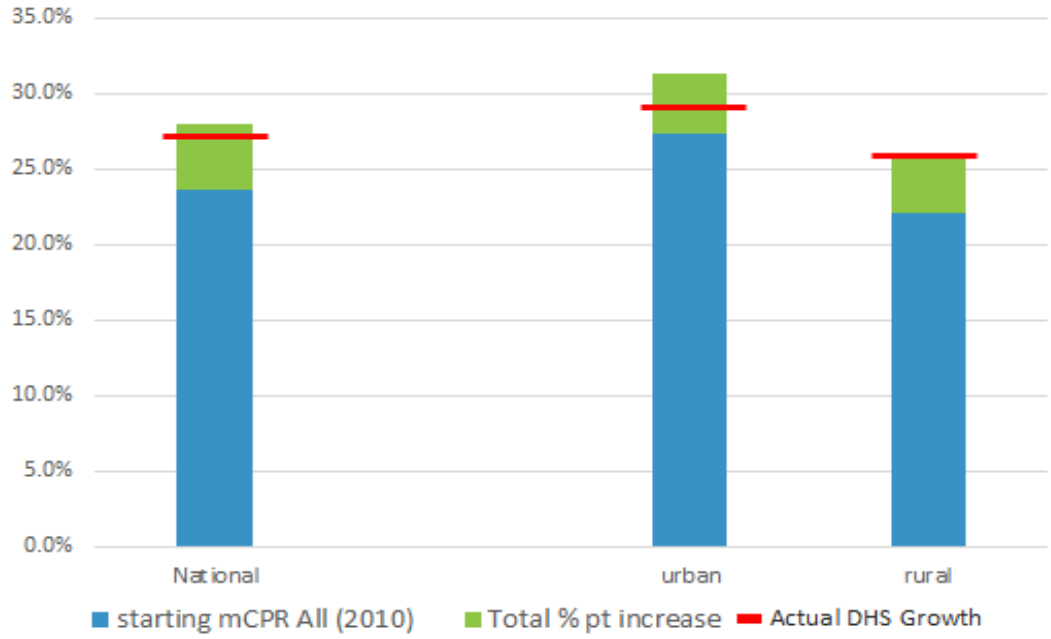
The *FP Goals Model* came within one percentage point of predicting the mCPR in Tanzania in 2015, overshooting the actual figure by 0.9 percent (see Figure 5). The model had predicted that the mCPR would increase from 23.6 percent in 2010 to 28 percent in 2015, compared to the actual 27.1 percent. The data sources used to populate the FP Goals Model for Tanzania are listed in Appendix C.2.

Figure 5: *Growth in National Modern Contraceptive Prevalence Rate (mCPR) in Tanzania*



In addition to closely predicting the national growth of mCPR in Tanzania, the model also predicted the changes in mCPR in both urban and rural areas (see Figure 6). However, the model was considerably more accurate in projecting the urban than the rural mCPR. In the baseline year, the mCPR in urban areas began at 27.4 percent, with the model predicting it to reach 31.3 percent by the endline year. The DHS indicated that the real endline mCPR in urban areas was 28.8 percent, 2.5 percentage points less than the prevalence predicted by the model. In rural areas, 22.1 percent of women used a modern method of contraception in 2010, where the model predicted that by 2015, the mCPR in rural areas would be 26.1 percent. According to the DHS, the real endline mCPR in rural areas was 26.2 percent—a mere 0.1 percent difference from the model's projection. (See Appendix B for mCPR projections.) The model suggests that there were no demand-based limits in Tanzania on the increase of mCPR.

Figure 6: *Growth in National, Urban and Rural mCPR in Tanzania*

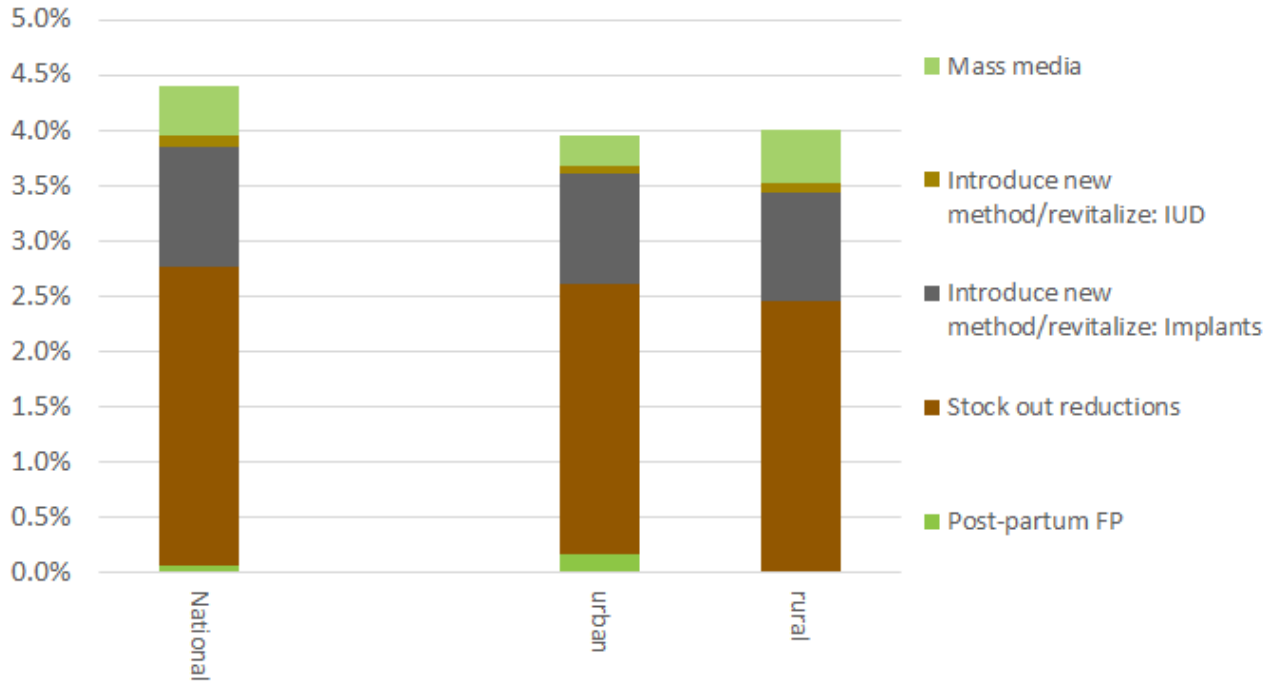


See Appendix A.2 for Complete Details

Factors Significantly Impacting mCPR Growth in Tanzania

Efforts to improve reliable access to contraception between 2010 and 2015 played the largest role in Tanzania's admittedly limited increase in mCPR (see Figure 7). The specific factors which contributed most to the growth were, in order of impact: stock out reductions (61.5 percent), introduction/revitalizations of implants (24.8 percent), and mass-media campaigns (10.1 percent). These findings are consistent with Tanzania's efforts between 2010 and 2015, which focused on eliminating stock outs and ensuring contraceptive security through promoting LARCs (MoHSW 2010).

Figure 7: *Interventions Contributing to Growth in Tanzania*



(See Appendix B.2 for complete details)

Comparison of Family Planning Efforts between Ethiopia and Tanzania

Despite representing different levels of family planning effort and programs, the model projected mCPR within one percentage point of the DHS in both Ethiopia and Tanzania. Ethiopia's contraceptive prevalence rate nearly doubled during the time period analyzed, while Tanzania experienced slower growth overall, but applied to a higher mCPR than Ethiopia.

The family planning initiatives and funding in both countries also varied. The mCPR increased so dramatically in Ethiopia because there was political will supported by international funding. Family planning initiatives in Ethiopia focused on building health infrastructure, especially in rural areas, through community based distribution and health extension workers. In contrast, the Tanzanian government provided weaker support to promote family planning initiatives. Although program documents stated a commitment to increasing the mCPR, few programs and national initiatives were fully implemented (Service Provision Assessment 2006 and Service Provision Assessment 2014-15).

Both countries experienced high fertility, high levels of unmet need, and high desired fertility during the time periods measured. These factors all contributed to high rates of population growth: the population of Ethiopia grew from 89.86 million in 2011 to 99.39 million in 2015, and in Tanzania, population increased from 47.12 million in 2011 to 53.47 million in 2015 (World Bank, 2017). The increased government support in Ethiopia encouraged higher donor funding (Olsen & Pillar, 2013); between 2000 and 2010, Ethiopia received US $2 per capita in donor funding for family planning, while Tanzania received only US $1.5 per capita (Olsen & Pillar, 2013).

The model additionally captured the differences in the family planning environment in Ethiopia and Tanzania. While both countries experienced notable change in their mCPR due to stock-out reductions, the remaining change in mCPR was attributed to different interventions in each country.

The model differed in how well it predicted urban and rural mCPR; the model more closely captured urban estimates for Ethiopia, and rural estimates for Tanzania. This outcome may be due to the Health Extension Program in Ethiopia, which focused on providing family planning methods to rural areas, where the exact number of clients is difficult to estimate. When inputting data into the model, urban and rural breakdowns were often unavailable, requiring an estimation of the urban/rural split. Similarly, for Tanzania, the indicators with the largest impact (stockouts and implant revitalization) were only available on the national level, thus also requiring an estimation of the urban and rural divide. This data limitation may explain why the model over-predicted the urban uptake in modern contraceptive prevalence, as using the national level breakdown as a proxy for an urban-rural split is an imperfect estimation of what occurred in country. As with all models, however, these urban/rural differences indicate that inputting accurate data into the model will increase the reliability of projections.

Study and Model Limitations

Access to data was a primary challenge during this analysis. The model is, by design, highly dependent on the DHS, and the years in which the DHS was carried out. While we found rich data in country and NGO reports for Ethiopia, fewer such reports were available for Tanzania. For indicators required by the *FP Goals Model* but unavailable in the DHS, the greatest challenge was

trying to source data from over ten years ago, in nations that have a poor monitoring infrastructure. Specifically, it was challenging to find data by region and source of contraception. For Ethiopia, vouchers, mobile clinics, social franchising, social and behavior change communication, pharmacies, and youth interventions were difficult to find. Had all data been available, it is expected that the model might have come even closer to predicting actual mCPR. For Tanzania, data were hard to find on family planning integration into abortion care, vouchers, the integration of family planning and immunization, community based distribution, social franchising, availability of family planning services in different levels of public sector facilities, youth based interventions, and the reach of community engagement efforts. On a whole, data was more accessible for Ethiopia than Tanzania.

Finding sub-national data, even though such data would be extremely useful in depicting the unique family planning needs of smaller regions within each country, was also particularly difficult. Ethiopia has nine regions that vary, not only by political leaders, but also by culture and ethnicity. Tanzania had five regions by 2015, but the administrative boundaries changed between the chosen baseline and endline years, requiring additional efforts to regroup the data so the regions would be comparable between the two years. Additionally, there were a few instances where we found data for only a baseline or endline year, thus limiting their utility.

Populating the model with data also posed a number of challenges, some of which will be faced by those using it in developing countries. These challenges included: how to determine appropriate proxies for unavailable data; how to properly calculate subnational estimates from national data; and how to prioritize search efforts for missing data. For example, the model uses Family Planning Effort (FPE) Index scores as an indicator of the accessibility of different LARCs. In Tanzania, we had to use the IUD FPE score as a proxy for the implant FPE score, as implant FPE scores were unavailable during the baseline year. However, as the DHS indicated that implants were more popular than IUDs during the baseline year, the use of the IUD FPE score will inherently underestimate growth in the accessibility of implants in Tanzania between 2010 and 2015.

Preferences for different methods will impact the importance of accessibility of different methods, as well as the importance of different interventions within a country. These preferences

are highly relevant to the interpretation of the model, as the model does not measure preferred methods, and only measures methods that are actually being used for contraception.

In addition, the model only takes into account the number of women who have been reached by interventions, and does not account for efforts to educate men on family planning issues. Cases like Pakistan suggest it is particularly important in Muslim-majority communities to include men in outreach interventions, where most religious jurisprudence agrees that contraception must be a joint decision between husband and wife (Ashfaq et. al., 2015).

Lastly, reflecting data availability, the model only allows the inclusion of data from "all women" or "married women," and not specifically "unmarried women." By excluding unmarried women, the model fails to take into account the different family planning needs of these two different populations, thus complicating any effort to develop a targeted plan for each. Unmarried women are a small part of the population of women who need contraception; however, this population is likely to grow in size as women marry later with increased education and empowerment.

Conclusion

This validity check showed that the *FP Goals Model* can predict modern contraceptive prevalence growth rate to within one percentage point. For both Ethiopia and Tanzania, the model's forward projecting scale-up overshot the actual national modern contraceptive prevalence rate (mCPR) by one percent. For Ethiopia, the model was more accurate in predicting the urban rate, whereas for Tanzania, the model was more accurate at predicting the rural rate.

The factors that contributed most to the mCPR growth in Ethiopia were the improved health infrastructure by the Health Extension Program in the rural areas, stock-out reductions, and postpartum family planning. Tanzania's efforts were concentrated around stock-out reductions and the scale-up of implants. Tanzania, however, had weaker government support than Ethiopia, that hindered full implementation of the efforts, which led to the slower mCPR growth.

Overall, this exercise demonstrates that the *FP Goals Model* is a tool likely to be of use to many developing country governments who are working to expand family planning initiatives.

Appendix

Appendix A: mCPR Growth Rates

A.1. Breakdown of Growth in National Modern Contraceptive Prevalence Rate (mCPR) in Ethiopia

	National	Urban	Rural
Starting mCPR All (2005) - DHS	9.7%	19.0%	7.6%
Ending mCPR All (2011) - DHS	18.7%	25.5%	16.5%
Projected Ending mCPR All (2011) - FP Goals	19.7%	24.6%	18.2%
Total % pt increase - DHS	9.1%	6.5%	8.9%
Total % pt increase - FP Goals	10.1%	5.6%	10.6%
Difference between projected and actual	+1.0%	-0.9%	+1.7%

A.2. Breakdown of Growth in National Modern Contraceptive Prevalence Rate (mCPR) in Tanzania

	National	Urban	Rural
Starting mCPR All (2010) - DHS	23.6%	27.4%	22.1%
Ending mCPR All (2015) - DHS	27.1%	28.8%	26.1%
Projected Ending mCPR All (2015) - FP Goals	28.0%	31.3%	26.2%
Total % pt increase - DHS	3.5%	1.4%	4.0%
Total % pt increase - FP Goals	4.4%	3.9%	4.1%
Difference between projected and actual	+0.9%	+3.5%	+0.1%

Appendix B: Interventions Contributing to Growth

B.1. Interventions Contributing to Growth in Ethiopia

	National	**Urban**	**Rural**
Post-partum FP	2.0%	0.9%	2.1%
Community Based Distribution (CBD)	2.5%	N/A	6.2%
Stock Out Reductions	2.7%	4.2%	2.3%
Mass Media	0.1%	0.5%	N/A

B.2. Interventions Contributing to Growth in Tanzania

	National	**Urban**	**Rural**
Post-partum FP	0.1%	0.2%	n/a
Stock Out Reductions	2.7%	2.4%	2.4%
Introduce New Method/Revitalize: Implants	1.1%	1.0%	1.0%
Introduce New Method/Revitalize: IUD	0.1%	0.1%	0.1%
Mass Media	0.4%	0.3%	0.5%

Appendix C: Data Sources

C.1. Data Sources: Ethiopia

Ethiopia	**Baseline**		**Endline**	
Indicator	Data sources	Notes	Data sources	Notes
Demographic Information	DHS 2005 UN Population Division		DHS 2011 UN Population Division	
Modern Contraceptive Use	DHS 2005	Modern contraceptive prevalence by method, estimated from data	DHS 2011	Modern contraceptive prevalence by method, estimated from data
Youth Modern Contraceptive Use (15-24)	DHS 2005	Modern contraceptive prevalence rate for unmarried sexually active youth (15-24), estimated from data	DHS 2011	Modern contraceptive prevalence rate for unmarried sexually active youth (15-24), estimated from data
Policy- FPE Score	Track 20	2004 FPE score for Ethiopia	Track 20	2009 FPE score for Ethiopia
Post-Abortion FP	DHS 2005	Percent of facilities offering FP based on Tigray data; urban/rural estimates	DHS 2011	facilities offering FP based on Tigray data; urbal/rural estimates
	IPAS Report		IPAS Report	
Public Sector Facilities	Health Sector Strategic Plan	Total number of public sector facilities	Health Sector Development Program IV	Total number of public sector facilities
	FHI360 Report	Percent of family planning clients per facility type	FHI 360 Report	Percent of family planning clients per facility type
	Health Policy Initiative Report	Percent of facilities offering pills	No data found	

	Health Policy Initiatives Report	Percent of facilities offering injections	No data found	
	No data found	Percent of facilities offering IUDs	No data found	
	No data found	Percent of facilities offering implants	No data found	
Community Based Distribution	World Bank report	Clients per HEW estimated through total clients per health post	World Bank report	Clients per HEW estimated through total clients per health post
	DHS 2010		LARC: Ministry of Health Report	
			DHS 2016	
Mobile Outreach	Marie Stopes International Report	Clients per team calculated through MSI outreach source	Marie Stopes International Report	Clients per team calculated through MSI outreach source
	Marie Stopes Report		Marie Stopes Report	
Social Franchises	Comparing family planning services in Ethiopia and Pakistan	Pathfinder International	Comparing family planning services in Ethiopia and Pakistan	Pathfinder International plus MSI
			Marie Stopes Report	
Pharmacies/Drug Shops	No data found	Average number of family planning clients per pharmacy	No data found	
	No data found	Number of pharmacies or drug shops offering condoms only	No data found	
	No data found	Number of pharmacies or drug	No data found	

		shops offering condoms and pills		
	No data found	Number of pharmacies or drug shops offering condoms, pills and injectables	No data found	
Stock Outs	UNFPA Report	No Stock-out rate of facilities, urban/rural/national, estimated urban/ rural 50/50	UNFPA Report	No Stock-out rate of facilities, urban/rural/national, estimated urban/ rural 50/50
	USAID Report	Percent of facilities stocked out of Male Condoms	No data found	
	USAID Report	Percent of facilities stocked out of Injectables	No data found	
	USAID Report	Percent of facilities stocked out of Implants	No data found	
	USAID Report	Percent of facilities stocked out of IUD	No data found	
	USAID Report	Percent of facilities stocked out of Pills	No data found	
Vouchers	No data found		Marie Stopes Report	
Access to New Method	Programming this through interventions above (e.g. CHWs)	No data for Implant for 2005, coverage estimated based on uptake	Programming this through interventions above (e.g. CHWs)	
Youth Interventions	No data found		No data found	
Mass Media	DHS 2005		DHS 2011	

SBCC	No data found		No data found	

C.2. Data Sources: Tanzania

Tanzania	**Baseline**		**Endline**	
Indicator	Data sources	Notes	Data sources	Notes
Demographics	UNPD/WPP 2015 DHS 2010	Urban/rural splits estimated using DHS data	UNPD/WPP 2015 DHS 2016	Urban/rural splits estimated using DHS data
Modern Contraceptive Use	DHS 2010	Urban/rural splits estimated using DHS data	N/A	N/A
Policy	Family Planning Effort Index 2009		Family Planning Effort Index 2014	
Post-Abortion FP	DHS 2010		DHS 2016	
Post-Partum FP	DHS 2010	No data on programs found, coverage estimated based on baseline PPFP uptake	DHS 2016	No data on program scale up found, coverage estimated based on endline PPFP uptake
Public Sector Facilities	No data found		No data found	
Community Based Distribution	No data found		No data found	
Mobile Outreach	No data found		No data found	
Social Franchising	No data found		No data found	
Pharmacies/drug shops	Tanzania MOH Report	Estimated based on percent of dispensaries offering FP services	Tanzania MOH Report	Estimated based on percent of dispensaries offering FP services and

	Service Provision Assessment 2006	and percent of dispensaries offering 2 or 4 temporary modern methods. Urban/Rural Distribution of pharmacies estimated based on the Assessment of the Pharmaceutical Human Resources in Tanzania and The Strategic Framework	Service Provision Assessment 2014-2015	percent of dispensaries offering 2 or 4 temporary modern methods. Urban/Rural distribution of pharmacies estimated based on the Assessment of the Pharmaceutical Human Resources in Tanzania and The Strategic Framework
Stock outs	Service Provision Assessment 2006		Service Provision Assessment 2014-15	
Introduce new method or revitalize under-used method	Family Planning Effort Index 2009	IUD value used as a proxy for the implant value as implant value not available in baseline.	Family Planning Effort Index 2014	
Community Health Workers/CHEWs	No data found		No data found	
Youth	No data found		No data found	
Mass media	Report DHS 2010		Report (hyperlink) DHS 2016	

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