

## ORIGINAL RESEARCH ARTICLE

# Provision of Family Planning Services in Tanzania: A Comparative Analysis of Public and Private Facilities

Deodatus C.Kakoko<sup>\*1,2</sup>, Evert Ketting<sup>2</sup>, Switbert R. Kamazima<sup>1</sup> and Ruerd Ruben<sup>2</sup>

<sup>1</sup>Department of Behavioural Sciences, School of Public Health and Social Sciences, Muhimbili University of Health and Allied Sciences, Tanzania; <sup>2</sup>Radboud University Nijmegen, Faculty of Social Sciences - Centre for International Development Issues (CIDIN); The Netherlands

\*For correspondence: Email: knkuru@yahoo.com; Tel: 25522152531

## Abstract

Adherence to the policy guidelines and standards is necessary for family planning services. We compared public and private facilities in terms of provision of family planning services. We analyzed data from health facility questionnaire of the 2006 Tanzania Service Provision Assessment survey, based on 529 health facilities. Majority of public facilities (95.4%) offered family planning services, whereas more than half of private facilities (52.1%) did not offer those. Public facilities were more likely to offer modern contraceptives as compared to private facilities. However, private facilities were more likely to offer counseling on natural methods of family planning [AOR = 2.12 (1.15-3.92),  $P \leq 0.001$ ]. Public facilities were more likely to report having guidelines or protocols for family planning services and various kinds of visual aids for family planning and STIs when compared to private facilities. This comparative analysis entails the need to enforce the standards of family planning services in Tanzania (*Afr J Reprod Health 2012; 16[4]:140-148*).

## Résumé

L'adhérence à des lignes directrices et des normes est nécessaire pour les services de planification familiale. Nous avons comparé les établissements publics et privés en matière de prestation de services de planification familiale. Nous avons analysé les données tirées du questionnaire de l'enquête sur l'évaluation de la prestation de service en Tanzanie de 2006, basée sur 529 établissements de santé. La majorité des établissements publics (95,4%) assuraient des services de planification familiale, alors que plus de la moitié des établissements privés (52,1%) ne les assuraient pas. Les établissements publics sont plus susceptibles d'offrir des contraceptifs modernes par rapport à des installations privées. Toutefois, les établissements privés étaient plus susceptibles de rendre des conseils sur les méthodes naturelles de planification familiale [AOR = 2,12 (1,15 à 3,92),  $P \leq 0,001$ ]. Les établissements publics étaient plus susceptibles de déclarer avoir des conseils ou des protocoles pour les services de planification familiale et de divers types de supports visuels pour la planification familiale et les IST, par rapport à des établissements privés. Cette analyse comparative implique la nécessité de respecter les normes de services de planification familiale en Tanzanie (*Afr J Reprod Health 2012; 16[4]:140-148*).

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**Keywords:** Family planning, sexually transmitted infections, public facility, private facility

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## Introduction

Availability and quality of family planning services in health facilities is necessary in increasing contraceptive use and declining fertility rates in developing countries<sup>1, 2</sup>. Accordingly, in 1994, the International Conference on Population and Development (ICPD) declared family planning (FP) as an essential component of primary health care that plays a major role in reducing maternal and newborn morbidity and mortality<sup>3</sup>. This was later supported by the United

Nations Population Fund (UNFPA), which stated that stating that if a woman becomes pregnant less than six months after a previous birth, her baby is 2.5 times more likely to die in the first month of life than a child conceived three years after the previous birth<sup>4</sup>. Thus, availability and accessibility of family planning is not only the health obligation but also a human right issue. According to ICPD Plan of Action, people should be able to have a satisfying and safe sex life and that they should have the capability to reproduce and the freedom to decide if, when and how often to do so.

Moreover, ICPD Plan of Action stresses the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice<sup>3</sup>. However, the right to family planning may not be translated into action unless family planning services are scaled-up in both private and public facilities particularly in the developing countries.

In Tanzania, family planning services have a long history. Initially, a reproductive and good parenthood association of Tanzania namely UMATI (Chama Cha Uzazi na Malezi Bora Tanzania *in Kiswahili*) played a leading role in family planning services in the country. However, during the early years the services were mostly provided in a few urban areas with little support from the public sector. With the expansion of UMATI in the early 70's, family planning services were extended to cover more areas in the country. The public sector became actively involved in providing family planning services following the launching of the Maternal and Child Health (MCH) programme in 1974. Since then, UMATI also took responsibility for providing Information, Education and Communication (IEC) to the general public on family planning issues. UMATI has also played a central role in the training of service providers and procurement of contraceptives. Currently, family planning services are provided by both public and private facilities under the coordination of the Family Planning Unit (FPU) in the Ministry of Health and Social Welfare (MoHSW).

As regards to family planning service delivery in Tanzania, the Ministry of Health (MoH), by then, published the National Policy Guidelines and Standards for Family Planning Services Delivery and Training in the same year ICPD took place<sup>5</sup>. The guidelines reiterated the public's commitment to family planning and to providing comprehensive health services to all citizens equitably by stating that all males and females of reproductive age, including adolescents irrespective of their parity and marital status, shall have the right of access to family planning information, education and services<sup>5</sup>. Furthermore, it provides that any woman or man shall be provided with a family planning method of her or his choice after appropriate and adequate

counseling without requiring the consent of a spouse. Also IEC materials on the various contraceptive methods offered are to be available at each site. The family planning guidelines indicate that the MoHSW has to ensure the availability and accessibility of a wide range of family planning methods including temporary, long-acting, and permanent contraception to facilitate wider choice for the user. The guidelines also address the issues of counseling and screening of clients including for sexually transmitted infections (STIs). Furthermore, health service providers are expected to screen clients for STIs and to refer clients with STIs for treatment.

In realizing the importance of family planning in the country, the Tanzania National Health Policy under the MoHSW identified family planning as one of necessary elements of primary health care (PHC) services<sup>6</sup>. The essence of providing quality family planning, maternal and child health services is well stipulated in the mission of the National Health Policy stating that the role of the public sector is to facilitate the provision of equitable, quality and affordable basic health services, which are gender sensitive and sustainable, delivered for the achievement of improved health status<sup>6</sup>. Hence, the National Health Policy mandates the MoHSW to take responsibility for overseeing provision of quality health services both in public and private services. The National Health Policy specifies clearly that the Ministry of Health will continue to communicate, co-operate, coordinate and collaborate with the Private Sector providers in the Health Sector, and will regulate and co-ordinate the establishment of health facilities by the private sector" and that "the Ministry of Health will promote the delivery of health services by the private sector organizations, private for profit organizations, Faith Based Organizations (FBOs) and Community Based Organizations (CBO) in collaboration with Public Sector health facilities<sup>6</sup>. Private organizations (NGOs) are also allowed to run health facilities including hospitals, health centers and dispensaries. However, the role of monitoring the provision of quality services remains under the MoHSW. In view of that, the Reproductive and Child Health Service (RCHS) section, established under the Directorate of

Preventive Health Services, comprises the Family Planning Unit that ensures quality provision of family planning services.

Despite all these efforts to improve family planning services, the total fertility rate in Tanzania has remained high over time. According to the most recent Tanzania Demographic and Health Survey (TDHS) conducted by the National Bureau of Statistics (NBS) in 2010, the total fertility rate (TFR) in Tanzania stands at 5.4 births per woman<sup>7</sup>, which was a slight decline from 5.7 children per woman recorded in 2004<sup>8</sup>. Moreover, unmet need for family planning, which is the gap between women's desire to delay or avoid having children and their actual use of contraception, remains also high in the country. The 2010 TDHS reveal that 25 percent of married women have an unmet need for family planning<sup>7</sup>, which is the same rate to that of the least developed countries<sup>9</sup>. It is therefore justifiable to look at provision of family planning services in both public and private health facilities as the provision of quality services is one of factors that are likely to influence acceptance of the services and, in turn, enhance satisfaction and uptake of various methods of family planning<sup>10</sup>.

This paper compares public and private facilities in terms of provision of family planning services. Despite the fact that family planning services are offered free of charge in public facilities and at a subsidized cost in private facilities, both need to conform to the policy guidelines and standards family service provision. Specific objectives of the paper are to assess the variety of family planning services offered in public and private facilities and also compare public and private facilities in terms of availability of visual aids for family planning education; family planning methods offered; and availability of guidelines or protocols for family planning services. This comparative analysis contributes important information to the family planning policy makers and service supervisors.

## Methods

The paper focuses on Tanzania, which is one of the developing countries in East Africa. Tanzania is bordered by Kenya and Uganda to the north,

Rwanda, Burundi, and the Democratic Republic of the Congo to the west, and Zambia, Malawi, and Mozambique to the south. The country's eastern border lies on the Indian Ocean. Tanzania mainland is a state composed of 26 administrative regions with an area of 945,087 kilometer squares and population of around 41 million.

We used data from the Tanzania Service Provision Assessment (TSPA) survey of 2006 collected by Measure Demographic Health Survey (MDHS). As detailed in the 2007 TSPA report<sup>11</sup>, this was a nationally representative facility-based survey that covered 611 health facilities of Tanzania mainland (529) and the Islands (82), which were randomly selected out of 5,663 health facilities. The analysis for this paper was based on 427 health facilities that were providing family planning services in Tanzania mainland. These included 106 hospitals, 34 health centers, and 287 dispensaries/stand alone sites. Of these, 78 were private-owned facilities and 349 were public facilities. For the 102 facilities that were not offering family planning, 13 were hospitals, 5 were health centers and 84 were dispensaries composed of 17 public and 85 private facilities.

Data analysis was based on the health facility questionnaire that constituted questions on family planning service, among others. Specifically, respondents were asked about availability of various kinds of family planning that included; combined oral pill, progestin-only pill, counseling on natural methods, male condom, female condom, intrauterine device, implant (6 rod, 1 rod, Norplant, Implanon), spermicides, diaphragm, emergency contraceptive pill, and progestin-only injectable (2 or 3 monthly). Regarding availability of guidelines or protocols for family planning services and STIs diagnosis and treatment respondents were asked questions on availability of family planning procedure manual 2004, syndromic diagnosis and treatment of STIs, family planning program components and standards, other guidelines for STI diagnosis or treatment, and other guidelines or protocols on family planning. On availability of visual aids for family planning education and STI information, respondents were asked about availability of samples of family planning methods, other visual aids for teaching about family planning, visual

aids for teaching about STIs, posters for general awareness of STIs or HIV and AIDS, model for demonstrating how to use condoms, posters for general promotion of family planning, and visual aids for teaching about HIV and AIDS.

Data were analyzed using SPSS (version 15) computer programme in terms of frequencies, percentages as well as adjusted logistic regression analysis. Permission to use TDHS data was obtained from the National Bureau of Statistics (NBS) prior to the data analysis. For the sake of anonymity, specific information that could identify health facilities was not indicated.

## Results

### *Basic information of health facilities:*

Overall, 529 health facilities from 21 regions of Tanzania Mainland (by then) participated in the Tanzania Service Provision Assessment survey in 2006. Of these, 119 (22.5%) were hospitals, 39 (7.4%) were health centers and 371 (70.1%) were dispensaries/stand alone health sites. In terms of facility managing authority, 163 (30.8%) were private facilities and 366 (69.2%) were public or parastatal. As Table 1 indicates, the vast majority of public facilities offer family planning services, whereas more than half of private facilities do not offer those.

### *Comparison of family planning methods offered*

The questionnaire sought information about 11 kinds of family planning methods that could be offered by the health facilities. As Table 2 indicates, less than half of public and private facilities were offering the female condom, spermicides, diaphragm and emergency contraceptive pills. Compared to public facilities,

private health facilities were less likely to offer: combined oral pills (AOR=0.02; 95% CI: 0.01-0.08), progestin-only pill (AOR=0.37; 95% CI: 0.20-0.70), progestin-only injectable (AOR=0.06; 95% CI: 0.02-0.16), male condoms (AOR=0.11; 95% CI: 0.04-0.25), implants (AOR=0.53; 95% CI: 0.31-0.91), and emergency contraceptive pills (AOR= 0.49 (0.29-0.84). However, private facilities were about two times more likely to report offering counseling on natural methods of family planning as compared to the public facilities (AOR= 2.12; 95% CI: 1.15-3.92).

### *Comparison of availability of guidelines or protocols for family planning services and STI management*

Five items of the questionnaire sought information on availability of guidelines or protocols for family planning services. As shown in Table 3, about less than half of surveyed facilities reported to have family planning program components and standards, the family planning procedure manual 2004, guidelines for STI diagnosis or treatment, and syndromic diagnosis and treatment of STIs. Comparatively, public facilities were significantly more likely to report having family planning program components and standards (AOR=0.32; 95% CI: 0.16-0.65); family planning procedure manual of 2004 (AOR=0.43; 95% CI: 0.20-0.91); and guidelines for STI diagnosis or treatment (AOR=0.49; 95% CI: 0.29-0.82). However, there was no statistically significant difference between public and private facilities on availability of guidelines for syndromic diagnosis and treatment of STIs as well as other guidelines for STIs diagnosis or treatment after analysis was adjusted for the level and location of the health facility.

**Table 1:** Family planning offered by public versus private facilities

Health facility:	Public facilities		Private facilities		Total	
	n	(%)	n	(%)	n	(%)
Offering FP	349	(95.4)	78	(47.9)	427	(80.7)
Not offering FP	17	(4.6)	85	(52.1)	102	(19.3)
Total	366	(61.2)	163	(38.8)	529	(100.0)

### Comparison of availability of visual aids for family planning and STIs education

Seven items of the questionnaire sought information on the availability and types of visual aids for family planning and STIs education. As shown in Table 4, less than half of both public and private facilities reported to have visual aids for teaching about STIs, visual aids for teaching about HIV and AIDS; models for demonstrating how to use condoms; and posters for general awareness of STIs or HIV/AIDS. Private health facilities were significantly less likely than public facilities to

have samples of family planning methods (AOR=0.30; 95% CI: 0.17-0.53); visual aids for health education on STIs (AOR=0.46; 95% CI: 0.26-0.81), visual aids for HIV/AIDS (AOR=0.46; 95% CI: 0.26-0.83), models for demonstrating how to use condoms (AOR= 0.31; 95% CI: 0.17-0.57), and posters for general promotion of family planning (AOR=0.52; 95% CI = 0.31-0.87). However, there was no statistically significant difference between public and private facilities on availability of posters for the general awareness of STIs or HIV and AIDS.

**Table 2:** Comparison between public and private facilities on types of family planning methods offered (N = 427)

Type family planning method offered	Offered in:		Private facilities (N = 78)	Unadjusted OR (95% CI)	+Adjusted AOR (95% CI)
	Public facilities (N = 349)	Private facilities (N = 78)			
	n	(%)	n	(%)	
Combined oral pill	347	(99.4)	59	(75.6)	0.02 (0.01-0.08)***
Progestin-only pill	310	(88.8)	59	(75.6)	0.39 (0.21-0.72)**
Progestin-only injectable (2 or 3 monthly)	344	(98.6)	62	(79.5)	0.06 (0.02-0.16)***
Male condom	340	(97.4)	62	(79.5)	0.10 (0.04-0.24)***
Female condom	92	(26.4)	18	(23.1)	0.84 (0.47-1.49) ns
Intrauterine device	199	(57.0)	41	(52.6)	0.84 (0.51-1.37) ns
Implant (6 rod, 1 rod, Norplant, Implanon)	194	(55.6)	36	(46.2)	0.69 (0.42-1.12) ns
Spermicides	55	(15.8)	10	(12.8)	0.79 (0.38-1.62) ns
Diaphragm	45	(12.9)	8	(10.3)	0.77 (0.35-1.71) ns
Emergency contraceptive pill	173	(49.7)	29	(37.2)	0.60 (0.36-0.99)*
Counseling on natural methods	226	(64.8)	63	(80.8)	2.29 (1.25-4.18)**

\*\*\*P ≤ 0.001; \*\*P ≤ 0.01; \*P ≤ 0.05; ns = not significant; +Adjusted for level and location of health facility

**Table 3:** Comparison between public and private facilities on availability of guidelines or protocols for family planning services and STIs diagnosis and treatment (N=427)

Type of guideline or protocol	Available in:		Private facilities (N = 78)	Unadjusted OR (95% CI)	+Adjusted AOR (95% CI)
	Public facilities (N = 349)	Private facilities (N = 78)			
	n	(%)	n	(%)	
Family planning program components and standards	101	(28.9)	11	(14.1)	0.40 (0.21-0.79)**
Family planning procedure manual 2004	71	(20.3)	10	(12.8)	0.58 (0.28-1.18) ns
Other guidelines or protocols on family planning	191	(54.7)	32	(41.0)	0.58 (0.35-0.95)*
Syndromic diagnosis and treatment of STIs	126	(36.1)	19	(24.7)	0.58 (0.33-1.02) ns
Other guidelines for STI diagnosis or treatment	123	(35.2)	18	(23.1)	0.55 (0.31-0.98)*

\*\*\*P ≤ 0.001; \*\*P ≤ 0.01; \*P ≤ 0.05; ns = not significant; +Adjusted for level and location of health facility

**Table 4:** Comparison between public and private facilities on availability of visual aids for family planning education and STI information (N = 427)

Type of visual aids for teaching about family planning	Available in:				Unadjusted	+Adjusted
	Public facilities (N = 349)		Private facilities (N = 78)			
	n	(%)	n	(%)	OR (95% CI)	AOR (95% CI)
Samples of family planning methods	298	(85.4)	52	(66.7)	0.34 (0.20-0.60)***	0.30 (0.17-0.53)**
Other visual aids for teaching about family planning	254	(72.8)	41	(52.6)	0.41 (0.25-0.69)***	0.32 (0.19-0.55)***
Visual aids for teaching about STIs	140	(40.1)	20	(25.6)	0.52 (0.30-0.89)*	0.46 (0.26-0.81)**
Visual aids for teaching about HIV and AIDS	130	(37.2)	19	(24.7)	0.55 (0.32-0.97)*	0.46 (0.26-0.83)**
Model for demonstrating how to use condoms	154	(44.1)	21	(26.9)	0.47 (0.27-0.80)**	0.31 (0.17-0.57)***
Posters for general promotion of family planning	245	(70.2)	45	(57.7)	0.58 (0.35-0.96)*	0.52 (0.31-0.87)*
Posters for general awareness of STIs or HIV and AIDS	169	(48.6)	32	(41.0)	0.74 (0.45-1.21) ns	0.70 (0.42-1.15) ns

\*\*\*P ≤ 0.001; \*\*P ≤ 0.01; \*P ≤ 0.05; ns = not significant; +Adjusted for level and location of health facility

## Discussion

Findings in general reveal that few private facilities include family planning services. This means that potential users may have limited access to family planning if there is only a privately run health facility available in their area.

Our analysis indicated that public facilities were more likely to offer various types of family planning and services as compared to private facilities. This observation from the 2006 TSPA (based on providers) corroborate the 2010 TDHS (based on consumers) in that public sources such as government hospitals, government health centers, and clinics provide contraceptives to two-thirds (65%) of the users, while the private sector (primarily pharmacies) provides the services to 26% of users and religious/voluntary facilities provide to 6% of users<sup>7</sup>.

The majority of public and private facilities reported neither to have teaching aids for family planning education nor guidelines for family planning services. However, when compared public facilities were more likely to report having teaching aids for family planning education as well as guidelines for family planning services than

private facilities. Although findings of the present study may seem to contradict the observation that private facilities as a whole perform better than public ones<sup>12</sup>, it is likely that many private facilities carry out practices that do not fulfill the norms established by the public sector when it comes to family planning services.

As observed in the present analysis, some of the methods of family planning, mainly diaphragm and emergency contraceptive pill are still not popular in Tanzania. This finding corroborates the 2010 TDHS findings from interviews with women regarding their knowledge about family planning methods. Of the 10329 women interviewed, only 8.4 percent were knowledgeable of the diaphragm as a family planning method and 9.4 percent were knowledgeable of emergency contraception<sup>7</sup>. Moreover, the observation that female condoms and diaphragms were largely missing even in public facilities is worth noting as it may have some implications especially on women empowerment over matters pertaining to sexuality.

It is important to note that counseling on natural methods of family planning is more common in private than in public facilities. Despite that both public and private health facilities need to adhere to the policy guidelines

and standards for family planning service provision, some of the private facilities may prefer specific family planning methods. This is mostly in the context of faith based health facilities that prefers natural methods. For instance, periodic abstinence and the natural infertility through breastfeeding are the only methods deemed moral by the Roman Catholic Church for avoiding pregnancy<sup>13</sup>.

The fact that public facilities are significantly more likely to report having family planning program guidelines and standards; family planning procedure manual of 2004; and other guidelines or protocols on family planning is worth noting. This is particularly to a country like Tanzania that has invested in the family planning services enormously and for over decades. As such, availability of the required guidelines is the necessary component (though not sufficient) for the six quality standards of family planning services namely: appropriate choice of methods, responsible information, technical competence, interpersonal relations, and mechanisms to encourage continuity, and appropriate mixture of services<sup>14</sup>. The observation that there was no statistically significant difference between public and private facilities on availability of guidelines for syndromic diagnosis and treatment of STIs as well as other guidelines for STIs diagnosis or treatment may be due to the fact that family planning is controversial in religious facilities and STI diagnosis and treatment is not. As previous study on integration of prevention and care of STIs with family planning revealed that many family planning projects had trained family planning providers in syndromic STI management as well as STI education on prevention<sup>15</sup>.

Overall, the availability of visual aids for teaching about family planning, STIs and HIV/AIDS was low both in public and private facilities. However, using visual aids to increase information regarding options and side effects as well as appropriate use of the family planning method is one of key factors contributing to the appropriate, efficient and continuous use of contraceptive methods<sup>16</sup>. As the majority of infections of STIs and HIV/AIDS also occur during the reproductive ages where the uptake of family planning services is high, discussion of

family planning and high-risk fertility behavior is an opportunity to provide information to women and their partners on STIs and HIV/AIDS. Accordingly, the importance of visual aids for STIs and HIV/AIDS in public and private facilities providing family planning services should be emphasized.

To improve the quality of family planning services, more attention should be focused on certain aspects of family planning services. First, there is a need to ensure that a range of methods is provided by both public and private facilities as stated in the guidelines. Family planning programs that offer various choices are likely to be superior to those that offer few choices because individuals differ in their family planning needs, and a wide range of methods is needed to satisfy diverse requirements. As such, the needs of a single individual can vary during her lifetime. Second, supervision within family planning services is an area that requires strengthening in the effort to improve quality of care. Indeed, improving provision of family planning services is expected to have an impact on satisfaction with the services, continued use and on ability to achieve fertility goals or reproductive intentions. Therefore, it should be a role of supervisors to check whether the facility has complete and accurate information about all methods of family planning offered. Importantly, the supervisors should check whether a mix of methods available matches all potential clients' needs. Third, there is a need to ensure that key documents that guide the provision of family planning services are available both in public and private facilities. This should include availability of teaching aids for family planning education.

Our findings provide gaps for future research. The observation on the absence of guidelines for family planning services at most of health facilities surveyed, makes it vital to compare quality of family planning services offered by facilities that have the guidelines and those not having the guidelines. Also, research is needed to compare family planning services between health facilities that report having visual aids for family planning education and those without visual aids for family planning education. Moreover, in context where family planning methods are not in some of the facilities, referrals are of critical importance.

Beside this importance, little is known about referral and facilitation practices in provision of family planning services by the public and private facilities. Thus, further studies need to determine family planning provider referral and facilitation practices when potential users may have limited access to family planning. This is especially in context where there is only a privately run health facility available in their area.

The present paper has some limitations that need to be considered. First, the paper utilizes data collected in 2006 and therefore some changes may have occurred. Besides, analysis of the 2006 data may still be necessary in terms of provision of family planning services. Also, the findings of this paper will provide a base for future comparison. Second, the present paper may be limited in scope. Although it was intended to compare public and private facilities, there was a problem of the category of private facilities containing various subcategories of providers that might be incomparable extremes. On the one hand, UMATI and MSI specialize in family planning clinics, and on the other hand, Roman Catholic clinics not offering any FP. In that way, it was not possible to perform more detailed comparisons. Indeed, future large-scale studies, such as the TSPA, should make a point to distinguish between different types of private facilities, and to make this data available to researchers. Third, the paper presents descriptive statistics; it does not attempt to demonstrate cause-and-effect relationships.

## Contribution of Authors

DCV participated in study design, participated in data analysis and drafted the manuscript. EK participated in data analysis, reviewed and edited the manuscript. SRK reviewed the manuscript and editing of the manuscript. RR was involved in study design of the manuscript.

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## Conclusion

As expected, we found significant differences between public and private facilities in the provision of family planning in Tanzania. The comparative analysis of public and private facilities on provision of family planning services entails the need to scale-up the services particularly in private facilities. The finding that several private facilities tend to focus on counselling on far less reliable “natural” methods is a serious source of concern. The importance of providing sexually transmitted infections (including HIV and AIDS) information and services in the context of family planning services need to be underscored.

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