United Republic of Tanzania

Ministry of Health and Social Welfare

The National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania

2008 - 2015

April 2008

When a woman undertakes her biological role of becoming pregnant and undergoing childbirth, the society has an obligation to fulfil her basic human rights, which include the right to life, liberty social security, maternity protection and non discrimination.

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ABBREVIATIONS

ADDOS	Accredited Drug Dispensing Outlets
AIDS	Acquired Immuno Deficiency Syndrome
ALu	Artemether Lumefantrine
AMO	Assistant Medical Officer
ANC	Antenatal Care
ARH	Adolescent Reproductive Health
ARI	Acute Respiratory Tract Infection
BCC	Behaviour Change Communication
BEmOC	Basic Emergency Obstetric Care
BFHI	Baby Friendly Hospital Initiative
BMI	Body Mass Index
CBD	Community Based Distributor
CBIMS	Community Based Information Management System
CBO	Community Based Organization
CCHP	Comprehensive Council Health Plan
CEmOC	Comprehensive Emergency Obstetric Care
CHMT	Council Health Management Team
c-IMCI	Community Integrated Management of Childhood Illness
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
DHR	Director Human Resources
DPS	Director Preventive Services
EmOC	Emergency Obstetric Care
ENC	Essential Newborn Care
EPI	Expanded Programme on Immunization
FANC	Focused Antenatal Care
FBO	Faith Based Organization
FP	Family Planning
HIV	Human Immuno Deficiency Virus
HMIS	Health Management Information System
HPV	Human Papilloma Virus
HSSP	Health Sector Support Programme
ICPD	International Conference on Population and Development
IDWE	Infectious Disease Week Ending report
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPT	Intermittent Preventive Treatment
ITN	Insecticide Treated Net
IYCF	Infant Young Child Feeding

KMC	Kangaroo Mother Care
LLINs	Long Lasting Insecticide Treated Nets
LSS	Life Saving Skills
MDGs	Millennium Development Goals
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
MNT	Maternal and Newborn Tetanus
MoAFSC	Ministry of Agriculture, Food Security and Cooperatives
MoCDGC	Ministry of Community Development, Gender and Children
MoEVT	Ministry of Education and Vocational Training
MoFEA	Ministry of Finance and Economic Affairs
MoHSW	Ministry of Health and Social Welfare
MoICS	Ministry of Information, Culture and Sports
MoID	Ministry of Infrastructure Development
MoLEYD	Ministry of Labour, Employment and Youth Development
MVA	Manual Vacuum Aspiration
NACP	National AIDS Control Programme
NBS	National Bureau of Statistics
NGOs	Non Governmental Organization
NMCP	National Malaria Control Programme
NMW	Nurse Midwife
NORAD	Norwegian Development Cooperation
NPEHI	National Package of Essential Health Interventions
NPERCHI	National Package of Essential Reproductive and Child Health Interventions
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PAC	Post Abortion Care
PHAST	Participatory Hygiene and Sanitation Transformation
PHC	Primary Health Care
PHSDP	Primary Health Services Development Programme
PMNCH	Partnership for Maternal, Newborn and Child Health
PMO-RALG	Prime Minister's Office, Regional Administration and Local Government
PMTCT	Prevention of Mother to Child Transmission
POPSM	President's Office – Public Service Management
QIRI	Quality Improvement and Recognition Initiative
RED	Reaching Every District
REC	Reaching Every Child
RCH	Reproductive and Child Health

RCHS	Reproductive and Child Health Section
RHMT	Regional Health Management Team
RTI	Reproductive Tract Infection
SM	Safe Motherhood
SMI	Safe Motherhood Initiative
SNL	Saving Newborn Lives
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SWOT	Strengths, Weaknesses, Opportunities and Threats
TAMWA	Tanzania Media Women Association
TASAF	Tanzanian Social Action Fund
TBA	Traditional Birth Attendant
THIS	Tanzania HIV/AIDS Indicator Survey
TDHS	Tanzania Demographic and Health Survey
TFNC	Tanzania Food and Nutrition Centre
TFR	Total Fertility Rate
TGNP	Tanzania Gender Networking Group
TPMNCH	Tanzanian Partnership for Maternal, Newborn and Child Health
TRCHS	Tanzania Reproductive and Child Health Survey
TSPA	Tanzania Service Provision Assessment
TT	Tetanus Toxoid
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
VVF	Vesico Vaginal Fistula
WB	World Bank
WHO	World Health Organization
WRATZ	White Ribbon Alliance Tanzania
ZRCH	Zonal Reproductive and Child Health

FOREWORD

Reduction of maternal, newborn and child deaths is a high priority for all, given the persistently high maternal, newborn and child morbidity and mortality rates over the past two decades in African countries, Tanzania included. It is one of the major concerns addressed by various global and national commitments, as reflected in the targets of the Millennium Development Goals, Tanzania Vision 2025, the National Strategy for Growth and Reduction of Poverty (NSGRP-MKUKUTA), and the Primary Health Services Development Program (PHSDP-MMAM), 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.

Development of this plan for reducing maternal, newborn and child mortality is in line with the tenets of the New Delhi Declaration 2005. Tanzania and other countries committed to develop one national MNCH plan for accelerating the reduction of maternal, newborn and child deaths, in order to improve coordination, align resources and standardize monitoring. Further support for incorporating child health interventions into this plan was voiced by various stakeholders and development partners following the April 2007 launch of the Tanzania Partnership for Maternal, Newborn and Child Health (TPMNCH). The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (2008 – 2015) was subsequently developed as Tanzania's national response to the renewed commitment to improve maternal, newborn and child care. The Reproductive and Child Health Section (RCHS) of the Ministry of Health and Social Welfare (MoHSW), in collaboration with a number of different stakeholders, has developed this strategic plan to guide implementation of all maternal, newborn and child health interventions in Tanzania.

The National Road Map Strategic Plan stipulates various strategies to guide stakeholders for Maternal, Newborn and Child Health (MNCH), these include the Government, development partners, non-governmental organizations, civil society organizations, private health sector, faith-based organizations and communities, in working together towards attainment of the Millennium Development Goals (MDGs) as well as other regional and national commitments and targets related to maternal, newborn and child health

It is the expectation of the Government, particularly the MoHSW, that all stakeholders will make optimal use of this strategic framework to support the implementation of maternal, newborn and child health interventions, as this is in line with the National Health Policy and existing MNCH standards, guidelines and protocols.

The Government highly values your partnership in working towards realization of the objectives of the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths. Together, we can improve the health of Tanzanian mothers, babies and children, and build a stronger and more prosperous nation.

Professor David Homeli Mwakyusa (MP),
Minister for Health and Social Welfare

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Wilson C. Mukama
Permanent Secretary, MoHSW

CHAPTER 1: OVERVIEW

Purpose of the document

This document has been conceived for various purposes. The health of the mother is closely linked to the health and survival of the child. In addition, the socio-economic level of the mother and the maternal health status (HIV/AIDS, malaria, nutrition) has an impact on the survival of the child. Thus the primary purpose of "One Integrated Maternal Newborn and Child Health Strategic Plan" is to ensure improved coordination of interventions and delivery of services across the continuum of care. Another purpose of the document is to guide implementation across operational levels of the system so that policy drawn at national level will be carried out at the district and community levels, with support from the regional level. It is anticipated that a joint strategy will contribute to more integrated implementation, improved services, and ultimately a significant reduction in morbidity and mortality of Tanzanian women and children.

1.1 Introduction

The total population of Mainland Tanzania is estimated to be 39,384,223 (as of July 2007)[1]. Most of the population (75%) resides in the rural area. The annual growth rate is 2.9% with life expectancy at birth being 54 years for males and 56 years for females[2].

The total fertility rate in Tanzania has been consistently high over the past ten years and currently stands at 5.7 children per woman. There are regional variations with urban-rural disparities, where rural women have higher fertility rates than their urban counterparts[3].

The Maternal Mortality Ratio (MMR) has remained high for the last 10 years[4] without showing any decline and is currently estimated to be 578 per 100,000 live births[5]. While significant progress has been made to reduce child mortality in Tanzania, the neonatal mortality rate remains high at 32 per 1,000 live births, and accounts for 47% of the infant mortality rate which is estimated at 68 per 1,000 live births.

The critical challenges in reducing maternal, newborn and child morbidity and mortality comprise two categories:

(a) ***Health system factors*** - inadequate implementation of pro-poor policies, weak health infrastructure, limited access to quality health services, inadequate human resource, shortage of skilled health providers, weak referral systems, low utilization of modern family planning services, lack of equipment and supplies, weak health management at all levels and inadequate coordination between public and private facilities.

(b) ***Non health system factors***- inadequate community involvement and participation in planning, implementation, monitoring and evaluation of health services, some social cultural beliefs and practices, gender inequality, weak educational sector and poor health seeking behaviour.

1.2 Initiatives to improve maternal, newborn and child health in Tanzania

Maternal and child health services were established in Tanzania in 1974. In 1975 the Expanded Programme of Immunization (EPI) was initiated to strengthen immunization services for vaccine preventable childhood diseases. Tanzania adopted the Safe Motherhood Initiative (SMI) in 1989, following the official launch of the Global Safe Motherhood Initiative in 1987 in Nairobi, Kenya. Subsequently, the 1994 International Conference for Population and Development (ICPD) emphasized access to comprehensive reproductive health services and rights. In response to the ICPD Plan of Action, Tanzania established the Reproductive and Child Health Section (RCHS) within the Ministry of Health and developed a National Reproductive and Child Health Strategy.

[1] CIA World Fact Book, March 2008
[2] Census, 2002
[3] TDHS 2004/05
[4] Maternal Mortality ratio was 529/100,000 live births in TDHS 1996
[5] TDHS 2004/05

In 1996 Tanzania adopted the Integrated Management of Childhood Illness (IMCI) approach for reduction of childhood morbidity and mortality. Various nutrition interventions have also been adopted including the Baby Friendly Hospital Initiative (BFHI) in 1992, the Code of Marketing Breast Milk Substitutes in 1994 and Vitamin A Supplementation in 1997. Tanzania developed its National Strategy on Infant and Young Child Feeding and Nutrition in 2005.

In Tanzania, specific attempts have been made to address maternal, newborn and child health (MNCH) challenges through the National Health Policy (revised in 2003), the Health Sector Reforms and the Health Sector Strategic Plan (2003-2007). Furthermore, the Reproductive and Child Health Strategy (2005-2010) and the National Road Map Strategic Plan to Accelerate the Reduction of Maternal and Newborn Mortality (2006-2010) were also formulated to respond to these challenges.

Improving MNCH is also a major priority area in the National Strategy for Growth and Poverty Reduction (NSGPR/MKUKUTA) 2005-2010 which has three major interlinked clusters[6]. One of the goals clearly outlined in the second cluster of the strategy is to improve the survival, health and well being of all children and women and of especially vulnerable groups. Under this goal, there are four operational targets related to maternal and child health for monitoring progress towards achieving MDGs 4 and 5.

The Health Sector Support Programme III (2008 – 2012) will incorporate and address MNCH issues in terms of alignment with Government policies, resource mobilization and donor harmonization. The newly initiated Primary Health Service Development Programme, (PHSDP/MMAM) 2007 – 2017, will address the delivery of health services to ensure fair, equitable and quality services to the community and is envisioned to be the springboard for achieving good health for Tanzanians**.**

The Tanzania MNCH Partnership was officially launched in April 2007 to re-focus the strategies for reducing the persistently high maternal, newborn and child mortality rates, through adopting the One Plan and setting clear targets for improved MNCH.

1.3 Rationale for the Strategic Plan to accelerate reduction of maternal, newborn and child deaths in Tanzania

Annually, it is estimated that 536,000 women[7] worldwide die from pregnancy- and childbirth-related conditions, as do 11,000,000 under-fives, of which 4.4 million are newborns. Most of these deaths occur in Sub Saharan Africa. Tanzania is one of the ten countries contributing to 61% and 66% of the global total of maternal and newborn deaths, respectively. In Tanzania, the estimated annual number of maternal deaths is 13,000, the estimate for under-fives is 157,000, and newborn deaths are estimated at 45,000[8]. In committing to MDGs 4 and 5, the Government of Tanzania agreed to reduce the under-five mortality rate by two-thirds and reduce the maternal mortality ration by three-quarters, by 2015.

Maternal, newborn and child outcomes are interdependent; maternal morbidity and mortality impacts neonatal and under-five survival, growth and development. Thus service demand and provision for mothers, newborns and children are closely interlinked. Integration of MNCH services demands reorganization and reorientation of components of the health systems to ensure delivery of a set of essential interventions for women, newborns and children. A focus on the continuum of care replaces competing calls for mother or child, with a focus on high coverage of effective interventions and integrated MNCH service packages as well as other key programmes such as Safe Motherhood (SM), Family Planning (FP), Prevention of Mother to Child Transmission (PMTCT) of HIV, Malaria, EPI, IMCI, Adolescent Health and Nutrition. Sustained investment and systematic phased scale up of essential MNCH interventions integrated in the continuum of care are required.

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[6] Cluster 1: Growth and Reduction of Income Poverty; Cluster 2: Improved quality of life and social well being; Cluster 3: Good governance and accountability.

[7] *Maternal Mortality Estimates 2005*, WHO, UNICEF, UNFPA, World Bank

[8] Opportunities for Africa's Newborns 2006, the Partnership for MNCH

CHAPTER 2:
SITUATIONAL ANALYSIS OF MATERNAL, NEWBORN AND CHILD HEALTH IN TANZANIA

Introduction

Maternal, newborn and child health care is one of the key components of the National Package of Essential Reproductive and Child Health Interventions (NPERCHI) focusing on improving the quality of life for women, adolescents and children. The major components of the package include:

- antenatal care;
- care during childbirth;
- care of obstetric emergencies;
- newborn care;
- postpartum care;
- post abortion care;
- family planning;
- diagnosis and management of HIV/AIDS including PMTCT, other sexually transmitted infections and • reproductive tract infections (STI/RTI);
- prevention and management of infertility;
- prevention and management of cancer;
- prevention and management of childhood illness;
- prevention and management of immunisable diseases;
- nutrition care.

When a woman undertakes her biological role of becoming pregnant and undergoing childbirth, the society has obligation to fulfil her basic human rights and that of her child.

In spite of the good coverage of health facilities, not all components of the services are of good quality and provided to scale; hence, maternal, newborn and child mortalities remain a major public health challenge in Tanzania.

2.1 Maternal Health

- *Antenatal care*

  According to TDHS (2004/05), 94% of pregnant women make at least one antenatal care (ANC) visit and 62% of women have four or more ANC visits. The number of pregnant mothers in Tanzania making four or more ANC visits appears to have declined slightly from 70% in 1999[9]. However, the quality of antenatal care provided is inadequate. About 65% of the women have their blood pressure measured and 54% have blood samples taken for haemoglobin estimation and syphilis screening. About 41% have urine analysis done and only 47% are informed of the danger signs in pregnancy.

  Approximately 80% of pregnant women received at least 1 dose of tetanus toxoid (TT), and 56% of women received two or more TT doses[10]. Younger mothers, women in their first pregnancy, women of the higher education and wealth strata and urban women are more likely to receive two or more doses of TT.

  Despite high ANC attendance, only 14% of pregnant women start ANC during the first trimester as per the national guidelines. The median number of months that women are pregnant at their first visit is 5.4. One-third of women do not seek ANC until their sixth month or later[11]. However, early booking has an advantage for proper pregnancy information sharing and pregnancy monitoring.

[9] TRCHS 1999
[10] TDHS 2004/05
[11] TDHS 2004/05

- *Malaria in pregnancy*

Pregnancy alters a woman's immune response to malaria, particularly in the first malaria-exposed pregnancy, resulting in more episodes of severe infection and anaemia, all of which contribute to a higher risk of death. Malaria is estimated to cause up to 15 % of maternal anaemia, which is more frequent and severe in first pregnancies. Malaria is a significant cause of low birth weight which is the most important risk factor for newborn death and is also a risk factor for stillbirth.

Efforts to combat malaria among pregnant mothers are being scaled up. Pregnant women are supposed to receive two doses of SP for intermittent preventive treatment (IPT) of malaria during routine antenatal care visits. However, according to TDHS (2004/05), only 22% of pregnant women attending the ANC clinic receive the complete course of IPT, and only 16% use Insecticide Treated Nets (ITNs). Recent data from the National Malaria Control Programme (NMCP) indicate that the proportion of pregnant women sleeping under ITNs has increased to 28%[12].

- *Intrapartum care*

Only 47% of all births in Tanzania occur at health facilities and 46% of all births are assisted by a skilled health worker. Out of the 53% of births which take place at home, 31% are assisted by relatives, 19% by traditional birth attendants (TBAs) and 3% are conducted without assistance. As expected, births to women in the highest wealth quintile are more likely to be assisted by a skilled birth attendant (87%) than women in the lowest quintile (31%)[13].

Emergency obstetric care services are crucial for handling complicated deliveries. Findings from TDHS (2004/05) revealed that only 3% of all babies were delivered by caesarean section – this figure is below the WHO-recommended standard of 5-15%, and is partially due delay in timely referral, lack of skilled attendance and functioning blood banks at most hospitals and health centres. About 64.5% of public hospitals provide Comprehensive Emergency Obstetric Care (CEmOC), whereas only 5.5% of public health centres are providing Basic Emergency Obstetric Care (BEmOC)[14]. Furthermore, the referral system has serious challenges including limited number of ambulances; unreliable logistics and communication systems; and inadequate community-based facilitated referral systems.

- *Postnatal care*

Postnatal care is an important component of good maternal and baby health care is not very well utilized in Tanzania. Eighty-three percent of women who delivered a live baby outside the health facility did not receive a postnatal check-up, and only 13% were examined within two days of giving birth as recommended. Women in the highest income quintiles were more likely to receive a timely postnatal check-up compared to those in the lowest quintiles[15].

Prevention of Mother-to- Child Transmission of HIV

The key to ensuring an HIV-free start in life is prevention of HIV transmission to children by preventing HIV in mothers. PMTCT interventions include testing and counselling for HIV, antiretroviral prophylaxis for HIV-infected pregnant women and their exposed children, treatment of eligible women, counselling and support for infant feeding, safer obstetric practices and family planning to prevent unintended pregnancies in HIV-infected women. By September 2007, there were about 1,311 PMTCT sites established within reproductive and child health (RCH) clinics throughout the country[16]. Additional sites need to be established to provide services as close to the community as possible. The goal, objectives and strategies to scale up quality PMTCT services are stipulated in the Health Sector Strategy for HIV/AIDS (2008-2012).

[12] NMCP-MoHSW 2007
[13] TDHS 2004/05
[14] MoHSW, 2006. Situation Analysis of Emergency Obstetric Care for Safe Motherhood in Public Health Facilities in Tanzania
[15] TDHS 2004/05
[16] NACP 2007

Integration of PMTCT interventions in ANC, nutrition programmes, IMCI and other HIV/AIDS services enhances opportunities for reducing paediatric HIV and its associated deaths.

- *Nutrition*

Maternal nutrition during the pre- and postnatal periods is extremely important for the outcome of pregnancy as well as infant feeding. A good and adequate balanced diet, as well as vitamin and mineral supplementation, improves birth outcome and maternal well-being.

Underweight status contributes to poor maternal health and birth outcomes. Overall, 10% of Tanzanian women of reproductive age (15–49 years) are considered to be undernourished, having a Body Mass Index (BMI) of less than 18.5. Women living in rural areas are more affected compared to those living in urban areas[17].

Maternal under-nutrition, is often reflected in the proportion of children born with low birth weight (below 2.5 kg). Representative data on the prevalence of low birth weight babies is not readily available but estimates from UNICEF suggest that 10 % of Tanzanian newborns are low birth weight[18].

Pregnant women are particularly vulnerable to anaemia due to increased requirements for iron and folic acid. According to TDHS (2004/05), 48% of women aged 15-49 years were found to be anaemic, whereas 58% of pregnant women and 48% of breast-feeding mothers were anaemic. Ten percent of pregnant women took iron tablets for at least 90 days, while about half (52%) took iron tablets for less than 60 days, and 38% did not take iron tablets at all. Haemorrhage is the most frequent cause of maternal deaths, and pregnant women who are anaemic are more vulnerable to postpartum haemorrhage.

- *Family planning*

Spacing the intervals between pregnancies can prevent 20 to 35% of all maternal deaths[19]. However, family planning services continue to face challenges in meeting clients' expectations and needs. Despite having high knowledge of contraceptives (90%), only 26 % of married women use any method of contraception, with only 20% using a modern method. The most commonly used methods are injectables (8%), pills (6%) and traditional methods (6%)[20]. Current usage of any modern method is higher among sexually active unmarried women than among married women (41% and 26%, respectively). To be noted is the fact that the percentage of married women using any method of contraception has changed little from the 1999 TRCHS. The total demand for FP among married women is 50%, while 22% have an unmet need for FP[21].

Factors contributing to low contraceptive prevalence include low acceptance of modern FP methods, erratic supplies of contraceptives with limited range of choices, limited knowledge/skills of providers and provider's bias affecting informed choice. The situation is worsened by limited spousal communication, inadequate male involvement and lack of adolescent-friendly health services and misconceptions about modern family planning methods. In an attempt to improve access to family planning services, community-based programmes are being implemented in 46 mainland districts; however, this represents less than half of all districts in the country.

- *Challenges in accessing quality care*

Data from TDHS (2004/05) revealed that the major barriers perceived by women in accessing delivery health services include lack of money (40%), long distance to health facility (38%), lack of transport (37%), and unfriendly services (14%). The high rate of home deliveries is also attributable to a malfunctioning referral system, inadequate capacity of health facilities in terms of available space, skilled attendants and commodities, and other socio-cultural aspects affecting the pregnant women. Additional factors include gender inequalities in decision-making and access to resources at household-level.

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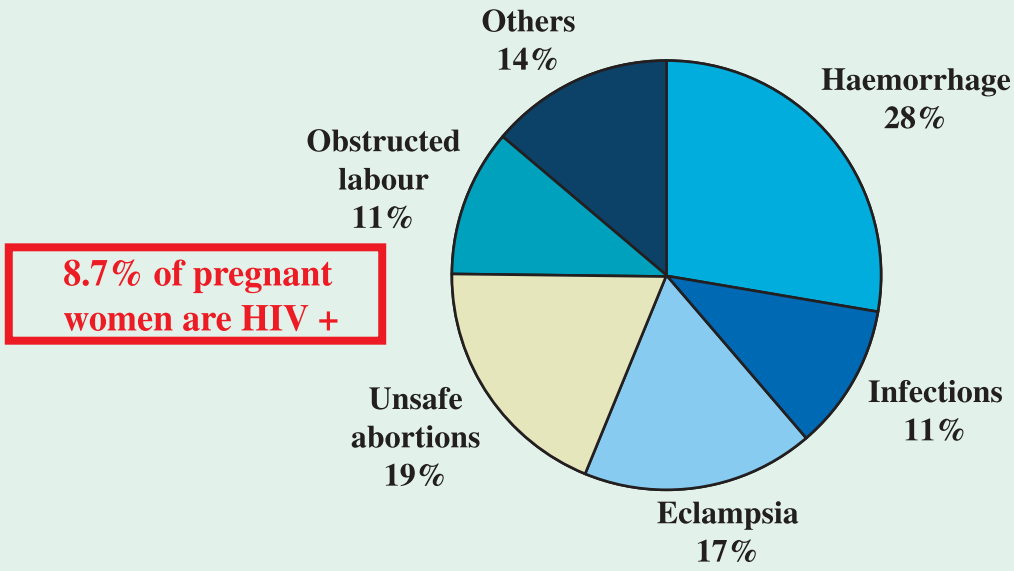
[17] TDHS 2004/05
[18] *State of the World's Children Report*, 2008
[19] Singh S. et al. 2004. *Adding it Up: The Benefits of Investing in Sexual and Reproductive Health Care.* Washington D.C. and New York: The Alan Guttmacher Institute and UNFPA.
[20] TDHS 2004/05
[21] TDHS 2004/05

- *Maternal morbidity and mortality*

According to TDHS (2004/05), the maternal mortality ratio is estimated at 578/100,000 live births. Major direct causes of maternal mortality include obstetric haemorrhage, obstructed labour, pregnancy induced hypertension, sepsis and abortion complications.

Figure 1: Direct Causes of Maternal Deaths



Source: The World Health Report, 2005

It is estimated that abortion complications contribute to about 20% of maternal deaths worldwide[22]. In Tanzania, induced abortion is illegal hence the actual magnitude of the problem is not known. However, several attempts have been made to document the severity of the issue – in Hai District, for example, it was reported that nearly a third of maternal deaths are related to unsafe abortion (Mswia et al, 2003[23]). Post abortion care (PAC) services can significantly reduce maternal mortality due to unsafe abortions; however, only 5% of health facilities in Tanzania currently provide this service[24].

Indirect causes leading to poor maternal health outcomes are malaria, anaemia, and HIV/AIDS. With specific regard to HIV, prevalence in Tanzania is estimated to be 7% in adults aged 15-49 years, with prevalence among women being higher (8%), compared to 6% among men[25].

2.2 Newborn Health

- *Newborn morbidity and mortality*

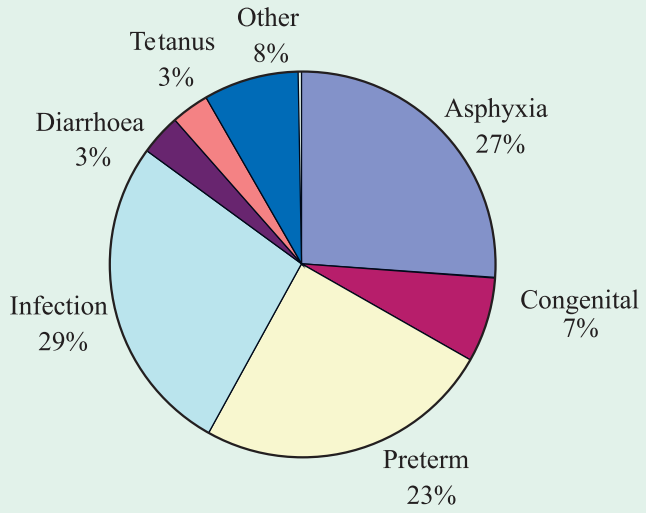
Tanzania is among those countries that have had success in reducing child mortality, but there has been no measurable progress in reducing neonatal deaths. The neonatal mortality rate was 40.4 per 1,000 live births in 1999 and 32 per 1,000 live births in 2004/05. Up to 50% of neonatal deaths occur in the first 24 hours of life, with over 75% of them arising in the first week of life. Newborn mortality is a sensitive indicator of the quality of care provided during the antenatal period, delivery and immediate postnatal period.

According to modelled estimates for Tanzania, 79% of newborn deaths are due to three main causes: infections including sepsis/pneumonia (29%), birth asphyxia (27%); and complications of preterm birth (23%) (Figure 2). Sepsis was the most common cause of death noted in a study conducted in Mbulu and

[22] The World Health Report, 2005
[23] Mswia et al, 2003. Community Based Monitoring of Safe Motherhood in United Republic of Tanzania
[24] TDHS 2004/05
[25] THIS, 2003/04

Hanang districts of rural northern Tanzania[26]. Many of these conditions are preventable and closely linked to the absence of skilled birth attendance at delivery. Eighty-six percent (86%) of neonatal deaths in Tanzania are also low birth weight, many of whom are preterm. On average in Tanzania, new born deaths are 67% higher in the poorest families as compared to the wealthier families, and the majority of deaths occur in rural areas[27].

Figure 2: Estimated Causes of Neonatal Deaths



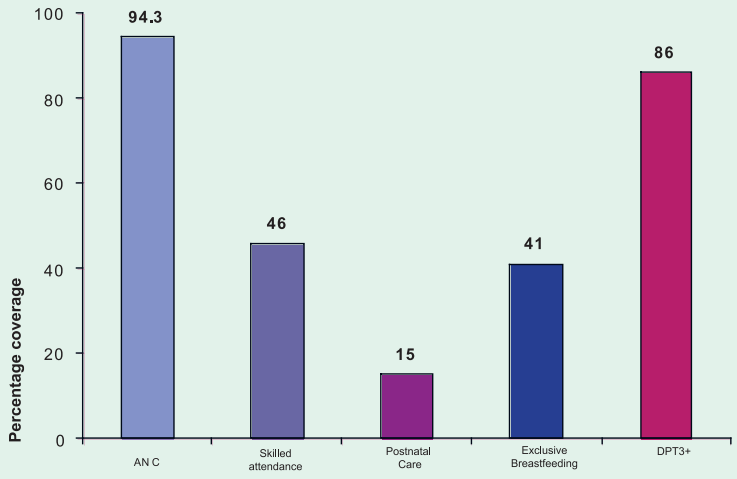
Source: 2004/5 TDHS

Low birth weight (birth weight less than 2500 grams) and preterm birth (less than 36 completed weeks of gestation) together contribute to 28% of neonatal deaths globally[28]. The recent Tanzania DHS (2004/05) asked mothers to estimate whether their infant was "very small, small, average, or large". They were also asked to report the actual birth weight, if it was known. The TDHS data cite a neonatal mortality of 86% in the five-year period prior to the survey among "small/very small" newborns. However, other all-cause mortality estimates indicate a mortality rate of 23% for preterm infants (who are most likely also of low birth weight.).

- *Continuum of care*

It is important to address the coverage of interventions along the continuum of care from pregnancy, neonatal period, infancy and childhood. It is critical to note that the coverage of essential interventions is lowest at the time when needed most: that is, during child birth and the early neonatal period when more than 50% of maternal and newborn deaths occur (Figure 3).

Figure 3: Coverage of Interventions along the Continuum of Care in Tanzania



Source: Opportunities for Africa's Newborns, Lawn JE, et al 2006

[26] Hinderraker et al, 2003
[27] TDHS, 2004/05
[28] Lancet Neonatal Survival Series, 2005

- *Other challenges*

Furthermore, quality newborn and child care faces other challenges including poor health infrastructure and referral for neonatal care, child care and poor skills of service providers related to inadequate incorporation of neonatal content in pre- and in-service training curricula. A recent study conducted in Dar es Salaam in 2005 showed that none of the primary and secondary level health facilities was providing basic/essential newborn care.

2.3 Child Health

Only 20% of women receive Vitamin A supplementation within 2months after childbirth.

- *Immunization*

The Expanded Programme of Immunization (EPI) has performed well over the past decade with immunization coverage of 71% for all vaccines for children 12-23 months (TDHS, 2004/05). Currently the policy is to provide each child with one dose of BCG, four doses of OPV, three doses of DTP-HB and one dose of measles vaccine. As expected, children born to mothers in the lowest wealth quintile are less likely to be fully immunized than those born to mothers in the highest wealth quintile.

Pneumonia is one of the major contributors towards under five mortality and it accounted for 21.1% of under five deaths in 2006. The Lancet series on child survival identifies Hib vaccine as an intervention that could reduce under five mortality due to pneumonia by 20%. Plans are under way to consider introduction of Hib and pneumococcal vaccines in the national policy.

Measles outbreaks are still happening despite high measles routine immunization coverage (above 80% in almost all districts). Tanzania has been implementing the Reaching Every District (RED) strategy to improve immunization coverage for all antigens including measles but also conducting periodic measles supplementation immunization campaigns after every three years.

The achievement of TT and polio vaccines is evident by the significant reduction in neonatal tetanus deaths and polio cases. The last polio case in the country was identified in 1996; however, there is a high risk of wild polio virus importation from polio-endemic countries. In this regard polio eradication initiatives need to be sustained until polio is eradicated.

Tanzania is close to achieving Maternal Neonatal Tetanus (MNT) elimination; however, there are still some pockets in high risk districts. Implementation of MNT elimination strategies will focus more in high risk districts.

- *Integrated Management of Childhood Illness*

Case management of common childhood illness is a key step to reducing child mortality. Appropriate management of malaria, pneumonia, diarrhoea and dysentery can reduce under five mortality by 5, 6, 15 and 3% respectively. The IMCI strategy has been implemented at scale in Tanzania from 1996 with all districts implementing at different levels of coverage. Tanzania was part of an IMCI inter-country evaluation and the results were encouraging, but issues around quality of care and supervision were noted[29].

IMCI has been found to be an effective delivery strategy for various child survival interventions and has contributed to a 13% mortality reduction over a two-year period in those districts in Tanzania where it has been implemented[30]. Management of diarrhoeal disease has been improved to include low osmolarity oral rehydration solution (ORS) and zinc supplementation. The IMCI clinical guidelines have been updated accordingly and have also included the newborn, HIV/AIDS and strengthened nutrition.

[29] MCE Report, 2005
[30] MCE Report, 2005

- *Prevention and management of malaria*

Malaria contributes to 23% percent of under five mortality in Tanzania[31]. Use of ITNs contributes to 7 percent reduction of overall deaths among under-fives [32]. Only 47% of under fives in Tanzania sleep under ITNs[33]. ITNs are distributed through the health system by vouchers, as well as by free distribution of long lasting insecticide treated nets (LLINs) through catch up campaigns and replacement campaigns to replace worn out ITNs in the period 2008 – 2012 when appropriate.

Malaria management has been improved using the combination therapy of Artemether and Lumefantrine (ALu). The MoHSW is training district focal persons for both IMCI and malaria and regional focal persons for coordination of malaria and IMCI interventions. Since a good proportion of caretakers seek treatment outside of the health facility, the MoHSW is also training the private sellers to dispense basic essential drugs to the community through Accredited Drug Dispensing Outlets (ADDOs).

- *Care seeking*

Care seeking for sick children needs to be improved. The TDHS 2004/05 showed that among children with symptoms prior to the survey, half of the children (57%) with symptoms of Acute Respiratory Infection (ARI) or fever and 47% of children with diarrhoea were taken to a health facility. Those in urban areas were more likely than rural children to be taken to the health facility. However, a vast majority of the children with diarrhoea (70%) were also given some form of ORT and 54% were given a solution prepared from ORS.

In Tanzania, although access to health services is good, many people seek care when it is too late or not at all. Attention should be paid to the fact that only 57% of under-fives receive anti- malarial treatment within 24 hours of developing symptoms. In this perspective the MoHSW has always prioritized community IMCI (c-IMCI) as a way of identifying danger signs among under-fives and when to seek care.

- *Nutrition*

Nutrition indicators for under-fives have shown some improvement over the years but undernutrition is still widely prevalent in Tanzania. Stunting, underweight status and wasting among children aged 0-59 months have reduced from 44%, 29% and 5% in 1999 to 38%, 22% and 3% respectively[34] . Anaemia is also highly prevalent among under-fives with 72% of all 6-59 months children being anaemic. The main causes of anaemia are nutritional deficiency, intestinal worms and malaria.

Optimal breastfeeding can reduce under-five mortality by up to 13%[35]. The majority of Tanzanian babies are breastfed, for a median duration of 21 months. Fifty-four percent (54%) are breastfed up to two years. However, initiation of breastfeeding within one hour of birth is only 59% and the exclusive breastfeeding rate (0-5 months of age) is estimated to be 41%[36] . Early complementary feeding is common with 39% of infants below 3 months already introduced to complementary foods[37]. About 12% of infants are not complemented at the age of 6-7 months. Furthermore feeding frequency during complementation is too low (about 2-3 feeds a day), nutrient density is low and the preparation and feeding practices are often unsafe[38]. Children 2 – 5 years old are fed family foods; however, feeding frequency and nutrient density are also inadequate in this group.

Coverage of health workers trained on infant and young child feeding is low and only 68 have been accredited as baby friendly[39]. Training on Essential Nutrition Actions (Vitamin A supplementation, exclusive breastfeeding, complementary feeding, iodine) is in the early stages of implementation. Coverage of

[31] Country Health System Fact Sheet 2006, WHO
[32] Lancet Child Survival Series, 2003
[33] TNVS Survey, 2007
[34] TDHS, 2004/05
[35] Lancet Child Survival Series, 2003
[36] TDHS, 2004/05
[37] TDHS, 2004/05
[38] TDHS, 2004/05
[39] Communication with TFNC, April 2008

appropriate facility management of severe malnutrition is still low and community management of severe malnutrition has not been implemented.

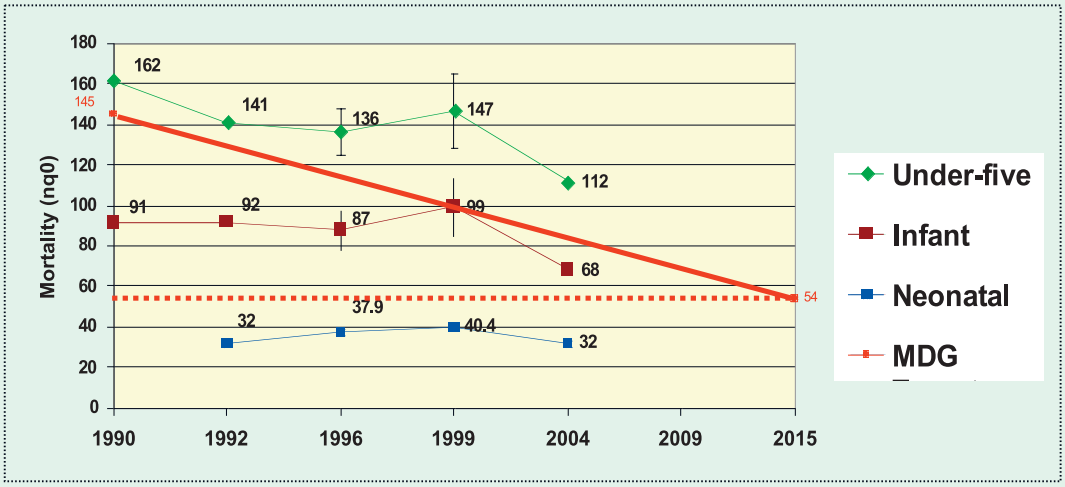
Vitamin A deficiency is the leading cause of preventable blindness in children and raises the risk of disease and death from severe infections. Vitamin A supplementation twice a year has been estimated by the World Bank (1993) to be one of the most cost-effective health interventions, yet in Tanzania the coverage is only 20%[40]. Currently the biannual Vitamin A supplementation campaign is the main strategy to combat vitamin A deficiency and it is estimated that the coverage is 85%[41].

Iodine deficiency during pregnancy has a great impact on physical and mental development of the foetus and is related to poor educational outcomes and productivity. In Tanzania the prevalence of goitre among school children is estimated at 7%[42]. Salt iodation is the most effective strategy for the control of iodine deficiency. However, currently only 75% of households consume iodated salt[43].

- *Child morbidity and mortality*

Although the most recent Demographic Health Survey (TDHS, 2004/5) has shown decline in under-five and infant mortality by 24% and 31% respectively to 112 and 68 per 1,000 live births, the infant and under-five mortality rates in Tanzania are still unacceptably high. Every year about 154,000 children die before reaching their fifth birthday. In addition, as expected, the mortality rates are highest in the lowest, second and middle wealth quintiles (137, 156 and 147, respectively) as compared to the highest wealth quintile (93).

Table 1: Trends in Infant and Under-Five Mortality Rate in Tanzania, 1990-2004/5



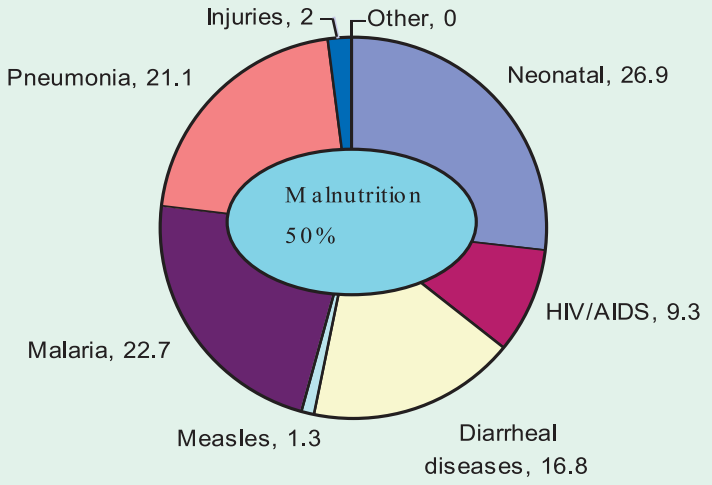
Source: TDHS, 2004//05

Although under-fives constitute about 16% of the population, they account for 50% of the total mortality burden for all ages. Most of these deaths are due to preventable diseases. Malaria, pneumonia, diarrhoea, HIV/AIDS and neonatal conditions account for over 80% of deaths. Malnutrition is a contributory factor to about fifty percent of all deaths.

The under-five mortality rate for children whose mothers were less than 20 years of age when they gave birth is 157/1,000, versus 120/1,000 for children whose mothers were in their twenties. Children whose birth order is seven or higher have a mortality rate of 151/1000, compared with 121/1,000 for those born second or third.

[40] TDHS, 2004/05
[41] Helen Keller International, 2004/05
[42] TFNC, 2004/05
[43] NBS and TDHS 2004/05

Figure 4: Causes of Deaths for Children Aged less than Five Years, in the Year 2006*



Source: WHO, 2006

- *Adolescents*

Adolescents constitute a significant proportion of the population, at about 31% [44]. A high percentage of adolescents are sexually active and practice unsafe sex. Consequently, the majority of them are highly vulnerable to SRH problems that include adolescent pregnancy and early child bearing, the complications arising from unsafe abortion, and STIs including HIV/AIDS[45]. In Tanzania, more than half of young women under the age of 19 are pregnant or already mothers, and the perinatal mortality rate is significantly higher for young women under the age of 20 (at 56 per 1,000 pregnancies) than it is for women aged 20-29 (at 39 per 1,000 pregnancies), and older women aged 30-39 (32 per 1,000 pregnancies). Obtaining permission to access services is a greater obstacle for young women age 15-19 than for their older counterparts. Young women age 15-19 also cited not knowing where to go as a barrier to accessing services[46]. Hence the need to invest in adolescent sexual reproductive health (SRH) services, including HIV/AIDS is paramount given the fact that SRH needs are not only basic human rights but that adolescents form a significant section of the population and bear a disproportionate burden of disease with regards to reproductive ill-health and HIV prevalence

Good governance is participatory, consensus-oriented, accountable, transparent, equitable, and follows the rule of law.

2.4 Cross-Cutting Issues

- **National Policies and Guidelines**

Tanzania has mainstreamed maternal, newborn and child survival into its national health policy. The services for maternal, newborn and child health are exempted from cost sharing. However, the exemption policy faces difficulties in its implementation at lower level due to lack of clarity on how to effect the exemption mechanisms.

Several national policy documents have been developed targeting improvement of reproductive and child health services, which include maternal and newborn health. However, certain professional regulations and legislations contribute to compromised implementation of the policies.

The MoHSW and partners have developed several clinical national protocols; however, there is need to have an integrated protocol. Although training on RCH interventions has been ongoing nationally through the MoHSW, district councils and NGOs, the quality of the trainings, transfer skill to practice and follow up

[44] Census, 2002
[45] National Adolescent Health and Development Strategy, 2004-2008
[46] TDHS, 2004/05

supervision are still challenges that need to be addressed. National capacity development is also compromised by poor working environment; low geographical coverage; weak integration of gender and human rights issues.

- **Community Mobilization and Participation**
  Community-based maternal, newborn and child health interventions are crucial in complementing services at the health facility level. Since the Alma Ata Declaration on Primary Health Care (PHC) in 1978 and the subsequent health sector reforms initiated in 2000, there has been increased focus on community participation in the delivery of health services. Community participation has been strengthened further by local Government reforms, which interface the health sector within the overall Government policy of decentralization by devolution. In Tanzania communities play an increasingly important role in the development of the Comprehensive Council Health Plans (CCHPs) through the decentralised district planning framework. Further community participation has been strengthened through community representation on the Council Health Service Boards and Health Facility Governing Committees.

  Though a few districts have been successful in involving communities in the process of planning, monitoring and evaluation of health services, their participation is still compromised by the low capacity of health boards and health facility governing committees and inadequate outreach activities.

  Other challenges include weak partnership between clients and service providers, which is compounded by low awareness of clients' and service providers' rights and obligations; low public awareness of reproductive health matters such as management of pregnancy, newborn care and child care and related complications, socio-cultural barriers; gender inequalities, low women empowerment; and myths and misconceptions of various health-related issues.

- **Water, Sanitation and Hygiene**
  The proper sanitation, hygiene and use of safe water are vital in containing the spread of water borne and water related diseases. The TDHS (2004/0) also showed that during the two weeks that preceded the survey 13% of children under-five had diarrhoea. The rate was highest among children 6-11 months old (25%).

  Less than half of all households are within 15 minutes of their drinking water supply. Nineteen percent of urban households have water piped into their compound and 33% from neighbours' taps while rural households primarily rely on public wells both open and protected (43%) and rivers and streams (18%) for their drinking water. About a half of households (47%) have improved toilets.

  Improved household water, sanitation and promotion of key hygiene behaviour changes will be critical to complement and strengthen the essential health package. Various community-based interventions are being implemented to improve hygiene and sanitation such as Participatory Hygiene and Sanitation Transformation (PHAST) and c-IMCI.

- **Human Resources**
  Human resources for health is a crisis in the country with only one-third of posts filled. The situation is worse especially for the lower-level health facilities, where dispensaries and health centres have shortages of 65.6% and 71.6% respectively[47]. This has a major impact on maternal, newborn and childcare, most significantly recognizable in the lack of skilled attendants during childbirth. Efforts are being made by MoHSW to recruit additional skilled health providers but challenges remain such as poor skills mix; non-attractive incentive and salary packages; poor motivation; inadequate performance assessment; rewarding systems; retention of staff especially in remote and hard to reach areas;.
- **Monitoring and Evaluation**

[47] MoHSW, 2006

Monitoring and evaluation play a critical management function by assessing whether implementation of programmes proceeds according to plan and leads to the desired outcomes. Monitoring of maternal, newborn and childhood health in Tanzania has been implemented through HMIS, annual RCH reports, TDHS, Tanzania Service Provision Assessment (TSPA), maternal and perinatal death review reports, Infectious Disease Week Ending Report (IDWE) and other health facility and household surveys. Some of the limitations in reporting maternal, newborn and child deaths are the problem of incorrect and incomplete recording, proper case definition, data management, source of information (i.e. facility versus community-based data) and methods of estimation. Further, the use of process indicators is critical for evaluation of implementation. However, process indicators are not widely used at all levels. In order to achieve coherent and useful data for monitoring and evaluation of maternal, newborn and child health in Tanzania it is crucial to strengthen the current health information system to address the information gaps for maternal, newborn and child care.

- **Advocacy and Resource Mobilization**

  Although there has been advocacy and commitment at different levels in addressing maternal, newborn and child health issues, the meagre budget allocation to the health sector has been a hindrance to effective implementation of the Essential RCH Package. During FY 2005/06, the health budget allocation was Tsh. 453.2 billion, which is 10.1% of the total Government budget, below the recommended Abuja target of 15%. Due to other competing health priorities such as malaria, HIV/AIDS and tuberculosis, the budget allocation for reproductive and child health is still limited.

  Opportunities and synergies for addressing maternal, newborn and child health include introduction and scaling up of the TASAF II initiative, which will enable communities to address their infrastructure development needs, logistics and human capacity gaps, in order to provide appropriate maternal, newborn and child care interventions and services. The existence of the Joint Rehabilitation Fund, District Demand Driven Initiative, GAVI and Global Fund for AIDS, TB and Malaria, also provide opportunities for the districts to strengthen maternal, newborn and child health interventions.

- **Partnerships and Coordination**

  Maternal, newborn and child health interventions need to be addressed in the context of a multi-sectoral approach. Partnerships, resources and more effective and coordinated programmes at all levels are increasingly needed to reach the MDGs.

Due to other competing health priorities such as Malaria, HIV/AIDS and Tuberculosis, Reproductive and Child Health budget is still limited. This has affected implementation of comprehensive interventions on maternal, family planning and newborn care.

Strategic Plan

CHAPTER 3:
STRATEGIC FRAMEWORK

Maternal, Newborn and Child Health Strategic Plan

The development of the MNCH Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths is a response to the New Delhi Declaration (April 2005) which urged all countries to develop strategies to reducing the persistently high rates of maternal, newborn and child deaths in order to reach MDG 4 and 5. This plan is expected to contribute to the achievement of MKUKUTA and MMAM goals and targets, as well as objectives and targets of other existing national programmes, interventions and strategies, which focus on improving MNCH.

This strategic plan aims to address maternal, newborn and child health and accelerate mortality reduction 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 from 578 to 193 per 100,000 live births.

3.4.2. To reduce neonatal mortality from 32 to 19 per 1000 live births

3.4.3. To reduce under-five mortality from 112 to 54 per 1000 live births

3.5 Operational targets to be achieved by 2015

1. Increased coverage of births attended by skilled attendants from 46% to 80%.
2. Increased immunization coverage of DTP-HB 3 and Measles vaccine to above 90% in 90% of the districts.
3. New EPI vaccines introduced (Hib, Pneumoccocal, Human Papilloma Virus (HPV) and Rota Virus

vaccines).

4. Reduced stunting and underweight status among under-fives from38% and 22% to 22% and 14%, respectively.
5. Increased exclusive breast feeding coverage from 41% to 80 %
6. PMTCT services provided to at least 80% of pregnant women, their babies and families.
7. 90% of sick children seeking care at health facilities appropriately managed.
8. Increased coverage of under-fives sleeping under ITNs from 47% to 80%.
9. 75% of villages have community health workers offering MNCH services at community level.
10. Increased modern contraceptive prevalence rate from 20% to 60%
11. Increased coverage of CEmOC from 64% of hospitals to 100% and of BEmOC from 5% of health centres and dispensaries to 70%
12. Increased proportion of health facilities offering Essential Newborn Care to 75%.
13. Increased antenatal care attendance for at least 4 visits from 64% to 90%
14. Increased number of health facilities providing Adolescent friendly reproductive health services to 80%

3.6. Strategies

3.6.1. **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;

3.6.2. **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;

3.6.3. **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;

3.6.4. **Fostering partnership** to implement promising interventions among Government (as lead), donors, NGOs, the private sector and other stakeholders engaged in joint programming and co-funding of activities and technical reviews;

3.6.5.**Information, education and communication /behavioural change communication (IEC/BCC).** Promotion of appropriate reproductive health behaviours is critical in accelerating reduction of maternal, newborn and child deaths. With implementation of the MNCH Strategic Plan, the use of IEC/BCC approaches for positive behaviour adoption and create demand for quality maternal, newborn and child care.

3.7. Guiding Principles

The following principles will guide the planning and implementation of the MNCH Strategic 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.

For majority of women, especially the poor and disadvantaged groups, the pathway to safe motherhood is blocked by the underlying factors that lead to delays in accessing appropriate care.

CHAPTER 4:
IMPLEMENTATION FRAMEWORK

4.1 Introduction

The MNCH Strategic Plan has been designed to accelerate the reduction of maternal newborn and child deaths with the aim of attaining MDGs 4 and 5 by 2015. It should be implemented jointly by all stakeholders as a multi-sectoral strategy for comprehensive reproductive and child health care.

Good governance is a critical element for successful implementation of the strategic plan, right from central level to the grass root level. Good governance is participatory, consensus-oriented, accountable, transparent, equitable, and follows the rule of law. It assures that corruption is minimised, and voices of the most vulnerable in society are heard in decision making.

The MNCH Strategic Plan will be implemented in collaboration with relevant stakeholders, which include related Ministries and agencies, development partners, the civil society, community based organisations, professional associations, faith-based organisations, voluntary agencies, and the private sector, among others.

4.2. Specific Roles and Responsibilities of Different Levels

4.2.1 Ministry of Health and Social Welfare (National Level)

The MoHSW will mobilise resources and advocate for reduction of maternal, newborn and child deaths. It will also be responsible for the overall technical leadership, guidance and advice on the implementation and monitoring of the strategic plan. The following will be the specific roles and responsibilities of the various Directorates of the MoHSW.

i) **Directorate of Policy and Planning** will ensure adequate budget allocation for MNCH and mainstreaming of MNCH indicators into policy frameworks. The HMIS Unit will facilitate the monitoring of all indicators from routine data collection systems including community-based data through Community Based Management Information System (CBMIS).

ii) **Directorate of Hospital Services** will ensure availability of essential drugs, supplies, equipment and diagnostics by facilitating efficient procurement and distribution to all levels of service delivery.

iii) **Directorate of Human Resource and Development.** The training department will be responsible to review and update pre- and in-service curricula to ensure relevant issues for MNCH are adequately addressed. The department will also promote accelerated training of mid-level cadres in order to increase the available number of skilled health workers, and will facilitate effective development, recruitment and deployment of skilled health workers at health units to address the human resource crisis[48]. This will be done in collaboration with the Prime Minister's Office - Regional Administration and Local Government (PMORALG) , the President's Office - Public Service Management (POPSM) and Ministry of Finance and Economic Affairs..

iv) **Directorate of Preventive Services** will supervise and coordinate all activities with respect to all sections under its charge for the realisation of the strategic plan objectives. It will particularly undertake the following activities:

- Advocate for the implementation of the MNCH Strategic Plan by
- Coordinate the implementation, monitoring of MNCH activities
- Involve and collaborate with various stakeholders at all levels for planning and implementation of the MNCH Strategic Plan

[48] MMAM

- Facilitate capacity development at national, zonal, regional and district levels by developing protocols and training packages for MNCH
- Design and develop IEC/BCC materials with stakeholders and disseminate them to the intended users
- In collaboration with the procurement unit, facilitate procurement of communication equipment and its installation at hospital, health centres and selected dispensaries
- Identify and propose disaggregated indicators and update monitoring data collection tools to include process indicators for EmOC, newborn care, nutrition, postnatal care, child care and Adolescent health including functioning monitoring and evaluation systems and userfirendly data base
- Review and harmonize existing CBMIS, in collaboration with the district councils
- Facilitate integration of nutrition actions in maternal, newborn and child care programmes.
- Promote research on MNCH including FP and nutrition
- Capacity developemnt for the implementation of maternal, newborn, child and Adolescent health

4.2.2 Zonal Level

- Disseminate the MNCH Strategic Plan to their respective districts
- Support capacity development in MNCH in the districts
- Zonal Training Centres and ZRCH coordinator maintain effective partnership with key stakeholders (MoHSW- RCHS, RHMTs, CHMTs, NGOs, CBOs etc)
- Conduct and build research capacity in the regions and districts

4.2.3 Regional Level

- Provide technical support for effective planning and implementation of the integrated MNCH activities in the CCHPs.
- Coordinate, monitor and supervise MNCH activities in the region
- Technical support for training and ensuring quality in service provision
- Support districts in analysis and utilization of MNCH data and disseminate/report to the national level

4.2.4 District Level

- Disseminate MNCH Strategic Plan to all stakeholders in the District Council including NGOs, FBOs and other private sector partners.
- Incorporate MNCH activities into the CCHPs
- Coordinate and supervise all MNCH activities planned and implemented by all stakeholders in the district
- Provide technical support for quality MNCH services
- Capacity development for facility and community MNCH interventions
- Follow up maternal, perinatal, neonatal and child death reviews at health facility (dispensaries, health centres, district hospitals, regional hospitals, as well as voluntary agencies and private hospitals) and community levels
- Council Management Teams and District Health Boards to ensure adequate resource allocation for implementation and monitoring of the MNCH interventions

4.2.5 Health Facility (Dispensary, Health Centre and Hospital)

- Incorporate MNCH activities into facility health plans
- Provide quality MNCH services
- Implement quality improvement approaches such as Quality Improvement and Recognition Initiative (QIRI), Pay for Performance, Integrated Management Cascade and Collaborative Approach
- Ensure timely availablity of essential equipment, supplies and drugs for service MNCH provision
- Conduct maternal, perinatal, neonatal and child death reviews, involving the community
- Health facility committees to monitor and ensure quality MNCH service provision
- Provide technical and supportive supervision to community interventions

4.2.6 Community

The Village Government and Ward Development Committee through the Primary Health Care (PHC) committee and health facility governing committee will be responsible for supervision and implementation of MNCH activities in their areas. Other responsibilities include:

- Facilitate development and monitoring of community MNCH action plans
- Mobilize the community to participate in community interventions
- Establish and/or strengthen CBMIS
- Leverage community resources for the implementation of MNCH interventions

4.2.7 Roles and Responsibilities of other Ministries

Key Ministries should be involved to ensure that the reduction of maternal, newborn and child mortality is high on their agenda. These include Ministry of Finance and Economic Affairs (MoFEA), PMORALG, Ministry of Community Development Gender and Children (MoCDGC), Ministry of Education and Vocational Training (MoEVT), Ministry of Agriculture, Food Security and Cooperatives (MoAFSC), Ministry of Labour, Employment and Youth Development (MoLEYD), Ministry of Infrastructure Development (MoID), Ministry of Communication, Science and Technology (MoCST), and Ministry of Information, Culture and Sports (MoICS).

i) Ministry of Finance and Economic Affairs

- Give priority to health, especially MNCH, in budget guidelines for allocation of resources
- Increase financial resources for health and especially implementation of MNCH activities as guided by the MNCH Strategic Plan

ii) Prime Minister's Office Regional Administration and Local Government

- Provide technical support to regions and councils for planning and implementation of CCHPs
- Mobilize funds to support implementation of CCHPs including CBMIS
- Support infrastructural development, rehabilitation and maintenance to improve access for MNCH services
- Include maternal, perinatal, newborn and child health indicators in the national health sector monitoring and evaluation framework.

iii) Ministry of Education and Vocational Training

- Promote universal access to education, especially education for girls and women
- Review and update components of MNCH and SRH in various school and pre-service curricula in collaboration with MoHSW particluarly on provision of adolescent friendly services

iv) Ministry of Agriculture, Food Security and Cooperation

- Promote food security at household, community, district and national levels

v) Ministry of Community Development, Gender and Children

- Support community development extension workers to supervise and identify problems and derive solutions for MNCH in the local context
- Facilitate the establishment of community mechanisms to support emergency transportation for MNCH services
- Advocate for gender issues to improve MNCH decision-making at all levels
- Support and promote rights-based approach to programming for MNCH
- Advocate for revision of laws, legislations and policies to improve MNCH
- Promote parental support for adolescents to access information and health services

vi) Ministry of Infrastructure Development

- Improve road networks to facilitate access to services at primary and referral levels, especially in rural areas where the majority of Tanzanians live

vii) Ministry of Labour, Employment and Youth Development

- In collaboration with the MoHSW and the MoCDGC, develop a Youth Communication Strategy
- Develop capacity for life skills and livelihood young people
- Advocate for adoption of maternity protection conventions (ILO, convention 183)

viii) **Ministry of Communication, Science and Technology**

- Promote the development, availability of and access to appropriate technology to support MNCH service provision

ix) **Ministry of Information, Culture and Sports**

- **Promote positive RH behaviours including early health care seeking for MNCH services.**
- **Disseminate information aimed at promoting early care seeking behaviour for MNCH and use of preventive care services**

4.2.8 Roles and Responsibilities of Development Partners

- Provide technical and financial support for the coordination, planning, implementation, capacity developemnt and monitoring and evaluation of MNCH services
- Advocate for increased global and national commitment to the reduction of maternal, newborn and child morbidity and mortality
- Mobilise and allocate resources for the implementation of MNCH interventions

4.2.9 Roles and Responsibilities of Civil Society Organisations (NGOs, FBOs, CBOs, Professional Associations)

- Advocate for the rights of women and children.
- Forge partnership with different stakeholders including political leaders to promote MNCH
- Implement community based strategies to promote healthy behaviours during pregnancy, child birth, post partum period, childhood and adolescence
- Complement governement efforts in the provision of quality MNCH services
- Disseminate the MNCH Strategic Plan to accelerate the reduction of maternal, newborn and child morbidity and mortality
- Mobilize and allocate resources for implementation of the MNCH Strategic Plan

4.2.9 Roles and Responsibilities of Private Sector

- Complement Government efforts in the provision of quality MNCH services
- Invest in commodites and supplies for MNCH interventions

4.2.10 Role of Training and Research Institutions

- Undertake relevant MNCH research to provide evidence for policy directions and implementation guidance
- Review and update curricula to ensure relevant MNCH issues are adequately addressed
- Provide technical advice and updates on current developments on MNCH and SRH to policy makers

4.3. Key Strategies to be Implemented

4.3.1. Advocacy and Resource Mobilization

In advocating for improved MNCH, the following issues will be emphasized:

- Increased budget allocation for MNCH interventions including FP and nutrition. The target is to mobilize resources from internal and external sources in order to complement the Government's efforts towards reducing maternal, newborn and childhood deaths
- Revision of laws, legislations and policies that hinder effective provision of maternal, newborn and childcare services
- Improved production, employment, deployment and retention of a skilled health work force at all levels

4.3.2. Health Systems Strengthening and Capacity Development

Health system strengthening for MNCH involves improving; service delivery; health workforce; information; medical products , vaccines and technologies; financing; and leadership/ governance as well as managing interactions among them, so that more equitable and sustained improvements across services and health outcomes will be achieved.

4.3.2.1 Capacity development

- The strategy aims to increase the number of skilled health work force required, as well as the knowledge and skills of existing service providers and supervisors so that quality care is provided.
- User friendly protocols will be developed/reviewed and the mechanisms for making essential commodities for MNCH, including FP, available will be strengthened
- Basic and comprehensive EmOC as well as essential newborn services will be strengthened at dispensaries, health centres and hopsitals
- Skills for planning and management of MNCH services, including FP and Nutrition, will be imparted to the CHMTs.
- Necessary infrastructure, logistics and equipment support will be provided for the effective delivery of the comprehensive MNCH packages.

4. 3. 2.2 Referral systems

- Referral systems will be improved to ensure equitable access to quality MNCH services through making appropriate means of transportation available and improve linkages between community and referral facilities
- Communications equipment (e.g., radio calls and mobile phones) will be installed in hospitals, health centres and selected dispensaries.
- Community emergency committees will be established and oriented to emergency preparedness and response.
- Maternity waiting homes will be established where appropriate.

4.3.2.3 Research, Monitoring and Evaluation

- Capacity building for conducting operational research will be strengthened at all levels. Districts will be encouraged to identify research priority areas according to their needs.

  Essential monitoring tools and indicators will be developed and mainstreamed into the HMIS. Data will be generated periodically to monitor the milestones and improvement of services provided at health facilities.
- Periodic reviews and reporting will be carried out every two years to assess progress. A mid-term review will be conducted between 2010 – 2011, and an end of term review will be conducted in 2015 to report on the attainment of the MDGs.

4.3.3. Community Mobilization

- Communities will be mobilised to participate fully in initiatives aimed at improving maternal, newborn and child care by:
- Educating and sensitising them on community-based MNCH interventions
- Mobilizing resources at the village level for MNCH including emergency referral as well as building and

strengthening health facilities.

- Orienting the facility governing committees to the MNCH Strategic Plan to ensure effective implementation of the plan at the health facility and community levels
- Re-institutionalizing quarterly village health days

4.3.4: Information Education and Communication (IEC)/Behaviour Change Communication (BCC)

- Use of IEC/BCC approaches will be intensified towards adoption of positive behaviours for quality MNCH including nutrition and adolescent sexual reproductive health.
- The IEC/BCC activities will target community-based initiatives particularly in addressing birth preparedness, with an emphasis on birth planning for individual couples, transport in case of emergency, and promotion of key MNCH practises at the household and community levels.

4.3.5: Fostering Partnership and Accountability

Effective implementation of the MNCH Strategic Plan will entail fostering and establishing strategic partnerships to improve coordination and collaboration between communities, partners and among programmes as well as galvanizing resources for long term sustainable actions for MNCH.

- Coordinate regular planning, implementation, monitoring and evaluation of MNCH activities to assess progress towards attainment of the MDGs

The goal of this National Strategic Plan is to accelerate the reduction of maternal, newborn and child mortality and morbidity, and the atteinment of the MDGs 4 and 5 in Tanzania.

CHAPTER 5: STRATEGIC PLAN AND ACTIVITIES: 2008 -2015

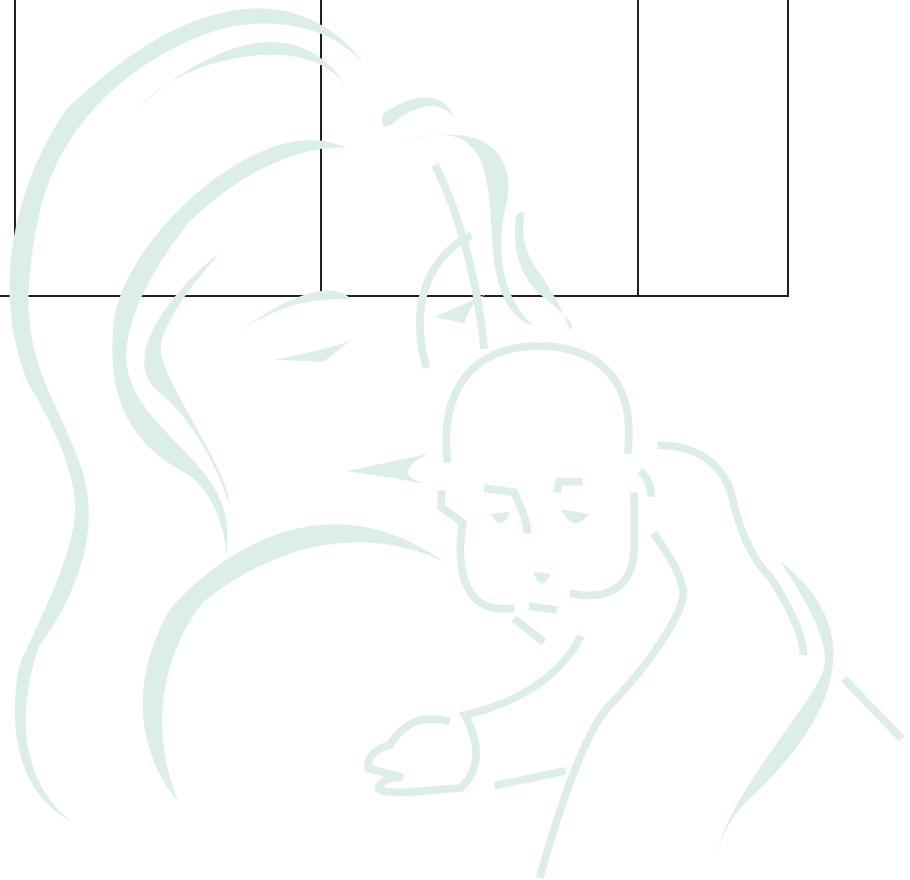
Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
5.1 Advocacy and Resource Mobilisation												
5.1.1 Budget allocation for health, particularly for maternal, newborn & child health including FP and nutrition increased at all levels.	5.1.1.1Cost the package for maternal, newborn and child health including FP and nutrition by establishing: • Unit cost per intervention per area; • Operational costs; • Recurrent costs.	X	X			X				The package for maternal, newborn and child health including FP and nutrition costed and in place.	MoHSW (RCHS, Policy and Planning) Development Partners Research Institutions	80,000
	5.1.1.2. Conduct Advocacy for maternal newborn and child care through **Deliver Now for Women and Children campaign**	X	X	X	X	X	X	X	X	Number of advocacy events conducted annually	MoHSW (RCHS, HEU) Development Partners CSOs	200,000
Strategic Output Indicator: *Budget for maternal, newborn and child health including FP and nutrition increased by 50% by 2015.*	5.1.1.3 Develop an advocacy package targeting the following: MoHSW, PMO-RALG, MoFEA and other relevant line ministries, partners, parliamentarians (using REDUCE/ALIVE and other materials) to mobilise human and financial resources from Government, political and community leaders.	X	X			X			X	Advocacy package developed and disseminated.	Professional Associations Academic and Research Institutions Media	
	5.1.1.4 Identify focal persons among members of parliament and other influential leaders to advocate for maternal, newborn and child health.	X		X						Numbers of influential leaders advocating for maternal, newborn and child health identified.	MoHSW (RCHS) Development Partners CSOs	-
	5.1.1.5 Provide support to MNCH champion and other focal persons.	X	X	X	X	X	X	X	X			

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
	5.1.1.6 Conduct advocacy meetings to policy/decision - makers on the MNCH Strategic Plan, to support implementation of the strategy at the central, regional and district levels.	X	X	X	X	X	X	X	X	Number of advocacy meetings conducted	MoHSW (RCHS) CSOs Professional Associations Development Partners	680,000
	5.1.1.7 Lobby with the government for subsidy on ITNs in order to ensure equitable access to the materials by all vulnerable groups.	X	X	X	X	X	X	X	X	Subsidy policy on ITN for all vulnerable group in place		
	5.1.1.8 Establish and conduct Mother-Baby Day/ Week, annually at all levels through: • Public awareness campaigns (media/rallies/debates). • Programme communication development.	X	X	X	X	X	X	X	X	Mother-Baby Day/Week commemorated	MoHSW, Ministerial Department Agencies (MDAs) Media Development Partners CHMTs Professional Associations CSOs	400,000
	5.1.1.9 Advocate for bi-annual Child and village health days at all levels through : • Public awareness campaigns • Programme Communication development	X	X	X	X	X	X	X	X	Proportion of villages conducting semi annual child health day	MoHSW, MDAs Media RHMTs CHMTs NGOs, Professional Associations Village Governments Development Partners	600,000
	5.1.1.10 Sensitize RHMTs and CHMTs of the importance of including child and village health days in the CCHPs	X	X	X	X	X	X	X	X	Proportion of CCHPs with budget allocation for Village Health Days		
	5.1.1.11 Train, establish and support Media Groups to report on MNCH	X	X	X	X	X	X	X	X	Number of established media groups		100,000

STRATEGIC PLAN AND ACTIVITIES: 2008 -2015

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
5.1.2 Regulations, laws and policies to support effective implementation of maternal, newborn and Child health reviewed. **Strategic Output Indicator:** *Number of regulations approved by regulatory bodies.* *Number of laws approved by regulatory bodies.*	5.1.2.1 Review regulations and legislations related to the provision of maternal, newborn and child care.	X				X	X			Number of regulations, laws and policies to support effective provision of quality maternal, newborn and child care reviewed.	MoHSW (RCHS) Professional Associations Development Partners Medical Council Nurses & Midwives Council CSOs	60,000
	5.1.2.2 Advocate for review and adoption of laws such as the Marriage Act of 1970, and the Sexual Offence Special Provision Act (SOSPA) of 1998 that influence maternal, newborn and child health.	X	X							Laws affecting maternal and newborn health reviewed and adopted.	MoHSW, Ministry of Justice and Constitutional Affairs MCDGC, MDAs, Development Partners, Professional Associations CSOs	120,000

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
5.1.3 Implementation of the exemption policy for maternal and child health strengthened. **Strategic Output Indicator:** *Exemption policy effectively implemented.*	5.1.3.1 Advocate for exemption policy on MNCH to be effected in voluntary and public health facilities (Service Agreement)	X	X							Proportion of public and voluntary health facilities implementing the Exemption Policy.	MoHSW (RCHS & Policy and Planning) Health professional associations Private sector CSOs	25,000



STRATEGIC PLAN AND ACTIVITIES: 2008 -2015

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
5.1.4 Employment, deployment and retention of skilled health workers at all levels of care improved. **Strategic Output Indicator:** *Number of skilled health workers increased to 100% of established need by 2015*	5.1.4.1 Advocate for review of the 1999 Human Resources Establishment (and 2006 proposed revision) in line with skilled attendance requirements for maternal, newborn and child care.	X	X							Human Resource Establishment of MoHSW (1999) reviewed.	MoHSW (DHR, DAP) PMO-RALG PO- Public Service Management MoFEA Health professional associations, CSOs Development Partners	62,000
	5.1.4.2 Advocate for recruitment and deployment of skilled health workers at all levels of care.	X	X	X	X	X	X	X	X	Proportion of districts with appropriate number of skilled health workers.	MoHSW PMO-RALG Health professional associations Development Partners CSOs	37,000
	5.1.4.3 Advocate to the Government to motivate skilled health workers by providing a package of incentives in order to ensure optimum performance.	X	X	X	X	X	X	X	X	Types of Incentive package provided by the Government at all levels. Proportion of districts providing incentive packages	MoHSW (DHR, DAP, Policy & Planning) PMO-RALG PO-Public Service Management MoFEA Health professional associations CSOs	66,000

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
5.2. Health Systems Strengthening and Capacity Development												
5.2.1 Knowledge and skills of supervisors and service providers on maternal, newborn and child care including FP and nutrition increased. **Strategic Output Indicator:** *Maternal, newborn and child health service provided according to standards.*	5.2.1.1 Review/develop user-friendly protocols for antenatal care, postnatal care, newborn and child care, EmOC, FP and nutrition. Specific activities include: • Develop/adapt/review and disseminate Community Maternal, Newborn and Child Care packages • Develop/adapt/review standards job aides and tools for MNCH service provision • Develop/adapt/review and disseminate Nutrition Packages including ENA, SAM, IYCF/BFHI • Review EPI guidelines for inclusion of new vaccines • Adaptation of Essential Newborn Care (ENC) and Kangaroo Mother care guidelines (KMC) • Adaptation and adoption of the new child growth standards and charts	X	X			X	X			Protocols on antenatal care, EmOC, newborn care, severe malnutrition, growth monitoring, child care and postnatal care developed and adopted by the MoHSW.	MoHSW (RCHS, DHS HEU) Development Partners Health professional associations CSOs	147,000

STRATEGIC PLAN AND ACTIVITIES: 2008 -2015

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
	5.2.1.2 Support pre-service training institutions to provide updated and competency-based teaching on maternal, newborn and child care including FP and nutrition (LSS-EmOC, ENC, KMC FANC, PAC, FP, newborn care, nutrition, BFHI, IYCF, SAM, PMTCT , IMCI, ETAT, Referral Care Package, Immunization) by: • Updating pre-service curricula to address current changes in maternal, newborn and child care including FP and nutrition • Developing and providing an orientation package and other educational materials to tutors and clinical preceptors. • Update and standardize knowledge, clinical and teaching skills of tutors and clinical preceptors at medical, nursing and paramedical schools. • Provide schools and clinical practice sites with necessary teaching and clinical practice materials and equipment	X	X	X	X	X	X	X	X	1000 tutors/clinical preceptors from various institutions updated on maternal and newborn care including FP and nutrition. All preservice MNCH curricular components updated All preservice institutions provided with necessary teaching materials, equipment and supplies	MoHSW (RCHS, PMTCT, TFNC) Human Resource Development and Training Health Training Institutions Regulatory bodies Private institutions CSOs Development Partners	680,000
	5.2.1.3 Update knowledge and skills of supervisors on maternal, newborn and child care including FP, nutrition and supervisory skills (LSS-EmOC, ENC, KMC, FANC, PAC, FP, newborn care, nutrition, BFHI, IYCF, PMTCT , IMCI, ETAT, Referral Care Package, immunization)	X	X	X	X	X	X	X	X	910 CHMT members (130 Councils), and 147 Zonal and RHMT members, all updated in supervisory skills.	MoHSW (RCHS, DRH) Development Partners CSOs	1,525,000

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
	5.2.1.4 Update knowledge and skills of service providers on maternal, newborn and child care including FP and nutrition (LSS-EmOC, ENC, KMC, FANC, PAC, PNC, FP, ENA, IMCI, ETAT, BFHI, IYCF, PMTCT, SAM, immunization) and link the interventions to malaria, HIV/AIDs, and STIs control programmes.	X	X	X	X	X	X	X	X	Number of service providers trained in MNCH service delivery	MoHSW (RCHS), District Councils, and Development Partners. CSOs Private institutions Health pProfessional associations	7,000,000
	5.2.1.5 Review maternal, perinatal and child deaths at all levels (facility & community). • Train service provider on maternal, perinatal and child death reviews • Develop a system to review child deaths • Employ/train the community health workers to conduct verbal autopsies Produce weekly, monthly, quarterly and annual summary reports of maternal, perinatal and child death reviews	X	X	X	X	X	X	X	X	Proportion of health facilities with maternal, perinatal and child deaths review reports. Proportion of facilities with health workers trained in maternal, perinatal and child death review	MoHSW (RCHS) PMORALG MoCDGC RHMTs CHMTs CMTs	700,000

STRATEGIC PLAN AND ACTIVITIES: 2008 -2015

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
5.2.2 Planning and management capacity for maternal and newborn care including FP and nutrition strengthened. **Strategic Output Indicator:** *Relevant sector (Ministry of Finance, MoHSW) allocating 15% of the Health budget for maternal and newborn care.*	5.2.2.1 Train CHMT/RHMTs on evidence-based planning [1] in order to ensure that strategic interventions on maternal newborn and child care including FP and nutrition are incorporated in the CCHP and implemented.	X	X	X	X	X	X	X	X	Proportion of CHMTs and RHMT's trained on planning for MNCH Proportion of districts with increased budget allocation for maternal newborn and child health interventions in CCHPs.	MoHSW (RCHS, Policy and Planning Unit) District Councils Development Partners.	290,000

[1] Examples of tools to be used include Plan Rep, costing tools and other relevant sources of information

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
5. 2.3 **Basic (BEmOC) and Comprehensive EmOC (CEmOC)and newborn services at all levels strengthened.** **Strategic Output Indicator:** *% of health facilities providing BEmOC and CEmOC and Essential Newborn care*	5.2.3.1 Strengthen the capacity of all dispensaries and all health centres to provide BEmOC, essential newborn care and KMC through: • Deployment of skilled health workers (Nurse midwives, Clinical Officers, laboratory assistants) • Provision of essential equipment and supplies.	X	X	X	X	X	X	X	X	Proportion of health facilities providing Basic EmOC in the essential newborn care	MoHSW (Directorates of Preventive and Hospital Services) PMO-RALG, CSOs Private sector	80,800,000
	• Infrastructural improvement for service delivery (Delivery room, postnatal room, laboratory) 5.2.3.2 Strengthen the capacity of all hospitals and upgrade 50% of health centres to provide CEmOC and essential newborn care through: • Deployment of skilled health workers (Nurse midwives, MO, AMOs, Anaesthetists, Laboratory technicians) • Provision of essential equipment and supplies. • Infrastructural improvement for service delivery (Operating theatres, Labour ward, Blood storage facilities, incinerators) • Establish neonatal and KMC units 5.2.3.3 Develop and conduct tailor made training for AMOs and Nurses to provide CEmOC, Essential Newborn and child health services	X	X	X	X	X	X	X	X	Proportion of health facilities providing Comprehensive EmOC and essential newborn care Number of AMOs trained using tailor made curricular	MoHSW (Directorates of Preventive and Hospital Services), and PMO-RALG. APHTA PRINMAT Development Partner and UN Agencies	48,400,000

[4] Every population of 500,000, at least 4 Basic EmOC are needed (See Glossary for components of Basic and Comprehensive EmOC)
[5] Every population of 500,000, at least 1 comprehensive EmOC is needed (See Glossary for components of Basic and Comprehensive EmOC)

STRATEGIC PLAN AND ACTIVITIES: 2008 -2015

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
5.2.4 Mechanisms for availability of essential commodities, supplies and medicines for maternal, newborn and child health including family planning strengthened. **Strategic Output Indicator:** *Essential commodities, supplies and medicines for maternal, newborn and child care available all the time at every health facility*	5.2.4.1 Forecast demand, procure and supply essential commodities and supplies for maternal, newborn and child care[6] including contraceptives. Emphasis to be put on: • Essential obstetric supplies and medicines for ANC, delivery and postpartum. • Newborn resuscitation kits, supplies and drugs. • Contraceptives (pills, IUCD, implants, injectables and condoms). • Vaccines • Laboratory reagents. • Paediatric emergency equipment (oxygen concentrator, glucometers, ambu bags, suction, infusion pumps) and IMCI drugs and supplies • Supplies for therapeutic feeding for management of severe acute malnutrition	X	X	X	X	X	X	X	X	Percentage of health facilities with stock-outs of essential commodities, supplies and medicines for maternal, newborn and child care including contraceptives.	MoHSW (Directorate of Hospital Services, RCHS and MSD) District Councils, Development Partners CSOs Private sector	400,000,000
	5.2.4.2 Revive and/or establish maintenance units for various equipment at the hospital level.	X	X	X	X	X	X	X	X	Proportion of hospitals with functioning equipment maintenance units.	MoHSW (RCHS, Directorate of HS) RHMTs District Councils	100,000,000

[6] Essential Newborn equipment and supplies (See Annex 8)

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
5.2.5 Referral system at all levels strengthened. **Strategic Output Indicator:** *Functional referral systems in place at all levels*	5.2.5.1 Procure and install communication equipment (Two way radio communication, phones) in district hospitals, selected health centres and dispensaries.	X	X	X	X	X	X	X	X	Proportion of health units with 2way Radio communication equipment	MoHSW/ RCHS District Councils Development Partners CSOs Private sector	2,800,000
	5.2.5.2 Procure and utilise ambulances for referral purposes, at least one per district hospital and one per health centre and selected dispensaries. 5.2.5.3 Procure motorbike Ambulance for Health Centre /dispensaries where applicable 5.2.5.4 Provide sufficient fuel for vehicles/motorbikes 5.2.5.5 Conduct maintenance services for communication equipments and vehicles/motorbikes	X	X	X	X	X	X	X	X	Proportion of health facilities with functioning ambulances and motorbikes for referral.	MoHSW RCHS PMORALG MoID District Councils Development Partners CSOs Private sector	6,000,000
	5.2.5.6 Orient regional and district health committees on obstetric, newborn and child emergency preparedness	X	X	X	X	X	X	X	X	Proportion of regional/district health committees oriented on emergency preparedness.	MoHSW/ RCHS ZTCs RHMTs CHMTs Development Partners CSOs	1,000,000

STRATEGIC PLAN AND ACTIVITIES: 2008 -2015

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
	5.2.5.7 Orient other support staff (community health workers, ambulance drivers and attendants) on emergency and response preparedness.	X	X	X	X	X	X	X	X	Number of health facilities with support staff oriented on emergency and response preparedness.	MoHSW/ RCHS ZTCs, RHMTs CHMTs, Development Partners CSOs	1,000,000
	5.2.5.8 Establish/revive community emergency committee in every village to mobilise community resource for emergency transport and for blood donors.	X	X	X	X	X	X	X	X	Proportion of villages with functioning emergency committees for MNCH	PMORALG MoCDGC MoHSW/ RCHS, District Councils CHMT Village Government Development Partners CSOs	300,000
	5.2.5.9 Establish maternity waiting homes where applicable.	X	X	X	X	X	X	X	X	Proportion of health facilities (where applicable) linked to functioning maternity waiting homes.	MoHSW/ RCHS District Councils CHMTs Village Government Development Partners CSOs Private sector	500,000

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
Research, Monitoring and Evaluation												
5.2.6 HMIS capacity to capture information on maternal, neonatal and child indicators including FP and nutrition improved. **Strategic Output Indicator :** *Key Maternal, newborn and child health indicators reported annually through HMIS*	5.2.6.1 Develop and update monitoring and evaluation framework for MNCH 5.2.6.2 Update monitoring data collection tools to include EmOC process indicators and other missing information on nutrition, post abortal care, postnatal care, newborn and child care and referral forms, register for referral, log-books.	X X	X X			X		X		Monitoring and evaluation framework for MNCH in place Monitoring data collection tools updated	MoHSW (HMIS Unit) NBS (Poverty Monitoring Unit) CHMT and Development Partners	45,000
	5.2.6.3 Produce, disseminate ,distribute updated data collection tools at all levels.		X	X	X					Proportion of facilities using updated data collection tools	MOHSW (RCHS, HIS) MSD CHMTs CSOs Private sector	500,000

STRATEGIC PLAN AND ACTIVITIES: 2008 -2015

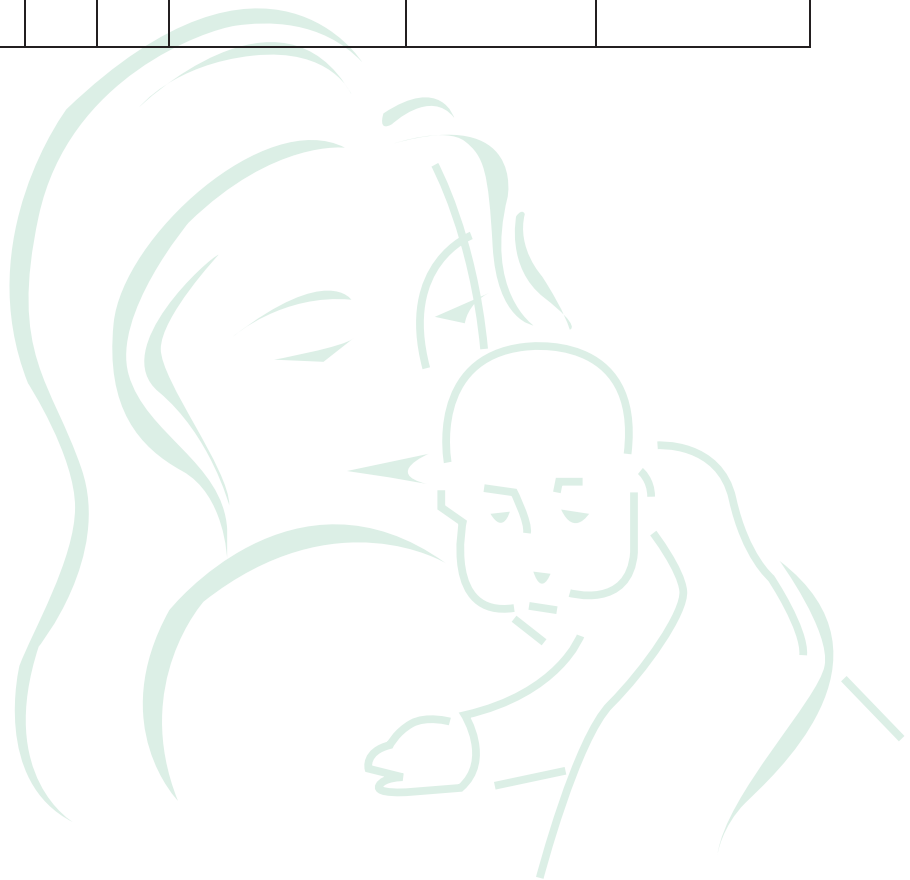
Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
5.2.7 Monitoring and evaluation framework for MNCH strengthened and implemented. **Strategic Output Indicator :** *Progress on Maternal, newborn and child health status/trends reported.*	5.2.7.1 Orient health service providers/supervisors on MNCH monitoring and evaluation framework and effective data management (data collection, analysis and utilization.)	X	X	X	X	X	X	X	X	Number of health service providers/ supervisors oriented on data management.	MoHSW (HMIS Unit) RHMTs CHMTs	1,000,000
	5.2.7.2. Conduct supportive supervision for MNCH in both public and private health facilities. 5.2.7.3 Conduct follow up of health workers after training on MNCH packages.	X X	X X	X X	X X	X X	X X	X X	X X	Proportion of health facilities receiving quarterly supportive supervision. Proportion of health workers that received follow up after training on MNCH packages yearly	MoHSW (Inspectorate Unit, RCHS) RHMTs CHMTs CSOs .	850,000
	5.2.7.4 Conduct periodic surveys on quality of care, client satisfaction and care seeking behaviour in selected districts and factors facilitating or hindering access for maternal, newborn and child care. 5.2.7.5 Conduct Biennial Review meetings to assess progress on the implementation.	X		X X		X X		X X		Number of surveys conducted on quality assurance of service delivered. Number of review meetings conducted	MoHSW PMORALG Development Partners Research institutions NBS Academic institutions, Health professional associations CSOs	

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
	5.2.7.6 Document and share best practices on maternal, newborn and child health.	X	X	X	X	X	X	X	X	Number of best practices documented and scaled up.	MoHSW/ RCHS CSOs Development Partners Private sector	100,000
	5.2.7.7 Institutionalize maternal, newborn and child mortality review approaches at all levels • Vital registration system (birth and death) • Confidential enquiry • Near miss surveys • Mortality surveys • Verbal autopsy • Other appropriate review mechanisms	X	X	X	X	X	X	X	X	Number and type of MNCH mortality review reports.	MoHSW/ RCHS RHMTs, CHMTs Facilities Village Governments RITA NBS Research and academic institutions Development Partners CSOs	200,000

STRATEGIC PLAN AND ACTIVITIES: 2008 -2015

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
5.2.8 Community based management information system strengthened. **Strategic Output Indicator**: *Community based data effectively collected and used in planning*	5.2.8.1 Review and harmonize existing community based management information tools.	X	X			X				Harmonized community based management information tools in place	RCHS HMIS PMO-RALG, RHMTs CHMTs Development Partners CSOs, Village Governments	18,000
	5.2..8.2 Orient village Governments on the community based management information tools.	X	X	X	X	X	X	X	X	Proportion of village Government members oriented on community based data management.	RCHS HMIS PMO-RALG RHMTs CHMTs Development Partners CSOs Village Governments	600,000
	5.2.8.3 Train community health workers and other service providers on community based information management.	X	X	X	X					Proportion of community health workers and service providers trained on data management.	RCHS HMIS PMO-RALG RHMTs CHMTs Village Governments , Development Partners CSOs	900,000

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
5.2.9 Capacity for conducting MNCH operational research strengthened **Strategic output indicator:** *Evidence on MNCH available for planning and programme development*	5.2.9.1 Identify MNCH operational research priorities 5.2.9.2 Conduct MNCH operational research and document and disseminate results	X X	X X	 X	 X	 X	 X	 X	 X	Number of MNCH operational researches conducted	MoHSW-RHCS, Research and academic institutions	1,000,000



STRATEGIC PLAN AND ACTIVITIES: 2008 -2015

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
5.2.10 Quality assurance and management (supervision, client satisfaction, performance assessment) strengthened. **Strategic Output Indicator:** *Proportion of health facilities delivering MNCH services according to nationally defined service standards*	5.2.10.1 Adapt quality assurance approaches for MNCH (QIRI, PIA, COPE, Collaborative)	X	X							Number of quality assurance approaches adapted	MoHSW (RCHS, Inspectorate unit) RHMTs District Councils CHMTs Development Partners CSOs	50,000
	5.2.10.2 Orient supervisors and service providers on quality assurance methods for MNCH services. 5.2..10.3 Orient service providers on the Client Health Charter as tool to improve relationship with client. 5.2.10.4 Update code of conduct and job description. 5.2.10.5 Orient health facility committees and district health boards on Client Service Charter to ensure satisfactory client-service relationship.	X X X X	X X X X	X X X	X X X	X X X	X X X	X X X	X X X	Number of supervisors and service providers oriented on quality assurance approaches. Proportion of health service providers oriented on Client Service Charter at all levels. Code of conduct and job description updated. Proportion of health facility committees and district health boards oriented on client-service relationship at all levels.	MoHSW(RCHS, Inspectorate unit) RHMTs District Councils CHMTs, Development Partners CSOs	400,000

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
5.3 Community Mobilisation												
5.3.1 Community based maternal, newborn and child health care including FP and nutrition strengthened **Strategic Output Indicator:** *Maternal, newborn and child health care services provided at community level*	5.3.1.1 Train community based health workers on MNC care including community IMCI. 5.3.1.2 Train Employed CHW on Comprehensive Maternal, Neonatal and child Package. 5.3.1.3 Re-instutionalize quarterly village health days 5.3.1.4 Conduct monthly outreach and mobile clinic services for MNCH. 5.3.1.5 Provide community health workers with necessary equipment, commodities, supplies and transport. 5.3.1.6 Develop and implement incentive mechanism for community health workers	X	X	X	X	X	X	X	X	Proportion of villages with community health workers[7], trained on maternal, neonatal and child health issues including nutrition and FP. Proportion of villages conducting village health days. Proportion of dispensaries and health centres conducting monthly outreach and mobile clinic services. Proportion of villages with incentive mechanism for community health workers.	MoHSW/RCHS ,MoCDGC PMORALG RHMTs, District Councils CHMTs, Village Governments, Development Partners CSOs	2,800,000

[7] Required ratio 1/30 households

STRATEGIC PLAN AND ACTIVITIES: 2008 -2015

Strategic Objective/	Activities		Timeframe								Process	Responsible	Resources
Output			08	09	10	11	12	13	14	15	Indicators	Person	Needed in US dollars
5.3. 2 Community participation in maternal newborn and child health care increased. **Strategic Output Indicators** *Community leaders and members participating actively in MNCH issues*	5.3.2.1	Sensitize community leaders and communities on participatory planning , implementation and monitoring of community based MNCH interventions.	X	X	X	X	X	X			Proportion of villages with community leaders and members sensitised on maternal, newborn and child health issues. Proportion of villages plans with MNCH activities.	MoHSW / RCHS, MoCDGC PMORALG District Councils CHMTs, Communities CSOs Development Partners	2, 500,000
	5.3.2.2	Orient health facility committees and district health boards on Client Service Charter to ensure satisfactory client-service relationship	X	X	X	X	X	X	X	X	Proportion of health facility committees and district health boards oriented on client-service relationship at all levels.	MoHSW, District Councils	500,000

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
5.4 Behaviour Change												
5.4.1 Key community and household practises for maternal, newborn and child care improved . **Strategic Output Indicator:** *Improved practises for maternal, newborn and child health care at all levels.*	5.4.1.1 Design, develop IEC/BCC messages and materials for community members (men, women and adolescents) for specific maternal newborn and child issues, with emphasis on: • Postnatal and Newborn care; • Advantages of early attendance to health facilities (ANC); • Birth preparedness; • Essential nutritional practices and actions for maternal newborn and child; • Causes of maternal, newborn and child deaths and identification of Danger signs; • Early Care seeking and compliance • Home management of common childhood illness • Disease prevention (ITN's, immunization, hygiene and sanitation) • Interventions to prevent HIV and Mother to Child transmission of HIV • Repositioning family planning • Prevention on early and unwanted pregnancies • Role of men in Maternal newborn and child health care	X	X	X	X	X				IEC/BCC messages and materials addressing specific maternal and newborn issues developed for community members.	MoHSW, PMORALG, MoCDGC, MoEVT, MoISC District Councils, CHMT's, Village Government, Development Partners , Media , CSOs,	100,000

STRATEGIC PLAN AND ACTIVITIES: 2008 -2015

Strategic Objective/ Output	Activities	Timeframe								Process Indicators	Responsible Person	Resources Needed in US dollars
		08	09	10	11	12	13	14	15			
	5.4.1.2 Disseminate and distribute IEC/BCC messages and materials for community members through different media. 5.4.1.3 Develop the capacity of community theatre groups to disseminate MNCH messages									Proportion of IEC/BCC materials disseminated through different media (Road shows, TV, Radio etc). Number of community theatre groups established to disseminate MNCH messages	MoHSW , PMORALG MoCDGC MoEVT, MoISC District Councils CHMTs, Village Governments, Development Partners , Media CSOs.	4,000,000 350,000
5.5 Fostering Partnership												
5.5.1 Partnership and coordination for MNCH activities at all levels improved. **Strategic Output Indicator:** *Coordinated response and leveraging of resources for MNCH activities.*	5.5.1.1 Orient partners on One MNCH Strategic Plan 5.5.1.2 Conduct joint planning and coordination meetings with stakeholders/partners for maternal, newborn and child care at all levels 5.5.1.3 Conduct quarterly PMNCH committee meetings 5.5.1.4 Conduct bi-annual PMNCH forum	X X X X	X X X X	X X X	X X X	X X X	X X X	X X X	X X X	Number of orientation sessions on One MNCH Strategic Plan conducted Number of joint planning and coordination meetings conducted Number of PMNCH committee meetings held annually Number of PMNCH fora held	MoHSW/RCHS MOCDGC, PMORALG Regional Secretariat District Councils Development Partners Health professional associations CSO 's	65,000
	5.5.1.4 Provide support to the PMNCH secretariat for Partnership co-ordination	X	X	X	X	X	X	X	X	Functional secretariat for partnership in place	MoHSW Development Partners Health professional associations CSO 's	-
										GRAND TOTAL US$674,030,000		

CHAPTER 6
MONITORING FRAMEWORK

Maternal, newborn and child care programmes will be evaluated based on an agreed set of indicators, both qualitative and quantitative. Routine health information systems currently track outputs such as number of admissions, management of childhood illnesses, immunization, antenatal care, births, and caesarean sections. There is little information on quality of maternal and newborn care, such as intrapartum care, stillbirth rate, babies receiving resuscitation and outcome, and percentage of newborns receiving essential newborn care.

List of indicators to assess MNCH Progress

a) Indicators at National level:

Sources of data will be a combination of HMIS, District Health Surveys, Household surveys, Health Facility surveys, Demographic Health Surveys (DHS), Tanzania Service Provision Assessment surveys (TSPA), Roll back Malaria M&E surveys and financial records. Collected data will be grouped according to gender, age groups, income/wealth quintiles, geographical location (rural and urban) as well as ethnic groups.

b) 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 conducting quarterly village health days
- Proportion of villages with community health workers implementing MNCH interventions
- Coverage of access to potable water (improved drinking water source)
- Coverage of improved latrines
- Use of solid fuels for cooking
- Households' care-seeking rate for diarrhoea, malaria and pneumonia
- ITN use in under-fives and pregnant women

c) Neonatal Indicators

- Neonatal mortality rate
- Prevalence of low birth weight
- Early initiation of breast feeding (within the first hour)
- 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)
- Postnatal care attendance rate
- Proportion of district hospitals implementing Kangaroo Mother Care for management of Low Birth Weight
- Proportion of district hospitals that are accredited baby friendly
- Postnatal vitamin A coverage

d) Family Planning Indicators

- Contraceptive prevalence rate by method, by age group, by socio economic quintiles
- 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 population offering full range of contraceptive information counselling and supplies.

e) Maternal Health Indicators:

- Maternal mortality ratio
- Proportion of deliveries taking place in a health facility
- Proportion of births assisted by a skilled attendant
- Proportion of facilities offering BEmOC services and CEmOC services
- 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
- Proportion of first level facilities (PHC) with two or more skilled attendants
- Percentage of pregnant women attended at least once by skilled personnel; percentage attended by skilled personnel at least four times
- Proportion of HIV positive women provided with ARV's during pregnancy
- Proportion of pregnant women with access to PMTCT services
- Prevalence of positive syphilis serology in pregnant women
- Percentage of pregnant women tested and treated for syphyllis
- Percentage of pregnant women receiving two doses of SP
- Percentage of service delivery points providing youth friendly services

f) Child Health Indicators

- Under-five mortality rate
- Exclusive breastfeeding rate <4 and <6 months
- Continued breastfeeding rate 6-23 months
- Timely complementary feeding rate
- Under-weight prevalence
- Stunting prevalence
- Wasting prevalence
- 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
- DTP- HB3 immunization coverage (Hib coverage after introduction)
- Proportion of HIV positive children accessing ARV
- Proportion of HIV exposed infants accessing ARV prophylaxis

g) Increased Political Will and Commitment Indicators:

- Proportion of Government budget allocated to health
- Proportion of MoHSW/ district budget allocated to MNCH and FP
- Availability of policies addressing increased coverage for skilled care
- Development plans integrating MNCH (Development Vision 2025, MKUKUTA, MMAM,HSSP)

h) Indicators for Measuring Progress of the MNCH Strategic Plan

- Existence of Partnership for Maternal Newborn and Child Health (Partnership)
- Total resources mobilized for MNCH Strategic Plan
- Biennial implementation report tracking progress on indicators listed above

Table 2: Results based Matrix

Table 2 : Results based Matrix

MKUKUTA broad outcomes: • *Improved quality of life and social well-being, with particular focus on the poorest and most vulnerable groups.* • *Reduced inequalities in outcomes (e.g. education, survival, health) across geographic, income, age, gender and other groups.*			
MKUKUTA (Goal 2.2): *To improve survival and well-being of all children and women and of especially vulnerable groups.*			
MKUKUTA (Goal 2.5): *To ensure effective systems to permit universal access to quality and affordable public services.*			
Roadmap Operation targets: 1. *Increased coverage of births attended by skilled attendants from 46% in 2004/5 to 80%.* 2. *Increased immunization coverage of DTP-HB 3 and Measles vaccine to above 90% in 90% of the districts.* 3. *Introduced new vaccines to EPI (Hib, Pneumoccocal, Human papiloma (HPV) and rota virus vaccine) .* 4. *Reduced stunting and underweight among under-fives from _38% and 22% to 22% and 14% respectively.* 5. *Increased exclusive breast feeding coverage from 41% to 80 %* 6. *PMTCT services provided to at least 80% of pregnant women, their babies and families.* 7. *90% of sick children seeking care at health facilities appropriately managed.* 8. *Increased coverage under-fives sleeping under ITN's from 16% to 80% .* 9. *75% of villages have community health workers offering MNCH services at community level.* 10. *Increased modern contraceptive prevalence rate from 20% to 60%* 11. *Increased coverage of comprehensive EMOC from 64% of hospitals to 100% and basic EMOC from 5% of Health centres and Dispensaries to 70%* 12. *Increase the number of health facilities offering Essential Newborn Care to 75%.* 13. *Increased antenatal care attendance for at least four visits from 64% to 90%*			
Focus Area	**Indicators of Results**	**Means of Verification**	**Assumptions**
6.1 Advocacy and Resource Mobilisation			
Increased budget allocation for health especially for maternal and newborn services at all levels.	• 15% of Government budget allocated to health • % Health budget available to cater for maternal, newborn and child health services at all levels • Budget for maternal, newborn and child health including FP and nutrition increased by 50% by 2015.	• Medium Term Expenditure Framework (MTEF) cash flow at central level. • Comprehensive Council Health Plan cash flow at district level. • Cash and receipt at all levels. • Public Expenditure Review reports	• HIPC funds allocated to health. • Stable economic growth. • Basket fund available • Commitment by donors/ partners

Focus Area	Indicators of Results	Means of Verification	Assumptions
Regulations/ laws/policies that hinder effective implementation of maternal and newborn care by relevant regulatory bodies reviewed.	• Number of regulations and laws approved by regulatory bodies	• Policy documents available for implementation.	• Willingness of regulatory bodies to review and endorse policy documents.
Implementation of the exemption policy for maternal and child health strengthened. .	• ***Exemption policy effectively implemented***	• Exemption policy guidelines in place at all facility levels. • Survey findings.	• Exemption mechanisms implemented according to policy.
Employment, deployment and retention of skilled health workers at all levels of care improved.	***Number of skilled health workers increased to 100% by 2015*** •	• Human resource survey • Health Statistics Abstract	•
6.2 Health Systems Strengthening and Capacity Development			
Knowledge and skills of supervisors and service providers on maternal, newborn and child care including FP and nutrition increased.	• Proportion of health facilities providing quality maternal and newborn care. • Maternal, newborn and child health service provided according to standards. • Proportion of under-fives receiving correct anti-malarial treatment. • Proportion of under-fives receiving appropriate anti-biotic treatment for pneumonia and dysentery. • Proportion of under-fives receiving ORS and zinc treatment in management of diarrhoea • Percentage of pregnant women receiving to doses of SP • Percentage of pregnant women tested and treated for syphilis	• Training and follow up reports • Health facility survey • Services statistics • Tanzania Service Provision Assessment (TSPA), • Service Availability Mapping (SAM) • Roll back malaria (RBM) survey	• Resources for updating knowledge and skills available. • Availability of personnel to be trained.

Results based Matrix

Focus Area	Indicators of Results	Means of Verification	Assumptions
Planning and management capacity for maternal and newborn care including FP and nutrition strengthened.	• Relevant sectors (Ministry of Finance, MoHSW) allocating at least 15% of Government budget for .health • ***MoHSW allocating 15% of the Health budget for maternal and newborn care***	• Training reports MTEF cash flow at all levels. • CCHP cash flow at district level. • Cash and receipt at all levels. • Public Expenditure Review reports	• Planning and management tools available. • Stable economic growth. • Basket fund available • Commitment by donors/ partners
	• Evidence-based maternal and newborn care planning at RCHS and CHMT	• Planning documents. • CCHPs • MTEF	• Personnel available.
	• Proportion of districts with increased budget allocation for maternal newborn and child health interventions in CCHP	• CCHP cash flow	• Stable economic growth. • Basket fund available
Basic and Comprehensive EmOC and newborn services at all levels strengthened.	• % of health facilities providing Basic and comprehensive EmOC and Essential Newborn care	• Health facility survey • service statistics (TSPA, SAM)	• CHMT and HF managers trained on how to measure/ use the indicators. • Availability of funds • Availability of skilled attendants
	• Proportion of births assisted by a skilled attendant	• Demographic Health Survey, Household surveys	• Availability of skilled attendants
	• Proportion of caesarean sections as a percentage of live births.	• Service statistics	• Availability of skilled attendants
	• Case fatality rate due to obstetric complications.	• Service statistics	• Availability of skilled attendants
	• **Essential commodities, supplies and medicines for maternal, newborn and child care available all the time at every health facility**	• Inventory reports • Health facility surveys (TSPA) • Annual Contraceptive Procurement Tables (CPTs) • Monthly contraceptive stock status reports from MSD	• Adequate resource available • Political will and commitment

Focus Area	Indicators of Results	Means of Verification	Assumptions
Mechanisms for availability of essential commodities, supplies and medicines for maternal, newborn and child health including family planning strengthened.	• **Essential commodities, supplies and medicines for maternal, newborn and child care available all the time at every health facility**	• Inventory reports • Health facility surveys (TSPA) • Annual Contraceptive Procurement Tables (CPTs) • Monthly contraceptive stock status reports from MSD	• Adequate resource available • Political will and commitment
Referral System			
Referral system at all levels strengthened.	• **Functional referral systems in place at all levels** • Percentage of all women with major obstetric complications treated in EmOC facilities (met obstetric need) • Percentage of referred under-fives who actually go for referral	• Special Survey • Service statistics reports	• Availability of funds to improve referral system • Willingness of community members to participate in emergency preparedness
Research, Monitoring and Evaluation			
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	• Health statistics reports • Health Statistics Abstract	• HMIS reviewed to incorporate maternal and newborn health indicators

Results based Matrix

Focus Area	Indicators of Results	Means of Verification	Assumptions
Monitoring and evaluation framework for MNCH strengthened and implemented.	• Progress on Maternal, newborn and child health status/trends reported. o **Maternal mortality rate** o **Under-five mortality rate** o **Infant mortality rate** o **Neonatal mortality rate** o Contraceptive prevalence rate by method, by age group, by socio economic quintiles o Under weight, stunting rate o Exclusive Breast Feeding rate o Measles immunization coverage o DTP-HB3 immunization coverage • Proportion of health facilities receiving quarterly supportive supervision. • Proportion of health workers that received follow up after training on MNCH packages yearly • Number of surveys conducted on quality assurance of service delivered. • Number and type of MNCH mortality review reports. Birth registration rate	• Special reports/surveys • Service statistics reports • Supervision reports • Mortality review and notification reports • Demographic health survey, • Census • Vital statistics	• Adequate resources to conduct Operational Research • Capacity to conduct research
Community based management information system strengthened.	• **Community based data effectively collected and used in** planning.	• Community development plans. • CBMIS data available	• Adequate resources to facilitate planning at community level. • Capacity and capability of the community members to use evidence based information for planning.
Quality assurance and management (supervision, client satisfaction, performance assessment) strengthened.	• Proportion of health facilities delivering MNCH services according to nationally defined service standards • Proportion of clients satisfied with maternal and newborn services	• Health facility and household Surveys • Service statistics • Supervision reports	• Standards for quality improvement will be implemented.

Focus Area	Indicators of Results	Means of Verification	Assumptions
	to health facility for care sick/ postnatal • Percentage of pregnant women attended at least once by skilled personnel; percentage attended by skilled personnel at least four times • Households care seeking rate for diarrhoea, malaria, pneumonia and neonatal conditions		

ANNEX 1
SWOT ANALYSIS

ANNEX 1: SWOT ANALYSIS

(A) Maternal Care

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
(i) Policy Issues			
• Existence of national policies which address maternal health such as the National Health Policy, Reproductive and Child Health Policy, *MKUKUTA*, MMAM etc. • The National Health Policy and the Reproductive and Child Health Policy emphasise a multisectoral approach to reproductive health issues, which include male involvement. • The National Health Policy promotes the right of all women to access quality reproductive health services. • Existence of various tools such as the RCH Strategy, RCH Essential Package and policy guidelines which address maternal health. • Maternal health is reflected in the District Planning Guideline as one of the key reproductive and child health interventions. • Existence of establishment/ manning level (1999) of health staff for health delivery tiers • Some existing health cadres have been reviewed (MCHA, RMA/CA upgrading)	• Minimal budget allocation to health sector especially maternal health (at all levels) • Weak multisectoral linkages at all levels in addressing maternal health • The RCH strategy have not been able to prioritise key interventions to reducing maternal death • Inadequate dissemination and interpretation to user-friendly formats of RCH policies, strategy and guidelines. • Some managers and supervisors at all levels are not familiar with policies and guidelines related to RCH • CCHP do not comprehensively addressing RH/maternal and child health interventions • RCH Coordinator not full member of CHMT but more of co-opted member (in some districts) as such not able to influence district health plans • Manning level not implemented accordingly due to insufficient linkages and mixed roles of HS and LG. • Establishment/manning level of staff has not been reviewed according to recent developments in RCH care (PMTCT, VCT, ARH/YFS) • Current deployment system doesn't follow the manning level guidelines.	• Development partners and Government aligning to joint support according to Joint Assistance Strategy. • Existence of Health basket funds to support district health services • Establishment of MNC partnership at central level • Existence of Government led SWAPs, MOH Technical committee and subcommittee that can be used to push Maternal and Newborn health issues • Existing Annual Health Sector Reviews have taken into consideration RH/Maternal health issues • Political will and commitment is showing positive signs towards addressing maternal health (DHA tool) • Existence of Health SWAPS • Zonal RCH reviews Care and Treatment Plan gives opportunity to mainstream maternal health care	• More focus on HIV/AIDS than RH/Maternal health • Short time towards attainment of MDGs • Bigger proportion of health sector budget is donor dependant. • Donor driven initiatives • Reproductive health concept may be overridden by maternal health (threat of returning to old MCH concept) • Competing priority programmes • HIV/AIDS • Human resources • Logistic Management capacity • TBA policy review and part of the Annual Health Sector Review milestone

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
• Exemption policy for deliveries and all RCH services • Decentralisation of health services to district level (advance health sector reforms) • Existence of various financial resources to health sector at the district level (Basket, Block, District own source, cost sharing, NHIF, CHF etc) • Existence of Paramedical, Medical and Nursing Institutions for pre-service training • Existence of training guidelines on PAC, LSS, FP, PMTCT+, STI, FANC • Availability of committed Development Partners supporting RH/maternal health • MTEF allocated funds for procurement of contraceptives • Maternal nutrition linked with child nutrition in the RCH package • Community based RCH guidelines, strategic plan (draft) available • Infrastructure at all levels overseeing health services - national, regional, district and community	• Inadequate number of skilled service providers that can be trained and capture the knowledge required on specific skills. • Some skilled providers are not allowed to do life saving skills procedures due to statutory regulations e.g. IV drip giving, manual removal of retained placenta, MVA usage. • There's no mechanism to assess pre-qualification of service providers in terms of attitude and psychological behaviour before joining nursing and medical schools. • Weak incentive package to service providers • Poor motivation and inadequate performance assessment and rewarding of service providers • Inconsistency of Skilled attendance definition and how do we attain Skilled attendance in our settings • Inadequate Plans for human resource development including continuing education on maternal health issues • Lack of continuing education among tutors at pre-service and regional institutions. • Poor interpretation and implementation of exemption policy for maternal health • Informal payments hinders implementation of exemption policy • Due to minimal allocation to RCH services, women are asked to purchase or come with essential supplies/drugs for delivery since they are frequently out of stock	• Existence of Annual RMOs, DMOs and RCH Meetings as fora to discuss RH/maternal and newborn issues • Increasing Government and DPs attention on addressing Human resource crisis • Presence of guidelines from FCI on caring behaviours among service providers • Ongoing review on incentive package for health care providers • Introduction of OPRA at all levels. • MKUKUTA • Existing plans of strengthening and expanding ZTC for in-service trainings.	• Overstretching of health system as per current development which is already compromised.

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
	• Lack of costed RCH package including maternal health that can justify how much is being exempted • At all levels there has been slow follow up and scaling up of interventions related to maternal health • Inadequate documentation of evidence based intervention focusing on maternal health • Untimely/Irregular review of Pre-Service training curriculum to include current maternal health developments. • Lack of postnatal guides • Policy not allowing MVA kit to be made available except when there's presence of skilled attendant and after being trained. • Poor coordination and linkages between different actors from central to local level. • Existence of vertical programme/projects support to RH (including FP/maternal health) • Weak linkages between Directorates of Preventive, Hospital and Training at MOH	• PMNCH promotes need for MNCH Strategic Plan where all partners buy in • Existence of Reproductive Health Commodity Security committee under Govt leadership • Existence of IYCF strategy • Maternal nutrition aspects integrated into Infant and young child feeding strategy • Existence of Health insurance (NHIF) and some coming up • Birth and death registration (vital statistics) in place in few villages which can be adopted in the rest of the country. • Existing health MCH structure from community to hospital level • Use of alternative service providers to support health system such as retired health skilled staff, performance contract and Retention schemes in MKUKUTA	
	• Inadequate linkages and collaboration between RCH Section with TFNC and PMTCT Unit		

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
	• Role of TBA in prevention of maternal mortality is unclear. (Role remains unclear in the strategies. Weaknesses in SWOT should guide strategies • CHF exist in most areas but with limited use of the funds for maternal health care • Few districts have implemented community based RCH program • Village health committee not legally recognised. • Shortage of Skilled attendance (more pronounced in rural areas) • Unattractive working condition especially in rural areas		
(ii) Health Systems			
• Presence of ZRCHCO, RRCH Co and DRCHCo • Service delivery points well distributed to consultant, regional and district hospitals followed by health centres and dispensaries. • Indent system for obtaining essential drugs and supplies • Integration of FP and HIV/AIDS condom supply/request at district level	• Health services including maternal care not operating for 24 hours • Low knowledge on SRH among service providers • Despite training on Focused ANC, there's still problem in its implementation due to attitude and low educational background of providers who cannot capture the skills; inadequate supplies such as Hb, RPR, contraceptives etc. • Limited training of Service providers on PAC, FP, LSS • RH services not youth friendly • Inadequate/inappropriate EmOC (basic and comprehensive services) at facility level	• Existence of both private and public health facilities that provide maternal health services. • Plan to strengthen ZTC • Existence of good practices on youth friendly services (AYA, UMATI, UNICEF supported interventions) • Existence of good practices/research on maternal care improvement (though a few)- FCI, WDP, Care, TEHIP, QIRI	• Overwhelming the ZTC capacity • Cultural barriers

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
• Local Government authorities reforms are supporting implementation of HSR • Presence of referral structure within the health delivery system • Most of essential RCH services are in place (ANC, Intrapartum/ obstetric, FP, STI, Immunization, PMTCT, Post partum) IMCI at all levels.	• Lack of functioning of blood banks at hospital and health centre level • Inadequate coverage of PAC services • Essential equipment, supplies and drugs on maternal care including FP not readily available • Bottlenecks in procurement of drugs, supplies and equipment (both ways district level and MSD) • Fragmented program support in provision of essential supplies e.g. syphilis screening reagents • Facility buildings and providers' attitude not accommodating male and youth friendly services • Presence of vast Geographical area with poor transport/roads, inadequate health facilities and therefore poor geographical accessibility to EMOC • Inadequate ambulances within the country • Many health units do not have reliable communication system (radio call, mobile) • Lack of protocols on specific maternal health/obstetric care • Counselling skills on FP, PAC, PMTCT and maternal nutrition not adequately provided by service providers • Limited postnatal care due to lack of guidelines	• Blood safety programme • Existence of RHMT and CHMT which coordinates district health activities including maternal health care • Currently Joint Rehabilitation Programme has been initiated at district level which can be used to accommodate structure improvement for maternal and newborn care • Existence of mobile communication network in rural areas • Presence of job aid for EMOC	
(iii) Support Systems			
• Existence of Community development officers at district and ward level.	• Premises of most health facilities are inadequate and non-user friendly (privacy, space) • Inadequate awareness and advocacy on maternal complications/care at all levels including health facilities support staff		

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
(iv) Planning, Monitoring and Evaluation			
• Planning decentralised to district level • Monitoring of Maternal death done through week ending reporting, HMIS, DHS and Annual ZRCH Co reports • Presence of HMIS in all health delivery systems • Supervision system in place • Presence of health facility committee and district boards in majority of districts • Presence of CHMT in all districts	• Poor mainstreaming of maternal health intervention into CCHP and thereafter into Overall Council Plans as such intervention is not addressed Multisectoral. • Centralization of services/health plans at CHMT level and less on lower level • District Health planning process rarely take into consideration inclusion of other relevant multi sectoral officers (Education, Agriculture, Engineer, Community development) in addressing maternal health issues. • Inadequate capacity of CHMT to plan for RCH activities including maternal health • Poor record keeping and therefore planning is not evidence based • Most CHMTs still see RCH including maternal health interventions as donor/project supported and not responsibility of district budgets • Family Planning given less priority in planning at district level (CCHP). • Conflicting priorities during joint supervision	• District health boards and health facility committees present according to set guidelines • Existence of TEHIP tool though has limitation on RCH intervention package • Proposal for records management improvement has been made to MoHSW • Process and impact indicators have been identified and defined in recently released RCH strategy • Existence National EMOC survey document will provide benchmark of EMOC situation countrywide.	
	• Insufficient involvement of other stakeholders in the district during planning process, monitoring and evaluation • Village and ward plans not capturing maternal and newborn interventions/issues • Maternal health indicators used are mainly impact and less/none on process indicators • Some EMOC process indicators are difficult to calculate since some data is not captured in the routine HMIS/facility based data records. • Inadequate utilisation of data/indicators for planning purpose and prioritisation at all	• Introduction of maternal and perinatal death reviews • Existence of various national surveys (Census, DHS, THIS) that can give picture on RCH situation • Current there's demand driven capacity building initiative (piloted in lake zone regions) that requires district to demand for	

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
	levels. • Inadequate functioning of HMIS • Lack of disaggregated data by sex and age specific • Insufficiently capturing data from private health facilities • Weak/absence of Community Based Management Information System • Poor documentation of clients notes including treatment plan, referral notes at facility level • Low coverage of supervision • Lack of comprehensive and integrated Supervision tool and process • Inadequate accountability among service providers and managers/supervisors • Weak system for monitoring and addressing clients complaints/suggestions • Poor supportive supervision due to inadequate skills, commitment and attitude.	trainings (under DANIDA support) • Quality of Care framework to consolidate supervisory tools • Presence of Client health service charter and Guidelines on roles and responsibilities of HF committees/district boards.	
(v) Community			
• Presence of Primary Health Committee/Village health committees that discuss issues on maternal health. • Presence of c-IMCI corps • Presence of Community Based RCH Strategic plan, guidelines • Community recognised as key stakeholders in both Local Govt and health sector reforms. • Local Government reforms have a structure/link down to the village level.	• Weak implementation of district guide of involving community • Low population coverage • Limited male involvement on issues related to maternal health • Obstetric emergencies are not considered by the Community emergency committee • Community plans not incorporated into the CCHP. • Weak capacity of health facility committees and district boards • The process of developing bylaws and the time it takes to be effected. • Inadequate outreach services due to poor planning, inadequate resources. • Inadequately functioning village health committees since they're not facilitated.	• Presence of O& OD planning process • Allocation of 10% of CCHP funds to community interventions. • Presence of TASAF II that provides financial support for community based social service delivery. • Presence of community mobilization and empowerment initiatives on reproductive health. • Existence of the CBD programme • Health facilities committees and district health boards	• Presence of harmful traditional practices that can adversely affect maternal and newborn e.g. taking herbs that have oxytoxic effects can lead to ruptured uterus.

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
	• Knowledge on Birth preparedness is poor among communities • Community not aware of their rights and obligations in improving maternal health care • Gender inequalities existing in the community contributes to poor maternal health outcomes • Low awareness on reproductive system functions and pregnancy related issues such as danger signs/complications	recognised legally • Ability of communities to devise by-laws to address issues related to maternal health such as violence, delivery at homes, etc. • Existence of Community based maternal health care system in some areas • Existence of client health service charter • Existence of CSOs/NGOs	
(vi) Public-Private Partnership			
• One of components of HSR strategy • Presence of active Association of Private Hospitals in Tanzania and PRINMAT • Non-for profit sector (FBOs) providing maternal care especially in rural areas. •	• Inadequate coordination in planning and implementation among partners at central and district level • Partnership policy guidelines present but more visible/known at central level and less at district level. • Some Private health facilities/CSOs not submitting data to district/central level • Majority of Private for Profit provide services on other health issues and less on maternal health care • Faith based organizations providing limited maternal services (no FP service provided) • Some CSOs that are pro-life provide negative information on contraceptives.	• Existence of Professional associations (AGOTA, TAMA) • Existence of advocacy groups that are non-health professionals (TAMWA, TGNP, TAWLA, Private media companies, WRA)	• Competition for recognition and resources between public and private sector.

(B) Newborn Care

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
(i) Policy Issues			
• National health policy includes child health • National strategy on Infant and Child Nutrition and plan of action in place • Policy guideline on RCH available and reflecting neonatal health care • Availability of PMTCT and HIV Care and treatment guides that integrates neonatal care • Exemption policy for under-fives includes neonatal health services/care • Institutionalisation of IMCI within the MoHSW structure/RCHS • IMCI deals with neonate from 8th day of life • C-IMCI promotes community maternal care and lactation • Established postnatal follow up first week of life • Establishment of baby friendly hospital services within some hospitals • Reviewed LSS manual incorporated Newborn care according to WHO guidelines • Availability of committed development partners supporting newborn health	• Neonatal care obtaining limited budget allocation within the health sector/RCH services • Nursing training not comprehensively addressing neonatal care • Age specific interventions for 0-1 months are not well spelt out in policy guides on RCH • Policy guideline to manage newborn care is lacking • Routine health data lacks neonatal health progress including community-based data. • Lack of understanding on the magnitude of neonatal health problems • IMCI does not address first week of life • Facility IMCI does not include home care and care seeking for newborns • Lack of concentration on maternal care and immunization and absence of a guide • Inadequate availability of paediatricians and neonatal nurses • Lack of costing of Neonatal care package • Lack of postnatal guide thus not incorporating newborn care	• Decentralisation of health services to district level (advance health sector reforms) can accommodate newborn care • Financial resource allocation to the district level (from various sources) • Establishment of MNC partnership at central level • On going reviews of MoHSW in addressing human resource crisis • Existence of ZTC, Nursing and Medical schools • HIV Care and Treatment Plan give opportunity to mainstream newborn care. • Coverage of IMCI case management High adding first week could rapidly increase coverage • Donors, partners interested to support incorporation of newborn care • Policy guide on Infant and early feeding for newborn introduced • Existence of Health basket funds to support district health services • Existence of Govt led SWAPs, MoHSW Technical committee and subcommittee that can be used to push Maternal and NB health issues • Existence of Annual RMOs, DMOs and RCH Meetings a forum to discuss RH/maternal and newborn issues	• Short time towards attainment of MDGs • For mother not aware of their HIV sero-status • Multiplicity of guidelines overwhelms service providers • HIV pregnant mothers face stigma/dilemma in infant feeding options • Bigger proportion of health sector budget is donor dependant • Donor driven initiatives?? • Harmful practises and beliefs • Women not empowered • Traditional practises hindering postnatal attendance

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
(ii) Health Systems			
• Infrastructure at all levels overseeing health services - national, regional, district and community • Presence of ZRCHCO, RRCH Co and DRCHCo • Service delivery points well distributed to consultant, regional and district hospitals followed by health centres and dispensaries.	• Lack of appropriate resuscitation equipment and supplies e.g. infusion pumps, injectables phenobarbitone etc • Unattractive working condition especially in rural areas • Health services including neonatal care not operating for 24 hours • HMT are unaware in addressing neonatal health issues • Limited training of Service providers on LSS which has a component of neonatal care • Inadequate/inappropriate EMOC (basic and comprehensive services) at facility level • Some neonatal supplies/ equipments are not made available at MSD • Poor supply plan at service delivery point/districts • Neonatal services are not adequately provided by majority for public and private health facilities • Facility buildings not suitable providing neonatal services • Kangaroo method for low birth weight babies in resource poor countries has not been adopted. • Under-fives care does not focus age specific with special needs, as a result neonatal are not taken into consideration, especially the 1st week	• Existence of Paediatric Association of Tanzania (PAT) and other health professional associations. • The ongoing Joint Rehabilitation Funds within districts can facilitate improving buildings to provide neonatal care • Presence of District Nursing Officer and Hospital matron that can focus on neonatal care • Presence of Indent system for obtaining essential drugs and supplies • Plan to strengthen ZTC • Existence of RHMT and CHMT which coordinates district health activities including maternal & newborn care • Rehabilitation of health facilities • Partners ready to support	• Overwhelming the ZTC capacity
(ii) Systems Support			
• Local Government authorities reforms are supporting implementation of HSR	• There's vast Geographical area with poor transport/roads, inadequate health facilities and therefore poor geographical accessibility to EMOC	• Currently Joint Rehabilitation Programme has been initiated at district level which can be used to accommodate structure improvement for maternal and newborn care	

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
• Presence of referral structure within the health delivery system	• Inadequate ambulances within the country • Many health units do not have reliable communication system (radio call, mobile) • Inadequate awareness and advocacy on Neonatal care at all levels including health facilities support staff	• Existence of mobile communication network until rural areas	
(iv) Planning, Monitoring and Evaluation			
• Planning decentralised to district level	• Poor mainstreaming of neonatal health intervention into CCHP • Centralization of services/health plans at CHMT level and less on lower level • Inadequate capacity of CHMT to plan for RCH activities including neonatal health • Poor record keeping and therefore planning is not evidence based	• District health boards and health facility committees present according to set guidelines • Proposal for records management improvement has been made to MoHSW • Introduction of maternal and perinatal death reviews	
(v) Community			
• Presence of HMIS in all health delivery systems • Supervision system in place • Presence of health facility committee and district boards in majority of districts • Presence of CHMT in all districts • •	• Inadequate functioning of HMIS • Lack of disaggregated data by sex and age specific • Weak/absence of Community Based Management Information System • Supervision undertaken is not comprehensive and does not capture neonatal care • Weak implementation of district guide of involving community	• Quality of Care framework to consolidate supervisory tools • Presence of Client health service charter and Guidelines on roles and responsibilities of HF committees/district boards. • Presence of O& OD planning process which involves the community • According to district health planning guides there's 10% funds allocated for community intervention	• Conflicting priorities during joint supervision • Presence of harmful traditional practices that can adversely affect maternal and newborn

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
• Presence of Primary Health Committee/Village health committees that discuss issues on maternal health • Presence of Community Based RCH strategic plan guidelines • Community recognised as key stakeholders in both Local Govt and health sector reforms • Existence strong administrative support at the community level, through the local Government structures.	• Cultural belief and practise does not take into consideration neonatal death • Community plans not incorporated into the CCHP • Weak capacity of health facility committees and district boards • The process of developing bylaws takes time to be effected. • Inadequate outreach services due to poor planning, inadequate resources. • Inadequately functioning village health committees since they're not facilitated. • Knowledge on Birth preparedness is inadequate among communities	• Health facilities committees and district health boards recognised legally • Advocate for some good traditional norms and practices used in some tribes to promote neonatal health. • Existence of client health service charter • Presence of Tanzania Social Action Fund (TASAF) that provides financial support to village/community based social services intervention.	

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
Health Systems Support for IMCI			
▪ Budget for purchasing drugs is incorporated in the CCHP from different sources and IMCI recommended drugs are available at all levels ▪ Rational use of drugs in under-fives ▪ Improved Counselling skills are emphasized during IMCI case management training ▪ Module for treatment of children where referral is not possible has been developed and incorporated into IMCI case management training ▪ Availability of Referral Care Packages in 7 facilities ▪ Indent system in place which improved drugs availability at health facility level ▪ Hospital assessment tools developed ▪ Identification of IMCI drugs as pre-referral drugs in indent system compulsory	▪ Drugs are not appropriately recorded in ledger books ▪ Some of IMCI trained health workers are not using chart booklets. ▪ New version of chart booklets are not yet printed and distributed to health facilities ▪ Poor counselling and communication skills resulting into poor compliance to referrals ▪ Unreliable and inadequate communication means to facilitate referrals at health facilities. ▪ IMCI indicators not yet integrated into HMIS ▪ Inadequate and unreliable supplies at all referral levels from MSD i.e. equipment, oxygen concentrators, quality of oxygen flow meters, paediatric ambu bags, suction tubes, catheters etc ▪ Poor quality of care at all referral levels ▪ Nurses are not allowed to prescribe IMCI drugs	▪ Presence of routine supervision useful to emphasize the use of chart booklets and recording of drugs in the ledger books ▪ Presence of the Medical Stores Department and other relevant for a that can be used in the distribution of referral care manuals ▪ Districts allowed to purchase equipment and supplies from other stores when MSD is unable to supply	▪ Inadequate financial and human resources ▪ Competing health priorities at all levels

ANNEX 2

INPUTS FOR IMPROVING MATERNAL, NEWBORN AND CHILD HEALTH AT ALL LEVELS

ANTENATAL CARE

TRAINED HEALTH CARE PROVIDER COMMUNITY	DISPENSARY	HEALTH CENTRE	HOSPITAL	SUGGESTED INPUTS
Provide IEC, health education and counselling to women, men, families and communities about: • The needs of pregnant women • Danger signs and appropriate action • Birth preparedness, including local transportation for emergencies • Work, rest and nutrition • HIV/STD prevention • The importance of social support Involve the husband/partner in IEC and counselling sessions Planning for birth and emergencies Adolescent girls encouraged to continue to go to school Promote beneficial traditional practices and advise against harmful ones Promote ITNs Identify pregnant women and refer early to antenatal clinic Provide follow up care and support between scheduled antenatal clinic visits Identify problems and complication and refer Record community-based health information (e.g. number of women referral for antenatal care)	As at community level, plus: Obtain targeted history and perform physical examination, monitor progress of pregnancy and assess maternal and fetal well-being Develop an individualised birth plan (e.g. place of delivery, birth attendant, emergency preparedness) Perform standard testing: • Syphilis (including treatment as needed) • Urinalysis • Haemoglobin • Pregnancy confirmation Screen for other STDs where applicable and provide appropriate treatment and counselling Assess Female genital mutilation Manage minor complications such as mild anaemia, uncomplicated urinary tract infection and mild vaginal infections, uncomplicated malaria Provide tetanus toxoid immunization Provide intermittent presumptive treatment of malaria Sell/dispense ITNs Treat intestinal parasites as needed Provide iron, folic acid and other micronutrient supplementation Manage certain problems and complications (e.g. anaemia, PIH,	As at dispensary level, plus: Manage certain problems and complications (e.g. mild pre-eclampsia, incomplete abortion); refer more serious complications Offer voluntary counselling and testing for HIV as possible Provide FP and post abortion care Pre-referral treatment of severe complications - pre-eclampsia - eclampsia - bleeding - infection - complicated abortion Support of women with special needs e.g. adolescents and women living with violence Manage or refer for PMTCT Treatment of mild to moderate opportunistic infections in pregnant women with HIV	As at health centre level, plus: Manage major problems and complications - ectopic pregnancy - Anaemia - severe pre-eclampsia - eclampsia - bleeding - infection - other medical complications Treatment of abortion complications Treatment of severe HIV infection Treatment of severe malaria	**Community level** IEC messages/materials about: • The needs of pregnant women • Danger signs and appropriate action • Birth preparedness, including local transportation for emergencies • HIV/STD prevention • Insecticide-treated bed nets (ITNs) • The importance of male involvement Refresher in-service training for community-level health workers about using IEC messages/materials In-service training for supervisors of community-level health workers to enable them to conduct refresher on job training of community-level workers In-service training for community-level health workers involved in antenatal care, including problem/complication identification and referral; follow up support, recording **Dispensary level** In-service training for healthcare providers responsible for antenatal care about: • Content of antenatal care • Revised schedule of visits • Assessment skills (history taking and physical examination; routine testing) • Care provision, including the development of individualized birth plan, health education and counselling Supplies for syphilis testing, urinalysis, haemoglobin, and other STD tests as necessary Consistent supply of TT vaccine, syringes/needles, antihelminthic drugs, basic drugs such as antimalarial drugs (SP), antibiotics and fungicides ((SP) and ITNs, iron, folic acid and other micronutrient supplements

TRAINED HEALTH CARE PROVIDER COMMUNITY	DISPENSARY	HEALTH CENTRE	HOSPITAL	SUGGESTED INPUTS
	slight bleeding); refer other problems Provide additional health education and counselling about: • Preparation for breastfeeding • Prevention and recognition of STDs/HIV/AIDS • Prevention of malaria and helminth infestation Mother-to-child transmission of HIV/AIDS			**Health Centre level** **All of the above and:** • Supplies for HIV testing, IV fluids, parental drugs (antibiotics, MgSO4, antimalarials) Supplies and training for Manual Vacuum Aspirations In-service training for healthcare providers responsible for antenatal care about: • Content of antenatal care and treatment mild complications as well as pre-referral treatment • Revised schedule of visits • Assessment skills (history taking and physical examination; routine testing) • Care provision, including the development of individualised birth plan, health education and counselling **Hospital level** **All of the above and:** Competency-based training for doctors in the management of eclampsia, severe anaemia, ectopic pregnancy Supplies, equipment and drugs for the management of complications (blood transfusion, laboratory tests, obstetric care and surgery)

CARE DURING CHILDBIRTH including obstetric emergency situations

TRAINED HEALTH CARE PROVIDER COMMUNITY	DISPENSARY	HEALTH CENTRE	HOSPITAL	SUGGESTED INPUTS

Provide a warm and caring approach to the woman
 	
Monitor progress of labour using simple aide
 	
If delivery occurs at community level:
 	
Follow clean and safe delivery practices
 	
Discuss and reach consensus on the labour and birthing position of mother's choice
 	
Recognise problems or complications early and refer
 	
Inspect placenta; examine perineum for injuries and refer as needed
 	
After deliver, notify maternal and foetal outcomes and report to next level
 	
Care for the newborn baby including KMC, recognise danger signs and refer as appropriate
 	
Perform obstetric first aid including stabilisation
 	
Arrange for transport and accompany mother to the next level
 	
Record community-based health information (e.g. number of women with complications referred
	As at community level, plus:
	
	Obtain targeted history and perform physical examination
	
	Diagnose labour and monitor progress using adapted WHO partograph
	
	Provide supportive care and pain relief
	Perform interventions such as amniotomy and episiotomy, only if necessary
	
	Inspect placenta and vagina for injuries
	
	Repair minor lacerations and episiotomies
	
	Actively manage the third stage of labour (oxytocin, controlled cord traction, fundal massage)
	
	Care for the baby after birth incl. KMC, monitor the baby and treat or refer as appropriate
	Newborn resuscitation
	
	Recognize complications early (e.g. malpresentations, prolonged or obstructed labour, hypertension, bleeding and infection) and manage or refer as appropriate
	
	Perform emergency obstetric procedures including:
	• Repair of vaginal and cervical lacerations
	• Vacuum extraction
	• Manual vacuum aspiration (MVA)
	Manual removal of the placenta
		As at dispensary level, plus:
		
		Treatment of abnormalities and complications (prolonged labour, vacuum extraction, breach presentation, episiotomy, repair of genital tears, manual removal of placenta and treatment of moderate post-haemorrhagic anaemia
		
		Pre-referral management of serious complications (obstructed labour, fetal distress, preterm labour, severe peri- and postpartum haemorrhage)
		
		Emergency management of complications if birth is imminent
		
		Support for the family in case of maternal death
			As at health centre, plus:
			
			Treatment of severe complications in childbirth and the immediate postpartum period, including caesarean section, blood transfusion and hysterectomy)
			- obstructed labour
			- malpresentations
			- eclampsia
			- severe infections
			- bleeding
			
			Induction and augmentation of labour
			
			Management of complications related to FGM
			
			Prevention of Mother to Child transmission of HIV by mode of delivery, provision of ARV's, guidance and support for chosen infant feeding option.
				Community level
				In-service training for community-level health workers about appropriate interpersonal support for the woman during childbirth; simple labour monitoring; clean and safe delivery practices; early recognition of and response to obstetric complications
				
				Basic delivery kits
				
				WHO adapted partograph forms
				
				Dispensary level
				As for the community level, plus:
				In-service training about:
				• Assessment of woman in labour
				• Clean and safe delivery practices
				• Use of WHO adapted partograph
				• Amniotomy/episiotomy
				• Active management of third stage
				• Recognition of and response to problems/ complications
				  • Essential newborn care
				  • KMC
				Consistent supply of
				Gloves, aprons, soap and water, antiseptic solution, basic instruments for amniotomy and episiotomy, oxytocin, Vitamin A basic oral drugs, partograph forms, suture materials/needle holder, Vaginal speculum,, suture materials/needle holder, vacuum extractor, MVA equipment, IV fluids and infusion sets
				In-service training about:
				Competency-based skills training for clinical officers and nurse-midwives in:
				• Repair of vaginal and cervical lacerations
				• Vacuum extraction
				• MVA
				• Manual removal of the placenta
				• Emergency management of complications if birth is imminent
				• Pre-referral management of serious complications
				• Treatment of minor complication
				• Essential newborn care
				
				Availability of Newborn resuscitation equipment
				
				Health Centre level

TRAINED HEALTH CARE PROVIDER COMMUNITY	DISPENSARY	HEALTH CENTRE	HOSPITAL	SUGGESTED INPUTS
	Initiate management and refer patients with: • Haemorrhage • Eclampsia • Obstructed labour Puerperal infections Delivery and immediate care of the newborn including KMC and immediate initiation of breastfeeding Immediate postpartum care of the mother: - Assessment of maternal well being and detection of complications (e.g. bleeding, infections, hypertension and anaemia) - Advice on danger signs, emergency preparedness and follow-up Vitamin A administration Recording and reporting on delivery			All of the above plus: Continuous Supply of: Vacuum extraction equipment, IV fluids and IV sets, MGSO4, parental uterotonics and antibiotics, drugs and equipment for essential newborn care. **Hospital level** All of the above plus: Health workers trained in: • Management of obstetric complications and emergencies including Surgery (caesarean section and other abdominal obstetric surgery ectopic pregnancy, hysterectomy) • Providing safe anaesthesia for pregnant women • Safe blood transfusion • PMTCT Stable supply of: Equipment and drugs for anaesthesia, instruments and consumable supplies for obstetric surgery, blood transfusion equipment , Oxygen, laboratory equipment for both biochemical and microbiological assessments and ARV's.

NEWBORN CARE

TRAINED HEALTH CARE PROVIDER COMMUNITY	DISPENSARY	HEALTH CENTRE	HOSPITAL	SUGGESTED INPUTS
Provide immediate care of the newborn, including the following: • KMC stimulate and warm baby • Clear airway if necessary to establish respiration • Tie, cut and care of cord using clean, safe procedures • Establish breastfeeding immediately after birth Avoid contacts with sick family members Extra care for low-bithweight babies including KMC Recognition of danger signs and referral Counselling on homecare, danger signs, safe disposal of baby stools, nutrition, ITN and hygiene for newborn, need for growth monitoring and immunizations	As at community level, plus: Ensure warmth of sick or preterm/low birth weight babies as necessary Perform basic newborn Resuscitation Provide newborn immunizations and administer eye care Provide counselling and support for: • Care of the newborn • Care of preterm/low birth weight babies, including skin-to-skin method • Breastfeeding • Counselling and support on feeding fro HIV positive mothers Monitoring and assessment of wellbeing, detection of complications (breathing, infections, prematurely, low birth weight, injury, malformation) Infection prevention, control and rooming-in Immunization according to national guideline Initiate management of newborn illness and refer to appropriate level of care Additional follow-up visits for high risk babies (preterm, after severe complications, low-birthweight babies HIV-exposed babies, babies with feeding problems and babies on replacement feeding Supporting mother if perinatal death	As at dispensary level, plus: Care if moderately preterm, low birth weight or twin; support for breastfeeding, warmth, frequent assessment of wellbeing and detection of complications e.g. feeding difficulties, jaundice or other perinatal problems. Treatment of mild to moderate: - local infections (cord, skin, eye, thrush) - birth injuries Pre referral management of infants with severe problems: - very preterm babies And/or low birth weight - severe complications - malformations Presumptive treatment of congenital syphilis Management of minor to moderate problems such as feeding difficulties pre-referral management of severe problems such as convulsions and inability to feed Recognize danger signs give appropriate pre-referral treatment and refer as appropriate	As at health centre level, plus: Management of severe newborn problems such as: - neonatal sepsis - neonatal Jaundice - neonatal Tetanus - breathing difficulties - severe birth trauma and asphyxia - correctable malformations - Neonatal syphilis - failure to thrive Refer for further care, if necessary	**Community level** In-service training for community-level health workers in essential newborn care IEC messages/materials about: • The danger signs of newborn illness and the need to seek immediate care • The importance of immunizations, growth monitoring and follow up • Infant and young child feeding In-service training for community-level health workers in essential newborn care **Dispensary level** All of the above plus: Training of health workers in essential newborn care Continuous supply of: Essential drugs and vaccines and equipment for newborn resuscitation (mucous extractor, newborn tube and mask device for newborn resuscitation) **Health centre level** All of the above plus: Continuous supply of: oxygen, I.V. fluids, parental antibiotics **Hospital:** All of the above plus: Training of health workers and lab-technicians in: - management of the severely sick newborn baby Continuous supply of laboratory test equipment, equipment and supplies for anaesthesia and surgery

POSTPARTUM CARE

TRAINED HEALTHCARE PROVIDER AT COMMUNITY	DISPENSARY	HEALTH CENTRE	HOSPITAL	SUGGESTED INPUTS
Provide IEC to women, men, families and communities about: • the needs of postpartum women • breastfeeding • danger signs for mother and baby • the importance of social support - ITN Promote beneficial traditional practices and discourage harmful ones Refer for first postpartum care visit within 48 hours of delivery Provide follow-up care and support between postpartum clinic visits and refer for problems and complications Record community-based health information (e.g., number of women referred for postpartum care)	As at community level plus: Obtain pregnancy/birth history and perform physical examination of mother and baby Recognise problems or complications early (infections, bleeding and anaemia) and manage appropriately or refer for further care Iron and folic acid supplementation Provide vitamin A and Micronutrient supplementation where Appropriate Provide counselling about: - Breastfeeding and baby care - Maternal nutrition -home care - ITN - Danger signs and appropriate care seeking Contraception and resumption of sexual activity • Other RH concerns (e.g., STDs/HTV)	As at dispensary level, Manage moderate postpartum problems/complications including: • mild to moderate anaemia - Mild puerperal depression Pre-referral treatment of severe problems such as severe post partum bleeding, puerperal sepsis and severe puerperal depression.	As at health centre level, Manage severe postpartum complications problems - severe haemorrhage - severe post partum infections - severe post partum depression - female sterilization	**Community Level**: IEC messages about: • the needs of postpartum women • breastfeeding • immunization • danger signs for mother and baby • beneficial traditional practices and the importance of avoiding harmful ones In-service training for community-level health workers about the importance of early postpartum referral and follow up care, recording **Dispensary level** In-service training for healthcare providers responsible for postpartum care about: • Content of postpartum care • Schedule of visits • Assessment skills (history taking and physical examination of mother and baby • Care provision, including micronutrient supplementation and counselling about breastfeeding, baby care, maternal nutrition, contraception, and other RH concerns I(e.g. STDs/HIV) • Pre-referral treatment and referral of women with complications Consistent supply of vitamin A and other micronutrients and basic oral drugs **Health centre level** All of the above plus: Consistent supply of IV. Fluids, Parental drugs (antibiotics, antimalarials, MgSO4), gloves, soap and other equipments for manual removal of placenta **Hospital Level** All of the above plus: Training of health workers in managing severe complications including surgical, laboratory and anaesthesiological procedures Continuous supply of equipment and utilities for surgery , laboratory tests both microbiology and biochemistry, oxygen, equipment and utilities for blood transfusion.

POSTABORTION CARE

TRAINED HEALTH CARE PROVIDER COMMUNITY	DISPENSARY	HEALTH CENTRE	HOSPITAL	SUGGESTED INPUTS
Provide IEC to women, men, adolescents and communities about: • The dangers of unsafe abortion • The need to seek immediate care at a health facility for complications Recognise signs of abortion early Rapidly assess condition of patient Stabilise and refer immediately Initiate management of shock Initiate treatment of sepsis Refer patient for further care, if necessary Provide post-abortion family planning (FP) counselling and methods and other RH services as necessary (e.g. STDs/HIV)	As at community level, plus: Rapidly assess condition of patient Initiate management of shock Initiate treatment of sepsis Refer patient for further care, if necessary Provide post abortion counselling and family planning methods Provide other RH services as necessary (e.g. treatment of STDs)	As at dispensary level, plus: Perform manual vacuum aspiration (MVA) Refer cases not appropriate for MVA Initiate pre-referral treatment of and refer for further care as needed	As at health centre level, plus: Manage complications, including: • Intra-abdominal injury • Uterine perforation • Transfusion for blood loss • Sharp curettage • Infection	**Community level** IEC messages/materials about: • The dangers of unsafe abortion • The need to seek immediate care at a health facility for complications • Options for family planning and access to FP services In service training for Community health workers about the early recognition of and response to signs of abortion **Dispensary level** In-service training for healthcare providers about the early recognition of and response to signs of abortion In-service service training for health care providers about post abortion FP counselling and methods Consistent supply of IV fluids and infusion sets, intramuscular(IV/AM) antibiotics, syringes **Health centre** All of the above plus: Service providers trained in assessment of complications related to post abortion, performance of MVA , early recognition of danger signs, pre-referral, referral management and post abortion counselling of women on FP Consistent supply of IV fluids and infusion sets, intravenous/intramuscular (IV/IM) antibiotics, syringes/needles, contraceptives (oral pills, injectables, condoms), MVA equipment, gloves, soap and water, antiseptic solution **Hospital level** All of the above plus: Competency-based skills training for doctors in surgical procedures for intra-abdominal injury and uterine perforation Equipment and drugs for anaesthesia, instruments and consumable supplies for obstetric surgery, blood transfusion equipment

FAMILY PLANNING

TRAINED HEALTH CARE PROVIDER COMMUNITY	DISPENSARY	HEALTH CENTRE	HOSPITAL	SUGGESTED INPUTS
Provide IEC to women, men, adolescents and communities about the health benefits of: • Delaying first pregnancy • Spacing births and limiting family size Counsel clients for FP, including all methods Provide contraceptive pills Provide barrier methods (condoms, foams, jellies) Refer clients for other FP services as necessary Record community-based health information (e.g. number of clients recruited for FP)	As at community level, plus: Obtain targeted history; perform physical examination Screen for STDs; treat as necessary Provide counselling about all method and provide method of choice, including IUD and injectables (where skills and supplies are available) Refer as needed	As at dispensary level, plus: Provide Norplant insertion and removal Refer clients who desire surgical sterilization	As at health centre level, plus: Perform surgical sterilization (permanent methods)	**Community level** IEC messages/materials about the health benefits of: • Delaying first pregnancy • Spacing births and limiting family size In-service training for community level health workers about FP counselling for: • Condoms and other barrier methods • Spermicides • Oral and injectable contraceptives • IUD • Permanent methods In-service training for community level health workers about • Distribution of pills and barrier methods • Referral • Recording **Dispensary level** All of the above plus: In-service training for healthcare providers responsible for FP services about assessment and screening, including history and physical examination; counselling; STD screening and treatment, method provision; referral Consistent supply of Vaginal speculum, gloves, soap and water, IUD insertion kits, antiseptic solution **Health Central level** All of the above plus: Continuous supply of oral and injectable contraceptives, IUDs, condoms, foams, jellies, Norplant and equipment for removal. **Hospital level** All of the above plus: Competency-based skills training for doctors in male and female sterilization procedures and anaesthesiology Continuous supply of Surgical instruments and supplies as well as supplies and drugs for local and general anaesthesia

PREVENTION AND MANAGEMENT OF CHILDHOOD ILLNESS

TRAINED HEALTH CARE PROVIDER COMMUNITY	DISPENSARY	HEALTH CENTRE	HOSPITAL	SUGGESTED INPUTS
Provide IEC to mothers, fathers, families and communities about: • Recognition of diseases • The danger signs of illnesses • Promotion of key healthcare practices • Availability and use of oral rehydration solution (ORS) • Nutrition • Breastfeeding • Immunization • Insecticide treated bednets • Water and sanitation • Household preparedness for prevention and treatment of illness	As at community level, plus: Assess and manage according to the IMCI guideline uncomplicated cases of:: • Diarrhoea • Acute respiratory infection (ARI) • Malaria • Malnutrition • Other childhood illnesses • Paediatric HIV Use of oral and IM antibiotics, medications Recognition of danger sign and pre-referral treatment and referral according to IMCI guideline. Counsel caregiver on appropriate homecare and nutrition Provide growth monitoring, vitamin A supplementation and vaccination services Ensure all children are assessed and managed comprehensively during all points of contact with the health facility including (assessment and treatment of illnesses, growth monitoring and nutritional counselling, immunization status)	As at dispensary level, plus: Use of IV fluids medications	As at health centre level, plus: Laboratory diagnosis of respiratory infections, diarrhoea, malaria, anaemia Treatment of child with complicated illnesses Provision of HIV testing and treatment for Children with HIV	**Community level** IEC messages/materials about: • Recognition of diseases • The danger signs of illnesses • Promotion of key healthcare practices • Availability and use of ORS • Nutrition • Breastfeeding • Immunization • Insecticide treated bednets • Water and sanitation • Household preparedness for prevention and treatment of illness Community-level health workers with improved skills about the prevention, recognition, home care and referral of common childhood diseases **Dispensary level** In-service training for healthcare providers in The prevention and management of childhood illness, growth monitoring, immunization services, counselling for parents of sick children, recognition of danger signs, pre-referral treatment and timely referral Consistent supply of: Injectable medications, Antimalarials, Antibiotics, Syringes/needles, ORS, Zinc **Health centre level** As above plus: Training of lab assistant in biochemical and microbiological tests Continuous supply of IV sets, syringes, needles and parental drugs (anticonvulsants, antibiotics, antimalarials, IV fluids), equipment and utilities for biochemical and microbiological laboratory tests **Hospital level** All of the above plus: Training of health workers in management of severely ill child including triage, evaluation of x-rays

TRAINED HEALTH CARE PROVIDER COMMUNITY	DISPENSARY	HEALTH CENTRE	HOSPITAL	SUGGESTED INPUTS
				Continuous supply of essential drugs for management of the severely sick child, nasogastric tubes, oxygen equipment, self inflating resuscitation bags with masks, folly catheters, Gloves, disinfectants, nebuliser, equipment for lumbar puncture, formulas for management of sever acute malnutrition, equipment for blood transfusion, X-ray facility

ANNEX 3
RELEVANT POLICY DOCUMENTS

MoHSW (2004). Reproductive and Child Health Strategy, 2005-2010..

MoHSW- Expanded Programme on Immunization (2005). Comprehensive Multiyear Plan, 2006-2010.

MoHSW (1999). Staffing Levels for Health Facilities and Institutions.

MoHSW (2002) EPI Multi Country Evaluation Report

MoHSW (2004). National Adolescent Health and Development Strategy, 2004 -2008.

MoHSW (2005). Guidelines for Reforming Hospitals at Regional and District Levels.

MoHSW (2005). Communication Strategy for Child Health, 2005-2010.

MoHSW (2005). National Tracer Standards and Indicators for Quality Improvement in Health Care (Draft).

MoHSW (2005). Proposed Staffing levels for Health Facilities and Training Institutions.

MoHSW (2006). The National Road Map Strategic Plan to Accelerate Reduction of Maternal and Newborn Deaths in Tanzania, 2006-2010.

MoHSW (2006). Situation Analysis of Emergency Obstetric Care for Safe Motherhood in Public Health Facilities in Tanzania

MoHSW (2007). Primary Health Services Development Programme (PHSDP/MMAM), 2007-2017.

MoHSW (2007). Tanzania National Health Policy (draft).

MoHSW (2007) Tanzania National Voucher Scheme Survey.

MoHSW (2008). Human Resource for Health Strategic Plan, 2008-2013.

MoHSW (2008). National Supervision Guidelines for Quality Health Care Services (Draft).

MoHSW (2007) Postnatal Care Guidelines (draft)

MoHSW (2007) Maternal and Perinatal Death Audit Guidelines (draft)

MoHSW (2007) Kangaroo Mother Care Guidelines (draft)

MoHSW, Prime Ministers Office Regional Administration and Local Government (2007). Comprehensive Council Health Planning Guidelines.

MoPE (2006). Tanzania Population, Reproductive Health and Development. Population and Planning Section Tanzania Partnership for Maternal Newborn and Child Health Work Plan, 2007-2008.

Vice President's Office (2005). National Strategy for Growth and Reduction of Poverty (NSGRP).

ANNEX 4

MOST COST EFFECTIVE INTERVENTIONS BASED ON EVIDENCE TO DATE FOR REDUCTION OF PERINATAL AND NEONATAL MORTALITY

Pre conception	**Amount of Evidence**	**Reduction (%) in all cause neonatal morbidity and mortality/major risk factor if specified (effect range)**
Folic acid supplementation	1V	Incident in neural tube defect: 72% (42-87%)
Antenatal		
Tetanus toxoid immunization.	V 1V	33%-58% Incidence of neonatal tetanus 88-100%
Syphilis screening and treatment	1V	Prevalence dependant
Pre eclampsia and eclampsia. prevention (calcium supplementation	1V	Incidence of prematurity 34%(-1-57%) Incidence of low birth weight31%(-1-53%)
IPT for malaria.	1V	32%(-1-53%)
Detection and treatment of symptomatic bacteriuria	1V	Incidence of prematurity, low birth weight 40 %(20-55%)
Intrapartum		
Antibiotics for pre term rupture of membranes.	1V	Incidence if infections 32 %(13-47%)
Corticosteroids for preterm labour	1V	40 %(25-52%)
Detection and treatment of breech (c-section)	1V	40%(25-52%
Labour surveillance (including partograph)	1V	Early neonatal death40%
Clean delivery practices	1V	Incidence of neonatal tetanus.55-90%
Postnatal		
Resuscitation of new born	V	6-42%
Breast feeding	V	55-87%
Prevention and management of hypothermia	1V	18-42%
Kangaroo mother care	1V	Incidence of infections52 %(7-75%)
Community based pneumonia case management.	V	27% (18-35%).

Source: Neonatal Survival 2 Darmstadt, G. Bhutta, ZA, Cousens, S, Taghreed, A, Walker, N, de Bernis, L, Evidence-Based, Low-cost interventions: How many newborn babies can we save?
www.the lancet.com published on line 3 March 2005 http:// image. The lancet.com/extras/05 art 17 web. The authors use scale ranging from 1 to 5, with 5 having the most evidence of effectiveness[1]

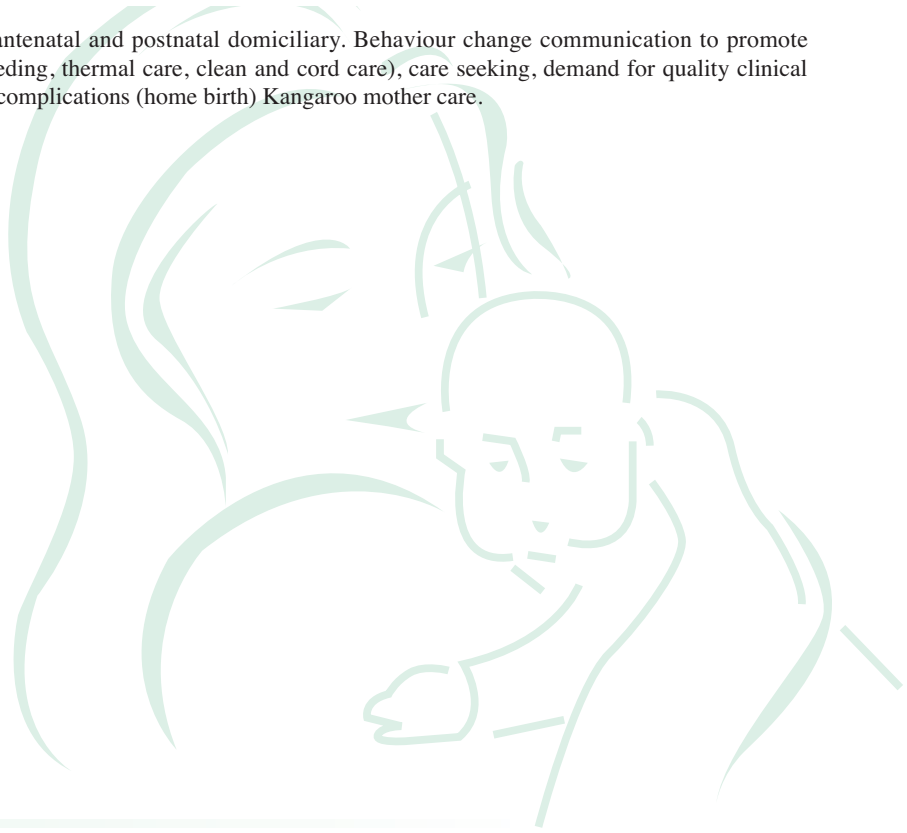
ANNEX 5

Evidence-Based Interventions that Influence Child Health

Various evidence-based child health interventions have been identified. These interventions can contribute to reduction in neonatal and under-five mortality when implemented in high coverage 90%. The packaging of these interventions results into great/significant impact.

Interventions Preventive	% of reduction	Neonates	Child	Pregnant mother	Lactating mother
Breastfeeding	13%	X	X		X
Complementary feeding	6%		X		
Vitamin A supplementation	2%	X	X		X
Vaccination-measles	1%		X		
Family and Community care package	10-20%	X	X	X	X
ITN	7%		X	X	X
Water, sanitation and hygiene	3%	X	X	X	X
KMC for low birth weight	2%	X			
Resuscitation of newborn	4%	X			
Zinc	5%		X		
Clean delivery	4%	X		X	
Nevirapine and replacement feeding	2%	X			
Treatment interventions					
Antibiotics for dysentery	3%		x		
Antibiotic for sepsis	6%	X	X		
Oral rehydration	15%	X	X		
Antibiotic for pneumonia	6%	X	X		
Antimalaria	5%		X	X	
Zinc	4%		X		
Emergence neonatal care: management Of serious illness (infections Asphyxia, prematurity,jaundice)		X			

Community mobilization and engagement and antenatal and postnatal domiciliary. Behaviour change communication to promote evidence-based neonatal care practices (breastfeeding, thermal care, clean and cord care), care seeking, demand for quality clinical care) Promotion of clean delivery and referral of complications (home birth) Kangaroo mother care.



ANNEX 6

EVIDENCE-BASED INTERVENTIONS FOR MATERNAL, NEWBORN AND CHILD HEALTH

Intervention package
The following evidence based interventions are expected to be provided at all levels.

1. **For Adolescent girls and women in childbearing age (Pre-pregnancy)**
   - Adolescent friendly health services
   - Family planning
   - Folic acid.
   - Iron tablets
   - Tetanus toxoid
   - Prevention, care and treatment for HIV/AIDS

2. **Post abortion care**
   - Manual vacuum aspiration and if not available sharp curettage
   - Uterotonic drug (ergometrin or misoprostol)
   - I.V. antibiotics if infection suspected

3. **During Antenatal period: at least 4 antenatal care visits for normal pregnancies, including one visit within the first 3 months of pregnancy.**

   Key ante-natal services include
   - Confirmation of pregnancy
   - Monitoring of progress of pregnancy and assessment of maternal fetal well-being
   - Prevention, care and treatment for HIV/AIDS (PMTCT).
   - Tetanus toxoid immunization.
   - Counselling on nutrition, breastfeeding, healthy life style.
   - Insecticide treated bed nets
   - Development of birth preparedness plan, emergencies, referral care in case of complication, breastfeeding and advice on danger signs.
   - Screen for protein and anaemia including blood group
   - Iron and folic acid supplementation.
   - Deworming
   - Identification and treatment of bacteriuria
   - Identification and treatment of problems complicating pregnancy: hypertension, bleeding, malpresentation, multiple pregnancy, etc.
   - Screening and treatment of syphilis and malaria. (IPT and promotion of ITN).
   - Assessment for female genital mutilation

4. **Services delivered during Labour, delivery, and first 1 to 2 hours**
   - killed attendance at birth
   - Monitoring progress of labour, maternal and fetal well being with partograph
   - Providing supportive care and pain relief
   - Clean and safe delivery
   - Temperature maintenance of mother and child including Kangaroo Mother Care.
   - Immediate and exclusive breast-feeding.
   - Cord and eye care.
   - Emergency obstetric care for complications including*:

- Treatment of abnormalities and complications (prolonged labour, vacuum extraction, breech presentation, episiotomy, repair of genital tears, manual removal of placenta)
- Pre-referral management of serious complications (e.g. obstructed labour, fetal distress, preterm labour, severe peri- and postpartum haemorrhage)
- Emergency management of complications if birth is imminent
- Treatment of severe complications in childbirth and immediate postpartum period, including caesarean section, blood transfusion and hysterectomy:
- Induction and augmentation of labour
- Antibiotics for premature rupture of membranes*
- Neonatal resuscitation. *
- Management of newborn complications. *
- Prevention, care and treatment of HIV/AIDS(PMTCT)
- Active management of third stage of labour
- Vitamin A supplementation

5. Maternal care: 1 to 2 hours care and after delivery to six weeks.

- Prevention and detection of complications (e.g. infections, bleeding and anaemia)
- Anaemia prevention and control (iron and folate supplementation)
- Information and counselling on nutrition, safe sex and family planning
- Advice on danger signs and emergency preparedness
- Provision of contraceptive methods
- Promote use of ITN
- Pre-referral treatment of complications (e.g. severe postpartum bleeding and puerperal sepsis)*
- Treatment of complications (anaemia, postpartum bleeding, infections and postpartum depression)*

6. Newborn care: 1 to 2 hours care and after delivery to 2 months.

- Promotion, protection and support for exclusive breast-feeding.
- Monitoring and assessment of wellbeing and detection of complications
- Rooming-in
- Eye care
- Temperature management (kangaroo mother care)
- Cord care and hygiene.
- Information and counselling on home care, breastfeeding, hygiene and advice on danger signs and care seeking.
- Promotion of ITN
- Recognition of danger signs and prompts care seeking.
- Detection and management of local infections, diarrhoea, and feeding problems
- Special care for the small baby (low birth weight). *
- Treatment of infections*
- Pre-referral management of infants with severe problems (Very preterm babies and/or very low birth weight; severe complications; malformations)*
- Presumptive treatment of congenital syphilis*
- Prevention, care and treatment of HIV/AIDS (PMTCT). *
- Management of complication, serious infections, severe jaundice, very low birth weight babies, preterm birth, breathing difficulties, severe birth trauma and asphyxia*.
- Management of correctable malformations*
- Treatment of neonatal tetanus*
- Follow up of new born in need of special care*

7. Older infants and children (2 month to 5 years)

Preventive

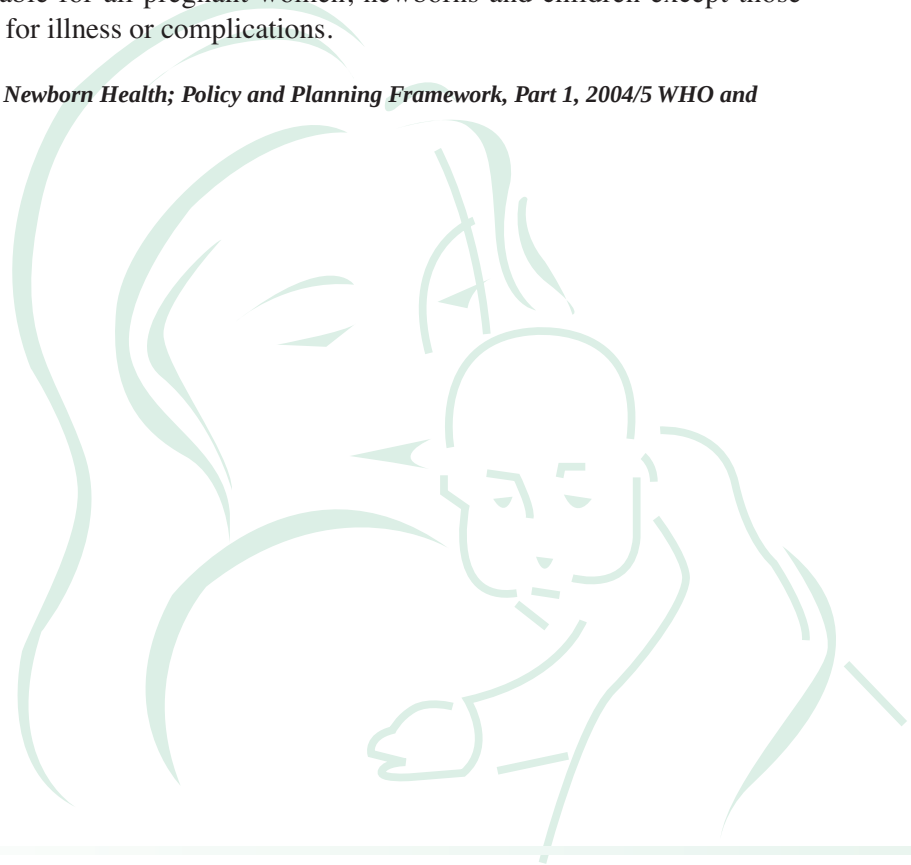
- Assessment of infants wellbeing, detection of complications and responding to maternal concerns
- Information and counselling on home care
- Additional follow-up visits for high risk babies (pre-term or after complicated delivery or neonatal period)
- Exclusive breast-feeding up to 6 months
- Continued breastfeeding (at least up to 2 years)
- Nevirapine and replacement feeding (PMTCT)
- Safe and appropriate complementary feeding (from 6 months)
- Insecticide treated nets
- Immunization
- Vitamin A supplementation twice a year
- De worming twice a year
- Water, sanitation, hygiene.
- Growth monitoring and follow-up interventions
- Salt iodation

Curative

- Integrated management of childhood illnesses
- Oral rehydration therapy and Zn for diarrhoea*
- Antibiotics for dysentery*
- Antibiotics for pneumonia*
- Treatment of malaria with recommended combination therapy*
- Vitamin A for measles*
- Detection and management of severe and moderate malnutrition*
- Care and treatment of HIV/AIDS*
- Pre-referral management of severe conditions*
- Quality management of seriously sick children*

Note: All interventions should be available for all pregnant women, newborns and children except those marked* which need to be provided only for illness or complications.

Indicates care if condition arises adapted from: Newborn Health; Policy and Planning Framework, Part 1, 2004/5 WHO and Save the Children.



ANNEX 7

WHERE DOES TANZANIA STAND IN TERMS OF MNCH SERVICE DELIVERY?

PROCEDURE	SCORE %	DEFICIT	EXPECTED 2015
Antenatal care four visit	68%	32%	90%
Blood Pressure taken	65%	35%	All must have BP checked
Blood taken for Haemoglobin and Syphilis screening	50%	50%	More than 70% must be screened
Urine Analysis	41%	59%	All must have urine checked if equipment available
Information of danger signs in pregnancy childbirth	47%	53%	At risk mothers should be identified
Delivery at health facilities	47%	53%	Health facility deliveries 80%
Skilled birth attendant deliveries	46%	54%	Skilled birth attendant 80%
Delivery by Caesarean Section	3%	12%	15% should be delivered by C/S
Emergency Obstetric Care in hospitals	64.5%	35.5%	All first referral centres must provide EmOC
Emergency Obstetric Care Health Centres	5.5%		To achieve MDG 5 all Health Centres must provide EmOC
Breastfeeding at any given time	95%	5%	All women should breast feed
Exclusive breastfeeding rate 0 – 6ms	41%	58%	EBF rate 0-6 mo 80%
Vitamin A supplementation within 2 months after delivery	20%	80%	All post delivery mothers should receive Vitamin A
Iron tablets for at least 90 days to pregnant mothers	10%	90%	All women for ANC must be given Iron/Folic acid
Tetanus Toxoid			
Current usage of contraceptives	26% married, 41% unmarried		Family planning to address unmet needs
Community Based Programmes RCH	46 districts out of 124	78 districts have no CBD Programme	All districts should target to have CBD

Basic Essential Newborn Care with Resuscitation equipment like AMBU BAGS and Oxygen	None in DSM for secondary and primary health facilities	Municipalities hospitals in DAR and health centres must establish Basic Essential Newborn Care to decongest MNH neonate ward	All labour wards in the country must have a small unit for care of neonates
PMTCT Plus	700 sites so far established by Sept. 2007		Ideally all hospitals and health centres country wide should have PMTCT established and coordinated through RCH services
Paediatric HIV care and treatment			
Integrated case management of Childhood Illnesses	60% of sick children seen by IMCI trained HW	100% of sick children seen by IMCI trained HW	80% of health facilities have 60 % of health workers trained in IMCI
Community IMCI	41 out of 114 LGA's implementing	73 LGA's	All districts should have c-IMCI CORP's in at least 75% of villages
ORS use rate	54%	46%	90% ORS use rates
Zinc supplements for diarrhoea	0%	100%	80%
Anti- Malarial treatment within 24hrs of fever onset	57%	43%	80% prompt treatment
ITN coverage for under-fives	21%	79%	80%
Immunization coverage for all antigens	71%	29%	Over 85%
Facility management of severe malnutrition	6 hospitals		All hospitals
Community Management of Severe Malnutrition	0 LGA's	114 LGA's	Established in all LGA's
Baby friendly health facilities	28%	72%	All hospitals baby friendly

ANNEX 8

ESSENTIAL MATERNAL NEWBORN AND CHILD HEALTH MEDICINES, EQUIPMENT AND SUPPLIES

A. Neonate and Child medicines

1. Chloramphenicol inj 1g
2. Benzathine Penicillin inj 5 MU
3. Gentamicin inj 40mg
4. Procaine Penicillin Fortified inj; 4 MU/vial
5. Cotrimoxzole syrup 200/40 mg /5 ml susp
6. Cotrimoxzole tab 400/80mg
7. Cotrimoxzole paediatric tab 100/20mg
8 Amoxycillin 250mg tab
9 Amoxycillin syrup 250mg/5ml or 125mg/5ml
10 Salbutamol metred dose inhaler 100μg/puff (0.1mg/enhale)
11. Salbutamol tab 1mg
12. IV infusion Ringers Lactate 250mls
13. IV infusion Normal Saline
14. Low Osmolarity Oral Rehydration Solution sachets
15. Zinc dispersable tablets 20mg
16. Quinine injection 300mg/ml; 2ml
17. Quinine tab 300mg
18. Quinine syrup 150/300mg
19. 25% Dextrose IV infusion
20. Artemether Lumefantrine (Alu) (paediatric
21. Paracetamol tab 500mg
22. Paracetamol syrup 120mg
23. Vitamin A 200,000 IU oil capsule with nipple
24. Vitamin A 100,000 IU oil capsule with nipple
25. Vitamin A 50,000 IU oil capsule with nipple
26. Oxytetracycline eye ointment 0.1% 5g tube
27. Ciprofloxacin ear drops
28. Ferrous Sulphate 100mg/ml
29. Ferrous fumarate 20mg/ml
30. Fe/folic acid tab 200mg/0.25 mg
31. Nystatin oral susp 100,000IU/ml
32. Gentian Violet paint 0.5%
33. Mebendazole tab 500mg
34. Formula 100 (F100)
35. Formula 75 (F-75)
36. Combined Mineral Vitamin Mix
37. Metronidazole 250mg
38. Daizepam inj 5mg/ml; 2ml vial
39. Phenobarbitone inj 200mg/ml;
40. Vitamin K1 inj
41. Savlon solution
42. Povidone Iodine solution10%
43. Water for inj
44. Metered infusion giving sets
45. Cannula size 25G
46. Cannula size 24G
47. Scalp vien 23 G
48. Blood infusion giving sets

B. Child Essential equipment and supplies

1. Oxygen concentrator
2. Haemoglobimometers
3. Glucometers
4. Glucostics
5. Suction Machines
6. Suction catheters 6FG, 8FG
7. Paediatric resuscitation kit
8. Nebulisers
9. Paediatric infusion pump
10. Warming devices
11. Thermometers- normal reading
12. Thermometers-low reading
13. NGT, 5-8
14. Feeding cups
15. Nasal prongs
16. Weighing scale
17. Syringes, disposable- 2mls/5mls
18. Feeding syringes 20mls
19. Feeding syringes 50mls
20. Cotton wool absorbent non sterile 500gm
21. Plaster adhesive, plastic perforated 25mm x 10m
22. RCH 1 card
23. Methylated spirit
24. Inpatient record book
25. Inpatient monitoring form

C. Neonatal Essential Equipments and supplies:

1. Towels
2. Cord ties or clamp, sterile blade
3. Container of eye ointment/drops
4. Clock with second hand
5. Clinical thermometers (preferably low reading
6. Secca weighing scales
7. Newborn size Masks, size 0 and 1
8. Self inflating bag
9. Suction machine
10. Suction tubes
11. Surgical blades
12. Surgical gloves and clean gloves
13. Canulas
14. Bucket of water
15. Small graduated feeding cups
16. Container for expressed breast milk
17. Kettle or jug
18. Gallipot
19. Heater radiant/movable
20. Resuscitation tables
21. Phototherapy machines
22. Pulse Oxemetry
23. Stands
24. Exchange blood transfusion set

25. Linen Baby Package, blankets, sheets and pillows for mothers
26. Scissors
27. Waste disposal containers

D. Maternal medicines

1. Ergometrine 0.5mg inj
2. Oxytocin 5 IU/ml , 10 IU/ml;
3. Frusemide 10mg / ml
4. Magnesium Sulphate inj 50% (500mg / ml)
5. Fe/ Folic acid 200mg /0.250mg tab
6. Folic acid 5mg tab
7. Ferrous Sulphate 100mg/ml
8. Ferrous fumarate 20mg/ml
9. Lidocaine inj 1% 10ml vial
10. Mebendazole 100mg tab
11. Aminophyline 100mg tab
12. Aminophyline 25mg/ml 10ml inj
13. Amoxycillin 250mg tab
14. Methlydopa (Aldoment) 250mg
15. Chloramphenicol inj 1g
16. Co-trimoxazole 400/80mg tabs
17. Cloxacillin 250mg tab
18. Clotrimazole vaginal pessary
19. Ceftriaxone 500mg tab
20. Erythromycin 500mg tab
21. Ciprofloxacin 500mg tab
22. Tetracycline or doxycycline500mg tab
23. Diazepam 5mg/ml 2ml inj
24. Doxycycline 100mg tabs
25. Epinephrine (Adrenaline) 1mg/ml inj; 1ml
26. Metronidazole 250mg tab
27. Procaine penicillin Fort. 4MU/vial
28. Sulfadoxine 500mg/Pyrimethamine 25 mg (SP) tabs
29. Nevirapine (adult, infant)
30. Zidovudine (AZT) (adult, infant)
31. Lamivudine (3TC)
32. FP contraceptive - pills (COC,POC), injectables, IUCD, condoms (FP & HIV prevention)
33. Vaccine - Tetanus toxoid , BCG, OPV, DTP, Measles
34. Dextrose 5% (IV infusion)
35. Normal Saline 0.9% (IV infusion)
36. Ringers lactate IV infusion
37. Glucose 50% solution
38. Water for injection

E. Maternal essential equipment and supply

1. Infusion giving sets (I.V giving set)
2. Blood infusion giving sets
3. Cannula size 14 – 18 G
4. Catgut chromic 2.0, 3.0
5. Cotton wool absorbent non sterile 500g
6. Gauze absorbent BPC 90 cm x 100m hosp quality
7. Surgical latex rubber sterile gloves 7.5
8. Syringe disposable 5ml + needle
9. Syringe disposable 2ml + needle
10. Catheters 30cc two ways
11. Umbilical cord tie, cotton, (Ligature) 3mm; 100m
12. Sheeting rubber Mackintosh 1 meter
13. Cotton sheet / green 1 meter
14. Savlon solution
15. Povidone Iodine solution 10%
16. Bleach (chlorine base compound)
17. Soap bar 113g
18. Impregnated bed net
19. Register Books for – ANC, FP, Delivery, Neonatal, Child, Postnatal
20. Client cards - Ante-natal cards -RCH 4, FP card - RCH 5

F. Maternal equipment

1. Blood pressure machine and stethoscope
2. Foetal stethoscope
3. Delivery kit
4. Laparatomy set
5. IUCD insertion kit
6. Manual Aspiration kit
7. Vacuum extractor, Bird, manual/SET,
8. D&C curettage /SET:
9. Dressing Tray, sets, 300 x 200 x 30 mm

G. Maternal tests reagents

1. RPR testing kit;
2. Test strips for urinalysis, glucose ,protein ,;
3. HIV testing kit (2 types),
4. Hemoglobin testing kit
5. Container for catching urine,

ANNEX 9

GLOSSARY	
Basic emergency obstetric care:	Functions that can be provided by an experienced nurse/midwife or physician, saving the lives of many women, and stabilizing women who need to go further for more sophisticated treatment
Caesarean section rate	Number of caesarean section performed per total number of births
Comprehensive emergency obstetric care	Includes basic EMOC functions as well as blood transfusion and caesarean sections Comprehensive Post Abortion Care
Contraceptive Prevalence rate	The percentage of women using method of family planning
Exclusive breast feeding	An infant receives only breast milk and no other liquids or solids, NOT even water, with the exception of drops or syrups consisting vitamins, mineral supplements of medicines.
Infant mortality rate	The probability of dying before the first birthday expressed per 1000 live births
Maternal death	The death of a woman while pregnant or within 42 days of termination of pregnancy
Maternal mortality ratio	The number of pregnancy rated deaths per 100,000 live births
Neonatal death	Probability of dying within the first 28 days birth.
Neonatal mortality rate	Probability of dying within the first month of life expressed per 1000 live birth
Perinatal deaths	Death of a foetus from 28 weeks of gestation to seven completed days of life including still births
Reproductive health	Reproductive health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to reproductive system and its functions and process. This implies the rights to have satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when and how often to do so.
Skilled care	Refers to the care provided to the woman and her newborn during pregnancy, childbirth and immediately after, by an accredited and competent provider who has at her/his disposal necessary equipment and the support of a functioning health system including transport and referral facilities for emergency obstetric and newborn care.
Skilled attendants	Is an accredited health professional such as the midwife, doctor or a nurse who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complication in women and newborns.
Under-five mortality rate	The probability of dying between birth and fifth birthday

REFERENCES

Ajibola S. (2004). African Health Monitor: Reducing Maternal and Newborn Mortality in Africa; WHO Regional Office for Africa, Brazzaville; AFRICAN HEALTH MONITOR.

Bale J.R. Stall B.J. Lucas A.O. (eds.) (2003). Improving Birth Outcomes: Meeting the Challenges in Developing World, A Committee on Improving Birth Outcome Board on Global Health; Washington D.C. THE NATIONAL ACADEMIC PRESS.

Hinderraker et al., BJOG, 2003

Liljestrand, J. and Gryboski, K. Maternal mortality as a Human Rights Issue. In Murphy, E. And Ringheim, K, eds. Reproductive Health and Rights: reaching the Hardly Reached. Washington, DC: PATH (2001).

Mswia R., Lewanga M et al, (2003). Community Based Monitoring of Safe Motherhood in United Republic of Tanzania, WHO Bulletin 81:87-94.

National Bureau of Statistics, Dar-es-Salaam, ORC Macro, Calverton, Maryland, USA: Tanzania Demographic and Health Survey, 1996.

National Bureau of Statistics, Dar-es-Salaam, ORC Macro, Calverton, Maryland, USA: Tanzania Service Provision Assessment Survey 2006 (TSPA).

National Bureau of Statistics, Dar-es-Salaam, ORC Macro, Calverton, Maryland, USA: Tanzania Demographic and Health Survey, 2004-2005.

Regional Reproductive Health Newsletter (2004). Road Map: African Union resolves to tackle Maternal Mortality: DIVISION OF FAMILY AND REPRODUTIVE HEALTH (DRH) – WHO/AFRO.

UNICEF. State of the World Children Report 2008.

The Lancet Child Survival Series, Vol 362, 2003

The Lancet Neonatal Series, Vol 365, 2005.

The Lancet Maternal Series, Vol 368, 2006

The Partnership for Maternal Newborn and Child Health (2006). Opportunities for Africa's Newborns.

Urassa E, Carlstedt A, Nystrom L, Massawe S, Lindmark G. 2002 Quality assessment of the antenatal program for anaemia in rural Tanzania. International Journal for quality in Health Care 14: 441-448.

World Bank (1993). Human Development Report.

WHO, UNICEF, UNFPA, WB (2005). Maternal Mortality Estimates.