

United Republic of Tanzania



Ministry of Health and Social Welfare

**The National Road Map Strategic Plan
To Accelerate Reduction of Maternal,
New born and Child Deaths in Tanzania 2008-2015**

Sharpened One Plan

April 2014

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ABBREVIATIONS

| | |
|--------|---|
| ARR | Average annual Rate Reduction |
| ANC | Antenatal Care |
| APR | A Promise Renewed |
| ARHS | Adolescent Reproductive Health Services |
| ART | Anti Retroviral Therapy |
| ARV | Anti Retroviral |
| BCC | Behaviour Change Communication |
| BEmOC | Basic Emergency Obstetric Care |
| BEmONC | Basic Emergency Obstetric and Newborn Care |
| BF | Breastfeeding |
| CARMMA | Campaign on Accelerated Reduction of Maternal Mortality in Africa |
| CCHP | Comprehensive Council Health Plan |
| CEmOC | Comprehensive Emergency Obstetric Care |
| CEmONC | Comprehensive Emergency Obstetric and Newborn Care |
| CHW | Community Health Worker |
| COIA | Commission on Information and Accountability |
| COLSC | Commission on Life Saving Commodities |
| CPR | Contraceptive Prevalence Rate |
| d-IMCI | Distance Integrated Management of Childhood Illness training |
| eLMIS | Electronic Logistics Management Information System |
| EmOC | Emergency Obstetric Care |
| EmONC | Emergency Obstetric and Newborn Care |
| eMTCT | Elimination of Mother to Child Transmission |
| ENAP | Every Newborn Action Plan |

| | |
|---------|---|
| EPI | Expanded Programme on Immunization |
| FP | Family Planning |
| HBCI | High Burden Country Initiative |
| Hib | Haemophylus Influenza type b |
| HIV | Human Immuno Deficiency Virus |
| HMIS | Health Management Information System |
| HPV | Human Papilloma Virus |
| HRH | Human Resource for Health |
| HSSP | Health Sector Support Programme |
| IEC | Information Education and Communication |
| ILS | Integrated Logistics System |
| IMCI | Integrated Management of Childhood Illness |
| IPT | Intermittent Preventive Treatment |
| ITN | Insecticide Treated Net |
| LGA | Local Government Authority |
| LMIS | Logistic Management Information System |
| LiST | Lives Saved Tool |
| MDGs | Millennium Development Goals |
| MESI | Monitoring and Evaluation Strengthening Initiative |
| MKUKUTA | Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania (The National Strategy for Growth and Reduction of Poverty) |
| MMAM | Mpango wa Maendeleo wa Afya ya Msingi (The Primary Health Services Development Programme) |
| MMR | Maternal Mortality Ratio |
| MNCH | Maternal, Newborn and Child Health |

| | |
|----------|---|
| MoHSW | Ministry of Health and Social Welfare |
| NHA | National Health Account |
| NMR | Newborn Mortality Rate |
| NPS | National Population Survey |
| NSGRP | National Strategy for Growth and Reduction of Poverty |
| PHSDP | Primary Health Services Development Programme |
| PMO-RALG | Prime Minister's Office, Regional Administration and Local Government |
| PMTCT | Prevention of Mother to Child Transmission |
| RBF | Results Based Financing |
| RCH | Reproductive and Child Health |
| RCHS | Reproductive and Child Health Section |
| RMNCH | Reproductive, Maternal, Newborn and Child Health |
| SARA | Service Availability and Readiness Assessment |
| SBA | Skilled Birth Attendant |
| SUN | Scaling Up Nutrition |
| TDHS | Tanzania Demographic and Health Survey |
| TFR | Total Fertility Rate |
| TT | Tetanus Toxoid |
| TOT | Trainer of Trainers |
| UN | United Nations |
| UNCoLSC | United Nations Commission on Life Saving Commodities |
| U5MR | Under 5 Mortality Rate |

EXECUTIVE SUMMARY

With less than 2 years to the completion of the 2008-2015 National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Death, and MDG 2015 deadline; Tanzania has shown slow progress on two of the three key indicators. Neonatal mortality rate has declined from 32 deaths to 26 deaths per 1,000 live births by 2010 whereas the under-five mortality rate has declined from 112 to 81 per 1,000 live births by 2010 (TDHS 2010). UN Interagency child mortality estimates of September 2013 shows further decline of under-five mortality rate to 54 deaths per 1,000 live births which indicates that Tanzania has achieved MDG 4 target. Maternal mortality ratio has declined over the past ten years, from 578 per 100,000 in 2004/05 to 454 per 100,000 live births in 2010 (TDHS 2010). Recent data from the UN estimates of 2013 shows further decline of maternal mortality to 410 per 100,000 live births. Thus, based on these data Tanzania has shown a slow progress towards attainment of maternal and neonatal mortality as compared to a significant progress made in child mortality.

In line with the objective of conducting periodic review of the progress of Road Map implementation, The Ministry of Health and Social Welfare conducted a Mid Term review of to assess and document the performance and progress of different MNCH program indicators in relation to set 2015 targets; identify key gaps and challenges in the implementation; highlight priority areas requiring strengthening. The review was also set to indicate evidence based MNCH interventions to be scaled up as well as potential research gaps for further exploration. The findings from the review together with lives saved analysis formed the basis for development of this sharpened plan for the reduction of reproductive, maternal, newborn and child deaths to be focused during the remaining 500 days to the end of 2015. The focus has been refined guided by on five strategic areas: Increase efforts in those geographic locations with highest maternal, newborn, and child mortality to start with Lake and western zones; Refocus health systems to scale up access for underserved women, adolescents and children in rural and urban areas while maintaining gains in maternal and child health; Target and expand coverage of selected evidence-based interventions that will have the greatest impact on lives saved giving support to districts by ensuring districts have the capacity, information, data, policy standards and strengthened systems; Advocate for education and empowerment of girls and women and Expand environmental activities particularly sanitation and hygiene and Create transparency and mutual accountability at all levels of the health systems to monitor and evaluate progress using RMNCH score card.

The sharpened plan will emphasize on access and quality of family planning, care at birth and commodity security to maximize health outcomes for women and children. It also underscores the critical need to strengthen accountability and monitoring mechanisms as well as reinforcing partnerships for social mobilization, funding and technical assistance. This plan recognizes that there are other interventions happening in other zones, it therefore recommits to sustain strategies and high impact interventions that need to be scaled-up and prioritized to accelerate progress towards attainment of maternal, newborn and child health targets. The full execution of this plan of the next five hundred days will require **\$ 206,180,327.00** for interventions and commodities. Tanzania will use this plan for advocacy, resource mobilization and guided implementation. It is the expectation of the Government, that all stakeholders will align and optimally use the Sharpened One plan to support the implementation of prioritized reproductive, maternal, newborn and child health interventions.

**STATEMENTS FROM HIS EXCELLENCY THE PRESIDENT
OF UNITED REPUBLIC OF TANZANIA**



“Delay in taking the right decision at home, delay in reaching to the health care facility and delay in receiving care at the health facility account for many women losing their lives. Increasing awareness and improving access to modern health care facilities will greatly help save many lives. This is the focus of our government’s efforts in this regard.” - **H E Jakaya Mrisho Kikwete, President, United Republic of Tanzania, Launch of Deliver Now for Women and Children in Tanzania, 22 April 2008.**

“In order to be successful in our commitment to improving the lives of women and children, we are inviting all stakeholders to join us in continuing to work together to improve accountability for resources and results linked to women’s and children’s health.” - **H E Jakaya Mrisho Kikwete President, United Republic of Tanzania and Rt. Hon. Stephen Harper Prime Minister of Canada, Letter to the UN Secretary General, Ban Ki Moon, 31 May 2011.**

“My Government is committed to double the number of family planning users from the current 2.1 million to 4.2 million towards achieving the national contraceptive prevalence rate target of 60 per cent by 2015.” - **H E Jakaya Mrisho Kikwete President United Republic of Tanzania, London Summit on Family Planning, July 2012.**

“Every one of us should be committed to make sure that our children have access to quality health care and none of our children die from preventable causes.” - **H E Jakaya Mrisho Kikwete President, United Republic of Tanzania, Paediatric Association Fund raising event, 22nd February 2014.**

FOREWORD

Tanzania like many other countries is striving to attain the 2015 Millennium Development Goals (MDGs), particularly numbers 4, 5 and 6 which relate to health. In this regard, the reduction of maternal, newborn and child deaths has been given a high priority and is addressed in various national commitments, including Tanzania Vision 2025, the National Strategy for Growth and Reduction of Poverty (NSGRP), and the Primary Health Services Development Program (PHSDP), among others.

Maternal deaths are caused by factors attributable to pregnancy, childbirth and poor quality of health services. Newborn deaths are related to the same issues and occur mostly during the first week of life. Child health depends heavily on availability of and access to immunizations, quality management of childhood illnesses and proper nutrition. Improving access to quality health services for the mother, newborn and child requires evidence-based and goal-oriented health and social policies and interventions that are informed by best practices. Based on a September 2013 UN Interagency Report, Tanzania is among the few Countdown countries which has achieved its MDG 4 target by reducing under five mortality rate to less than 54 per 1000 live births before the end of 2015. Moreover, the neonatal mortality rate has declined from 32 deaths to 26 deaths per 1,000 live births by 2010.

Thus, the slow reduction of newborn mortality, which constitutes about 32 % of under-five mortality (TDHS 2010), has been a major bottleneck for further child mortality decline since 2008. There has been a slight decline in maternal mortality over the past ten years, from 578 per 100,000 in 2004/05 to 454 per 100,000 live births in 2010. Recent data from the UN estimates of 2013 shows further decline of maternal mortality to 410 per 100,000 live births.

TDHS 2010 survey data showed a high utilization of antenatal care services at 96% for at least one antenatal care visit, although the rate for four visits has declined over time; however, only 50% of all births in Tanzania occur at health facilities. Postnatal care service utilization is still low, at 31% within 2 days after delivery. Despite high knowledge of contraceptives (98%), the fertility rate remains high at 5.4, the modern methods contraceptive prevalence rate relatively low at 27% and unmet need relatively high at 25 % (TDHS 2010).

As we approach 2015, the Ministry of Health and Social Welfare (MoHSW) conducted a midterm review of *The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania* in collaboration with a number of different stakeholders fulfil Tanzania's commitment to A Promise Renewed. The findings from the review called for the development of a **sharpened** plan for the reduction of reproductive, maternal, newborn and child deaths. This plan is intended for advocacy, resource mobilisation and prioritisation of high impact interventions, such as family planning and emergency obstetric and newborn care particularly to poor and underserved women in rural areas in Western and Lake Zones, to accelerate progress towards achieving MDG 4 and 5 targets. The plan places a strong emphasis on strengthening accountability and monitoring mechanisms as well as reinforcing partnerships for social mobilization, funding and technical assistance. It is the expectation of the Government, particularly the MoHSW, that all stakeholders in government, private sector, development partners and civil society organizations will align with the optimal use of this sharpened strategic plan to support the implementation of prioritized reproductive, maternal, newborn and child health interventions.

The Government of Tanzania highly values partnership in working towards realization of the objectives of **The Sharpened One Plan**. Together, we can improve the health of Tanzanian mothers, babies and children, and build a stronger and more prosperous Nation.



Dr Seif S. Rashid (MP)

Minister for Health and Social Welfare

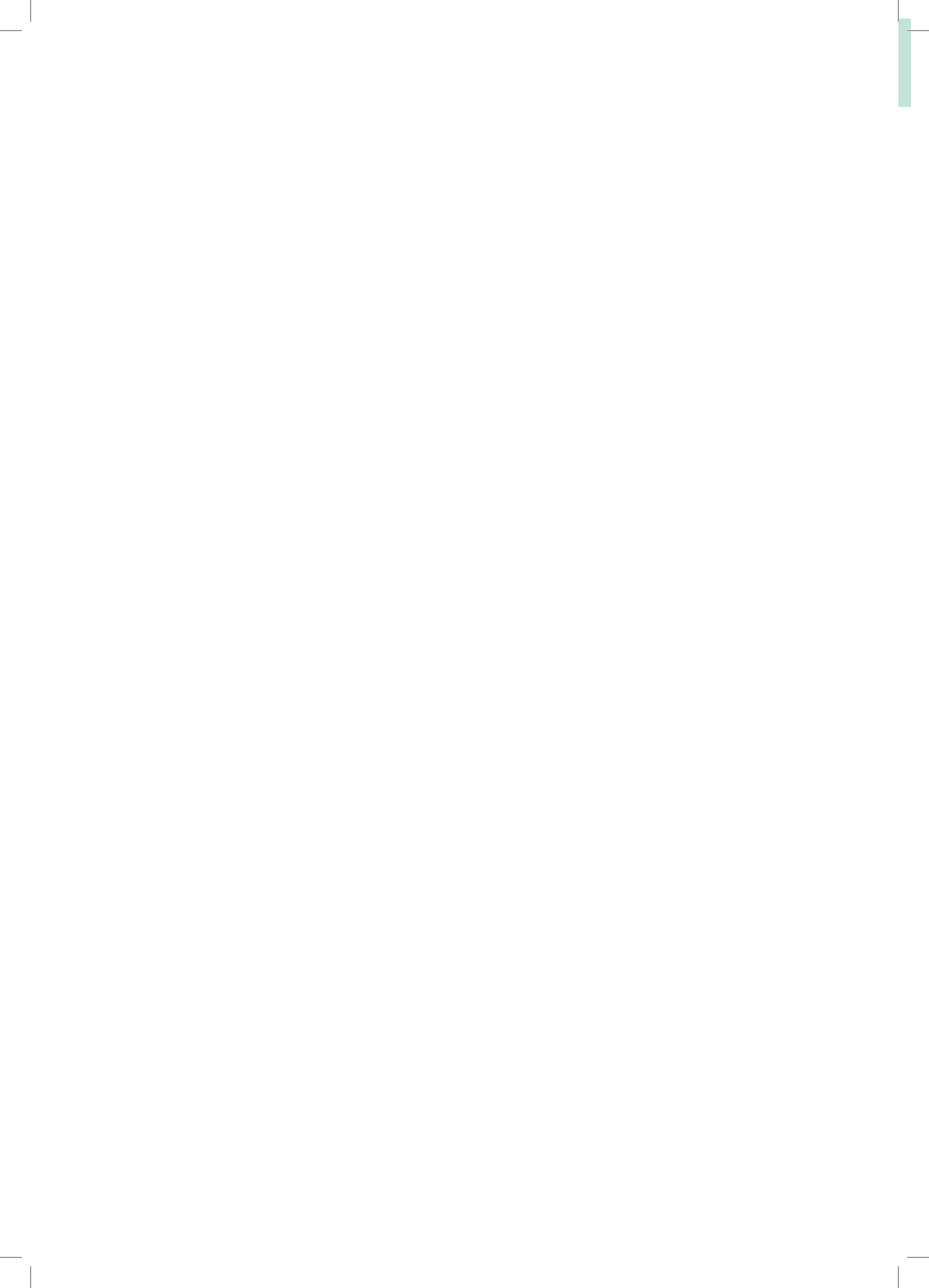
ACKNOWLEDGEMENT

The Ministry of Health and Social Welfare wishes to express its gratitude to the many individuals and development partners who worked with the Ministry in the development of *The Sharpened One Plan*. Completion of this document resulted from extensive consultations and collaboration with various stakeholders including development partners, interested organizations as well as committed individuals.

The Ministry would like to acknowledge all stakeholders who contributed in one way or another to the successful development of the document. The Ministry particularly wishes to acknowledge the invaluable technical and financial support of the members of the Maternal Newborn Child Health Technical Working Group, the Reproductive, Maternal, Newborn and Child Health (RMNCH) Mid Term Review Task Team, RMNCH development and implementing partners. Special thanks to UNFPA, UNICEF, WHO, USAID, Evidence for Action and Jhpiego for technical and financial support.



Charles Pallangyo
Permanent Secretary, MoHSW



CHAPTER 1: INTRODUCTION AND OVERVIEW

The Ministry of Health and Social Welfare (MoHSW) developed the *The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015 (One Plan)* to guide the efforts of the Government and stakeholders working to improve maternal, newborn and child health (MNCH). The One Plan's key objectives focus on reducing maternal, newborn, and under-five mortality. The fourteen operational targets and their associated sixty-six indicators reflect the continuum of care from cradle to menopause, as well as from the community to the health facility.

In order to maintain and further advance the progress made in implementation of the One Plan thus far, the MoHSW conducted a mid-term review of the strategies outlined in the document. The review took stock of the progress and achievements to date, and identified priority areas to be strengthened and interventions to be scaled up nationally to achieve the One Plan's original objectives and targets. Based on the findings of the review, this Sharpened One Plan was developed for the remaining period of the One Plan to December 31st, 2015.

During implementation of the One Plan, Tanzania signed the following global initiatives, demonstrating her continued commitment to improve RMNCH:

| Year | Signed Declaration by Tanzania |
|-------------|--|
| 2009 | Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) launched by African Union; in 2011 the Tanzania chapter was launched. |
| 2010 | Every Woman Every Child launched by the UN Secretary General <ul style="list-style-type: none">• UN Commission on Information and Accountability (COIA) of Women and Children's Health,• UN Commission on Life Saving Commodities (UNCoLSC) |
| 2012 | London Summit commitment on Family Planning 2020 Partnership |
| 2012 | Scaling Up Nutrition (SUN) |
| 2012 | Global Plan for the Elimination of Mother to Child Transmission (eMTCT) of HIV 2011 – 2015 |
| 2012 | Child Survival Call to Action: A Promise Renewed (APR) |
| 2013 | Global Vaccine Action Plan 2011 – 2020 |
| 2013 | Every Newborn Action Plan (ENAP) |

CHAPTER 2: FINDINGS FROM THE MID-TERM REVIEW OF THE ONE PLAN

The MoHSW carried out a mid-term review of the One Plan to determine the extent to which the 3 strategic and 14 operational targets referenced in that document have been attained and to complement on the findings from the Health Sector Strategic Plan III mid-term review.

Progress has been made in the area of MNCH over the past four years through: ensuring health facilities have adequate equipment and supplies and supporting a large number of health care staff to have the necessary competencies along the continuum of care of pre-pregnancy, pregnancy, newborn, postpartum/postnatal care and child health care i.e. family planning, antenatal care, emergency obstetric and newborn care (EmONC), postnatal, immunization, management of childhood illnesses.

However, the One Plan mid-term review noted that although the number of facilities providing services has increased, staff shortages and supply stock-outs have compromised quality of care. Based on the result of the review, it was recommended that the current highly fragmented approach to MNCH be reviewed and refined in order to ensure comprehensive improvement of all necessary supporting systems. See Annex I for detailed information against each of the 14 operational targets.

2.1 *Service delivery*

The RMNCH continuum of care includes integrated service delivery for mothers and children throughout the lifespan from pre-pregnancy, delivery, postpartum period, infancy and childhood. Such care is provided through outpatient services, clinics and within communities. The continuum of care recognizes that safe childbirth is critical to the health of both woman and newborn, and that a healthy start in life is an essential step towards a sound childhood and productive life.

Table 1 summarizes those interventions where good progress is being made in terms of increasing coverage along the continuum of care, as well as those that are lagging behind.

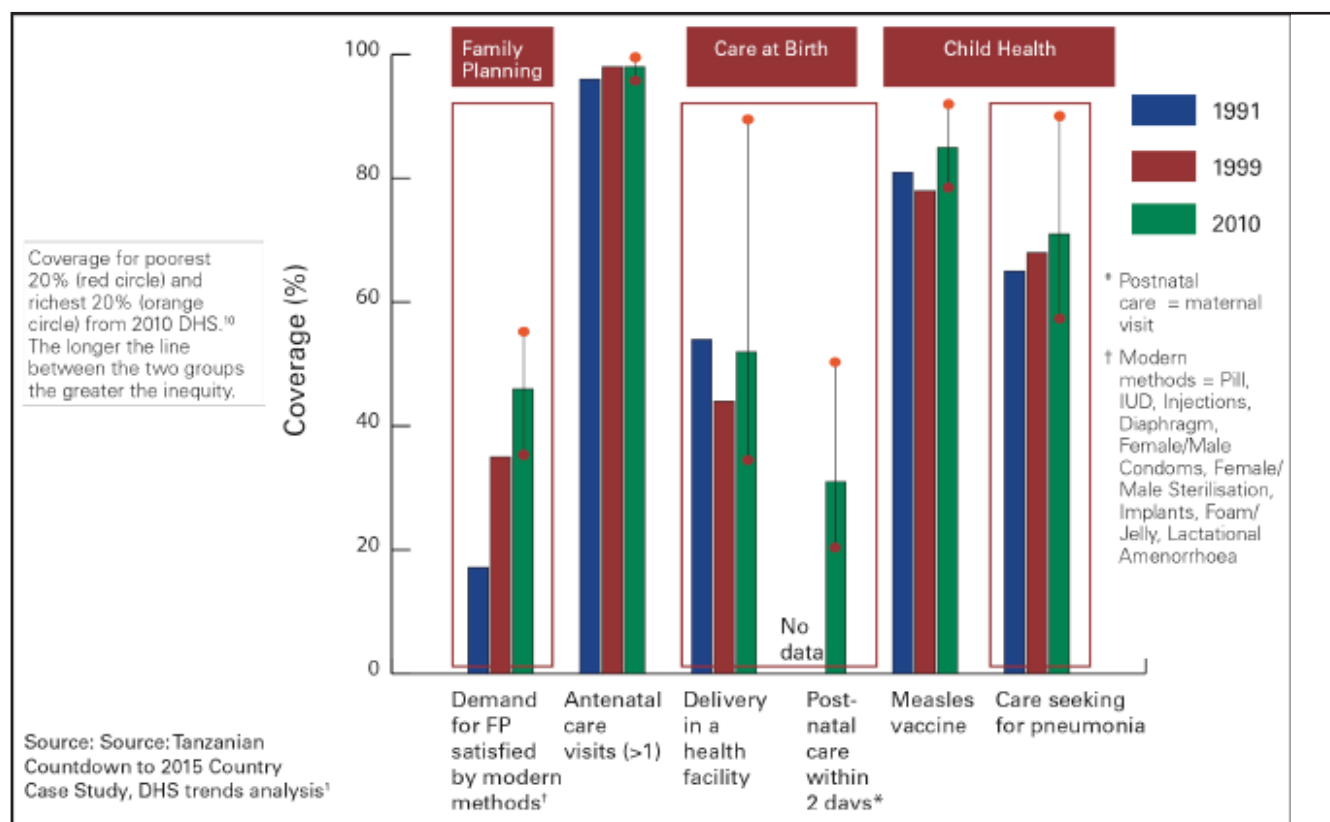
Table 1: Current status of selected Key indicators

| | Good progress | Poor progress |
|----------------------------|---|--|
| Outcome indicators | | |
| Mortality | <ul style="list-style-type: none"> • U5MR | <ul style="list-style-type: none"> • MMR • NMR |
| Coverage indicators | | |
| Pre pregnancy | | <ul style="list-style-type: none"> • Contraceptive prevalence rate • Adolescent birth rate |
| During pregnancy | <ul style="list-style-type: none"> • Proportion of women attending at least one ANC visit • Proportion sleeping under ITN • Proportion of pregnant women received TT2+ • Proportion of pregnant women received PMTCT services | <ul style="list-style-type: none"> • Proportion of women attending ANC 4+ visits • Proportion of pregnant women receiving IPT2 |
| During birth and postnatal | | <ul style="list-style-type: none"> • Proportion of pregnant women delivering with assistance from skilled providers (SBAs) • Proportion of pregnant women delivering in a health facility • Proportion of health facilities with EmONC • Proportion of health facilities providing essential newborn care • Proportion of mothers/newborns receiving PNC within 48 hours • Proportion of children receiving early initiation of BF (within one hour) |
| Childhood | <ul style="list-style-type: none"> • Proportion of children fully immunized • Proportion of children given Vitamin A supplementation • Proportion of under 5 children sleeping under ITN | <ul style="list-style-type: none"> • Proportion of children exclusively breast fed for 6 months • Proportion of HIV+ children receiving ART |

Figure 1 details trends in coverage along the continuum of care, with specific information on inequities among wealth quintiles and disparity among urban rural. This figure portray the picture of inequity in that the poor and marginalised are not access 'quality' RMNCH services. For example, Compared to women from the poorest 20%, women from the wealthiest 20% are:

- TWICE as likely to have their demand for family planning satisfied,
- THREE times more likely to deliver in a health facility,
- TWICE as likely to receive postnatal care, and
- TWICE as likely to seek care for their child with suspected pneumonia (Figure 1).

Figure 1: Coverage along the continuum of Care



There are clear programmatic gaps around family planning, care at birth, postpartum/postnatal and newborn care which justify the interventions proposed in Chapter 3 for immediate action.

2.1.1 Reproductive and maternal health

The midterm review observed that the rate of one antenatal visit remains high (96% TDHS 2010), however there has been a reduction in attendance for at least four visits - from 62% in 2005 to 43% in 2010 (TDHS). The reason for the drop in attendance rate for 4 visits is not well elucidated. Reports have shown that the quality of antenatal visits is poor - there is a consistent lack of key services such as checking Haemoglobin (Hb), testing for syphilis and HIV and providing medicines such as iron/folic acid, SP for malaria prophylaxis, tetanus prevention vaccine etc. Commodities for service provision are often lacking in health facilities, although they may be in stock at central level at the Medical Store Department (MSD).

During the same period, the proportion of births attended by skilled personnel increased from 46% in 2005 to 51% (TDHS 2010); moreover, recent HMIS data showed moderate increase of births in health facilities from 58% (2011) to 62% (2012). The access of birth by skilled personnel was shown to vary by region and place of residence - more women in urban areas were likely to access birth by skilled personnel than those from rural areas. Furthermore, the proportion of delivered mothers attending postnatal care within 48 hours after birth was low at 31% (TDHS 2010). All of the indicators referenced here were particularly poor in the Lake and Western Zones, justifying sharpened plan interventions in these areas during the remaining days to December 31st, 2015. Results from these sharpened plan interventions

will provide a benchmark for acceleration for the next strategy after the One Plan. The midterm review documented further that the maternal mortality ratio (MMR) in Tanzania has slowly declined from 870 per 100,000 live births (1990) to 454 per 100,000 live births in 2010. Tanzania has made insufficient progress in maternal survival between 1990 and 2013 (Figure 2). Approximately 7,900 women still die each year from complications of pregnancy and childbirth.[Ref:2013 UN estimates]. Despite a modest increase in the ARR between 2000 and 2010 (ARR = 4.6%), the ARR between 1990 and 2013 was only 3.5%. Tanzania is therefore off target to achieving MDG 5a (Figure 2a and Figure 2b).

The contributing factors to the high level of maternal mortality include limited access to family planning and poor quality of health services including EmONC. More critical is the shortage of skilled human resources and lack of enabling environment for human resources to function e.g. appropriate infrastructure, essential equipment and medicines and poor referral systems.

Figure 2a: Progress towards reducing the MMR by three quarters (MDG 5a) in Tanzania- TDHS

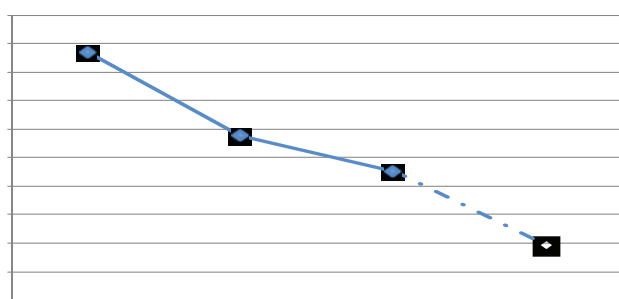
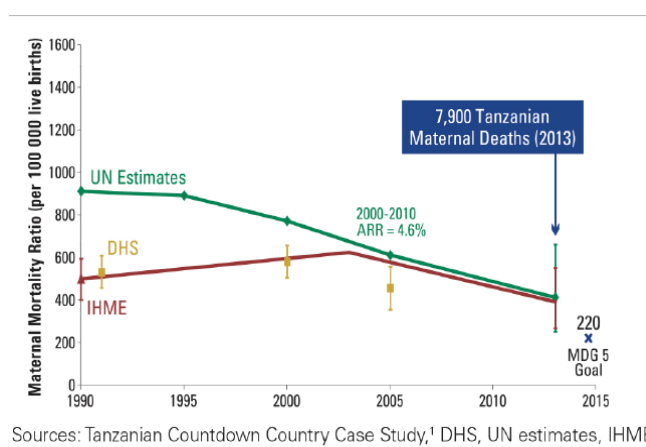
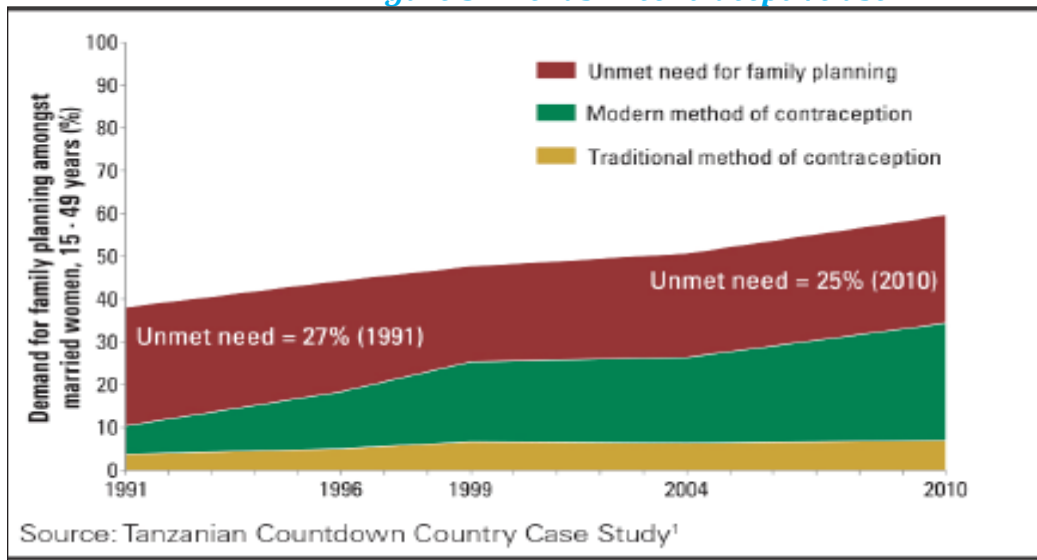


Figure 2b: Progress towards reducing the MMR by three quarters (MDG 5a) in Tanzania- UN Estimates



Global evidence has shown that family planning reduces MMR by almost 44% (S. Ahmed, et al 2012). Although there has been progress in the use of modern contraceptives, from 7% in 1990 to 27% in 2010 Tanzania continues to have a high unmet need for contraception at 25% and a high total fertility rate (TFR) of 5.4 births per woman according to 2010 TDHS findings. However the total fertility rate has shown a gradual decrease to 5.2 births per woman in 2012 according to preliminary results of the 2012 National Population and Housing Census. There is a wide variation in TFR in the country, ranging from 3.9 in Eastern Zone to 7.1 in Lake Zone (TDHS 2010) as per (Figure 3)..

Figure 3: Trends in contraceptive use

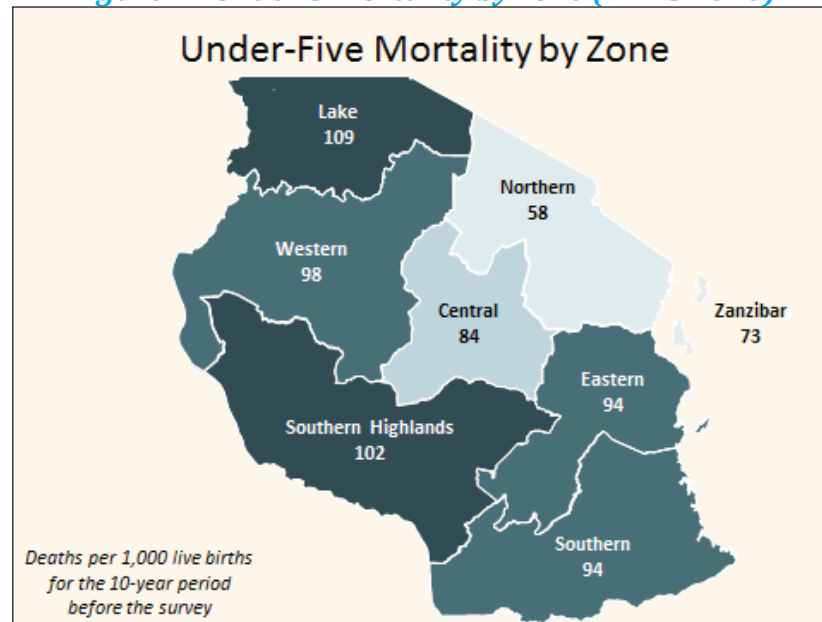


The adolescent fertility rate is persistently high in Tanzania. Reports show that 44% of adolescent girls are either mothers or have had their first pregnancy by age 19, 85% are married adolescents and 60% of unmarried sexually active adolescents are not using any modern contraception. Less than 50% of adolescents aged 15-19 years had their demand for family planning satisfied (TDHS, 2010). The mid-term review identified lack of accessible youth-friendly services as a gap for the provision of quality adolescent reproductive health services (ARHS).

2.1.2 Newborn and child health

Tanzania has made considerable progress in the reduction of child mortality. The under-five mortality rate declined from 112 per 1000 live births to 81 per 1000 live births (TDHS 2005 & 2010). A September 2013 UN Interagency Report confirms that Tanzania has achieved the MDG 4 target of reducing under-five mortality to 54 per 1,000 live births. Furthermore, the infant mortality rate has also decreased from 68 per 1000 live births to 51 per 1000 live births (TDHS 2005 & 2010). These achievements are due to Government commitments to increase and sustain use of key health interventions i.e. high coverage of routine immunization for under-fives, Vitamin A supplementation, and the use of insecticide treated bed nets and effective medicines to treat malaria. However, the review acknowledged that there are zonal disparities in child mortality that need to be addressed (Figure 4).

Figure 4: Under 5 mortality by zone (TDHS 2010)



Tanzania recognizes the need to sustain the gains achieved in MDG 4 through A Promise Renewed, which supports the Every Woman Every Child initiative. This commitment aims to accelerate the decline of under-five mortality by scaling up the full continuum of care interventions for women and children so as to lower child mortality to 20 or fewer deaths per 1000 live births by 2035.

Despite the overall success in MDG 4, little progress has been made in reducing deaths of infants in the first 28 days after birth. Newborn mortality declined from 32 per 1,000 live births (TDHS 2004/05) to 26 per 1,000 live births (TDHS 2010). The target is to reduce to 19 per 1,000 live births by 2015 (Figure 5a & 5b).

Figure 5a: Trends in child mortality- TDHS

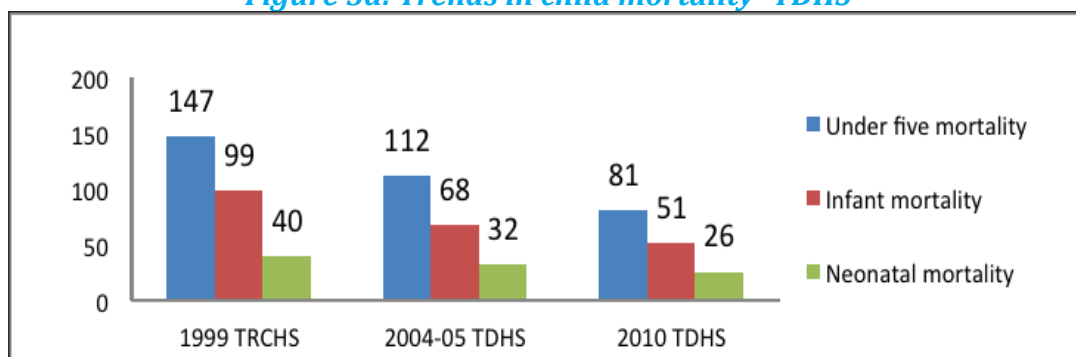
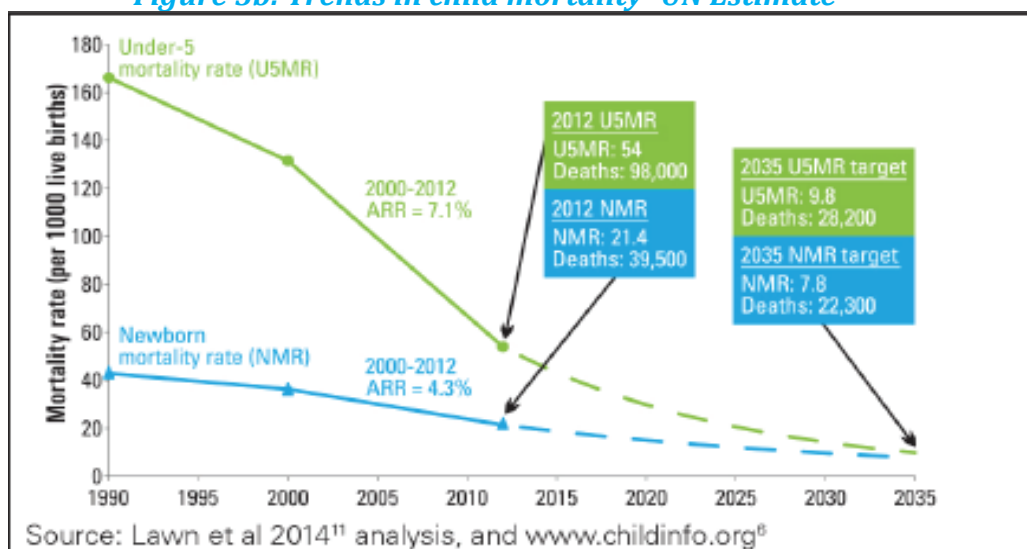


Figure 5b: Trends in child mortality- UN Estimate



The major contributors to newborn death are three - prematurity, asphyxia and sepsis. These conditions are closely linked to the health of the mother and baby during pregnancy, at birth and during the first week of life. The slow decline in newborn mortality accounts for its increasing proportion of overall underfive mortality (now at 32% (TDHS 2010)), which has implications for strategic prioritization of maternal and newborn health services with a focus on competency-based emergency obstetrics and care at birth, and care during the first 48 hours post-delivery.

2.2 Health systems strengthening

From the findings of the mid-term review, the cross-cutting bottlenecks that hinder access and provision of quality of MNCH services include mismatch between policies/guidelines and implementation with a gap in accountability, inadequate resources (financial and human), medicines, safe blood supplies and other essential commodities, equipment and infrastructure to support quality services.

Further, there has been uneven distribution of resources, and duplication of efforts in certain geographical areas reflected by relative concentration of services in urban as compared to rural areas. In addition, few health facilities, particularly health centres and dispensaries, offer all BEmONC signal functions and even fewer health centres are CEmONC-compliant (SARA 2013).

Other bottlenecks include unsatisfactory data collection and sharing due to challenges in availability and skills to use standardized service delivery registers, and heavy reliance on manual (rather than electronic) data capture and reporting.

Weak infrastructure to accommodate quality RMNCH services deters integration of related services. Within the community, there is a low level of understanding of the importance of these services resulting in delays in seeking care in a timely manner. This is further compounded by weak referral systems across different levels of health facilities and the community.

For further details on bottlenecks identified as part of the mid-term review see Annex II. More specific information regarding progress against each of the health system building blocks (apart from service delivery, which is referenced in Section 2.1) is as follows:

2.2.1 Strengthening leadership, governance and accountability

Tanzania enjoys international renown with regard to high level political commitment for addressing maternal, newborn and child health. In 2011, the President of the United Republic of Tanzania His Excellency, Dr. Jakaya Mrisho Kikwete, and the Prime Minister of Canada, Honourable Stephen Harper, co-chaired the UN Commission on Information and Accountability (COIA) on Maternal and Child Health. Dr. Kikwete has also made a number of public statements expressing his government's support for reducing maternal and child deaths. Given this high level commitment, donors have engaged in significant partnerships with the Government of Tanzania in its efforts to reach MDGs 4 and 5.

In the One Plan, the Government of Tanzania (GoT) pledged to accelerate the reduction of maternal, newborn and child deaths building on commitments in national documents such as National Strategy for Growth and Reduction of Poverty (NSGPR), Tanzania Development Vision 2025, Primary Health Services Development Programme (PHSDP) and Health Sector Strategic Programme (HSSP) III. The GoT has put in place a number of other key policies and strategies that support delivery of quality maternal and newborn health services, including National Health Service Provision Standards and the National Health Policy. In practical terms, the MoHSW states in the National Health Policy that the Government and its stakeholders will continue to provide free health care services to pregnant and postpartum women and to under-five children. Furthermore, the policy observes that the Ministry and its stakeholders will prepare and coordinate implementation of the guidelines, including sustainable strategies aimed at reducing maternal, newborn and under-five mortality.

Although significant political commitment is in place, and many good and supportive policies and guidelines are on paper, these have not been fully implemented throughout the country. It is clear that much needs to be done to ensure that the Government of Tanzania's vision as reflected in its policy documents becomes a reality.

2.2.2 Improving health financing

In accordance with national health policy, RMNCH services are expected to be free of charge to clients. However, insufficient funding for district procurement of necessary commodities as well as frequent stock outs of those commodities at a zonal level necessitates out-of-pocket expenditures. These financial barriers have been shown to promote non-use or delays in accessing critical services especially among the poor.

Supplementary funding through Community Health Funds (CHF) is recognised as important by community members, but enrolment in these funds remains low. A Results Based Financing (RBF) pilot was implemented as a way to motivate health care workers and incentivize performance; the coverage data following implementation reflects positive increases in rates for facility delivery, IPT2 provision, ANC laboratory testing and PMTCT coverage. The MoHSW is currently working to scale up this intervention from 2014.

Annual expenditure and budget tracking of all 'on-' and 'off-' budget RMNCH resources from the Government and partners can improve advocacy, allocation, and absorption to strengthen efficiency and effectiveness of RMNCH resources. A recently conducted RMNCH resource tracking exercise indicated that there is a lot of financing in this area. The identified gaps which need to be addressed in resource utilization include lack of transparency among partners, small scale interventions compared to available resource, lack of guidance in implementation and lack of focussed planning (RMNCH resource tracking 2013).

Improved planning of resources has important trickle-down effects which can allow for early stop gap measures to prevent stock-outs, and ensure that clients are receiving the services that are expected at facilities. Expenditure tracking for FY 2011-12 and budget tracking for FY 2013-14 were recently conducted through National Health Accounts (NHA) and an RMNCH specific resource mapping tool, respectively. Moving forward, expenditure and budget tracking will be conducted annually through concerted efforts by the Directorate of Policy and Planning, the Reproductive and Child Health Section, and engagement of communities and development partners in health.

2.2.3 Developing, deploying and retaining skilled human resources for health

As per the MoHSW Human Resource for Health (HRH) 2013 Country profile, the total number of health workers has increased from 47,000 in 2006/7 to 64,449 in 2012/13, with the highest increase among medical doctors and nurses. There are 1,135 medical doctors (0.260 per 10,000 population), 1,741 assistant medical officers (0.399 per 10,000 population), 4,248 assistant nursing officers (0.974 per 10,000 population), 14,096 nurse and nurse midwives (3.231 per 10,000 population) and 2,456 nursing officers (0.563 per 10,000 population) in Tanzania. If you add the availability of each of these cadres per 10,000 population, you arrive at a figure of 5.427, well below the WHO-endorsed figure of 23 health care professionals (physicians, nurses and midwives) per 10,000 population required to achieve adequate coverage rates for primary health care.

Field visit data collected as part of the 2012 draft High Burden Country Initiative (HBCI) report showed significant facility vacancy levels. An overall vacancy rate of 33% was found with a range among districts of 16%-73%. Vacancy rates of HRH broken down by type of facility show rates of about 30% for both hospitals and health centres and a slightly lower figure of 23% for dispensaries. Among the cadres, the shortage of medical officers was the highest (around 50%) followed by assistant medical officers (41%), and clinical officers and nurse/midwives (at 41% and 34%, respectively). Shortages of EmONC anaesthetists, laboratory technicians, pharmaceutical technologists and pharmacists have been anecdotally reported, which also affects quality and timeliness of service provision.

With specific regard to MNCH, the draft HBCI report shows a variation in level of competence among the cadres involved in providing RCH services. Competency-based training curricula are present across the spectrum of pre-service training for skilled birth attendants. The observed challenge is the adherence to the use of the curriculum due to inadequate skills among the tutors and poor supporting systems, including lack of appropriate training equipment.

The MoHSW's Human Resources Development Directorate recently completed a midterm evaluation of the HRH Strategic Plan (2009-2014) and is in the process of developing

the next HRH Strategic Plan (2014-2019). Although there will be continued emphasis on increasing the numbers of health workers produced, there will also be an added emphasis on equitable distribution of HRH as well as ensuring that funding is available in the most hard to reach areas to offer a local package of incentives to attract and retain staff. Midlevel cadres, including nurse and nurse midwives, will be the primary focus of this plan. A National Production Plan is also currently being developed to assess the long term training and production needs across all HRH cadres, including nurse and nurse midwives. Finally, the MOHSW is moving forward with developing a task sharing policy for Tanzania by 2016. An operational plan clearly defining a roadmap for updating scopes of practice, schemes of service, roll out of training for all staff in the field as well as a supervision structure will be developed by 2017.

2.2.4 Strengthening the supply chain system

Supply management continues to be a challenge for delivering quality RMNCH services. Frequent stockouts of essential medicines, supplies and commodities for RMNCH is a common problem for all services and levels of care. Although there is an annual quantification effort to determine national needs for RMNCH commodities, the supply chain system is not getting commodities to health facilities in a timely and sufficient manner. The tracking system for essential commodities is weak and forecasting ability of health facilities is generally poor.

In an effort to improve the system, the MoHSW introduced Integrated Logistic System (ILS) Gateway in November 2010 and the electronic logistics management information system (eLMIS) in October 2013. These systems intend to improve the transparency, visibility and accountability of supply management. The MoHSW also developed a Country Implementation Plan in line with the UN Commission on Life Saving Commodities (UNCoLSC). The plan addresses the issues of registration, quantification, logistic management information systems (LMIS), demand creation and provider knowledge.

2.2.5 Strengthening implementation of the national health management information system (HMIS)

The MoHSW, with support from development partners, has successfully scaled up HMIS nationwide, enabling routine tracking of key indicators. According to the MoHSW Monitoring and Evaluation Strengthening Initiative (MESI), the average national HMIS reporting level was 67% in December 2013, which is below the national reporting target of 80%. Fifteen regions surpassed the national average in terms of their reporting rate. Although HMIS reporting levels have continued to improve in many regions, there is a challenge in timeliness and completeness of data reporting, hence a need to strengthen the system and institute accountability through the use of the RMNCH scorecard.

2.2.6 Advocacy, Community Mobilization and Participation

A community perspectives study was conducted as part of the HSSP-III review, with the following key findings:

- Utilization of maternal and child health services is directly related to quality of services

- Lack of medicines and disrespectful care have direct effect on quality of health provided
- Exemption schemes cannot work properly unless there is a transparent identification of all people eligible for exemptions and a full understanding and acceptance of exemption schemes by staff in health facilities
- Community members are ready to register and contribute to health insurance schemes provided they are assured of quality services.
- Community is ready to participate in improving accountability of services through increased transparency and monitoring performance.

Recognizing the pivotal role of community mobilization and participation in achieving MDGs 4 and 5, the MoHSW launched the Integrated Community Maternal, Newborn and Child Health Guidelines in November 2012. These guidelines were developed bearing in mind that working with individuals, families and communities is critical for ensuring the recommended continuum of care throughout pre-pregnancy, pregnancy, childbirth, the immediate postpartum period and childhood. The guidelines emphasize empowerment of women, families and communities to improve maternal, newborn and child health outcomes, bridging the gap between communities and facilities. This will contribute to reduced morbidity and mortality, fostering improved health within communities at large.

CHAPTER 3: THE SHARPENED PLAN TO ACCELERATE PROGRESS

This Sharpened One Plan 2014 to 2015 aims to accelerate implementation of the existing “The National Road Map Strategic Plan to accelerate reduction of Maternal, Newborn and Child deaths in Tanzania 2008-2015 (One Plan)” in an integrated manner addressing the continuum of care. The rationale for taking the integrated approach relies on a number of factors:

- 1) Specific interventions delivered in a specific time frame have multiple benefits.
- 2) Linking interventions in packages can reduce costs, facilitate greater efficiency in training, monitoring and supervision, and strengthen supply systems.
- 3) Integration of services increases uptake and promotes continuation of positive behaviours
- 4) Integration maximizes programme achievements

3.1. Vision

A healthy and well-informed Tanzanian population with access to quality MNCH services, which are affordable, sustainable and accessible through an effectively functioning health system.

3.2. Mission

To promote, facilitate and support in an integrated manner, the provision of comprehensive, high impact and cost-effective MNCH services, in order to accelerate reduction of maternal, newborn and child morbidity and mortality.

3.3. Goal

To accelerate the reduction of maternal, newborn and childhood morbidity and mortality, in line with MDGs 4 and 5, by 2015.

3.4. Objectives

The following are the objectives for the MNCH Strategic Plan, which should be met by the end of the year 2015.

- 3.4.1. To reduce maternal mortality ratio from 578 to 193 per 100,000 live births.
- 3.4.2. To reduce neonatal mortality rate from 32 to 19 per 1000 live births
- 3.4.3. To reduce the under-five mortality rate from 112 to 54 per 1000 live births (This target has been reached- UN Interagency Child Mortality Estimate Sept 2013)

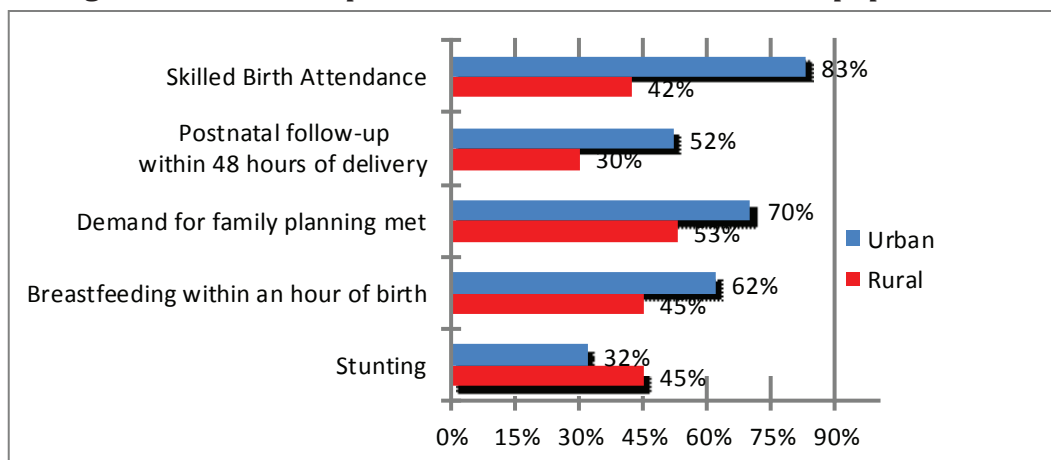
The focus of the sharpened One Plan for the remaining 600 days has been refined based on the One Plan Mid- term review findings in line with five strategic areas as defined by A Promise Renewed initiative.

Strategic area 1: Geographic Focus

- Increase efforts in Lake and Western Zones where there is highest maternal, newborn, and child mortality with focus on reducing rural-urban disparities (see Figure 6).
- Advocacy and resource mobilization for MNCH goals and agenda in order to promote, implement, and scale up evidence-based and cost-effective interventions, and allocate sufficient resources to achieve national and international goals and targets.

- Community mobilization and participation to improve key maternal, newborn and child care practices generate demand for services and increase access to services within the community.

Figure 6: Health disparities between urban and rural populations¹



Strategic area 2: High Burden Population

- Refocus health systems to scale up access for underserved women, adolescents and children
- Maintain gains in maternal and child health, scale-up interventions particularly in rural or marginally performing areas

Strategic area 3: High Impact Interventions

- Target and expand coverage of selected evidence-based interventions that will have the greatest impact on lives saved, specifically family planning, care at birth and postpartum/postnatal care
- Support districts in decision-making and implementation processes by ensuring districts have the necessary capacity, information, data, policy standards and systems
- Health System strengthening and capacity development at all levels of the health sector and ensuring quality service delivery to achieve high population coverage of MNCH interventions in an integrated manner

Strategic area 4: Education, Empowerment, Equality

- Collaborate and coordinate with supportive policies and legal environment that impact the social determinants of health: girls' education, women's empowerment, respectful care, opportunities for economic growth
- Emphasize nutrition, education, water and sanitation across the continuum of care and throughout the lifespan
- Information, education and communication /behavioural change communication (IEC/BCC)

Strategic area 5: Mutual Accountability and Transparency

- Strengthen transparency and mutual accountability at all levels of the health systems
- Invest in HMIS to capture data, monitor and evaluate progress using the RMNCH scorecard (See Annex 3)
- Fostering partnership to implement promising interventions among Government (as lead),

¹ TDHS 2010

donors, NGOs, the private sector and other stakeholders engaged in joint programming and co-funding of activities and technical reviews.

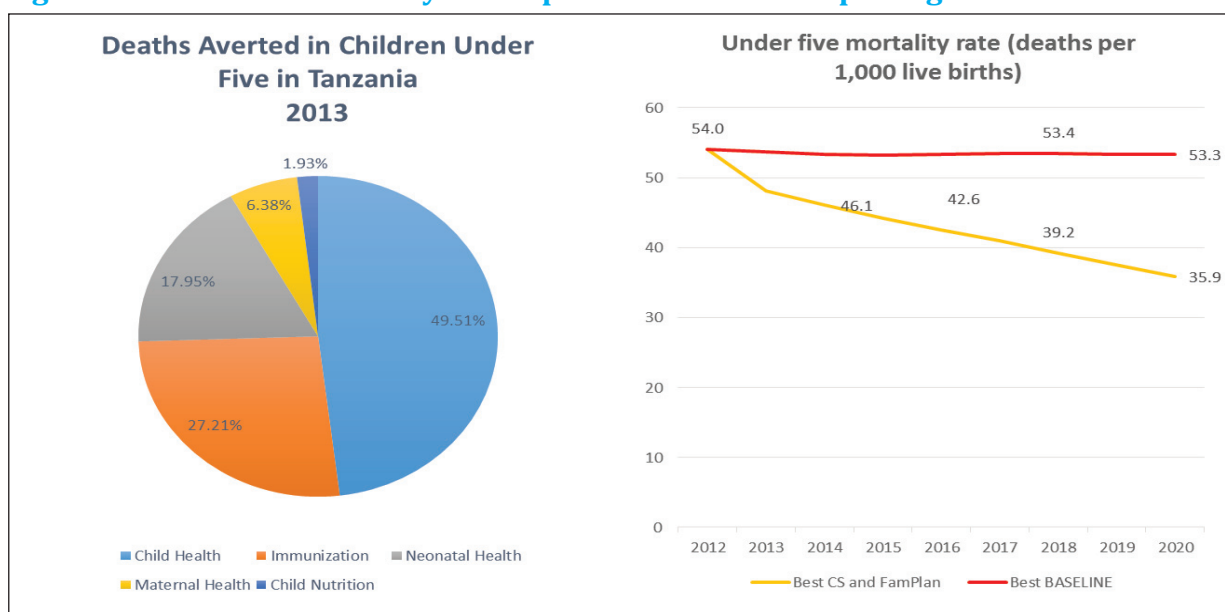
3.5 Identifying the potential impact of scaling-up high-impact interventions

In Tanzania, the Lives Saved Tool (LiST) was used to determine how much impact can be achieved by scaling up different high-impact interventions. LiST used specific health status data and intervention coverage levels to estimate the sizes of interventions based on best available evidence.

At this point in time, LiST analysis is most effective in the area of child health, while work continues to strengthen the maternal health application. The LiST results were generated in order to inform selection of the most appropriate child health interventions, while global evidence was used to select evidence-based, high impact maternal health interventions as priorities for the sharpened One Plan.

In Tanzania, the child health LiST results indicated that out of all potential interventions, efforts in preventing/treating malaria, diarrhoea and pneumonia, providing essential newborn care including management of pre-term birth would have the most impact on child health, reducing the child mortality rate from 54 per 1,000 to 36 per 1,000 by 2020. See Figure 7 and Table 2 for additional detail on the LiST analysis conducted for Tanzania.

Figure 7: Tanzania LiST analysis - impact of intervention packages on child mortality



For maternal health, both scaling up contraceptive use as well as ensuring quality labour and delivery management (including clean birth practices) were identified as interventions that would significantly contribute to reduction in maternal deaths in Tanzania.

Table 2: Estimated lives saved and births prevented by end of 2015 if the accelerated plan is acted on nationally

| | Sharpened One Plan by end of 2015 with faster progress for the 3 priority areas at National level | | |
|--------------------------|---|------------------------|------------------------------|
| | Reduction % | Mortality ratio / rate | Lives saved/births prevented |
| Under five deaths | 25% | 46 | 14,500 |
| • Neonatal deaths | 31% | 16 | 9,400 |
| • Deaths 1- 59 months | 21% | 30 | 5,100 |
| Maternal deaths | 30% | 382 | 1,400 |
| Stillbirths | 22% | 20 | 2,500 |
| Total lives saved | | | 18,400 |

3.6. Selected Interventions for the Sharpened One Plan

The Countdown to 2015 has started and there are critical areas of service and geographic need that the country must address in an accelerated manner in order to save lives and improve health outcomes for women and children, in line with the five strategic areas outlined above. The One Plan midterm review noted a marked shortfall in interventions across the nation, but the Western and Lake Zones are in particular need of attention. In the short-term a vision to 2015 has been created to support these zones in the priority areas of family planning, care at birth and commodity security in order to maximize health outcomes for women and children in these particular areas. Key activities are outlined below, with a more detailed plan in Section 6.

3.6.1. Family planning

Family planning (FP) is critical for the improvement of health status and reduction of both maternal and child mortality; in fact, evidence shows that family planning can reduce maternal deaths by 44% and also can reduce risk of infant mortality (Ahmed, et al 2012). However, provision of FP services continues to face challenges in meeting clients' expectations and needs. Identified gaps in modern FP use include regional variation; for example, Lake and Western zones have low utilization due to existence of myth and misconception, low male involvement, inadequate skilled human resource, erratic supply of family planning methods and unmet need among postpartum women and young people. Another gap is inadequate method mix at both facility and community levels. To address these gaps, increased efforts are required to achieve the target of 60% of modern family planning use by 2015.

The following are proposed interventions to increase the number of FP users by 2015 in Lake and Western Zones:

1. Demand creation and increased service provision through rolling out the Green Star campaign: This will promote increased access to FP services with a focus on access for youth, through working with community health workers to promote FP utilization and to provide referrals to health facilities, as well as working with community development officers by targeting out of school youth.
2. Scaling up of frequency and scope of FP outreach services: This will be achieved by using variety of methods including mobile and home-based outreach services, setting up family planning event days and weeks in all villages/outreach centers in the selected zones.
3. Increased number of skilled FP service providers in facility and at community: Taking into account that there are already trained providers, at least two health care workers per health facility will be trained to offer full range of FP methods as per FP guidelines; and at least two trained community health workers will be available per village according to the integrated community MNCH guidelines. Training for these CHWs will be broader (in accordance with the cMNCH guidelines) to support the full RMNCH continuum of care at community level, to improve linkages between facility and community.
4. Expand integration of FP with other RMNCH services: including post-partum care; post abortion care, HIV services, immunization outreach services and cervical cancer screening.
5. Increase access to sexual and reproductive health information and contraception for adolescents and youth (15-24): As the evidence shows that unwanted pregnancies for this group contributes to 16% of all maternal mortality through unsafe abortion and pregnancy-related complications, adolescents both in and out of school settings will be targeted for services.

3.6.2. Care at Birth, Postpartum and Postnatal care

The following activities are proposed for 2014-2015 in order to increase access to safe delivery in Western and Lake Zones:

1. Capacity building of health care providers and strengthening health facilities to provide EmONC and postpartum care: This will enable provision of quality EmONC services within the two zones. To facilitate this, the following will be conducted; mapping of EmONC facilities, finalize and print EmONC job aid, train facilitators and tutors, and roll out training of providers using competency based approach. Other activities will include procurement of training materials (mannequins and others) and facility EmONC equipment. Furthermore, situation analysis will be conducted to determine availability of blood and blood products, and based on the results two regional blood centres will be established. Facilities will be encouraged and guided to develop innovative emergency transport mechanisms, in consultation with district health management teams and community governing bodies.
2. Lay the foundation for introduction of antenatal corticosteroids (ACS) as part of pre-term birth management. This work will involve establishment of policy and guidelines, as well as quantification to ensure that ACS are available.

3. Conduct clinical mentoring and supportive supervision to all facilities providing EmONC: This will be conducted starting at least 6 weeks post-training.
4. Postpartum and Postnatal care: This will be facilitated through capacity building of service providers through integrated EmONC interventions which will include competence based training and linkage with communities through integrated RMNCH community interventions.

3.6.3. Commodity security and accountability mechanism on RMNCH Services

One of the primary bottlenecks identified during the mid-term review was recurrent stock outs of RMNCH commodities at facility level, despite the adequate stocks in Medical Store Department (MSD) at national level. The following activities are proposed to avert facility stock outs at all levels to effectively determine and respond to stock status in a timely manner:

1. Orient regions and councils Medicine Therapeutic Committees and Health Management Teams about the availability of RMNCH commodities at MSD so that they can order and hence avoid facility-level stock-outs.
2. Review Report and Requisition (R&R) forms and ensure all RMNCH commodities are incorporated so that consumption trend can be monitored and health facilities can order appropriately.
3. Conduct monthly follow up of ILS Gateway and eLMIS reports for commodity security, monitoring trends and respond promptly in improving stock status.
4. Institutionalize accountability mechanisms at national and Local Government Authority (LGA) levels through evidence-based planning (ILS and eLMIS data), advocacy, stock monitoring, timing distribution and redistribution to minimize stock outs and expiry stock at facility level.

3.6.4. Accountability and Transparency

PMORALG and MoHSW will develop accountability mechanisms at national, zonal, regional, council, ward, community and facility levels in order to ensure provision of quality RMNCH services in all health facilities. This will be facilitated through empowering communities and Facility Governing Committees, implementation of the maternal and perinatal death surveillance and response (MPDSR) including use of RMNCH Scorecard to monitor performance.

Advocate for increased RMNCH resources at CCHP level to ensure LGAs are prioritizing RMNCH in CCHPs in time for 2015/16 budget planning.

In line with accountability framework have a comprehensive system that annually monitors geographical coverage scope and size of support to capture how funds are being allocated and spent at national, regional and district levels; these will enhance policy and decision makers ability to understand the health system efficiently and effectively redirect support and funds if inequities are realized.

3.7. Guiding Principles

The following principles will guide the planning and implementation of the Sharpened One Plan in order to ensure effectiveness, ownership and sustainability of the initiative in Tanzania:

- **Continuum of Care:** Ensuring provision of the continuum of care from pregnancy, childbirth and neonatal period through childhood and across all services levels from family/household, community, and primary facility to referral care.
- **Integration:** All efforts will be made to implement the proposed priority interventions at various levels of the health system in a coherent and effective manner that is responsive to the needs of the mother, the newborn and the child.
- **Evidence-based approach:** ensuring that the interventions promoted through the plan are based on priority needs, up-to-date evidence, and are cost-effective.
- **Complementarities:** Building on existing programmes by taking into account the comparative advantages of different stakeholders in the planning, implementation and evaluation of MNCH programmes.
- **Partnership:** Promoting partnership, coordination and joint programming among stakeholders including the regional secretariat, district councils, private sector, faith-based sector, academia, professional organizations, civil society organizations, as well as communities, in order to improve collaboration and maximize on the available limited resources by avoiding duplication of effort
- **Addressing underlying causes of high mortality:** Taking a multi-sectoral and partnership approach to address the underlying causes of maternal, newborn and child death such as, transport, nutrition, food security, water and sanitation, education, gender equality and women empowerment to ensure sustainability.
- **Shared responsibility:** The family/household is the primary institution for supporting holistic growth, development and protection of children. The community has the obligation and the duty to ensure the survival and health of mothers and children and ensuring that every child grows to its full potential. The state, on the other hand, has the responsibility for developing a conducive legislation and public service provision for survival, growth and development.
- **Division of labour for increased synergy:** Defining roles and responsibilities of all players and partners in the implementation, monitoring and evaluation of the activities for increased synergy.
- **Appropriateness and relevance:** Interventions must rely on a clear understanding of the status and local perceptions of MNCH in the country.
- **Transparency and accountability:** Promoting a sense of stewardship, accountability and transparency on the part of the Government as well as stakeholders for enhanced sustainability.

- **Equity and accessibility:** Supporting scaling-up of cost-effective interventions that promote equitable access to quality health services with greater attention to the youth, poor and most vulnerable children and groups, especially in rural and underserved areas.
- **Phased planning, and implementation:** Promoting implementation in clear phases with timelines and benchmarks that enable re-planning for better results. Building and strengthening existing health infrastructures will be a priority.
- **Human rights and gender in health:** The right to life is a basic human right. Mainstreaming gender throughout the programme and adopting a human rights approach as the basis of planning and implementation is important. It is also critical to understand that children's rights are important human rights and therefore need to be respected at all times in order to uphold the dignity that enables child development and participation.

CHAPTER 4: MONITORING AND EVALUATION

The Sharpened One Plan is focusing on the following key qualitative and quantitative indicators as a subset of the broad indicators stipulated in the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015. There will be a special focus on monitoring progress in Lake and Western Zones, particularly in addressing the poorly performing indicators as referenced earlier in Table 1.

Primary data for monitoring and evaluating RMNCH interventions in Tanzania will be collected from a combination of sources. These include routine service delivery data, primarily through the Health Management Information System, as well as the planned 2015 Tanzania Demographic and Health Survey. To facilitate analysis and use of data collected from the above mentioned sources, data will be grouped according to gender, age groups, income/wealth quintiles, geographical location (rural and urban) as well as ethnic groups.

4.1 Family planning indicators

- Contraceptive prevalence rate by method
- Met need for FP by age group
- Total fertility rate
- Age specific fertility rates
- Number of individuals accepting contraceptives (new acceptors)
- Number of FP service delivery points per 500,000 populations offering full range of contraceptive information counselling and supplies.

4.2 Maternal health indicators

- Maternal mortality ratio
- Proportion of deliveries taking place in health facilities
- Proportion of births assisted by skilled attendants
- Proportion of facilities offering EmONC services (by basic and comprehensive)
- Coverage of met need for obstetric complications (coverage of women with obstetric complications that have received EmOC out of all women with obstetric complications)
- Caesarean sections as a percentage of all live births
- Case fatality rate for obstetric complications
- Percentage of pregnant women attending ANC 4+ times
- Proportion of HIV positive women provided with ARV's during pregnancy
- Percentage of pregnant women tested and treated for syphilis
- Prevalence of positive syphilis serology in pregnant women

- Percentage of pregnant women receiving two doses of SP
- Proportion of mothers receiving Postnatal Care within 48 hours
- Adolescent birth rate
- Percentage of service delivery points providing youth friendly services

4.3 Neonatal indicators

- Neonatal mortality rate
- Prevalence of low birth weight
- Early initiation of breast feeding (within the first hour)
- Proportion of health facilities providing essential newborn care
- Proportion of newborns receiving postnatal care within 48 hours
- Proportion of district hospitals that have functional newborn resuscitation facilities in the delivery room
- Number of perinatal deaths (still births, deaths within the first seven days of life)
- Proportion of district hospitals implementing Kangaroo Mother Care for management of Low Birth Weight

4.4 Child health indicators

- Under-five mortality rate
- Exclusive breastfeeding rate (for first 6 months of life)
- Vitamin A supplementation coverage (under-fives)
- Anti-malarial treatment in under-fives (within 24 hours of onset of fever, appropriateness)
- Antibiotic treatment for pneumonia and dysentery
- ORS and zinc treatment in management of diarrhoea
- Proportion of health facilities with 60% of health workers trained on IMCI
- Measles immunization coverage
- Penta 3 Immunization coverage (DTP- HepB, Hib3)
- Proportion of HIV positive children receiving ARV
- Proportion of HIV exposed infants receiving ARV prophylaxis

4.5 Community indicators:

- Proportion of communities that have set up functional emergency preparedness committees and plans for MNCH including FP and nutrition
- Proportion of pregnant women that have birth preparedness plans
- Proportion of women and children who needed referral who went for referral
- Proportion of women with knowledge of danger signs of obstetric, neonatal and child health complications
- Proportion of district management task forces and committees with representation from communities
- Proportion of facilities with a designated staff responsible for community health services
- Proportion of villages with community health workers implementing MNCH interventions
- Households' care-seeking rate for diarrhoea, malaria and pneumonia

4.6 Increased political will and commitment indicators

- Proportion of MoHSW and district budget allocated to RMNCH

4.7 Indicators for measuring progress of the MNCH strategic plan (Sharpened One Plan)

- Total resources mobilized for MNCH Strategic Plan - suggest revising this to - Total resources mobilized for the Sharpened One Plan

4.8 Indicators for monitoring RMNCH reporting rates from the HMIS/DHIS 2 database

- Data completeness rate
- Data timeliness rate

5.0 The Operational targets to be achieved by 2015 based on new findings

1. Increased coverage of births attended by skilled attendants from 51% to 80%.
2. Maintain immunization coverage of DTP-HB 3 and Measles vaccine above 90% in 90% of the districts.
3. Reduced stunting and under-weight status among under-fives from 42% and 16% to 22% and 14%, respectively.
4. Increased exclusive breast feeding coverage from 50% to 80%
5. Increased provision of PMTCT services from 77% of pregnant women and 56% of their babies to 80%.

6. 90% of sick children seeking care at health facilities appropriately managed.
7. Increased coverage of under-fives sleeping under ITNs from 72% to 80%.
8. 75% of villages have community health workers offering MNCH services at community level.
9. Increased modern contraceptive prevalence rate from 27% to 60%
10. Increased coverage of CEmOC from 73% of hospitals to 100% and of BEmOC from 39% of health centres and dispensaries to 70%
11. Increased proportion of health facilities offering Essential Newborn Care to 75%.
12. Increased antenatal care attendance for at least 4 visits from 43% to 90%
13. Increased number of health facilities providing Adolescent friendly reproductive health services to 80%

CHAPTER 5: LOOKING FORWARD

The acceleration plan for 2014-15 has been designed in line with the five strategic shifts outlined in section 3, with the expectation that progress made under this plan will lay the foundation for medium-term planning as part of preparation for the HSSP-IV. It is anticipated that, the subsequent plan for 2016-2020 will inform the HSSP-IV with a focus on the high-impact interventions that promote survival for women and children, using the LiST analysis as well as interventions and issues that indirectly contribute to maternal and child survival, such as human resources, demand creation/messaging, and commodities.

Moving forward, applying the five strategic shifts described in a Promise Renewed, the emphasis will be on supportive policies and human resources for health (specifically increasing availability of skilled birth attendants); a re-commitment to scaling up high-impact interventions with a focus in regions where most maternal, newborn and child deaths occur (promoting equity in distribution of services); prioritising budgets and committing to action plans. The priority areas of maternal and newborn health (particularly around increasing proportion of facility delivery) and family planning will remain, with efforts scaled up in the Lake and Western Zones during the remaining days to 31st December 2015, with additional interventions in child health, nutrition and water, sanitation and hygiene. It is anticipated that the role of the Community Health Workers (CHWs) will be greatly expanded within this mid-term plan to address delivery of specific interventions, both curative and preventive, at community level. This re-focus will be achieved through community empowerment and improved overall accountability for health resources and outcomes at all levels of decision making and implementation.

Global evidence support the implementation of interventions such as those referenced above in order to save most lives of mothers and children. However, it will also be important to focus on how to continue to strengthen the systems that support implementation and scale up the areas of most critical need (including health workforce, commodities, health financing and community empowerment). Ensuring accountability of all stakeholders at all levels of the system will be the key, building on lessons learned during implementation of the acceleration plan and the results from upcoming report on RMNCH resource tracking.

CHAPTER 6: SHARPENED ONE PLAN AND COSTED ACTIVITIES: 2014 -2015

| Sn | Strategic Objective/Output | Strategic Output Indicator | Activities | 2014 | | 2015 | | | Process Indicators | Responsible Person | Resources Needed in Tsh. |
|-------|--|--|---|-----------|---------|---------|----------|----------|--|--|--------------------------|
| | | | | July-Sept | Oct-Dec | Jan-Mar | Apr-June | Jul-Sept | | | |
| 6.1 | Advocacy and Resource Mobilisation | | | | | | | | | | |
| 6.1.1 | Budget allocation for health, particularly for maternal, newborn & child health including FP and nutrition increased at all levels | Budget for maternal, newborn and child health including FP and nutrition increased by 50% by 2015. | Activity 6.1.1.1 Develop RMNCH Advocacy package | X | | | | | Advocacy package developed | MoHSW (RCHS, Policy and Planning) Development Partners Research Institutions | 19,566,000.00 |
| | | | Activity 6.1.1.2 Conduct Advocacy Meeting for Key RMNCH related Ministries | | X | | | X | Number of advocacy events conducted quarterly | MoHSW (RCHS, HEU) Development Partners CSOs Professional Associations Academic and Research Institutions Media | 3,121,000.00 |
| | | | Activity 6.1.1.3 RMNCH Regional Accountability Advocacy meeting (2014-2015) | | | X | | | RMNCH Regional Accountability Advocacy meeting conducted | MoHSW (RCHS, HEU) Development Partners CSOs Media | 80,125,000.00 |
| | | | Activity 6.1.1.4 Conduct Regional ASRH Advocacy meetings | X | X | X | X | X | Number of advocacy events conducted quarterly | RCHS, HEU Development Partners CSOs Professional Associations Media | 487,200,000.00 |

| | | | | | | | | | | | | | | | | | | | | | | |
|-------|---|--|---|---|--|--|---|--|--|---|--|--|--|--|--|--|--|--|--|--|---------------|--|
| | | | | | | | X | | | | | | | | | | | MoHSW (RCHS) Development Partners CSOs | Number of Regions using regional consultative committee to follow up on service availability and quality | | 95,360,000.00 | |
| | | | | | | | | | | X | | | | | | | | MoHSW (RCHS) Development Partners CSOs | Number of GBV advocacy events conducted quarterly | | 51,659,000.00 | |
| 6.1.2 | Regulations, laws and policies to support effective implementation of maternal, newborn and Child health reviewed. | | Number of regulations approved by regulatory bodies. | NA | | | | | | | | | | | | | | | | | | |
| 6.1.3 | Implementation of the exemption policy for maternal and child health strengthened. Employment, deployment and retention of skilled health workers at all levels of care improved. | | Number of laws approved by regulatory bodies. Exemption policy effectively implemented | NA | | | | | | | | | | | | | | | | | | |
| 6.1.4 | | | Number of skilled health workers increased to 100% of established need by 2015 | Activity 6.1.4.1 HRH – mapping of cadres available by facility level | | | X | | | | | | | | | | | MoHSW PMO-RALG Health professional associations Partners CSOs | Proportion of health facilities covered by HRH mapping survey | | 57,414,000.00 | |
| 6.2 | Health Systems Strengthening and Capacity Development | | | | | | | | | | | | | | | | | | | | | |

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| 6.2.1 | Knowledge and skills of supervisors and service providers on maternal, newborn and child care including FP and nutrition increased. | Maternal, newborn and child health service provided according to standards. | Activity 6.2.1.1 Review, finalize and print for pediatric Standard Treatment Guidelines | | X | X | | | | | | Number of pediatric Standard Treatment Guidelines Reviewed, finalized, printed and disseminated | MoHSW (RCHS, DHS HEU) Development Partners Health Professional associations CSOs | 121,613,000.00 |
| | | | Activity 6.2.1.1 Review of EmONC guidelines to incorporate antenatal corticosteroids into EmONC job aid and SOP | | X | | | | | | | Number of EmONC Guidelines Reviewed, finalized, printed and disseminated | MoHSW (RCHS, DHS HEU) Development Partners Health Professional associations CSOs | 6,113,000.00 |
| | | | Activity 6.2.1.2 Antenatal corticosteroids job aids for facilities/providers (including wall charts) printed | | X | | | | | | | Number of Antenatal corticosteroids Job aids printed | MoHSW (RCHS, DHS HEU) Development Partners | 8,420,000.00 |
| | | | Activity 6.2.1.3 Dissemination of Antenatal corticosteroids guidelines | | X | | | | | | | Number of Antenatal corticosteroids Job aids disseminated | MoHSW (RCHS, DHS HEU) Development Partners Health Professional associations CSOs | 61,640,000.00 |
| | | | Activity 6.2.1.4 Finalize Guidelines for Maternal Perinatal Death Surveillance and Response | | X | | | | | | | Number of Guidelines for Maternal Perinatal Death Surveillance and Response finalized | MoHSW (RCHS, DHS HEU) Development Partners Health Professional associations CSOs | 10,410,000.00 |

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| | | | | | | X | | | | | | | | | | MoHSW (RCHS, DHS) HEU Development Partners CSOs | 1,600,000.00 |
| | | | | | | X | | | | | | | | | | MoHSW (RCHS, DHS) HEU Development Partners Health professional associations CSOs | 17,263,000.00 |
| | | | | | | | X | X | | | | | | | | MoHSW (RCHS, District Councils, and Development Partners. CSOs Private institutions Health Professional associations | 8,219,772,000.00 |
| | | | | | | | | | | | | | | | | MoHSW (RCHS, DHS) HEU Development Partners CSOs | 15,000,000.00 |
| | | | | | | | | | | | | | | | | MoHSW (Directories of Preventive and Hospital Services) PMO-RALG, CSOs Private sector | 1,411,964,000.00 |

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| | | | | | | | | | X | X | X | X | X | X | X | Activity 6.2.1.14 Capacity building for CHWs on cMNCH (FP) | | | | 499,008,000.00 | MoHSW (Directorates of Preventive and Hospital Services) PMO-RALG, CSOs Private sector | Proportion of Councils with CHWs trained on cMNCH (FP) | |
| | | | | | | | | | X | X | X | X | X | X | X | Activity 6.2.1.15 Capacity building for FP supervisors | | | | 732,000,000.00 | MoHSW (Directorates of Preventive and Hospital Services) PMO-RALG, CSOs Private sector | Proportion of Councils with FP supervisors trained | |
| | | | | | | | | | X | X | X | X | X | X | X | Activity 6.2.1.16 Conduct Family Planning logistics system training of FP trainers (TOT) on effective recording, data use, reporting and timely requisition of contraceptive commodities, and mentorship of frontline FP providers | | | | 654,005,500.00 | MoHSW (Directorates of Preventive and Hospital Services) PMO-RALG, CSOs Private sector | Proportion of Councils with TOTs/supervisors trained on Family Planning logistics system | |
| 6.2.2 | Planning and management capacity for maternal and newborn care including FP and nutrition strengthened. | | | | | | | | X | X | X | X | X | X | X | Activity 6.2.2. Work with Facility QI committees to conduct Maternal Perinatal Death Surveillance and Response reviews and provide reports to CHMT and further to the region. | Proportion of Councils / CHMTs receiving Maternal Perinatal Death Surveillance and Response reviews reports | | | | - | MoHSW (Directorates of Preventive and Hospital Services) PMO-RALG, CSOs Private sector | Proportion of Health Facility QI committees conducting Maternal Perinatal Death Surveillance and Response reviews and provide reports to CHMT and further to the region. |

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| 6.2.3 | Basic (BEmOC) and Comprehensive EmOC (CEmOC) and Newborn services at all levels strengthened. | % of health facilities providing BEmOC and CEmOC and Essential Newborn Care | Activity 6.2.3.1 Capacity building of pre service tutors on competency based training of EmONC | X | X | X | X | X | X | X | X | Proportion of pre-service training institutions providing EmONC training | MoHSW (Directorates of Preventive and Hospital Services) PMO-RALG, CSOs Private sector | 17,208,000.00 |
| | | | Activity 6.2.3.2 EmONC In-service training | X | X | X | X | X | X | X | X | Proportion of health facilities with SPVs received in-service EmONC training | MoHSW (Directorates of Preventive and Hospital Services) PMO-RALG, CSOs Private sector | 78,580,000.00 |
| | | | Activity 6.2.3.3 Kangaroo Mother Care training | X | X | X | X | X | X | X | X | Proportion of health facilities with Service Providers trained on KMC | MoHSW (Directorates of Preventive and Hospital Services) PMO-RALG, CSOs Private sector | 267,600,000.00 |
| | | | Activity 6.2.3.4 Neonatal resuscitation training | X | X | X | X | X | X | X | X | Proportion of health facilities with Service Providers trained on KMC | MoHSW (RCHS) PMORALG MoCDGC RHMTs CHMTs CMTs | 1,544,762,000.00 |
| | | | Activity 6.2.3.5 Essential Newborn Care | X | X | X | X | X | X | X | X | Proportion of health facilities with Service Providers trained on Neonatal resuscitation | MoHSW (RCHS) PMORALG MoCDGC RHMTs CHMTs CMTs | 2,872,320,000.00 |

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| | | | | | | | | | | | Proportion of health facilities with Service Providers trained in KMC | MoHSW (RCHS) PMORALG MoCDGC RHMTs CHMTs CMTs | 17,263,000.00 |
| | | | | | | | | | | | Antenatal corticosteroids registered for obstetric indication (premature birth) and incorporation in essential meds list | MoHSW (Directorates of Preventive and Pharmaceuticals and Supplies Section) | - |
| | | | | | | | | | | | Proportion of health facilities with KMC equipment | MoHSW (Directorates of Preventive and Hospital Services) PMO-RALG, CSOs Private sector | 3,248,000.00 |
| | | | | | | | | | | | Proportion of health facilities with resuscitation equipment | MoHSW (Directorates of Preventive and Hospital Services) PMO-RALG, CSOs Private sector | 99,023,000.00 |
| | | | | | | | | | | | Proportion of health facilities with EmONC equipment | MoHSW (Directorates of Preventive and Hospital Services) PMO-RALG, CSOs Private sector | 1,234,240,000.00 |
| 6.2.4 | Mechanisms for availability of essential equipment, commodities, supplies and medicines for maternal, newborn and child health including family planning strengthened. | Essential equipment, commodities, supplies and medicines for maternal, newborn and child care available all the time at every health facility | Activity 6.2.4.1 TFDA - Antenatal corticosteroids Registration for obstetric indication (premature birth) and incorporation in essential meds list | X | X | X | X | X | X | X | | | |
| | | | Activity 6.2.4.2 Kangaroo Mother Care equipment procurement | X | X | | | | | | | | |
| | | | Activity 6.2.4.3 Neonatal resuscitation equipment procurement | X | X | | | | | | | | |
| | | | Activity 6.2.4.4 Procure EmONC Equipment | X | X | X | X | X | X | X | | | |

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| | | | | | | | | X | X | X | X | X | X | X | Activity 6.2.4.5 MSD/ eLMIS – Antenatal corticosteroids incorporated into essential medicines requisition and reporting forms (for hospital level) | | | | | MoHSW (Directorates of Preventive and Hospital Services) PMO-RALG, CSOs Private sector | - |
| | | | | | | | | X | X | X | X | X | X | X | Activity 6.2.4.6 Procurement of Cervical Cancer Equipment | | | | MoHSW (Directorates of Preventive and Hospital Services) PMO-RALG, CSOs Private sector | 74,400,000.00 | |
| | | | | | | | | | | | | | | | Activity 6.2.4.7 Conduct semi annual quantification exercise and estimate needs for contraceptive commodities in Lake and Western zones | | | | MoHSW (Directorates of Preventive and Pharmaceutical and Supplies Section) MSD PMO-RALG, CSOs Private sector | 38,600,000.00 | |
| | | | | | | | | | | | | | | | Activity 6.2.4.8 Coordination of contraceptive commodity procurement to meet the national needs (National Commodity Security Meeting) | | | | MoHSW (Directorates of Preventive Services, NGOs CSOs Private sector | 1,200,000.00 | |

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| | | | | | | X | | | | | | | X | Activity 6.2.4.9 Print adequate RHCS client cards number 5 | | | | | | Adequate number of RHCS client cards number 5 printed and distributed | MoHSW (RCHS) Development Partners CSOs | 2,880,000,000.00 |
| | | | | | | | | | X | | | | | Activity 6.2.4.10 Print Family planning register books | | | | | | Adequate number of FP HMIS registers, tally sheets and monthly summary forms printed and distributed | MoHSW (RCHS) Development Partners CSOs | 1,197,378,000.00 |
| | | | | | | X | | | X | | | | X | Activity 6.2.4.11: Provide working kits to community mobilizers | | | | | | Proportion of Community Mobilizers provided with working kits quarterly\ | MoHSW (RCHS) PMORALG MoCDGC RHMTs CHMTs CMTs | - |
| | | | | | | | | | | | | | X | Activity 6.2.4.12: Orientation and dissemination of guidelines | | | | | | Proportion of CHMTs and RHMTs covered by RMNCH guidelines Orientations and dissemination sessions | MoHSW (RCHS) PMORALG MoCDGC RHMTs CHMTs CMTs | 119,040,000.00 |
| 6.2.5 | Referral system at all levels strengthened. | Functional referral systems in place at all levels | | | | | | | | | | | | Activity 6.2.5.1 Procurement of Ambulance | | | | | | | | |

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| 6.2.6 | HMIS capacity to capture information on maternal, neonatal and child indicators including FP and nutrition improved. | Key Maternal, newborn and child health indicators reported annually through HMIS | Activity 6.2.6.1 Coordination meetings between HMIS, eHealth, and programs with electronic innovations to produce an electronic register | X | X | | | | | | Coordination meetings conducted between HMIS, eHealth, and programs | MoHSW (Directorates of Preventive and Policy PMO-RALG, CSOs Private sector | 19,724,000.00 |
| | | | Activity 6.2.6.2 Training national RMNCH - HMIS Data Quality Assurance (DQA) team | X | | | | | | | National RMNCH - HMIS Data Quality Assurance (DQA) team trained | MoHSW (Directorates of Preventive and Policy and Planning) | 12,600,000.00 |
| | | | Activity 6.2.6.3 Orientation of RMNCHS technical staff on DQA | X | | | | | | | Proportion of RMNCH technical staff trained on DQA | MoHSW (RCHS) PMORALG RHMTs CHMTs CMTs | 54,960,000.00 |
| | | | Activity 6.2.6.4 Training of regional and council staff on DQA | | X | | | | | | Proportion of regional and council RMNCH technical staff (CHMTs/RHMTs) trained on DQA | MoHSW (RCHS) PMORALG RHMTs CHMTs CMTs | 150,080,000.00 |
| 6.2.7 | Monitoring and evaluation framework for MNCH strengthened and implemented. | Progress on Maternal, newborn and child health status/trends reported | Activity 6.2.7 Conduct Annual RCHS Meeting 2015 and share service data | | | X | | | | | Annual RCHS Meeting 2015 conducted | MoHSW (RCHS) PMORALG RHMTs CHMTs CMTs | 154,430,000.00 |
| 6.2.8 | Community based management information system strengthened. | Community based data effectively collected and used in planning | Activity 6.2.8 Produce and roll out routine community MNCH M&E tools | X | X | X | X | X | X | X | Proportion of communities with trained CHWs | MoHSW (RCHS) PMORALG MoCDGC RHMTs CHMTs CMTs | 4,777,920,000.00 |

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| 6.2.9 | Capacity for conducting MNCH operational research strengthened | Evidence on MNCH available for planning and programme development | Activity 6.2.9 Needs assessment of pre-service training programs in EmONC skills in nursing/midwifery, AMOs, ACO, CO, Medical attendants programs and standards for competency based training | X | X | X | X | X | X | X | X | Proportion of pre-service training institutions (programs in EmONC skills in nursing/midwifery, AMOs, ACO, CO, Medical attendants programs) assessed | MoHSW (RCHS, DHR) PMORALG | 3,135,000.00 |
| 6.2.10 | Quality assurance and management (supervision, client satisfaction, performance assessment) strengthened. | Proportion of health facilities delivering MNCH services according to nationally defined service standards | Activity 6.2.10 Set up consultative meeting with District Coordinator, MOHSW and PMORALG | X | | | | | | | | Number of consultative meeting conducted with District Coordinator, MOHSW and PMORALG | MoHSW (RCHS) PMORALG RHMTs CHMTs CMTs | 48,932,000.00 |
| | | | Activity 6.2.10.1 Set up meeting by zones in the 500 days together with RMO and DMOs to set up designated facility and levels of care by region | | | | | X | | | | Number of zonal meeting conducted with RMO and DMOs to set up designated facility and levels of care by region | MoHSW (RCHS) PMORALG RHMTs CHMTs CMTs | 48,932,000.00 |
| | | | Activity 6.2.10.2 Conduct HRH – mapping of cadres available by facility level | | | | | X | | | | Proportion of health facilities covered by the HRH – mapping of cadres available (by | MoHSW (RCHS, DHR) PMORALG Development Partners CSO | - |

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| | | | | | | X | X | | | | X | X | | | Number of National Level supportive supervision conducted per year | MoHSW (RCHS) PMORALG RHMTs CHMTs | 170,848,800.00 |
| | | | | | | X | X | | | | X | X | | | Number of National Level FP supportive supervision conducted to zones and MSD | MoHSW (RCHS) PMORALG RHMTs CHMTs CMTs | 31,383,000.00 |
| | | | | | | X | X | | | | X | X | | | Proportion of health facilities supervised quarterly | MoHSW (RCHS) PMORALG RHMTs CHMTs | 223,650,000.00 |
| | | | | | | X | X | | | | X | X | | | Number of National Level FP supportive supervision conducted to MSD and health facilities | MoHSW (HMIS Unit) RHMTs CHMTs | 842,656,500.00 |
| | | | | | | X | X | | | | X | X | | | Activity 6.2.10.6 To conduct National Level supportive supervision twice a year | MoHSW (RCHS) PMORALG RHMTs CHMTs | 170,848,800.00 |
| | | | | | | X | X | | | | X | X | | | Activity 6.2.10.7 Conduct HQ quarterly FP supervision to zonal MSD and selected facilities to verify contraceptives stock status, and quarterly | MoHSW (RCHS) PMORALG RHMTs CHMTs CMTs | 31,383,000.00 |
| | | | | | | X | X | | | | X | X | | | Activity 6.2.10.8 Conduct monthly district supervision to health facilities based on the recommendation /findings of quarterly HQ supervision visits (Lake and Western) | MoHSW (RCHS) PMORALG RHMTs CHMTs | 223,650,000.00 |
| | | | | | | X | X | | | | X | X | | | Activity 6.2.10.9 Conduct supportive supervision (Central, zonal, regional and district level supervisors) bi-annually to MSD, as well as Health facilities on Family Planning | MoHSW (HMIS Unit) RHMTs CHMTs | 842,656,500.00 |

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| | | | | | | | | X | X | X | X | X | X | X | X | X | Proportion of trained CHW on MNCH supervised | MoHSW (RCHS) PMORALG RHMTs CHMTs CMTs | 917,544,000.00 |
| | Community participation in maternal newborn and child health care including FP and nutrition strengthened increased. | Community leaders and members participating actively in MNCH issues | | | | | | X | X | X | X | X | X | X | X | X | Proportion of villages supervising CHW on MNCH | MoHSW (RCHS) PMORALG RHMTs CHMTs CMTs | 1,308,150.00 |
| | | | | | | | | X | X | X | X | X | X | X | X | X | Proportion of district hospitals covered by family planning service days per quarter | MoHSW (RCHS) PMORALG RHMTs CHMTs CMTs | 146,880,000.00 |
| | | | | | | | | X | X | X | X | X | X | X | X | X | Proportion of planned outreach services conducted quarterly by district hospitals | MoHSW (RCHS) PMORALG RHMTs CHMTs CMTs | 1,158,450,000.00 |
| | | | | | | | | X | | | | | | | | | Number of community champions oriented on demand creation for Family Planning quarterly | MoHSW (RCHS) PMORALG RHMTs CHMTs CMTs | 123,675,000.00 |

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| | | | | | | | | | X | | | | | | | Activity 6.3.7 Improve Service delivery system to attract men's participation in FP (signboard) | | MoHSW (RCHS) PMORALG RHMTs CHMTs CMTs | 7,497,600.00 |
| | | | | | | | | X | X | X | X | X | X | | | Activity 6.3.8 Immunization Area (ALL) Outreach activities for vaccinators | | MoHSW (RCHS) PMORALG RHMTs CHMTs CMTs | 76,627,710.00 |
| 6.4 | | | | | | | | | | | | | | | | Behaviour Change | | | |
| 6.4.1 | Key community and household practises for maternal, newborn and child care improved | Improved practises for maternal, newborn and child health care at all levels. | | | | | | X | | | | | | | X | Activity 6.4.1 Conduct training for community mobilizers | | MoHSW (RCHS) PMORALG RHMTs CHMTs CMTs | 251,430,000.00 |
| | | | | | | | | X | X | X | X | X | X | | | Activity 6.4.2 Print IEC materials for demand creation | | MoHSW (RCHS) PMORALG RHMTs CHMTs CMTs | 4,500,000,000.00 |
| | | | | | | | | X | X | X | X | X | X | | | Activity 6.4.3 Radio and TV spots for demand creation | | MoHSW, PMORALG MoCDGC MoEVT, MoISC District Councils CHMTs, Village Governments, Development Partners, Media CSOs. | 3,896,640,000.00 |
| | | | | | | | | X | X | X | X | X | X | | | Activity 6.4.4 Printing of RMNCH communication materials | | MoHSW, PMORALG | 314,400,000.00 |

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| | | | | | | X | X | X | X | X | X | | Activity 6.4.5 M4RH SMS campaign | | | | | | disseminated Number of M4RH SMS disseminated per quarter | MoHSW , PMORALG MoCDGC MoEVT | 394,632,000.00 |
| | | | | | | | | | | | | | Activity 6.4.6 Green star regional re-launch | | | X | | | Number of regions conducting Greenstar regional relaunch per quarter | MoHSW (RCHS) PMORALG RHMTs CHMTs CMTs | 34,084,200.00 |
| | | | | | | | | | | | | | Activity 6.4.6 MNCH multimedia Communication platform | | | X | X | X | Number of radio spots, tv spots, sms disseminated per quarter | MoHSW , PMORALG MoCDGC MoEVT, MoISC District Councils CHMTs, Village Governments, Development Partners , Media CSOs. | 7,844,822,000.00 |
| 6.5 | | | | | | | | | | | | | | Fostering Partnership | | | | | | | |
| | | | | | | | | | | | | | | Partnership and coordination for MNCH activities at all levels improved | | | | | Number of meeting conducted with PMORALG and RCHS to share plans and identify areas for collaboration | MoHSW (RCHS) PMORALG | 8,482,000.00 |
| | | | | | | | | | | | | | Activity 6.5.1 Set up meeting with PMORALG and RCHS to share plans and identify areas for collaboration | | X | | | TOR developed for an assessment of blood availability and distribution. | MoHSW (RCHS) PMORALG NBTS | 27,178,000.00 | |

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| | | | | | | | | X | X | Activity 6.5.3 Develop a situation analysis of the bottlenecks in setting up regional blood banking and collection points and connections with zonal facilities. Develop plan to address needs. | | | | | | Report on situation analysis of the bottlenecks in setting up regional blood banking and collection points and connections with zonal facilities | MoHSW (RCHS) PMORALG NBTS | | |
| | | | | | | | | X | X | Activity 6.5.4 Establishing one blood collecting satellite in Kagera and Kigoma. | | | | | | satellite blood banks established in Kagera and Kigoma regions | MoHSW (RCHS) PMORALG NBTS | 70,000,000.00 | |
| | | | | | | | | | | | | | | | | | | | 53,191,703,460.00 |
| | | | | | | | | | | | | | | | | | | | 32,753,511.98 |
| TOTAL IN TSHS | | | | | | | | | | | | | | | | | | | |
| TOTAL IN US \$ | | | | | | | | | | | | | | | | | | | |

| TOTAL NATION WIDE CONSUMPTION OF RMNCH COMMODITIES DURING THE 500 HUNDRED DAYS | | | | | | | |
|---|-----------------------------|----------------|----------------|-------------------------------|--------------|--------------|-------|
| Intervention / Area | Consumption + Wastage (TSh) | | | Consumption + Wastage (US \$) | | | Total |
| | Jul-Dec 2014 | Jan-Jun 2015 | Jul-Dec 2015 | Jul-Dec 2014 | Jan-Jun 2015 | Jul-Dec 2015 | |
| Immunization | 60,716,511,764 | 54,141,272,601 | 54,141,272,601 | 168,999,056,967 | | | |
| Child Health | 7,022,038,432 | 6,849,392,621 | 7,382,389,058 | 21,253,820,111 | | | |
| Family Planning | 8,678,001,890 | 9,241,991,104 | 9,241,991,104 | 27,161,984,098 | | | |
| Reproductive Health | 370,871,200 | 370,871,200 | 382,656,201 | 1,124,398,601 | | | |
| Maternal and Newborn Health | 19,903,042,738 | 21,110,492,658 | 22,904,353,252 | 63,917,888,649 | | | |
| Total Tshs | 96,690,466,024 | 91,714,020,184 | 94,052,662,217 | 282,457,148,425 | | | |
| Total US \$ | 59,538,464.30 | 56,474,150.36 | 57,914,200.87 | 173,926,815.53 | | | |

Therefore total cost of interventions and commodities for Strengthened One Plan is **Tsh 335,648,851,885 OR US \$ 206,180,327.11**

Annex 1: Status of the 14 Operational Targets as per One Plan MTR

| No. | Target | Status |
|-----|---|--|
| 1 | Increased coverage of births attended by skilled attendants from 46% to 80% | The proportion of SBA coverage shows a slow increase from 46 % in 2004-05 (TDHS) to 51% in 2010 (TDHS) |
| 2 | Increased immunization coverage of DTP-HB 3 and measles vaccine to above 90% in 90% of districts | In 2013 national coverage for Pentavalent 3 and measles was 91% and 99%, respectively. However, only 88 (61%) and 101 (70%) of the districts had coverage of 90% and above respectively. The increase of total number of districts from 129 in 2012 to 145 in 2013 resulted in lower national coverage if compared to 2012, although the number of districts with coverage of 90% and above remained the same (88) for Pentavalent and increased from 95 to 101 for measles (Joint Report Form 2013) |
| 3 | New EPI vaccines introduced (Hib, Pneumococcal, HPV and Rotavirus) | HiB, Pneumococcal, and Rotavirus vaccines have been introduced, thus meeting the One Plan target. HPV vaccine will be piloted in Kilimanjaro region in 2014. |
| 4 | Reduced stunting and underweight status among under-fives from 38% and 22% to 22% and 14%, respectively | The 2010 TDHS found that 42% of under-fives are stunted, well off the One Plan target of 22% by 2015. The prevalence of underweight children was estimated at 16% in 2010. The 2011 NPS showed the prevalence to be 14%, which means the goal for reducing the incidence of underweight children to 14% by 2015 has been met. |
| 5 | Increased exclusive breastfeeding coverage from 41% to 80% | Prevalence of exclusive breastfeeding among infants aged less than 6 months has increased from 41% in 2004-05 to 50% in 2010 (TDHS) |
| 6 | PMTCT services provided to at least 80% of pregnant women, their babies and families | 30% of pregnant women were reached with PMTCT services at ANC in 2007, and this has increased to 99% in 2010 according to program reports. 77 % of HIV positive pregnant women and 56 % of HIV exposed infants received ARV prophylaxis in 2011. |
| 7 | 90% of sick children seeking care at health facilities appropriately managed | 2010 TDHS data show that health care seeking for children has improved for malaria (77%), pneumonia (71%), and diarrhoea (53%) within 2 weeks before the survey. |
| 8 | Increased coverage of under-fives sleeping under ITNs from 26% to 80% | The proportion of children who slept under an ITN the night before the survey has increased to 72% in THMIS 2011/12, indicating we are on track to reach the 2015 target of 80%. |

| No. | Target | Status |
|-----|---|--|
| 9 | 70% of villages have community health workers (CHWs) offering MNCH services at community level | The National Integrated Community MNCH Guidelines were developed in July 2012 and are in the process of being rolled out. |
| 10 | Increased modern contraceptive prevalence rate (CPR) from 20% to 60% | The CPR among currently married women has increased from 20% in 2004/05 to 27% in 2010 (TDHS). There is need for additional effort in order to achieve the One Plan target of 60% by 2015. |
| 11 | Increased coverage of comprehensive emergency obstetric care (CEmOC) from 64% to 100% of hospitals, and of basic emergency obstetric care (BEmOC) from 5.5 % to 70% of health centres and dispensaries. | The 2012 SARA survey showed that only 20% of dispensaries and 39% of health centers surveyed were fully functional BEmOC facilities, which is well off the desired target of 70%. The SARA survey further showed that 73% of the surveyed hospitals offered all 9 CEmOC signal functions, while only 9% of the health centers could do so. CEmOC was overwhelmingly lacking in rural areas with only 5% of the surveyed facilities being fully functional. |
| 12 | Increased proportion of health facilities offering essential newborn care (ENC) to 75% | Initial evaluations of ENC conducted in 12 regions showed that cord cutting with sterile scissors was being practiced at 100% of facilities, wrapping at 91% of facilities and drying of the infant at 93% of facilities, while initiating breastfeeding within one hour (44%) was lagging behind. |
| 13 | Increased antenatal care (ANC) attendance for at least 4 visits from 62% to 90% | The attendance for ANC clinics 4 times+ during pregnancy has decreased over time. The 2010 TDHS shows that only 43% of pregnant women attended ANC 4 times+, compared to 62% in the 2004-05 TDHS and 71% in the 1999 TDHS. |
| 14 | Increased proportion of health facilities providing adolescent friendly reproductive health (RH) services to 80% | Based on Annual RCH reports, adolescent friendly RH services were being provided at 30% of health facilities in 2008, 23% in 2009, 18.3 % in 2010, and 21.1 % in 2012 well off the One Plan target of 80% by 2015. |

Annex II: Bottleneck Analysis Summary

| | General RMNCH | ASRH | ANC | Skilled care | BEEmo NC | CEmO NC | Preterm | Basic NB care | HBB | KMC | Sev NB infect | Inpatient care | IMCI | Immunization | Nutrition | Ped HIV care | GBV & VAC | RH cancers | Description of bottlenecks |
|---------------------------|---------------|------|-----|--------------|----------|---------|---------|---------------|-----|-----|---------------|----------------|------|--------------|-----------|--------------|-----------|------------|--|
| Leadership and governance | | | | | | | | | | | | | | | | | | | <ol style="list-style-type: none"> Lack of authority and voice as RMNCH at national as well as subnational structure. Lack of operationalization of the One Plan. (Not owned by LGA and not owned by CCHP) Weak accountability at all levels. |
| Health Financing | | | | | | | | | | | | | | | | | | | <ol style="list-style-type: none"> Budget for RMNCH is heavily donor dependent Free care policy is not operational because the policy is not budgeted. Insufficient and delayed fund disbursement makes it not possible to follow the free care policy. Weak accountability. Income for the facility is important but CHF is not well functioning. |
| Health Workforce | | | | | | | | | | | | | | | | | | | <ol style="list-style-type: none"> Insufficient health workers to provide MNCH services. No strategy specifically addressing RMNCH HR issues. Poor RCH representation at HRH TWG. Mal-distribution of available health providers especially at rural areas. Lower cadre or attendants are the ones mainly manning the rural and lower health facilities. Job description with clear responsibility is missing. |
| Essential Commodities | | | | | | | | | | | | | | | | | | | <ol style="list-style-type: none"> Lack of essential commodities at public health facilities (leads to out of pocket expenses) Weak system for timely distribution. No system to track the commodities at facility level |
| Health Service Delivery | | | | | | | | | | | | | | | | | | | <ol style="list-style-type: none"> Poor quality of services provided for most services along the continuum of care due to HR, commodities and financing issues No specific strategy for RMNCH Quality of Care guideline and there is lack of integrated standardized tool Weak systems in place to promote the adherence to national standard and clinical protocols on basic newborn care Regular supervision visits are constrained by inadequate resources There is no re-certification system in place for health workers |
| HMIS | | | | | | | | | | | | | | | | | | | <ol style="list-style-type: none"> Data quality audits are not routinely done to ensure data quality and sharing of audit information Stakeholders do not have access to HMIS data Lack of accountability for maternal, perinatal and child death reports Some key indicators for RMNCH are not in the current HMIS system e.g. reproductive health cancers, GBV, CEmOC etc Lack of child death surveillance and response guidelines Lack of compliance by private health facilities to provision of data |
| Community Ownership | | | | | | | | | | | | | | | | | | | <ol style="list-style-type: none"> Communities not sufficiently involved in health facility HF services, management and decisions National community health worker (CHW) cadre is not in place (as per MMAM requirement) Weak referral system/mechanism from the communities and first level health facilities Low level of male involvement |

Annex III Tanzania RMNCH scorecard



TANZANIA RMNCH SCORECARD

January - March 2014



| NATIONAL INDICATOR | | CPR | 27% | Stunting | 43% | NMR | 26 | | | | | | | |
|--------------------|---------------|--|---|--|---------------------------------|------------------------------|---|-------------------------------------|------------------------------|--|---|-------------------------------------|---------------------|------------------------------|
| USMR | | 54 | 454 | | | | | | | | | | | |
| Country | Pre-pregnancy | Pregnancy | Labour & Delivery | Newborn Health | Child Health | | | Health Systems | Human Resources | Health Financing | | | | |
| # | Region | % women 15-49 on contraceptives / long-term FP methods | % pregnant women attending ANC1 by 12 weeks / % pregnant women attending ANC4 | % deliveries w skilled attendants / % institutional deliveries | PNC (7 days) - mother / newborn | % children receiving Pentas3 | % infants exclusively breastfeeding (6 mos) | % infants receiving ARV prophylaxis | % infants receiving PCR test | % health facilities with no ORS stockout | % HF w no stockout of tracer drugs/supplies | Data completeness / Data timeliness | Midwives per 10,000 | % population enrolled in CHF |
| TANZANIA | | | | | | | | | | | | | | |
| 1 | Arusha | 34% 14% 19% 39% | 67% 52% 44% | 63% 72% | 54% 52% | 100% | 17% | 56% | 49% | 25% | 88% | 84% | 3 | 6% |
| 2 | Dar es Salaam | 13% 14% 31% 68% | 63% 66% | 63% 66% | 38% 29% | 100% | 21% | 77% | 48% | 48% | 85% | 86% | 3 | 2% |
| 3 | Dodoma | 43% 6% 16% 47% | 60% 87% | 60% 87% | 70% 69% | 100% | 22% | 37% | 13% | 13% | 54% | 71% | 4 | 7% |
| 4 | Geita | 21% 27% 18% 31% | 43% 48% | 43% 48% | 37% 34% | 100% | 8% | 44% | 8% | 22% | 36% | 49% | 11 | 1% |
| 5 | Iringa | 49% 18% 23% 41% | 93% 100% | 93% 100% | 100% 100% | 100% | 29% | 80% | 29% | 29% | 80% | 75% | 3 | 5% |
| 6 | Kagera | 29% 17% 11% 23% | 46% 60% | 46% 60% | 52% 38% | 100% | 11% | 31% | 29% | 29% | 63% | 77% | 6 | 4% |
| 7 | Katavi | 28% 15% 11% 24% | 44% 49% | 44% 49% | 39% 38% | 100% | 11% | 13% | 19% | 19% | 66% | 84% | 2 | 10% |
| 8 | Kigoma | 28% 15% 11% 24% | 44% 49% | 44% 49% | 39% 38% | 100% | 11% | 13% | 19% | 19% | 66% | 84% | 2 | 10% |
| 9 | Kilimanjaro | 49% 18% 23% 41% | 93% 100% | 93% 100% | 100% 100% | 100% | 29% | 80% | 29% | 29% | 80% | 75% | 3 | 8% |
| 10 | Lindi | 31% 8% 23% 51% | 77% 89% | 77% 89% | 88% 69% | 100% | 18% | 100% | 10% | 10% | 81% | 79% | 4 | 8% |
| 11 | Manyara | 32% 15% 19% 34% | 46% 52% | 46% 52% | 47% 36% | 100% | 15% | 33% | 11% | 11% | 69% | 72% | 3 | 4% |
| 12 | Mara | 35% 28% 16% 37% | 36% 44% | 36% 44% | 38% 37% | 100% | 16% | 60% | 5% | 5% | 48% | 71% | 4 | 2% |
| 13 | Mbeya | 35% 16% 20% 48% | 69% 71% | 69% 71% | 66% 67% | 100% | 23% | 88% | 28% | 28% | 72% | 76% | 4 | 8% |
| 14 | Morogoro | 30% 11% 23% 48% | 39% 51% | 39% 51% | 61% 57% | 100% | 20% | 36% | 6% | 6% | 81% | 73% | 3 | 4% |
| 15 | Mtwara | 73% 7% 22% 34% | 76% 83% | 76% 83% | 100% 97% | 100% | 27% | 52% | 9% | 9% | 75% | 73% | 3 | 4% |
| 16 | Mwanza | 20% 18% 17% 30% | 43% 52% | 43% 52% | 40% 31% | 100% | 10% | 56% | 14% | 14% | 50% | 72% | 4 | 3% |
| 17 | Njombe | 43% 26% 22% 30% | 48% 100% | 48% 100% | 100% 100% | 100% | 35% | 78% | 40% | 40% | 85% | 74% | 4 | 7% |
| 18 | Pwani | 51% 12% 15% 75% | 18% 100% | 18% 100% | 100% 100% | 100% | 45% | 61% | 19% | 19% | 69% | 68% | 3 | 6% |
| 19 | Rukwa | 37% 9% 23% 40% | 47% 58% | 47% 58% | 63% 66% | 100% | 19% | 33% | 19% | 19% | 87% | 84% | 3 | 8% |
| 20 | Ruvuma | 39% 17% 16% 29% | 62% 72% | 62% 72% | 58% 58% | 100% | 13% | 25% | 28% | 28% | 76% | 75% | 5 | 6% |
| 21 | Shinyanga | 31% 10% 15% 42% | 55% 70% | 55% 70% | 53% 54% | 100% | 13% | 45% | 18% | 18% | 38% | 52% | 4 | 2% |
| 22 | Simiyu | 20% 20% 13% 37% | 37% 44% | 37% 44% | 47% 41% | 100% | 13% | 48% | 3% | 3% | 34% | 57% | 3 | 8% |
| 23 | Singida | 50% 20% 17% 33% | 39% 49% | 39% 49% | 35% 35% | 100% | 33% | 23% | 7% | 7% | 67% | 77% | 3 | 3% |
| 24 | Tabora | 29% 17% 20% 29% | 49% 59% | 49% 59% | 38% 35% | 100% | 11% | 72% | 35% | 35% | 74% | 74% | 2 | 6% |
| 25 | Tanga | 52% 6% 16% 27% | 35% 44% | 35% 44% | 35% 33% | 100% | 11% | 72% | 35% | 35% | 78% | 81% | 4 | 16% |
| Source: | | | | | | | | | | | | | HR Directorate | DPP |

LEGEND

Target achieved / on track
 Progress, but more effort required
 Not on track
 N/A
 No data

▲ Increase from last period
 ▼ Decrease from last period

