Ministry of Health and Social Welfare

The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania (2016 - 2020)

One Plan II

March 2015

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ABBREVIATIONS

AFHS	Adolescent Friendly Health Services
ANC	Antenatal care
ARI	Acute Respiratory Infection
ARR	Annual Rate of Reduction
ART	Antiretroviral therapy
BCC	Behavior Change Communication
BEmOC	Basic Emergency Obstetric Care
BF	Breastfeeding
CCHP	Comprehensive Council Health Plan
CEmOC	Comprehensive Emergency Obstetric Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHF	Community Health Fund
CHMT	Council Health Management Team
CHW	Community Health Worker
COLSC	Commission on Life Saving Commodities
CPR	Contraceptive Prevalence Rate
EBF	Exclusive Breast Feeding
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Newborn Care
eMTCT	Elimination of Mother To Child Transmission
ENAP	Every Newborn Action Plan
EPI	Expanded Programme on Immunization
EPMM	Ending Preventable Maternal Mortality
FANC	Focused AnteNatal Care
FP	Family Planning
GBV	Gender Based Violence
HBF	Health Basket Fund
HF	Health Facility
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSSP III	Health Sector Strategic Plan III (2009 – 2015)
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
IMPAC	Integrated Management of Pregnancy And Childbirth
IMR	Infant Mortality Rate
IPT	Intermittent Preventive Treatment
ITNs	Insecticide Treated Nets
LGAs	Local Government Authorities

LMIS	Logistic Management Information System
LiST	Life Saved Tool
M & E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MMAM	Mpango wa Maendeleo ya Afya ya Msingi
MMR	Maternal Mortality Ratio
MNCAH	Maternal, Newborn, Child and Adolescent Health
MOHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
MVA	Manual Vacuum Aspiration
P4P	Pay for Performance
PHC	Primary Health Care
PMO-RALG	Prime Minister's Office – Regional Administration & Local Government
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
RCH	Reproductive and Child Health
RCHS	Reproductive and Child Health Section
RHMT	Regional Health Management Team
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SARA	Service Availability and Readiness Assessment
SBA	Skilled Birth Attendant
SUN	Scaling Up Nutrition
TDHS	Tanzania Demographic and Health Survey
TFNC	Tanzania Food and Nutrition Centre
TFR	Total Fertility Rate
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
TIKA	Tiba Kwa Kadi (CHF in urban areas)
U5MR	Underfive Mortality Rate
UNAIDS	United Nations Program on HIV/AIDS
UNCoLSC	United Nations Commission on Life Saving Commodities
UNICEF	United Nations Children Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

The first National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008-2015 (One Plan) was developed in 2008 with the aim to provide guidance on the implementation of Maternal, Newborn and Child Health (MNCH) programs across different levels of service delivery and to ensure coordination of interventions and quality service delivery across the continuum of care. The One Plan had three key target indicators and fourteen operation targets, which had to be achieved by 2015. The key indicators included reducing the maternal mortality ratio to 193 per 100,000 live births by 2015, reducing neonatal mortality to 19 per 1000 live births and reducing under-five mortality rates from levels in 2008 or before to 54 per 1000 live births, respectively. Progress has been measured in Mid Term Review reports; i.e. MTR Analytical Review of Performance of the HSSP III 2008-2015 and Mid Term Review of the One Plan and TDHS of 2015 (MOHSW, 2013 & 2014; TDHS, 2015). The summary of where the country has succeeded and needs to maintain the trend in the coming years and where there is poor progress with unfinished agendas needing to be addressed beyond 2015, are elaborated in this report. This forms the basis for interventions to be addressed in One Plan II 2016 - 2020. The interventions that Tanzania needs to embark upon in 2016 – 2020 and which are recommended here are guided by MTR reviews and evidence as suggested in different reviews by experts and leading UN bodies.

For the next five years, there will be a need to think beyond mortality and address morbidity in various groups. Key morbidities in RMNCAH need to be addressed in 2016-2020 as they influence quality of life and can lead to premature death. In the next 5 years while there are strategies in place for the country, the need to concentrate /target interventions in the zones and regions with poor indicators as well as rural areas needs to be strengthened. Further, even successful programs like immunization will need to make efforts in "the last mile" to reach every child and woman in hard to reach areas/populations. The strategies should strive to reach universal coverage of evidence-based interventions, provide high quality services, equity and accountability, based on human rights approach.

FUTURE DIRECTION

- Family planning services especially long term methods and community-based distribution of contraceptive commodities needs to be scaled up and strengthened. Integration of FP services into other reproductive and child health delivery points

should be given priority to minimize missed opportunities for women to access quality care.

- Strengthen adolescent/ youth friendly reproductive health services. Interventions geared to improve contraceptive use, life skills and knowledge in overall sexuality and reproductive health and rights are urgently required.

- Scale up of Emergency Obstetric and Newborn Care (EmONC), especially Basic Emergency Obstetric and Newborn Care (BEmONC), at primary health facilities to improve maternal and newborn survival.

- Improve coverage of postnatal care services to reach especially women and newborns that deliver at home (49%). The scaling up of services should target women and newborn in the first 7 days post delivery by increasing home visits by outreach teams or by community health workers.

- Scale up and strengthen Essential Newborn Care (ENC) for every newborn, Newborn resuscitation for children requiring help at birth and Kangaroo Mother Care for preterm and low birth weight babies.

- Ensure continuous improvement of clinical knowledge and skills of health providers in Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) to enable them to offer integrated care and services along the continuum of care. Integrated training package in RMNCAH to be developed and health providers trained on the integrated curriculum.

- Ensure an "enabling environment" for providers in order to provide quality services. This includes ensuring availability of key lifesaving commodities, supplies and medicines to offer RMNCAH services.

- Strengthen provision of RMNCAH services in an integrated manner. Integration should be reflected at all levels of policy, administration and service delivery.

- Strengthen Community health services by building capacity of Community Health Workers to provide integrated RMNCAH services. Community based services should include demand creation, health education, health promotion and provision of services in family planning, adolescent care, postnatal care, breastfeeding, nutritional care and referral of sick newborns, children and women.

- Having cross cutting issues integrated into RMNCAH services. These include; gender based violence and violence against children, male involvement, nutrition and, community engagement.

- Improved collaboration and coordination among key RMNCAH actors at all levels including MOHSW, PMO-RALG and partners in planning and implementing of RMNCAH interventions.

FOREWORD

In Tanzania the reduction of maternal, newborn and child deaths has been given a high priority and is addressed in various national commitments, including Tanzania Vision 2025, the National Strategy for Growth and Reduction of Poverty (NSGRP), and the Health Sector Strategic Plan IV, 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.

The 2015 Global Strategy for Women's, Children's and Adolescents' Health is so essential as one of the front-runner platform for delivery of the SDGs. It is based on lessons learned from the MDGs and new evidence on effective investments and action.

The SDGs are founded on human rights and equity and based on the recognition that healthy people are better able to realize their personal potential and human rights, and to drive the individual, family, community, social, structural and political changes demanded by the SDGs—without which they cannot be achieved.

Now, under the Sustainable Development Goals (SDGs), we have the opportunity and the responsibility to further transform the way we work in the period from 2016 to 2030, so that we create the conditions for a healthy, prosperous, sustainable future for every person, everywhere.

Based on the lessons learned from implementing the Strategy to accelerate reduction of maternal, newborn and child deaths in Tanzania and on new evidence on effective investments and action, It is the expectation of the Government, particularly the MoHSW, that all stakeholders will align with the optimal use of this strategic plan to support the implementation of prioritized reproductive, maternal, newborn and child health interventions. Together, we can improve the health of Tanzanian mothers, babies and children, and build a stronger and more prosperous Nation.

Dr

Minister for Health and Social Welfare

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Permanent Secretary, MoHSW

CHAPTER 1: INTRODUCTION

1.1 Historical perspective of RMNCAH services in Tanzania

Tanzania, with an estimated population of 47.5 million in 2014, a population growth of 3.1%, and 1.8 million expected births per year began investing in maternal and child health services (MCH) back in 1974 (MOHSW, 2008; NBS, 2014). The services included care during Pregnancy, delivery and family planning. In 1975 the Expanded Programme of Immunization (EPI) was initiated and in 1989 the country adopted the Safe Motherhood Initiative (SMI) and National Family Planning Services in 1989. The Baby Friendly Hospital Initiative (BFHI) was adopted in 1992 and in 1996 the country adopted the Integrated Management of Childhood Illness (IMCI) for care of common childhood illnesses. The National Program on Prevention of Mother-to-Child HIV Transmission started in 2003, The National Strategy on Infant and Young Child Feeding and Nutrition (IYCF) was developed in 2005. The National Adolescent Reproductive Health services were mainstreamed in the health sector after ICPD 1994 after understanding the country situation and putting in place strategic documents to guide implementers (Adolescent Health and Development Strategy 2004-2008, ARH strategy 2011-2015). In 2008 the country introduced National Reproductive Health cancers - Cervical Cancer Prevention and Control and Health Sector Prevention and Response to gender-based violence. These key programs have shown a positive evolution over time to save the lives of women and children in the country. Tanzania has also made a commitment to provide maternal, newborn and child health (MNCH) services free of charge in 1994 in order to improve access, availability and equity of life saving interventions.

1.2 Alignment of RMNCAH with National policies and strategies

In the National Health Policy of 1990 and 2007, it is clearly stated the country's commitment in addressing maternal, newborn and child health. Also being the signatory of the Millennium Development Goals (MDGs), Tanzania strengthened its commitment on reducing maternal, newborn and child deaths and improving the quality of maternal and child health care services in order to meet MDGs 4 and 5 targets by 2015. This priority is reflected in several policy documents produced by the Government of Tanzania.

In the Tanzania Vision 2025, "access to quality reproductive health services for all individuals and reduction in infant and maternal mortality" are among the most important health service goals cited. The National Strategy for Growth and Poverty Reduction (NSGRP/MKUKUTA) also seeks to improve maternal newborn and child health (MNCH) as one of its major objectives. The Primary Health Service Development Programme (PHSDP/MMAM 2007-2017) addresses the crucial issue of equity by calling for an increase in the coverage and quality of primary health care

services for communities living in rural and remote areas. The National RCH Policy guideline 2015, The National Guideline on Essential Reproductive and Child Health Interventions in Tanzania 2003, Reproductive and Child Health Strategy (2005-2010), National Population Policy 1992, 2007 and The Health Sector Strategic Plan III 2016-2020 (HSSP IV) also address importance of reducing maternal and child morbidity and mortality.

1.3 The Government's Commitment to RMNCAH

Tanzania has signed different global and regional initiatives (see Annex 1) to confirm its continued commitment to improving RMNCAH care in the country. In 2008 the Ministry of Health and Social Welfare developed the National Roadmap Strategic Plan to Accelerate Reduction in Maternal, Newborn and Child Deaths (2008 – 2015). In May 2014 the Ministry developed the Sharpened One Plan to prioritize and scale interventions that improve maternal, newborn, child and adolescent health.

CHAPTER 2 CURRENT SITUATION OF RMNCAH IN TANZANIA

2.1 Current situation of MDG 4, 5 & 6

2.1.1 Tanzania Progress in achieving the MDG 4

Globally, the number of Under 5 (U5) deaths has declined by almost 50% from 12 million deaths in 1990 to approximately 6.6 million in 2012 (Countdown Report, 2014). To achieve the MDG 4 of reducing U5 mortality by 2/3 by 2015, countries needed to have an annual rate of reduction (ARR) of at least 4.4% from 1990 – 2015.

Tanzania is among the countries that have achieved the MDG 4, reducing the U5 mortality rate (U5MR) from 166/ 1,000 live births in 1990 to 81 per 1,000 in 2010 (TDHS, 2010) and meeting the target of 54 per 1,000 live births in 2012 according to the UN estimates of 2013 (UN Inter Agency Group on Child Mortality Estimate, September 2013). The country had an ARR of 5.1% from 1990-2012 and an accelerated ARR of 7.4% was observed from 2000 – 2012. Despite achieving the MDG4, Tanzania still has a very high number of under-fives dying every year, 98,000 per year. Zonal disparities in achieving the MDG 4 were noted, with the Lake and Southern highland zones having U5MR of > 100 per 1,000 live births whereas Northern zone had the lowest (54 per 1,000 live births (TDHS, 2010).

Infant Mortality Rate (IMR) has declined from 68 in 2004/05 to 51 in 2010 and 45 per 1000 live births in 2013. By 2014, the country was able to further reduce IMR to 38 per 1,000 live births, surpassing the target of 46 deaths /1000 live births by 2015 (TDHS, 2010; UN Inter Agency Child Mortality Estimates 2013; Countdown Report, 2014).

Progress in reducing preventable newborn deaths has been slow compared to U5MR and IMR. In the One Plan, the target was to reduce neonatal mortality rate (NMR) to 19 per 1000 live births by 2015 (MOHSW, 2008). Unfortunately the goal was not attained as NMR had declined from 32 per 1000 live births in 2004/05 to 26 per 1000 live births in 2010 and 21 neonatal deaths per 1,000 live births in 2013 (TDHS, 2004/05 &2010; Countdown to 2015 Report, 2014). Neonatal deaths contribute to 40% of U5 deaths. Hence progress in averting neonatal deaths is critical in overall reduction of U5MR.

2.1.2 Tanzania Progress in achieving the MDG 5

Tanzania is one of the countries that have not attained its target of reducing maternal mortality ratio (MMR) to 193 per 100,000 live births by December 31st, 2015. The MMR has declined from 870 per 100,000 live births in 1990 (UN reports) to 454 per 100,000 in 2010 (TDHS 2010). The National Census Report (2012) recorded more progress, with further decline of MMR to 432 per 100,000 live births and in 2013 the UN-Interagency

Maternal Mortality Estimate Report showed reduction of MMR to 410 per 100,000 live births, Figure 1.

Despite a 47% reduction of MMR from 1990-2014, Tanzania made insufficient progress to attain the MDG 5. An average annual reduction rate (ARR) of 5.5% was required for countries to achieve the MDG goal, but from 1990-2013 Tanzania had an ARR in maternal mortality of 3.5% (Countdown to 2015 Report, 2014). The country had an accelerated ARR of 4.8% from 2000 – 2013, still below the annual reduction rate recommended. The countries that attained the MDG 5 such as Equatorial Guinea, Eretria, Egypt, Vietnam, Bangladesh and Rwanda had an ARR ranging from 5.5–8.0% (Countdown to 2015 Report, 2014).

Evidence based interventions that can significantly improve reduction in maternal deaths includes; reducing unmet need for family planning, skilled attendance and emergency obstetric care, quality antenatal services, and postnatal services (Lassi et al, 2014a & 2014b; Salam et al, 2014). However, these interventions do face various challenges and bottlenecks in ensuring universal coverage, quality and equity especially between rural and urban areas.

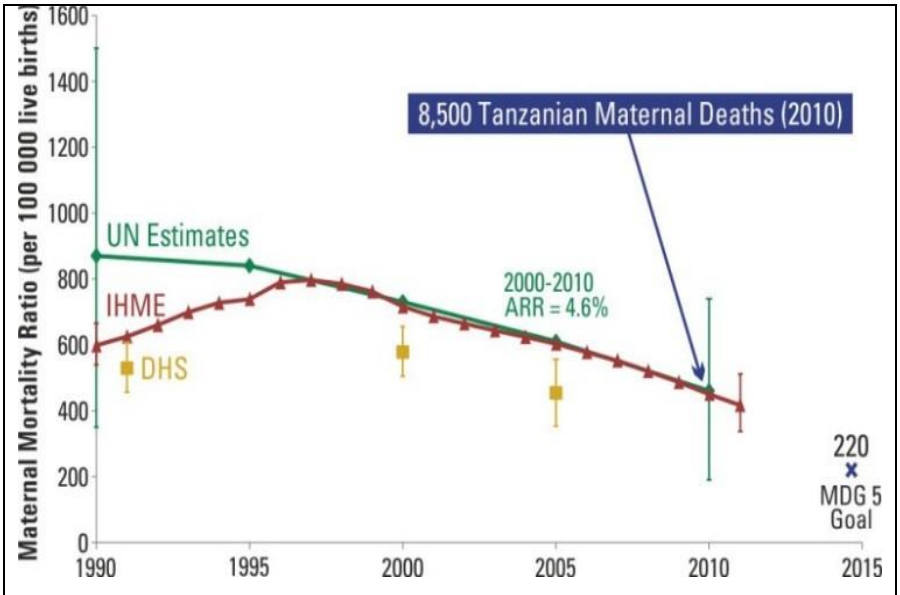


Figure 1: Progress of reducing MMR by 3/4 (1990-2010)

2.1.3 Tanzania Progress in achieving the MDG 6

The East African countries including Tanzania have experienced decline of HIV incidence per 100 people aged 15-49 from 0.36 in 2001 to 0.21 in 2012. In Tanzania, estimates showed that new HIV infections have declined by 49% (UNAIDS, 2013).

Tanzania HIV and Malaria Indicator surveys also showed decline in adult HIV prevalence from 2003-04 to 2011-12. The HIV prevalence among adults in the mainland declined from 7.0% in 2003-04 to 5.3% in 2011-12. The decline was significant among men from 6.3% in 2003-04 to 3.9% compared to women where the decrease was from 7.7% to 6.3% respectively (THMIS 2003-04; 2011-12). The country has met the goal of halting and starting to reverse the spread of HIV by 2015.

Mother-to-Child transmission of HIV has also declined from rates of 25-30% in early 90's to 12.7% in 2014 (UNAIDS, 2013; NACP, 2014).

Several preventive interventions were put in place to combat the HIV epidemic since early 90's including; behavioral, structural and medical interventions. Limiting number of sexual partners, condom promotion, STIs prevention and treatment, HIV voluntary counselling and testing, Antiretroviral Treatment program, PMTCT/EMTCT program, safe blood and male circumcision program are among the preventions that are implemented in the country.

The country is also on target to achieve malaria goal of halting by 2015 and begun to reverse the incidence of malaria. Malaria prevalence among under fives have declined from 18% to 9% in 2011-12 (THMIS, 2011-12).

2.2 Coverage and attainment of Reproductive, Maternal, Newborn, Child and Adolescent health targets in Tanzania

2.2.1 Maternal Health

Maternal health includes the period when a woman is pregnant, during delivery and up to 42 days after delivery.

In Tanzania, nearly 70% of maternal deaths are caused by five direct obstetric causes: hemorrhage, eclampsia, sepsis, abortion complications and obstructed labor. In 2012, direct obstetric causes contributed to 63% of maternal deaths in Tanzania, while indirect causes contributed to 25% (HMIS, 2012). For every death it is estimated that 15-20 women develop disability (Ref).

2.2.1.1 Care During Pregnancy

Tanzania adopted Focused Antenatal Care (FANC) in 2003, where the focus of care shifted from quantity to quality of visits, quality and goal oriented care at each visit,

managing every pregnancy as a risk pregnancy instead of classifying women into risk categories and empower women with information on danger signs, birth preparedness and complication readiness so that they can seek timely care (MOHSW, 2003; MOHSW, 2014). In the old model, women were advised to attend for ANC care monthly up to 28 weeks, then every 2 weeks up to 36 weeks and weekly up to delivery. FANC on the other hand recommends at least four ANC visit for women without complications (at < 12 weeks gestation age (GA), 20-24 GA, 28- 32 GA and at 36 weeks), and increased visits according to country guidelines when a problem is detected (Villar et al, 2001; MOHSW, 2003).

Number and timing of visits: TDHS 2010 report showed that attendance for antenatal care at least once is universal (98%). However, women start ANC care late i.e. only 15% of pregnant women attended for first antenatal care with less than four (16 weeks) month of gestation (TDHS 2004/05 & 2010). The attendance for ANC 4 or more times as recommended in the FANC has decreased over time from 71% in 1999, 62% in 2004/05 and 43% in 2010 compared to the national target of 90% (TDHS 2004/05; 2010). Booking late (after 4 months) for ANC, desire to delay pregnancy, perception of quality of antenatal services and long distance were factors associated with less than 4 antenatal care visits (Gupta et al, 2014). Country specific approaches to refocus ANC are a critical area that needs to be considered.

Table 1: Maternal health interventions; successful and unfinished agendas by 2015

	Current status	Target by 2015
	Antenatal	
	*ANC*1 coverage high at 96%*	*90%*
	ANC 4 visits – 43%	*90%*
	ANC before 16 weeks - 15%	*60%*
	TT lifetime protection – 88%	*90%*
	Anemia in pregnancy high; 53%	*< 20%*
	IPT 2 doses – low at 32%	*80%*
	ITN coverage – 71%	*80%*
	Syphilis screening during pregnancy- 38 %	*80%*
	PMTCT	
	% facilities screening pregnant women for HIV -94%	*100%*
	% pregnant women tested for HIV – 90%	*100%*
	% HIV-positive receiving ART (Option B+) - 79%	*90%*
	% of facilities with PMTCT implement	*100%*

	option B+ - 95%	
	Care during childbirth	
	SBA coverage 51%	*80%*
	Health facility deliveries 50%	*90%*
	BEmONC coverage low - 20% dispensaries & 39% health centers	*70%*
	CEmONC - 73% hospitals	*100% for hospitals*
	CEmONC - 9% of health centers	*50% for upgraded health centers*
	C/S rates in rural – low 3.2%	*5-15% recommended level*
	Postnatal care	
	PNC attendance within 2 days low – 31%	*60%*
	Prevention and treatment of maternal anemia not addressed	

2.2.1.2 Care during childbirth

Skilled Birth Attendance: Tanzania DHS survey indicates that the proportion of women giving birth under the supervision of skilled birth attendants (SBA) has slowly increased from 43% in 2004/05 to 51% in 2010. In the same period the proportion of women giving birth in the health facilities also increased from 47% to 50% (TDHS, 2004/05 & 2010). There is marked disparity in SBA coverage between urban (83% in 1999 & 83 in 2010) and rural areas (44% in 1999 & 51% in 2010), showing that urban settings had attained the 2015 goal of having 80% of births attended by SBA in 90's compared to rural areas which need accelerated efforts (TDHS 1999, 2004/05; 2010). Zonal and regional disparity on SBA coverage has been observed with Western and Lake Zones performing poorly compared to Eastern or Northern zones (MOHSW, 2014).

Emergency Obstetric Care: Tanzania is committed to ensuring every woman or newborn that develops complications during pregnancy or childbirth has an access to life saving emergency care (MOHSW, 2014). Basic Emergency Obstetric Care (BEmOC) is supposed to be offered at primary health care facilities (i.e. at dispensaries and health centre level) where 7 key interventions, termed 'signal functions' as shown in Table 2, must be offered. Comprehensive care (CEmONC) is offered at the hospital level, and these facilities must offer 9 signal functions.

Availability of BEmONC is limited in Tanzania with only 25% of the facilities offering all the 7 signal functions while the target was to have 70% of dispensaries and health centers fully functional by 2015 (SARA, 2013; MOHSW, 2014). The functionality is worse at the dispensaries (20%) than the health centers (39%) or hospitals (MOHSW, 2014).

Comprehensive EmOC facilities that offer blood transfusion and Caesarean section in addition to the 7 basic EmONC functions are available in 73% of the hospitals and 9% of upgraded health centers (SARA, 2013). The target was to have 100% and 50% being fully functional CEmONC facilities by 2015. The EmOC target was not met due to poor referral system, erratic supply of essential commodities and supplies and critical shortage of skilled staff especially at the rural areas and low technical competency of staff (SARA, 2013; MOHSW, 2014).

Other activities that can help to improve quality of childbirth and newborn care and accountability like maternal and perinatal surveillance and death review need to be improved (HSSP III MTR, 2013). Having quality of care committees and strengthening monitoring of indicators like case fatality rate at the facility level or met need for EmOC may help with accountability.

Labour and delivery care: Improving universal coverage of routine functions like monitoring and management of labour using partograph and active management of the 3rd stage of labour (AMTSL) for every woman would improve survival (WHO, 2012). Inconsistent use of the partograph is common at all levels of care in the country (Nyamtema et al, 2008; Sarker et al, 2010). Use of oxytocin for AMTSL is high in the country (97% - 100%), but stock out is a common reported problem (Mfinanga et al, 2009; SARA, 2013). Strategies like payment for performance (P4P) that improved use of partograph from 12% to 69% in Pwani region should be tried in other regions (P4P Assessment Report, 2013).

2.2.1.3 Postnatal care

Postnatal care (PNC) visit within the first 2 days is low in Tanzania, with only 31% of the women attending a post-natal care visit (TDHS, 2010). Low attendance for PNC visit is higher for women who; are from rural areas, less educated, poorer and residing at Lake and Western zones.

Table 2: EmOC signal functions and UN Process Indicators

Levels of EmONC and their signal functions
BEmONC • Parenteral antibiotics to treat sepsis • Parenteral oxytocics to treat hemorrhage • Parenteral anticonvulsants to treat pre-eclampsia and eclampsia • Manual removal of retained placenta • Removal of retained products of conception by manual vacuum aspiration (MVA) • Assisted vaginal delivery (vacuum extraction) • Newborn resuscitation using bag and mask
CemONC • All the 7 BEmONC functions plus; • Obstetric surgeries (Caesarian section) • Blood transfusion

2.2.2 Newborn Health

Globally, complications from preterm births (35%), birth asphyxia (24%) and infections –sepsis, pneumonia and meningitis (20%) are the three main causes of neonatal deaths (WHO & UNICEF, 2014; Lancet, 2014).

Table 3: Three major causes of neonatal deaths

Global	Tanzania
Complications from preterm - 35%	Asphyxia – 31%
Birth asphyxia -24%	Preterm – 25%
Sepsis, pneumonia, meningitis - 20%	Sepsis, pneumonia, meningitis -25%

In Tanzania, there are 395,000 neonatal deaths annually with NMR of 21 per 1,000 live births (MOHSW, 2014c). Birth asphyxia (31%) is the leading cause of neonatal deaths, followed by complications from preterm births (25%) and infections due to sepsis and meningitis (20%) or pneumonia (5%), Table 3; (Countdown report, 2014; MOHSW, 2014c). Quality care at birth, essential newborn care (ENC), newborn resuscitation, care of small and sick newborns, kangaroo mother care (KMC), antenatal steroids to improve survival of preterm babies, and prevention and timely management of sepsis are key interventions that targets the three common causes of newborn deaths and thus important to monitor in the country. Table 4 shows the current status of newborn interventions and 2015 targets.

Table4: Successful and unfinished agenda in newborn health interventions

	Current status	**Target by 2015**
	NMR – 21 per 1,000 live births	NMR – 19 /1,000 live births
	Postnatal care visit within 2 days - 31%	Postnatal care visit within 2 days - 80%
	Early breastfeeding (within 1 hour after birth) - 49%	Early breastfeeding (within 1 hour after birth) - 90%
	PMTCT	
	ARV prophylaxis for HIV exposed infants - 56%	ARV prophylaxis for HIV exposed infants - 80%; elimination at 90%

Postnatal care visit for newborns: Nearly 50% of newborn complications and deaths occur within the first 24 hours after birth, and care offered to newborn during this period is a key to survival. There is no data on the proportion of newborns that are seen within 48 hours after delivery (TDHS, 2010). Further, because 50% of births occur at home, there is a need for extending PNC to the community either by outreach or by community health workers.

Breastfeeding within 1 hour after delivery: Early initiation of Breast feeding is a cheap and cost-effective intervention in preventing neonatal deaths, and is associated with 38 – 44% decreased risk of all cause-neonatal mortality (Edmond et al, 2006 & 2007; Debes et al, 2013; Black et al, 2013). The prevalence of breastfeeding within 1 hour of birth is 59% in 2004/05 and declined to 49% in 2010, while coverage of 90% was required by 2015. In Tanzania, a higher prevalence of BF within 1 hour was noted in urban areas, among educated and wealthier women, among women delivering at health facilities (HF) and with a skilled birth attendant (SBA).

Essential Newborn Care (ENC): ENC is routine care that all newborns should receive immediately after delivery. The target was to have 75% of the facilities with deliveries offering ENC (MOHSW, 2014; WHO, 2014). The key components of ENC include; skin-to-skin contact immediately after birth, drying the baby immediately with a towel, wrapping the baby with a dry towel after discarding the wet one, cutting the umbilical cord with a sterile blade and helping to initiate breastfeeding within one hour (Manji, 2009). Eye care and provision of hygienic skin and cord care are part of routine ENC. Currently there is no data on coverage of ENC. Secondly, while the curriculum and training materials for ENC are in place, the program has not been rolled out due to financial constrains (RCHS, 2014), thus knowledge and skills of providers in ENC might be low.

*Newborn Resuscitation (NR)***:** Availability of NR with bag and mask for all newborns who have absent or ineffective breathing at birth is important in managing asphyxia, the most common cause of newborn deaths in Tanzania. Target in 2020 is to have at least 50% of babies requiring NR receiving the care as advised in the Ending Preventable Newborn Deaths (WHO, 2014). NR is limited at dispensaries and health centers compared to hospitals due to shortage of equipment and skilled providers (Jhpiego, 2013; MOHSW, 2014b&c). One in every 20 to 30 newborns will require resuscitation (Salam et al, 2014). Many providers lack adequate skills in neonatal resuscitation as shown by a study that showed the scores for NR were 48% and 28% before and 2 years after training respectively (USAID & MOHSW, 2013).

Kangaroo Mother Care (KMC): Avert 50% of deaths among preterm or babies < 2000 grams (Salam et al, 2014). Currently there is no data in the country on coverage of KMC intervention (MOHSW, 2014). RCHS reported that by the end of 2014, KMC

intervention was scaled up to the regional and few district hospitals. As a result only 35 of all the district hospitals are providing KMC services (MOHSW, 2014a).

Antenatal corticosteroid: Improving preterm babies survival by use of antenatal corticosteroid is a new intervention in Tanzania and has just been added in essential commodities and in the essential drug list.

Newborn infections: Infections due to sepsis, meningitis or pneumonia contribute to 25% of NMR, hence availability of recommended antibiotics for newborns (I/M or I/V Gentamycin and Ampicilin) is an essential aspect in averting neonatal deaths (Salam et al, 2014). Thirty seven (37%) of the dispensaries and 22% of the health centers do not have injectable antibiotics (SARA, 2013). Good infection prevention practices are essential in preventing sepsis at health facilities. In 2016-2020 more investment is needed in equipment and supplies as 60-80% of dispensaries or health centers lack sterilization equipment, 50% of PHC centers lack basic things like soap & water/alcohol based hand rub, and 20% lack disinfectant (SARA, 2013).

Further, availability of other interventions like ENC, NR or antibiotics is important at all levels, but availability of a neonatal care unit (NCU) at the district level to offer advanced care for sick newborns is important in improving chances of survival. Services like oxygen, heat, management of jaundice, extra support for feeding of small and preterms and management of very low birth weight babies needs to take place at the district hospital or higher level. Information on the proportion of district hospitals with functional neonatal care units is lacking and will need to be collected to monitor progress in the next 5 years.

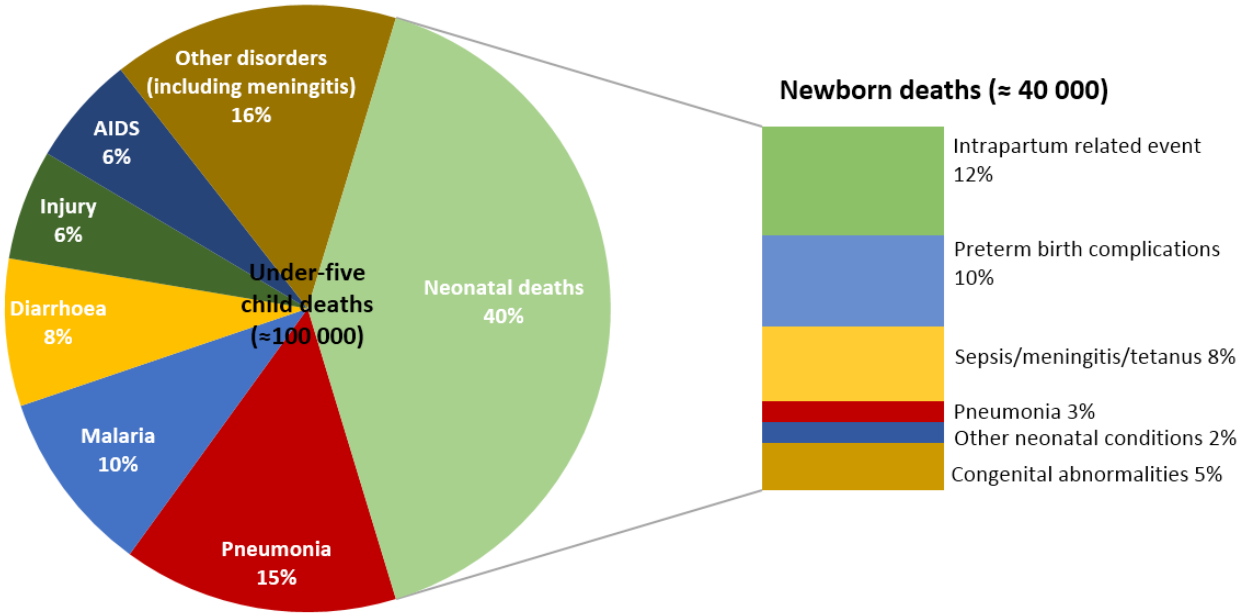
ARV Prophylaxis among HIV-Exposed Infants: While maternal coverage of option B+ is high (79%), coverage of PMTCT intervention during the neonatal period or infancy is low. The proportion of HIV- exposed infants receiving ARV prophylaxis for the first six weeks after birth was 56% in 2011 and the HMIS in 2014 showed a coverage of 52%, way below the target of 80% by 2015. This target was set at 90% in the elimination of MTCT of HIV goals (PMTCT Unit, 2014).

2.2.3 Child health

Despite the decline of under-five deaths by nearly 50%, still 6.6 million children U5 died in 2012, most in low and middle-income countries (LMIC). Pneumonia, diarrhea and malaria are still the leading causes of U5 deaths after the 1st month of life, (WHO, 2014). Under nutrition is the underlying cause in 45% of U5 deaths.

In Tanzania, Pneumonia (15%) followed by malaria (10%) is the leading causes of post-neonatal death, Figure 2.

Figure 2: Causes of U5MR in Tanzania; 2012. *Source: Countdown Report, 2014*



Child Immunization: Tanzania Demographic and Health Survey (2010) results indicates that routine immunization coverage by antigen by the time of the survey (according to vaccination card and history) was; 95.4% for BCG, 87.8% for DTP-HepB3 and 84.5% for measles. Similarly, immunization coverage survey conducted in September 2011 showed high coverage- BCG - 98.6%, DTP-HepB3 - 95.1% and measles - 95.1% (IVD, 2014; IHI, Red Cross & WHO, 2013).
There is however regional variation in immunization coverage. Some regions such as Manyara, Shinyanga, and Mtwara have persistently remained with coverage below 80% since 2009 (IVD, 2014).

In January 2013, Rota and pneumococcal (PCV 13) vaccines were introduced, and these two target pneumonia and diarrhoea - the two leading causes of child death. Hence it is hoped there will be further reduction in infection-related deaths among U5 children. New vaccines have been introduced; Measles second dose and rubella as MR, Human Papilloma Virus (HPV) that was piloted in May 2014 and inactivated polio vaccine. The target for these new vaccines is to reach coverage of 90% by 2020.

Table 5: Successful and unfinished agenda in Child health interventions

	Current status	Target by 2015
	U5MR to < 54 per 1,000 live births	54 per 1,000 live births
	Immunization	
	DPT-Hb-HiB - 3 coverage is more than 90% in most regions and districts	90% in 90% of the districts
	Measles coverage 95 - 97%	90% in 90% of the districts
	Vitamin A coverage 60%	90%
	Nutrition	
	Exclusive breastfeeding for 6 months – 50%	90%
	Appropriate complementary feeding at 6-9 months – 93%	90%
	Stunting – 42%	22%
	Underweight – 16%	14%
	Anemia in U5 – 59%	< 20%
	HIV prophylaxis and treatment	
	ARV coverage among HIV exposed children - 56%	80%; elimination 90%
	Cotrimoxazole coverage among HIV exposed children - 34%	80%
	Testing coverage among HIV exposed children at 6 weeks or 12-18 months -30%	90%
	Mother-to-child HIV transmission - 12.7%	Elimination < 5%
	% Children in need ART on treatment 26%	60%
	Pneumonia, Malaria & Diarrhea	
	Care seeking for pneumonia – 71%	90%
	Care seeking for diarrhea – 53%	90%
	Care seeking for malaria/fever – 77%	90%
	ITN use among U5 – 73%	80%

Exclusive Breastfeeding (EBF) for 6 months: The prevalence of EBF has increased from 41% in 2004/05 to 50% in 2010 (TDHS, 2004/05 & 2010). Improper breastfeeding practices contribute to 11.6% of all U5 deaths in LIMC (Black et al, 2013).

Thirty one (31%) of infants are given pre-lacteal feeds before starting to breastfed (TDHS, 2010). Rural women and women who were assisted by TBA during delivery are

more likely to give prelacteal feeding. By 2-3 months of age 33% of infants are given semisolids or solids and it increases to 64% by 4-5 months (TDHS, 2010).

Stunting: Chronic under-nutrition is a problem as 42% of the U5 children are stunted (height for age). Sub-optimal breast-feeding and EBF practices and poor infant & young child feeding practices (IYCF) may contribute to higher levels of stunting. Only 21% of children aged 6-23 months are fed in accordance with the recommended IYCF practices (TDHS, 2010). Stunting is associated with poor motor and cognitive development, affecting the capability of attaining full potential at schools and in later life. Further, stunting increases the risk of deaths due to pneumonia, diarrhea and measles (Black et al, 2013).

Anemia: Anemia among U5 children is high; 59%. This was a decrease from 70% in 2004-05 (TDHS 2004-05; 2010). WHO stipulates that once the prevalence of anemia is > 40% it constitutes a severe public health problem (WHO, 2008). Anemia influences growth, cognitive development and school performance hence, negatively influencing human capital and potential of the children (Black et al, 2013). The target is to reduce anemia in children by 30% from current level to 41% in 2020.

ARV prophylaxis and testing coverage: Coverage of PMTCT interventions during neonatal period or infancy are sub-optimal. The proportion of HIV- exposed infants accessing ARV prophylaxis was 52% in 2014, far below the elimination goal of 90% by 2015 (WHO, 2012; NACP, 2014). Performance of Cotrimoxazole prophylaxis (34%) and testing of HIV-exposed infants at 6-8 weeks after birth (30%) is also low and needs to be increased to 90% by 2020 (NACP, 2014). Low performance of PMTCT intervention during infancy may partly reflect weak postnatal care follow up services and lack of integration of services with programs like immunization which has > 95% coverage (NACP, 2011; MOHSW & USAID, 2012).

Mother-to-Child Transmission (MTCT) rates: Estimates show that by the end of 2014 MTCT of HIV was 12.7% in Tanzania (NACP, 2014; UNAIDS, 2014). HIV/AIDS contributes to 6% of child deaths in Tanzania.

HIV Treatment among infected children: In 2013 there are about 136,000 children living with HIV in Tanzania (MTR HSSP III, 2013). The coverage of ART among children is 26% using the cut-off point of 350 CD4 count in calculating the need for ART among children (HSSP III, 2013). Change in guidelines that requires any infected child < 2 years to be started on ART therapy would mean a higher proportion of children are required to be on ART. Currently the system is failing to reach children who need treatment earlier and in a timely manner. The goal in 2016-2020 is to have 60% of the children who require treatment to have access to this care.

Care seeking and Treatment patterns for Pneumonia, Malaria and Diarrhoea
Health care seeking for pneumonia, malaria and diarrhoea: Health care seeking for children with symptoms of ARI/pneumonia, fever and diarrhoea has improved over time (TDHS, 2010; THMIS, 2011/12). ITN use by children under age 5 has also increased from 36% in 2008 to 73% in 2012 (THMIS, 2011-12) leading to a decline of malaria prevalence among U5 from 18% in 2007/08 to 9% in 2011/12 (THMIS 2007.08 & 2011/12).
Treatment for pneumonia, malaria and diarrhoea: Among the children who had fever in the two weeks preceding the survey, 59% were treated with any antimalarial, 34% received the recommended drug i.e. ACT in 2011/12 an improvement from 25% in 2007/08 (THMIS 2007/08; 2011/12).

Information on the proportion of children treated with antibiotics for pneumonia is limited as it is neither collected in the TDHS, nor reported in the Countdown Report.

Treatment for diarrhoea is sub-optimal. Zinc is available in 5 out of 10 facilities (SARA, 2013) and diarrhoea corners for managing children with diarrhoea are non-existent at facilities (USAID, MCHIP, SHOPS, 2012).

Child deaths review: There is no system in place for reviewing child deaths (under-five death review) in Tanzania despite having 98,000 deaths annually. As a result, there is a missed opportunity to improve on avoidable causes of under-five deaths.

2.2.4 Family planning

In Tanzania, modern contraceptives have a potential to avert 2,360 maternal deaths that occur each year out of approximately 7,900 annual deaths. It can also improve neonatal and child outcomes by lengthen the birth interval, and reduce MTCT.

Contraceptive Prevalence Rate (CPR): Use of modern contraceptives is still low in Tanzania, though it has increased from 20% in 2004-05 to 27% in 2010 (TDHS, 2010). The target was having a CPR of 60% by 2015. The use of modern contraceptives methods differed significantly by residency, by zone, region, education and wealth. Women from rural areas, non-educated, poor and living in Western or Lake zones have lower CPR compared to others (TDHS, 2010).

Unmet need for FP: Unmet need for FP among married women is high - 25%, and has persisted at this level for the past ten years (TDHS, 2004/05; 2010). Only 58% of currently married women had their need for FP satisfied, a slight increase from 56% in 2004-05 (TDHS, 2010).

Total Fertility Rate (TFR): The TFR has declined from 6.3 births per woman in 1991-92, to 5.2 births per woman in 2012 (TDHS, 2010; Census, 2012). The zones, regions and areas with low CPR and high unmet need for FP are the ones with high TFR. TFR in rural areas is 6.1 per woman compared to 3.7 in urban areas.

Coverage of FP services at health facilities: Among the 6,734 health facilities with RCH services in 2011, 5,366 (80%) were offering family planning services. This proportion increased to 85% in 2012 (HMIS, 2011 & 2012).

Despite high facility coverage of FP services, there is limited availability of long term contraceptive methods such as implants, Inter-Uterine Contraceptive Devices (IUCD), and emergency contraceptives (SARA, 2013; MOHSW & USAID, 2012). This has severely hampered women's wider choice/method mix of contraceptive methods, a reality reflected in community surveys which show that only 0.6% of women use IUCD and 2% use implants (TDHS, 2010).

Community provision of FP services: There is lack of an effective and widespread community-based program for the provision of family planning services.

2.2.5 Adolescent Health

Tanzania has a population of 44 million and about 65% are those aged below 25 years. Young people aged 10-24 years constitute 31% of the total population (Census, 2012).

Contraceptive Prevalence Rate (CPR: Awareness on one or more modern contraceptive methods is high among adolescents (96%), but only 12% of 15-19 years married adolescents use modern contraceptives, an increase from 7% in 2004/05 (TDHS, 2004-05; 2010).

Use of condoms at last sex by sexually active unmarried adolescents aged 15-19 years has increased from 38% in 2004/05 to 50% in 2010 for women and from 39% to 46% for men (TDHS, 2010). There is marked variability by region for CPR and condom use among adolescents.

Sixteen percent (16%) of currently married young women aged 15-19 and 20% of those aged 20-24 have an unmet need for Family Planning (TDHS, 2010).

Adolescent Fertility Rate (AFR): The TDHS of 2010 showed that AFR among 15-19 years is high (116 per 1,000 population). But it has declined from 132 per 1,000 population in 2004/05. The decrease in AFR was noted in every region, social class and zone except for the Western zone (UNICEF, 2011). By the age of 19 years, almost half (44%) of the women are either mothers or are pregnant with their first child (TDHS, 2004-05, 2010). The target was reducing AFR to < 100 per 1,000 births by 2015.

One in five adolescents aged 15 -19 is married/cohabiting or divorced (18% and 1% respectively). Adolescents pregnancies have a four times higher risk of ending with maternal deaths than among older women, higher risk of ending with complications like obstetric fistula, twice the risk of perinatal, neonatal and U5 deaths, and a higher probability of ending with preterm delivery, thus pregnancy prevention strategies in this group should be strengthened (UNFPA, 2013). Thirty (30%) of incomplete abortions turning at hospitals are among 15-19 years (UNICEF, 2011). An improvement in coverage modern contraceptive use in sexually active adolescents is urgently needed in the country.

HIV: Nearly 7 out of 10 youths (15-24 years) are aware of two of the common HIV preventive methods. But only 39% and 25% of young women or men who are sexually active tested for HIV in previous year (UNICEF, 2011). Comprehensive knowledge of HIV is still low among youths; (48% and 43% of young women and men respectively); (THMIS, 2011/12). Youth aged 15 – 24 years account for 60 percent of the new HIV infections in the country. While young men and women are equally infected in the age group of 15-19 (1.3%), women aged 20-24 (1.4%) are more infected than men of the same age group. Also young people face gender inequality and inequity leading to gender based violence and putting them in a comprising situation.

Nutrition status: Prevalence of stunting among adolescents is high, reaching 70% at 13 years. Prevalence of anemia among 15-19 years old was 42% in 2010, a decline from 49% in 2004/05. Some studies have shown 75% of adolescents had anemia during their first pregnancy (UNICEF, 2011). Poor nutrition status among adolescent women has negative effect on pregnancy outcomes, namely preterm delivery, LBW or SGA age babies. This has a considerable impact on maternal nutrition as nearly half of young women under the age of 19 are pregnant or are already mothers.

Adolescent Friendly SRH (AFSRH) services: Access to AFSRH and FP services is still a challenge in the country. Studies show that only 30% of service delivery points in the country meet the national standards for AFRHS (UNICEF, 2011). The target was to have 80% of health facilities providing AFRHS/FP by 2015.

Currently there is limited community linkage and community outreach for provision of "youth/ adolescent friendly" SRH services. There is also no data on adolescent/youth friendly points providing AFSRH at the communities. Primary and

secondary schools have incorporated into the curriculum topics on RH, HIV/STIs, pregnancy and other life skills. They would have been good area to improve RH services and information among adolescents. Lack of trained teachers in the subject limits its availability (UNICEF, 2011).

Young adolescents (10-14 years): There is an important information gap on the sexual and reproductive health needs of very young adolescents (10-14) years. Eleven percent (11%) of adolescents report their sexual debut began before the age of 15 years and (5%) of women reported having given birth by age of 15 (TDHS, 2010). Another worrying trend is that by the age of 15 years 3.2% of adolescents in 2004/05 were pregnant or had a child compared to 5.2% in 2010 (TDHS, 2010). Yet information is scarce on their specific health needs as well as their health care seeking behavior.

2.2.6 Reproductive Health Cancers

Reproductive health (RH) cancers includes cervical, breast and prostate cancers were not included in the first National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015. As a result RH cancer prevention and control activities and interventions lagged behind as they were not given priority in planning, financing or in building health system delivery (MOHSW, 2014a). However in 2011, the MOHSW developed Strategic Planning for national cervical cancer prevention and control (MOHSW, 2011a) followed by development of service delivery guidelines.

The burden of cervical cancer in Tanzania is high, with age-standardized incidence rate (ASR) is 50.9 cases per 100,000 women compared to an incidence of 25.2 per 100,000 in other African countries (GLOBOCAN, 2008). In 2009 alone, cervical cancer accounted for 35.3% of all cancer patients seen at Ocean Road Cancer Institute (ORCI) (MOHSW, 2011a). Mortality rate due to cervical cancer is 37.5 per 100,000.

The major cause of cervical cancer is HPV sub type 16 & 18 infection and HIV infection being the risk factor for the disease.

Currently, the country has introduced cervical cancer screening using Visual Inspection with Acetic Acid (VIA) combined with cryotherapy and Loop Electro-surgical Excision Procedure (LEEP) as one of the strategies for cervical cancer prevention (MOHSW, 2011a). The screening has been introduced in about 250 sites in all the mainland regions; mainly at regional and district hospitals (RCHS, 2014). Further primary prevention of cervical cancer by using HPV vaccination has been introduced in Tanzania.

Thus in the next 5 years the program needs to scale-up training of health providers in cervical cancer prevention and management, equip the facilities to be able to offer routine screening and management for cervical cancer, increase community awareness on RH cancers in general and prevention as well as to develop guidelines and scale up prostate and breast cancer screening and care.

The burden of prostate cancer and breast cancer is not so well documented and in the next five year there is a need to collect baseline information.

2.2.7 Gender Based Violence and Male Involvement

2.2.7.1 Gender Based Violence (GBV) and Violence against Children (VAC)

GBV and VAC prevention is a new program with national policy and guidelines for the health-sector prevention and response developed in September 2011 (MOHSW, 2011b). The prevalence of physical and/or sexual intimate partner violence in Tanzania ranges between 41 – 56% (Garcia-Moreno et al, 2006). Data from the TDHS of 2010 also shows that, Intimate Partner Violence (IPV) is a problem in Tanzania. Thirty nine (39%) of ever married women aged 15-49 years had experienced physical violence, 17% experienced sexual violence and 36% have experienced emotional violence by their current or previous partners. The prevalence varied significantly between the regions.

A total of 7-12% of Tanzanian women reported an incidence of IPV during pregnancy. For some of these women the beatings got worse when they were pregnant (TDHS, 2010). Women who had IPV are less likely to seek antenatal care, less likely to attend ANC at required frequency, less likely to use skilled attendance, PNC or use family planning methods (Hindin et al, 2008; Stockl et al, 2012).

Violence is also reportedly to be high among adolescents in Tanzania. Twenty four (24%) of adolescents women aged 15-19 reported to have experienced physical violence since the age of 15 years and 13% had experienced sexual violence (TDHS, 2010). Young men also experience violence; 13% of males aged 13-24 years have experienced at least one incidence of sexual abuse before 18 years (UNICEF, 2011). Reports have shown children and adolescents who were abused ends up with poor health outcomes like; post-traumatic stress disorder (PTSD) syndrome, suicidal ides/ attempts, drug use, teenage pregnancy, higher HIV prevalence or become violent adults themselves (Garcia-Moreno et al, 2006; Hindin et al, 2008; MOHSW, 2011b).

2.2.7.2 Male involvement

Male involvement was also not involved in the Road Map Strategic Plan that was developed for 2008-2015. However men are key in improving RMNCAH in general, as they are key decision makers, they are partners and fathers. Their involvement in most MNCH programs is low e.g., in PMTCT program the data shows only 30% do come for couple counselling with their partners. Other MNCH programs also report similar low participation. The need to have positive male participation in different RMNCAH programs need to be addressed in the coming five years (MOHSW, 2014a).

2.2.8 Cross Cutting Areas/Issues

2.2.8.1 Community engagement and demand creation

Many of the interventions in RMNCAH depend on utilization of health services and timely care seeking for different services by the women, children and family members (WHO, 2014). Use of modern contraceptives, antenatal services, skilled attendance during childbirth, vaccination and attending at health facilities when children are sick are all evidence-based interventions to improve survival and quality of life for women and children (Lancet, 2014). But care seeking may be influenced by several factors including but not limited to; awareness and knowledge, cultural beliefs, decision making power, availability of services, distance, cost, infrastructure, quality of services offered and accessibility (Kruk et al, 2009; Finlayson & Downe, 2013; HSSP III MTR-AR, 2013; Lassi et al, 2014b; MOHSW, 2014a). Hence measures to improve community awareness in different RMNCAH issues, community engagement to make them partners in the process as well as demand creation are important (Lancet, 2014).

Further, there are many RMNCAH services whose coverage and uptake can be tremendously improved by offering the services at community level, Annex 5. Counselling on FP and distribution of some methods, promotion of healthy behaviors, promotion of facility care seeking during pregnancy and childbirth, postnatal care visits at home, counselling/education on child nutrition and on harmful cultural and gender practices are all important (Lassi et al, 2014b).

Different approaches may be used to engage the communities and reach the families with interventions. Elsewhere, Community Health Workers (CHWs) have been shown to improve coverage of family planning, increase utilization of SBA and reduce neonatal morbidity and morbidity (Mushi et al, 2010; Tylleskar et al, 2011; Lewycka et al, 2013). Use of CHW to deliver multiple RMNCAH interventions such as FP, adolescent health, counselling in key aspects of FANC, promotion of SBA use, post-natal follow-ups visits with women and neonates within 48 hours after delivery, promotion of EBF, initiation of community-based treatment for diarrhoea might be some of the functions. Developing and harmonizing integrated CHW curriculum will be key in the next 5 years.

Empower communities to design and collect data to monitor, plan, and manage their own health situations at the household, community, and primary health facility levels is critical for improving program functioning, ownership, and sustainability

2.2.8.2 Integration

The MOHSWS has prioritized integration of RMNCAH services and it is documented in several policy documents (MOHSW, 2014a). In 2012 there was an assessment by the RCHS to look at opportunities, challenges and models of integrating RMNCAH services within the facilities and at the ministry and department level (MOHSW & USAID, 2012). The conclusion was that integration of services at delivery points would help to reduce missed opportunities to offer care for women and children, it would increase efficiency and coverage of services. That's why it has been identified as one of strategic objective in 2016 – 2020 and specific activities have been formulated to introduce and scale it up.

2.2.8.3 Health system strengthening

Leadership and governance: Tanzania has good policies that support RMNCAH, Table 6 and Annex 1. It also has a strong support of His Excellency the President of United Republic of Tanzania. The Mid Term Review of the One Plan showed gaps in operationalizing and costing of RMNCAH activities, which were rectified in the Sharpened One Plan - country plan to accelerate reduction in maternal, newborn and child deaths in 2014-15. What needs to be addressed and strengthened however is collaborative planning and implementation of RMNCAH activities between the MOHSW and PMO-RALG. While the MOHSW is responsible for developing policies and guidelines, PMO-RALG is responsible for delivery of all social services at the districts including health. Further there is a need to improve communication pipeline between RCHS-MOHSW with regional, district and facilities on newly developed guidelines or priority interventions.

Table 6: HSS success and unfinished agenda

System	Status health system	Challenges in Accountability
Health Information System	Data are collected on: • Service delivery • Maternal, Newborn and Child deaths.	Timely and site specific action on available data is poor
Health Service Delivery	• Data shows there stock-out of the life saving commodities in health facilities i.e. Oxytocin, injection Magnesium sulphate, Iron-folate, ORS & Zinc sulphate, Antibiotics • Only 20%of dispensaries and 39% of health centres provide BEmONC services. • There is inequitable coverage of newborn services and other maternal	Poor logistic management system MSD Poor supportive supervision

	and child health between basic facilities (dispensaries) and hospitals	
Health financing	• Regional and district plans were not aligned with plans to reduce maternal, newborn and child deaths. • Assumption that allocated funds is inadequate to save the life of maternal and a child • Failure to guide and align implementing partners with country plans	• Lack of focused plan • Donor dependency • Unfocussed interventions and duplication of efforts • Resources used do not match with results
Health workforce	• Majority of skilled staff are in urban and at secondary or tertiary facilities that at primary level • Variation in life saving skills: o There new graduate employees and those who have been working for long time without fresher courses o Availability of new interventions that are not disseminated.	Human Resource for Health management
Medicines and Supplies	Though financial crisis is crosscutting but family planning commodities, EmONC medicines, ORS/Zinc, dispensable Amoxycilin, Fefol are available	The major challenge is to ensure they reach the health facilities.
National Health Policy	Tanzania is rich policies, guidelines • MKUKUTA • Tanzania vision 2025 • Tanzania National Health Policy, 2007 • MMMAM • Health Sector Strategic Plan (III)	Our major challenge is implementation and M&E

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

National Health Insurance (NHIF), Community Health Funds (CHF) and other health insurance schemes like ''TIKA'' have shown an alternative of fund contribution to health sector. The limiting factor is low enrolment of communities into schemes as many perceive there is no benefit if they reach the facilities and have to buy medications due to stock outs (HSSP III MTR, 2013).

Tracking of resources and funds from the Government and partners that are earmarked for RMNCAH services have been poor. If it is routinely implemented it can improve advocacy, allocation, and absorption to strengthen efficiency and effectiveness of RMNCH resources. A 2013 RMNCH resource tracking has shown that there is significant financing that is allocated or given by partners in this area (RCHS, 2013). There is however lack of stewardship, transparency among partners, focused planning and small scale & duplicated interventions compared to available resource. Addressing this as a challenge, in the next five years, the RCHS should; conduct annual RMNCAH resource tracking incorporated in National Health Accounts (NHA) to track performance of all partners and associated resources used. It will also establish register to record all partners, on their area of intervention and associated geographical coverage.

Human Resources for Health: There is a critical shortage of health care workers in Tanzania. As per the MoHSW Human Resource for Health (HRH) 2013 Country profile, the total number of health workers has increased from 47,000 in 2006/7 to 64,449 in 2012/13, with the highest increase among medical doctors and nurses. Despite of these promising figures, skilled health workers density per 10,000 population was reported to be of 5.4, below the WHO-standards of 23 health care professionals (physicians, nurses and midwives) per 10,000 population. By 2012, there was overall facility vacancy rate of 33%. The vacancy rate was higher in hospitals (30%) and dispensaries (23%). Among the cadres, the shortage of medical officers was the highest (around 50%) followed by assistant medical officers (41%), and clinical officers and nurse/midwives (at 41% and 34%, respectively). Shortages of anesthetists, laboratory technicians, pharmaceutical technologists and pharmacists have been anecdotally reported, which also affects quality and timeliness of service provision. Among the challenges surrounding HRH deployment include correct recruitment against the need, mal-distribution between facilities and between rural and urban health facilities (Prytherch et al, 2012; MOHSW, 2013). There is therefore a need to develop strategies that will incentivize and retain providers who are working now especially in the rural areas.

Another challenge is low competency and skills of available providers to offer integrated RMNCAH services (MOHSW & USAID, 2012). Competency-based training curriculums are present for each individual component of RMNCAH. The challenge is

harmonizing these training curriculums and develops an integrated curriculum so that the providers will be ready to offer care in continuum of manner approach.

Further treatment of patients in a respectful manner by the health providers needs to be improved (Msele et al, 2013).

In the next 5 years the priority will be improve the number, skills and competence of both tutors and health providers by support regions and districts to pay much attention to availability of the right HRH per need and advocate with the responsible directorate of training of HRH to build capacity on the competency based curriculum to ensure competent graduates in RMNCAH. Motivation schemes for available providers should be thought by each region/ district and incorporated in their plans.

Strengthening the supply chain system: Frequent stock outs of RMNCH medicines, supplies and commodities remains to be a common challenge in services delivery at all levels of care. RMNCH commodities may be available at MSD but yet there stock outs in the facilities, indicating a huge challenge of maintaining the supply chain system efficiently and effectively. This happens despite of the effort to improve the system through Integrated Logistic System (ILS) Gateway established in November 2010 and electronic logistics management information system (eLMIS) which started in October 2013 (MOHSW, 2014b). Frequent lack of required supplies and equipment at MSD is another bottleneck.

Strengthening implementation of the national health management information system (HMIS): By using the HIMS data for each region, RCHS produced the national RMNCAH scorecard. This card shows the current status of key RMNCAH interventions for each region with color codes showing which indicator is doing well or lagging behind. The regions are supposed to fill them quarterly and assess if there is annual change towards the set target. Furthermore, training by RCHS and its partners for Regional and District Management teams on use of the cards might help with the accountability. But the country needs to make HMIS electronic up to dispensary and health center levels by 2020.

2.3 Rationale for the One Plan II

This strategic plan provides guidance for implementation of RMNCAH interventions beyond 2015. This strategic plan builds on the progress made under One Plan (2008-2015). The plan takes into account sustainable development goals that aim to end preventable maternal, newborn and child deaths by 2035. as well as taking into account untouched issues by the One Plan i.e. cross cutting issues like gender-based violence, human rights, integration of services and community engagement that influence access and quality of RMNCAH care services.

The focus in 2016-2020 is on reducing morbidity and mortality by offering quality services, of equity, offered by skilled attendants, in enabling environment and in an integrated and continuum of care taking into consideration community and facility factors.

CHAPTER 3: VISION, GOALS AND TARGETS FOR RMNCAH IN TANZANIA

3.1 Vision

A healthy and well-informed Tanzanians with access to quality reproductive, maternal, newborn, child and adolescent (RMNCAH) services; which are affordable, equitable and sustainable.

3.2 Mission

To promote, facilitate and support in an integrated manner, the provision of comprehensive, high impact and cost effective RMNCAH services, along the continuum of care to men, women, newborns, children and adolescents.

3.3 Goal

To accelerate reduction of preventable maternal, newborn, child and adolescent morbidity and mortality in line with the National Developmental Vision 2025.

3.4 Strategic Objectives

1. To reduce maternal mortality from 410 to 292 per 100,000 live births by 2020.
2. To reduce neonatal mortality rate from 21 to 16 per 1,000 live births by 2020
3. To reduce infant mortality rate from 45 to 25 per 1,000 live births by 2020
4. To reduce under-five mortality from 54 to 40 per 1,000 live births by 2020.
5. To increase contraceptive prevalence rate from 36% to 60% for all methods by 2020.
6. To increase service delivery points providing friendly health services for adolescents and Youth from 30% to 80% by 2020.
7. To increase post GBV services from 30% to 80% health facilities.

3.5 Operational targets to be achieved by 2020

The following operational targets are expected to be reached by 2020. These are:

Maternal Health

1. Increase coverage of health facility delivery from 50% to 80% of all deliveries
2. Increase coverage of deliveries attended by Skilled Health personnel from 51% to 80% among facility deliveries
3. Increase coverage of CEmONC from 73% to 100% for hospitals and from 9% to 50% for upgraded health centers.

4. Increase coverage of BEmONC from 20% (dispensaries) and 39% (health centres) to 70%.
5. Increase antenatal care visit four or more from 43% to 90%.
6. Increase postnatal care within first 48 hours from 31% to 80%.
7. Increase ART coverage and retention among HIV-positive pregnant women from 79% to 100%

Newborns and Child Health

1. Maintain immunization coverage by antigen of Pentavalent 3 (DPT-Hepatitis B-Hib), vaccines to above 90% in 90% of the councils.
2. HPV and inactivated polio vaccines scaled up to 90% of the councils
3. Increase initiation of breastfeeding within 1 hour after delivery from 49% to 80%.
4. Increase proportion of health facilities conducting deliveries which provide Essential Newborn Care (ENC) to 75%
5. Increase proportion of councils with at least 80% of primary health facilities with at least 2 service providers trained in IMCI distance learning from 24 % to 75% by 2020
6. Increase proportion of councils with at least 60% of primary health service providers trained in IMCI through distance learning approach from 10% to 50% by 2020
7. Increase proportion of sick under five children seeking care at health facilities appropriately managed according to IMCI guideline from to 80%.
8. Increase ARV-prophylaxis coverage for HIV-exposed children from 56% to 90%
9. Increase coverage of Early Infant Diagnosis (EID) from 37% to 95% of all exposed Infants
10. Increase ART coverage for HIV infected children from 26% to 80%.

Adolescents Health Services

1. Increase number of health facilities providing Friendly Reproductive Health Services for adolescents and youth from 30% to 80%.
2. Increase community base outlets offering comprehensive SRH Information, Education and Counselling Services from 46% to 80%

Other Reproductive Health Services

1. To increase proportion of Health facilities providing screening services for reproductive health cancers (breast, cervical, Prostate) from 2% to 60% by 2020.

2. To increase Proportion of female clients 30-50 years screened for Cervical Cancer using VIA from 2.5% to 60% by 2020
3. Proportion of male clients above 45 years screened for prostate Cancer using PSA/DRE

Family Planning services

1. Increase modern contraceptive prevalence rate from 27% to 45%
2. Increase contraceptive prevalence rate of all methods from 36% to 60%
3. Increase Couple Year Protection rate by all modern methods from 27% to 45%

Cross cutting

1. Increase the proportion of health facilities that provides post GBV/VAC services from 4% to 20%
2. Increase the proportion of villages with community health workers offering RMNCAH services at community level to 75%.

3.6 Strategies

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.
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 high impact MNCH interventions in an integrated manner.
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.
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.
5. Collaborate and coordinate supportive policies and legal environment that impact on social determinant of health; girls and boys education, women empowerment; respectful care, opportunities for economic growth using IEC/BCC materials and put emphasize on nutrition, education, water and sanitation.

6. Strengthen transparency and mutual accountability, monitor and evaluate progress using the RMNCAH scorecard at all levels of the health system and decision-making.

3.7 Impact Indicators

- Reduced maternal mortality ratio from 410 in 2015 to 333 per 100,000 live births in 2020 (5.5% annual reduction rate).
- Reduced under-five mortality rate from 54 in 2015 to 40 per 1,000 live births in 2020 (5% annual reduction rate).
- Reduced infant mortality rate from 45 in 2015 to 25 per 1,000 live births in 2020
- Reduced neonatal mortality rate from 21 in 2015 to 16 per 1,000 live births in 2020 (> 4.3% annual reduction rate).
- Reduced stillbirth rate from 26 in 2015 to 19 per 1,000 total births in 2020 (5% annual reduction rate).
- Reduced Mother-to-Child Transmission rate from 15% in 2015 to < 5% in 2020.
- Reduced adolescent fertility rate from 116 per 1,000 in 2015 to < 100 per 1,000 in 2020.
- Increased Contraceptive Prevalence Rate from 36% for all methods in 2015 to 60% in 2020; and from 27% for modern methods to 45%.

3.8 Guiding principals

Guiding Principles

The following principles will guide the planning and implementation of the One Plan II.

- **Continuum of Care:** Ensuring provision of the continuum of care from pre-pregnancy, pregnancy, labour and delivery, neonatal, childhood and adolescence across all levels of services delivery (household, community, primary facility to referral level).

- **Integration:** Ensure RMNCAH services are delivered in an integrated manner at the primary point of care to improve access and minimize missed opportunities.

- **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 as in Sharpened One Plan.

CHAPTER 4 DETAILED INTERVENTIONS AND ACTIVITIES

This chapter outlines strategic objective, activities and targets that will contribute in achieving goals of One Plan II

Strategic Objectives, Activities and Targets for One Plan II: 2016 – 2020

Maternal health and survival improved by 2020				
Program		**Strategic objectives**	**Activities**	**Target 2020**
Maternal Health		Strategic Objective 1: Utilization and quality of ANC services improved by 2020	Activity 1.1: Procure and supply essential medicines, equipment and laboratory reagents Activity 1.2: Conduct training to service providers on Focused ANC Activity 1.3: Conduct external and internal supportive supervision Activity 1.4: Print ANC (RCH card No. 4) and TT cards, IEC materials guidelines and job aids	○ Increase 4 or more ANC visits from 43% to 90% ○ Increase % of pregnant women tested for Syphilis from 38% to 80% ○ Increase % pregnant women tested for HIV from 90% to > 95% ○ Increase ITN use for pregnant women from 71% to 90% • At least 75% of hospitals with antenatal care services have corticosteroids to reduce preterm births
		Strategic Objective 2: Skilled birth attendant utilization increased by	Activity 2.1: Mapping of cadres available by facility level	• Increased SBA coverage from 51% to 80%

		2020	Activity 2.2: Conduct advocacy meetings at council level to motivate skilled health workers by providing a package of incentives in order to ensure quality services Activity 2.3: To conduct advocacy meeting with councils to lobby with pre-service students in training institutions	
		Strategic Objective 3: Access and availability of BEmONC increased by 2020	Activity 3.1 : Review BEmOC guidelines, IEC materials and job aids Activity 3.2: Print BEmOC guidelines, IEC materials and job aids Activity 3.3: Conduct training to update knowledge and skills of health providers on Basic Emergency Obstetric and Newborn care Activity 3.4: Procure and distribute equipment to all dispensaries and health centers offering delivery services	• Increase BEmONC signal function coverage from 20% at dispensary and 39% at health centers to 70% • Hundred (100%) of health facilities conducting deliveries have recommended equipment for newborn resuscitation (bag, mask and suction)
		Strategic Objective 4: Access and availability of CEmONC including availability of safe blood increased by 2020	Activity 4.1: Review and update CEmONC guidelines including job aids Activity 4.2: Print CEmONC Training Package and IEC materials Activity 4.3: Conduct training to update	• Increase CEmONC coverage for hospitals from 73% to 100% • Increase health centre CEmONC facilities from 9%

			knowledge and skills of service providers in CEmONC Activity 4.4: Mapping of EmONC facilities Activity 4.5: Conduct refresher training to update competence of pre-service tutors in nursing, clinical and medical schools in EmOC and NC	to 50%. • 80% of CEmONC facilities quality improved to 3 stars (refer BRN).
		Strategic Objective 5: Enhanced accessibility and utilization of safe blood and blood products in hospitals and health facilities by 2017	Activity 5.1: Construct 5 Satellite and blood distribution sites Activity 5.2: Procure equipment, supplies for collecting safe blood for satellite sites.	• Blood supply improved to 80% of the need.
		Strategic Objective 6: MNCH referral system improved by 2020	Activity 6.1: Procure ambulances for EmONC facilities. Activity 6.2: Conduct sensitization meetings with business community to support referral system. Activity 6.3: Conduct advocacy meetings with councils through PPP to establish voucher scheme to enhance referral system	• At least 80% of the councils have functional referral system from the community to first level facilities.
		Strategic Objective 7: Availability of essential commodities, supplies	Activity 7.1: Procure and distribute life saving commodities i.e. Fefol, oxytocins,	• Maternal life saving commodities stock out

		and medicines for MNCH improved by 2020.	misoprostol, injection magnesium sulphate, injection hydralazine, tablet methyldopa, antenatal corticosteroids, MVA kits, newborn/adult ambu bag & mask for all EmONC facilities. Activity 7.2: Conduct monitoring of availability of life saving commodities in EmONC facilities. Activity 7.3: Conduct annual surveillances of availability of life saving commodities in EmONC facilities.	maintained to at least less than 80% of the times
		Strategic Objective 8: MPDSR framework and use is implemented by 2017.	Activity 8.1:Print Maternal Perinatal Death Surveillance and Response (MPDSR) guideline Activity 8.2:Disseminate MPDSR Guideline Activity 8.3:Institutionalize MPDSR Activity 8.4:Conduct biannual MPDSR National technical meetings Activity 8.5:Publish and disseminate MPDSR report	• 80% of councils have institutionalized MPDSR
		Strategic Objective 9:Elimination	Activity 9.1:Orient RHMTs, CHMTs on eMTCT	○ Reduce MTCT of HIV from

		of mother to child transmission (eMTCT) realized at below 5% transmission rate by 2020	interventions and bottleneck analysis Activity 9.2:Conduct eMTCT sub-team meetings Activity 9.3:Procure antiretroviral medicines, HIV test kits, DBS kits for RCH sites Activity 9.4: Conduct training to strengthen human resource capacity and systems to deliver quality and integrated comprehensive eMTCT services at all levels of service delivery. Activity 9.5: Conduct training to PLHIV groups to support delivery of PMTCT and pediatric HIV care. Activity 9.6:Conduct biannual PMTCT data quality assessment Activity 9.7:Print IEC materials for PMTCT Activity 9.8: Conduct PMTCT supervision to health care workers in RCHS facilities Activity 9.9: Printing registers, report forms, cards, laboratory forms, and	12.7% to 4% ○ Increase % of pregnant women tested for HIV and receiving results from 90% to > 95% ○ Increase ART coverage and retention among HIV-positive pregnant women from 79% to 90% ○ Increase % of couple counseled and tested for HIV from 30% to 50% • Increase % of HIV-exposed infants tested for HIV within 2 months of age from 30% to 90% • Increase % of HIV-exposed infants receiving ARV prophylaxis from 56% to 90% • Increase % HIV-exposed infants receiving

			training manuals	cotrimoxazole prophylaxis from 34% to 90% ○ Increase % of HIV-positive children on ART treatment from 26% to 60%
		Strategic Objective 10:MNCH community services improved by 2020	Activity 10.1:Train community health workers on integrated community maternal, newborn, child health Activity 10.2:Conduct advocacy meetings for every village to mobilize community resources for emergency transport Activity 10.3:Conduct training for community health supervisors on integrated maternal, newborn, child and adolescent health • Print CHWs materials on MNCAH	○ At least 80% of districts have institutionalized CHW services.
		Strategic Objective 11:Postnatal care services increased in coverage and quality by 2020	Activity 11.1:Review, update and distribute postnatal care guidelines Activity 11.2:Conduct training to update knowledge and skills of health care providers on essential postnatal care and monitoring Activity 11.3:To develop and print minimum	○ Increase % of women receiving PNC from 31% to 80%

			package for integrated RMNCAH outreach services to reach women and newborns at the community	
		Strategic Objective 12:Improve maternal and lactating mothers nutrition status and practices by 2020	Activity 12.1:Develop and print maternal, newborn, child and adolescent nutrition guideline Activity 12.2:Disseminate maternal, newborn, child and adolescent nutritional guidelines by orienting regional, district and health facility teams	○ Reduce anemia in pregnancy from 53% to 37%

Newborn health and survival improved by 2020				
Program		**Strategic objectives**	**Activities**	**Target 2020**
Newborn Health		Strategic Objective 1: Essential newborn care services provided at all facilities conducting deliveries by 2020.	Activity 1.1:Conduct Essential Newborn Care Training (ENC) to build capacity of health care workers to provide quality ENC Activit 1.2:Procurement of newborn resuscitation equipment(ambu bags/mask sizes 0 & 1, suction devices, Resuscitation tables with Radiant warmer)	○ At least 75% of the health facilities with deliveries provide ENC ○ At least 50% of the newborns without spontaneous breathing at birth are resuscitated with bag and mask

		Management of preterm and low birth weight babies improved by 2020.	• Conduct needs assessment site visit for Kangaroo Mother Care (KMC) service establishment • Conduct KMC training to build capacity of health care providers to provide quality care to preterm babies. • Establish KMC sites at all District hospitals (equipped with KMC beds, beddings, weighing scales, low reading thermometers, calibrated feeding cups)	○ At least 75% of district hospitals implement Kangaroo Mother Care (KMC) ○ At least 50% of preterm and LBW newborns receive KMC
		Strategic Objective 2: Management of preterm and low birth weight babies improved by 2020.	Activity 2.1:Conduct needs assessment site visit for Kangaroo Mother Care (KMC) service establishment Activity 2.2:Conduct KMC training to build capacity of health care providers to provide quality care to preterm babies. Activity 2.3:Establish KMC sites at all District hospitals (equipped with KMC beds, beddings, weighing scales, low reading thermometers, calibrated feeding cups)	○ At least 75% of the district hospitals have functional neonatal care unit ○ At least 50% of newborns with possible serious bacterial infection receives antibiotic therapy ○ At least 90% of facilities conducting deliveries have recommended antibiotics for newborn infections (I/M ampicilin and gentamycin)

		Strategic Objective 3: Management of sick newborn improved by 2020.	Activity 3.1: Integrated Management of Childhood Illnesses (IMCI) Training (Distance Learning mode) which includes management of sick newborns. Activity 3.2: Advocacy meetings for establishment of Neonatal Care Units/Room at district hospitals Activity 3.3: Procurement of essential equipment for care of sick newborn (Oxygen concentrators, Phototherapy machines, Suction machines, Low reading thermometers, room thermometers, room heaters, etc.)	○ At least 75% of the district hospitals have functional neonatal care unit ○ At least 50% of newborns with possible serious bacterial infection receives antibiotic therapy ○ At least 90% of facilities conducting deliveries have recommended antibiotics for newborn infections (I/M Ampicillin and Gentamycin)

Child survival improved by 2020				
Program		**Strategic objectives**	**Activities**	**Target 2020**
Child health		Strategic Objective 1:Management of common childhood illnesses improved by 2020.	Activity 1.1: Train health care workers on Integrated Management of Childhood Illnesses (IMCI) Training (Distance Learning mode).	• 80% of all health facilities in a district have at least 60% of providers trained on IMCI

			Activity 1.2: Train health care workers on Emergency Triage Assessment and Treatment (ETAT) to manage pediatric emergencies at hospital and health center level. Activity 1.3: Procurement of Pediatric emergency equipment for hospitals and health centers (Oxygen concentrators, Pulse Oxymeters, Nebulizers, Glucometers, Haemoques, Suction machines, Ambu bags/masks, Infusion pumps) Activity 1.4: Conduct Clinical Mentoring at hospital and health center level Activity 1.5: Conduct Supportive Supervision for quality pediatric and nutrition care to hospitals and health centers	• 90% of sick children seeking care at health facilities are appropriately managed for Pneumonia, Malaria and Diarrhea according to IMCI guidelines • 80% of hospitals and Health Centers with functional Diarrhea Treatment Corner (DTC) • 80% of hospitals with Triage system and functional emergency area
		Strategic Objective 2: Routine U5 vaccination sustained with equitable coverage by 2020	Activity 2.1: Implement Reach Ever District/Child (RED/REC) Strategy activities in all councils Activity 2.2: Intensify surveillance of vaccine preventable diseases Activity 2.3: Develop, print, and disseminate immunization policy guidelines	○ Maintain coverage of all vaccines at 90% in 90% of the districts

			Activity 2.4: In-service, refresher, and mid-level management (MLM) training at all levels Activity 2.5: Distribution, cold chain supply and vaccine management Activity 2.6: Develop, print, disseminate and implement communication strategy (mass media, IEC, immunization week) Activity 2.7: Supportive supervision for immunization Activity 2.8: Improve data management Activity 2.9: Introduce new and under used vaccine Activity 2.10: Coordination meetings at all levels	
		Strategic Objective 3: Improve breastfeeding rates and practices by 2020	Activity 3.1: Capacitate health care providers in assisting women to initiate breast feeding within 1 hour, and exclusive breastfeeding at all levels Activity 3.2: Train community health care workers at all levels on importance of early breastfeeding initiation and breast feeding techniques	• Increase exclusive breastfeeding prevalence from 50% to 80% • At least 75% of district hospitals are accredited BFHI
		Strategic Objective 4: Infant and	Activity 4.1: Train health care workers at all	• 90% of health facilities

		Young Child Feeding (IYCF) practices and nutrition status improved by 2020.	levels on new growth monitoring standards and tools Activity 4.2: Procure and distribute length/height boards and MUAC tapes to all health facilities offering under five growth monitoring services Activity 4.3: Print under 5 growth monitoring booklets (sex specific) Activity 4.4: Training health care workers and CHWs on adequate meal frequency and food diversity for pregnant women and children	monitoring length/height for under-five • Reduce stunting from 42% to 22% • Reduce underweight from 16% to 11% • Reduce prevalence of anemia among children from 59% to 41%
		Strategic Objective 5: Coverage of Management of Severe Acute Malnutrition (SAM) through the national health system increased by 2020	Activity 5.1: Train health care workers (including nutrition officers) and community health workers on management of MAM and SAM Activity 5.2: Conduct regular screening for malnutrition among all U5 attending at health facilities Activity 5.3: Procure essential supplies (therapeutic milk and food) to all district, regional, and referral hospitals for SAM treatment	• At least 50% of the hospitals implementing management of SAM

			Activity 5.4: Equip hospitals to manage nutritional rehabilitation	
		Strategic Objective 6: Improved community and household practices for child survival by 2020	Activity 6.1: Conduct Quarterly Village Child Health Days	○ Increase care seeking for U5 with diarrhea, pneumonia and malaria from 53%, 71% and 73% to 90% ○ Increase ITN use by U5 from 73% to 90% ○ At least 50% of villages conduct quarterly village child health days.
		Strategic Objective 7: Improved accountability for U5 deaths by 2020	Activity 7.1: Conduct Under-five Death Reviews Activity 7.2: Orientation to standard pediatric treatment guideline and facility assessment for pediatric quality of care	• At least 50% of the hospitals conduct U5 death reviews • At least 80% of hospitals conduct annual assessment for pediatric quality improvement (QI)

Adolescent sexual and reproductive health improved by 2020

Program		Strategic objectives	Activities	Target 2020
Adolescent Health		Strategic Objective 1: Adolescent and Youth Friendly Sexual and Reproductive Health (AYFSRH) including HIV service coverage and FP increased by 2020	Activity 1.1: Conduct rapid assessment of health programmes with integrated adolescent and youth friendly services based on the national standards. Activity 1.2: Survey on barriers to accessing and using adolescent and youth friendly health services Activity 1.3: Develop, adapt, and print tools for integrated supportive supervision of adolescent and youth friendly service provision at service delivery points. Activity 1.4: Develop, adapt, and operationalize a system for outreach, effective referral and networking for adolescent and youth SRH and HIV services. Activity 1.5: Procure essential equipment, materials and supplies for adolescent and youth friendly SRH and HIV services. Activity 1.6: Use Social marketing initiatives to	Increase proportion of health facilities providing AYFSRH services from 30% to 80%

			provide SRH and HIV services and to adolescents and youth. Activity 1.7: Disseminate the National Standards for Adolescent and Youth Friendly Reproductive Health Services to policy/decision makers, programme managers, supervisors and development partners at national, regional, district and community levels. Activity 1.8: Review, develop, adapt, and print training materials including a training plan to roll-out implementation of the national standards for adolescent friendly SRH Services. Activity 1.9: Assess the in-service training needs among various service providers on provision of adolescent and youth friendly SRH and HIV. Activity 1.10: Build capacity of human resource in public and private health facilities to implement the national standards for adolescent friendly SRH services.	

			Activity 1.11: Develop and outline a national minimum package of services for adolescents to be provided at each level of service delivery (job aid, SOP, and supervision checklist) Activity 1.12: Integrate adolescent health into the pre-service training curriculum Activity 1.13: Develop framework for monitoring implementation of adolescent and youth friendly SRH and HIV services in service delivery points Activity 1.14: Review meetings semi-annually and annually	
		Strategic Objective 2: Comprehensive knowledge, skills and positive behaviors on sexuality and reproductive health education improved among adolescent by 2020	Activity 2.1: Review, develop, adapt, print, disseminate and distribute adolescent and youth SRH and HIV rights advocacy messages and materials. Activity 2.2: Review, adapt, harmonize, print, and distribute national IEC/BCC materials related to adolescent and youth SRH (peer education, life skills, parent guide, para professional counseling, sermons	Increase community based outlets offering comprehensive sexuality education & SRHS services to 30%

			guide). Activity 2.3: Roll out adolescent SRH communication interventions delivered by CORPS e.g. lay counsellors, peer educators, village health workers using national guidelines and standards.	
		Strategic Objective 3: Linkage and capabilities among various stakeholders in the government, private sector and CSOs dealing with adolescent SRH strengthened by 2020	Activity 3.1: Conduct Stakeholders analysis and map key partners in advocating for adolescent SRH at all levels. Activity 3.2: Facilitate formation of adolescent SRH and rights coalition at all levels Activity 3.3: Build capacity of national, regional, district core teams and interested CSOs on advocacy on investing in adolescent and youth SRH and HIV. Activity 3.4: Advocate for resource mobilization and allocation for adolescent SRH interventions at all levels.	
		Strategic Objective 4: Institutionalize policies and supportive laws to improve access to information, education and services for adolescents by 2020	Activity 4.1: Review existing national policies and laws to conform to international/ regional conventions on adolescent sexual and reproductive health and rights.	Proportion of national policies and laws incorporating adolescent SRH and rights. Proportion of regions/districts

			Activity 4.2: Advocate for formulation of relevant national laws, district and village by-laws to promote adolescent and youth SRH and HIV and rights.	with advocacy plan for adolescent SRH and rights. Proportion of service providers oriented on adolescent SRH and rights, policies and laws.
		Strategic Objective 5: Knowledge, understanding and healthy practice for sexual and reproductive health and rights (SRHR)as well as socio-economic situation of adolescents and youth improved by 2020	Activity 5.1: Conduct rapid assessment and map existing community-based activities related to the National Youth Adolescent Parent Community Alliance (NYAPCA) Activity 5.2: Establish and strengthen National Youth Adolescent Parent Community Alliance (NYAPCA) in selected districts for provision of SRH information, education, and services (clinical and non-clinical SRH services, recreational activities, small library/learning services, and livelihood activities). Activity 5.3: Scale-up supervision of community based National Youth Adolescent Parent Community Alliance (NYAPCA) activities. Activity 5.4: Support implementation of	Increased number of districts/regions with outlets offering ASRH information and services to 40% Proportion of council plans integrating adolescent and youth issues. Increase economic empowerment networks supporting young people on Income Generating Activities to 10%.

			innovative information, education, and services for adolescent and youth SRH and HIV, including those with disabilities Activity 5.5: Support utilization of existing community structures (religious leaders, parents, community and government leaders) to reach young people with age-appropriate sexual and reproductive health information and link them to services. Activity 5.6: Design and advocate on use of culturally appropriate mass media communication strategies for ASRH/FP. Activity 5.7: Build capacity of LGAs (CHMTs) on integration of youth issues into planning processes. Activity 5.8: Liaise with other sectors (CSOs, MDAs etc) to support out of school youth access to income generating activities, business skills training, resource mobilization skills training and capacity building for youth led organization.	

Contraceptive utilization improved by 2020				
Program		**Strategic objectives**	**Activities**	**Target 2020**
Family Planning		Strategic Objective 1: Family Planning (FP) services and utilization improved by 2020	Activity 1.1: Train skilled health care providers to provide method mix with special focus on long term methods. Activity 1.2: Train on preceptorship, mentoring and coaching on FP Activity 1.3: Update FP contents of pre-service curriculum of different cadre/ health training institutions Activity 1.4: Conduct Contraceptive Technology Update for pre-service tutors	○ Increase modern CPR from 27% to 60%
		Strategic Objective 2: Integration of FP into other maternal, newborn, child, and adolescent health (MNCAH) programs improved by 2020	Activity 2.1: Train skilled health care providers to provide integrated FP/HIV, FP/Postpartum/Immunization outreach and cPAC/FP services Activity 2.2: Establish integrated outreach RMNCAH clinics to promote uptake of FP services	
		Strategic Objective 3: Contraceptive coverage at community level	Activity 3.1: Train skilled health care providers to provide male friendly FP services.	

Contraceptive utilization improved by 2020				
Program		**Strategic objectives**	**Activities**	**Target 2020**
		improved by 2020	Activity 3.3: Investigate challenges influencing male involvement and participation in FP services. Activity 3.4: Conduct FP outreach services to reach males in workplaces such as mining, constructions and fishing camps Activity 3.5: Ensure youth/young people access and use of contraception services Activity 3.6: Partner with private companies to increase accessibility and utilization of FP	
		Strategic Objective 4: Procurement and distribution of FP commodities improved by 2020	Activity 4.1: Procure and distribute FP commodities. Activity 4.2: Supervise zonal contraceptive stocks Activity 4.3: Publicize and re-launch Green star	
		Strategic Objective 5: Contraceptive coverage at community level improved by 2020	Activity 5.1: Train CHW to increase scope of FP service provision at community level. Activity 5.2: Train community	

Contraceptive utilization improved by 2020				
Program		**Strategic objectives**	**Activities**	**Target 2020**
			mobilizers/champions on how to influence people on FP Activity 5.3: Engage religious leaders to promote family planning	
		Strategic Objective 6: Demand for FP improved by 2020		
		Strategic Objective 7: M&E and management of FP service provision improved by 2020	Activity 7.1: Implementation of Costed Implementation Plan	

Prevention of reproductive health cancers improved by 2020				
Program		**Strategic objectives**	**Activities**	**Target 2020**
Reproductive Cancers		Strategic Objective 1: Increased coverage of reproductive cancers screening by 2020	Activity 1.2: Review and update cervical cancer strategic plan to incorporate prostate and breast cancer prevention Activity 1.3: Update national cervical cancer guideline to incorporate breast cancer prevention	○ Increase by 50% the sites providing RH cancer screening

			Activity 1.4: Develop guideline for prostate cancer screening Activity 1.5: Review the national training package for cervical cancer screening to incorporate breast screening Activity 1.6: Develop national training package for prostate cancer screening Activity 1.7: Strengthen and establish health facilities capacity to screen and manage RH cancers Activity 1.8: Develop outreach plan to increase uptake and utilization of reproductive health cancers Activity 1.9: Conduct supportive supervision	
		Strategic Objective 2: Community awareness and knowledge on reproductive health cancers improved by 2020.	Activity 2.1:Develop communication strategy for reproductive health cancers Activity 2.2:Develop IEC materials for community and messages for radio and TV on reproductive health cancers Activity 2.3:Conduct community sensitization and advocacy meetings at all levels	

			Activity 2.4: Develop and Print M & E tools	
		Strategic Objective 3: HPV vaccination coverage among adolescent girls increased by 2020	Activity 3.1: Develop HPV vaccine guidelines Activity 3.2: Finalize, print and distribute HPV training and IEC materials Activity 3.3: National launching of HPV rollout	• Increase coverage of HPV vaccine to 80% at national level
		Strategic objective 4: National level capacity for addressing RH cancers increased by 2020	Activity 4.1: Hire full-time staff to support RH cancer activities	

Cross cutting key issues				
Gender, GBV and male involvement strategies and programs improved by 2020				
Program		**Strategic objectives**	**Activities**	**Target 2020**
Gender and Male Involvement		Strategic Objective 1: Gender, GBV, VAC and male involvement guidelines and strategies in RMNCAH developed, updated and disseminated by 2017	Activity 1.1: Develop guidelines on integration of gender in RMNCH by 2017 Activity 1.2: Develop gender, GBV and VAC advocacy strategy Activity 1.3: Operationalize and roll out male involvement guidelines in RMNCH interventions Activity 1.4: Review other RMNCAH and HIV	Gender, GBV/VAC and male involvement guidelines and strategies available in 25% of the councils by 2017 25% of RMNCAH managers at all levels sensitized on Gender, GBV/VAC and Male involvement by 2020

			guidelines to include Gender, GBV and VAC issues Activity 1.5: Mobilize resources for GBV/VAC prevention and response activities	
		Strategic Objective 2: Gender, GBV and male involvement integration into RMNCAH and HIV improved by 2020.	Activity 3.1: SBCC interventions for addressing harmful GBV, VAC, gender norms and promoting male involvement and improving health seeking behaviors Activity 2.2: Integrate GBV and VAC one stop centers at referral hospital level Activity 2.3: Inclusion of Gender, GBV, VAC and male involvement in Pre-service Curricula	60% of health care providers trained on gender, GBV, VAC and male involvement by 2020 One stop centers for GBV/VAC available in 25% of all referral hospitals by 2020 GBV/VAC and male involvement included in pre-service curricula by 2020
		Strategic Objective 3: Community and households empowered with knowledge and information in understanding of harmful gender norms, male involvement, and prevention and response to GBV and VAC by 2020.	Activity 3.1: SBCC interventions for addressing harmful GBV, VAC, gender norms and promoting male involvement and improving health seeking behaviors Activity 3.2: Orient CHWs on Gender, GBV and VAC prevention interventions using national guidelines and standards Activity 3.3: Design and conduct outreach services to promote usage of	At least 50% of household members or communities have awareness on GBV, VAC and male involvement by 2020 At least 50% of CHWs oriented on gender, GBV, VAC and Male involvement by 2020

			GBV/VAC prevention and response services Activity 3.4: Develop and roll out school based and community curriculum and training package on prevention of harmful gender norms, GBV and VAC, and its implications on health	

Integration of RMNCAH programs and services improved by 2020				
Program		**Strategic objectives**	**Activities**	**Target 2020**
Integration		Strategic Objective 1: National coordination that deal with RMNCAH/HIV integration established by 2017	Activity 1.1: Appointment of integration focal person at the national level Activity 1.2: Identification of integration focal person at regional and district level Activity 1.3: Update existing RMNCAH national guidelines to take into account integration of services Activity 1.4: Financial mobilization by the government and stakeholders to support integration activities	

		Strategic Objective 2: Provision of integrated RMNCAH/ HIV services strengthened by 2020	Activity 2.1: Disseminate guidelines on RMNCAH integration Activity 2.2: Orientation of health care providers and supervisors on RMNCAH integration Activity 2.3: Assessment of facilities infrastructure to identify gaps in line with integration of service Activity 2.4: Advocate for infrastructure improvement or other steps to bridge identified gaps in line with integration of service	

		Strategic Objective 3: Environment to support awareness and demand creation for integrated RMNCAH/HIV services in the community strengthened by 2020	Activity 3.1: Develop SBCC materials and messages, in line with the national integrated RMNCAH communication guideline Activity 3.2: Disseminate SBCC materials on integration of RMNCAH services at the community level Activity 3.3: Community mobilization and outreach for integrated RMNCAH services using champions and CHWs	

Health Systems to provide RMNCAH services strengthened and improved by 2020				
Program		**Strategic objectives**	**Activities**	**Target 2020**
Leadership and governance		Strategic Objective 1: National coordination team responsible for collaborative planning and implementation of RMNCAH services between RCHS and PMO-RALG established by 2017	Activity 1.1: Orient national, zonal, regional, and district coordinators on management of integrated RMNCAH services	

		Strategic objective 2: Improve monitoring, documentation and sharing lessons learnt of key results in RMNCAH by 2020	Activity 2.1: RCHS – inter department meetings to be organized twice per year to share key results across units Activity 2.2: Each unit should present at least once per year key findings/ results in the RCHS TWG Activity 2.3: Producing and e-distribution of a newsletter with key lessons and results by the RCHS twice per year	
		Strategic Objective 3: Transformation of RCH from a section to a directorate completed by 2020	Activity 3.1: Conduct advocacy meetings at various levels to design steps to start a process of transforming RCHS into a department.	
Human resource for health (HRH)		Strategic Objective 1: Improve HRH situation in collaboration with other department of planning and pre-service training institutions by 2020.	Activity 1.1: Improve uptake of skilled health workers in the local government by right carder and equitable distribution .	
		Strategic Objective 2: Health care workers performance and competence in RMNCAH improved by 2020.	Activity 2.1: Conduct induction trainings for newly employed MNCH providers in RMNCAH competencies Activity 2.2: Conduct RMNCH refresher trainings s	
Health financing in		Strategic Objective 1: Budget allocation from Government to	Activity 1.1: Conduct bi-annual advocacy meeting to stakeholders at all levels	

RMNCAH		RMNCAH increased by 2020	for advocating government budget allocation for RMNCAH activities	
		RMNCAH resource mobilization from development partners improved by 2020		
		Strategic Objective 2: Resource tracking on RMNCAH plans and implementation on annual basis implemented from 2016-2020.	Activity 2.1: Conduct resource tracking annually.	
Monitoring and Evaluation:		Strategic Objective 1: Ensure paper based system for data collection is replaced by electronic system at all levels by 2020	Activity 1.1: Ensure paper based system for RMNCAH services data collection is gradually replaced by electronic data collection system for at all Tertiary and Secondary level facilities by 2020	
		Strategic Objective 2: Data management and use improved by 2020.	Activity 2.1: Ensure increased RMNCAH data completeness and timeliness through periodic field M and E supervisions by 2020 Activity 2.2: Ensure increased RMNCAH data quality through periodic data audits by 2020 Activity 2.3: Ensure that MPDSR data is integrated into the HMIS/DHIS 2 electronic data base at Council level by 2020.	

			Activity 2.4: Use of RMNCAH Score card improved by 2020	
		Strategic Objective 3: Share M&E results	Activity 3.1: Communicating M&E results	

CHAPTER 5 MONITORING AND EVALUATION

The goal of monitoring and evaluation of RMNCAH activities in Tanzania will be to provide reliable information on progress towards the achievement of the goal to accelerate reduction of preventable maternal, newborn, child and adolescent morbidity and mortality in Tanzania. The One Plan II will focus on tracking key qualitative and quantitative indicators as a subset of the broad indicators stipulated in the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2016 to 2020. There will be a special focus on monitoring progress in Lake and Western Zones, particularly in addressing the poorly performing indicators as referenced earlier in Sharpened One Plan 2014 to 2015. The monitoring and evaluation objectives for RMNCAH activities in Tanzania from 2016 to 2020 are:

Monitoring

- To coordinate collection, processing, analysis and management of RMNCAH data.
- To verify whether activities have been implemented as planned to ensure accountability and address problems that have emerged in a timely manner.
- To provide feedback to data providers and relevant authorities to improve future planning.
- To report monthly, quarterly, half-yearly and annual progress on all key RMNCAH activities.

Evaluation

- Measure the degree to which RMNCAH interventions have been successfully implemented and scaled-up, as measured against targets from 2016 to 2020.
- Assess changes in preventable maternal, new-born, child and adolescent morbidity and mortality after the scale-up of RMNCAH interventions (2016 – 2020)
- Assess the plausible attribution of the RMNCAH interventions to any observed decreases in maternal, new-born, child and adolescent morbidity and mortality due to RMNCAH interventions between 2016 – 2020
- Provide guidance for routine monitoring, as well as provide guidance on key operations research studies necessary to inform RMNCAH programmatic decisions.

The Main Monitoring and Evaluation tasks and activities during the operationalization of the One Plan II will include but not limited to:

- Work with RMNCAH partners to harmonize indicators, strategies, data collection strategies, analyses and reports
- Advocate for evidence-based RMNCAH planning at all levels of the health system
- Review public health goals in line with RMNCAH strategic objectives at all levels of the health system to determine the monitoring and evaluation needs.
- Coordination of RMNCAH monitoring and evaluation processes in the country including evaluating the relevance of data collected
- Identify possible sources of RMNCAH data for selected indicators.

- Assess RMNCAH data quality in terms of collection, reproducibility, and quantitative and qualitative data collection techniques.
- Assess and review research proposals developed by implementing RMNCAH partners before submission to COSTECH and / or NIMR National Health Research Ethics Review Committee.
- Collect, process, and analyse data, and interpret and report.
- Disseminate progress reports on a regular basis.
- Greatly contribute to the organization and management of the centralized electronic HMIS/DHIS2 database to which RMNCAH data is stored and secured.

5.1 Indicators

Indicators provide measures to assess whether adequate delivery systems exist, and provide measures to verify if RMNCAH activities were scaled-up and implemented successfully; and if there have been a change in RMNCAH-related morbidity and mortality. The tables below present a list of key RMNCAH indicators by data source(s) and target populations. These indicators correspond to the overall stipulated RMNCAH target objectives detailed and will be needed both to monitor scale-up activities and evaluate effectiveness. These indicators will be collected as part of routine monitoring and evaluation system at different levels and different spans of time.

Data from multiple sources will be used to provide strategic information for RMNCAH monitoring and evaluation. Data sources include standard monthly reports from the HMIS/DHIS2; routine reporting from national surveillance systems (HMIS/IDSR), Health Facility-based Sentinel Surveillance; periodic household surveys (population based: national and sub-national); and facility surveys (e.g. Service Provision Assessments). A description of the indicators by key interventions, data sources needed and the target population are presented below:

Impact Indicators

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
Maternal mortality ratio	The number of women who die of causes related to pregnancy (pregnancy, childbirth or within 42 days of termination of pregnancy, irrespective of the duration) in a given year or other period	All maternal deaths occurring in a period (usually a year)	Total number of live births occurring in the same period per 100,000 live births	410 (UN Estimates, 2013)	292	TDHS, Census	Every 4 to 5 years Every 10 years
Neonatal mortality rate	The number of deaths during the first 28 completed days of life per 1000 live births in a	Number of children who die within the first 28 completed days of life	Number of live births ÷ 1000	21 UN Estimates, 2013	16	TDHS Census	Every 4 to 5 years

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
	given year or other period.						
Infant mortality rate	The number of infants who die before completing the first year of life per 1000 live births in a given year or other period.	Number of deaths within the first year of life.	Number of live births ÷ 1000	45 (Census 2012)	25	TDHS Census	Every 4 to 5 years Every 10 years
Under-five mortality rate	The number of children who die within the first five years of life per 1000 live births in a given year or other period.	Number of deaths within the first five years of life.	Number of live births ÷ 1000	54 UN Estimate	40	TDHS Census	Every 4 to 5 years Every 10 years
Age specific fertility rates	The number of live births per	Number of live births to women in	1000				Every 4 to 5

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
	1000 women in a **specific age** group for a specified geographic area and for a **specific** point in time, usually a calendar year.	specified **age** group.					years Every 10 years
Total fertility rate	The average number of children a hypothetical cohort of women would have at the end of their reproductive period if they were subject during their	Sum of age specific fertility rates for age groups comprising 15-49 age group.	1,000	5.2 (Census 2012)	5.0	TDHS census	Every 4 to 5 years Every 10 years

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
	whole lives to the fertility rates of a given period and if they were not subject to mortality.It is expressed as children per woman.						
Adolescent fertility rate	The number of births per 1,000 women ages 15-19.	number of live births to women aged 15–19 years,	Estimate of exposure to childbearing by women aged 15–19 years	116 per 1,000 women (TDHS 2010)	80 per 1,000 women	TDHS Census	Every 4 to 5 years Every 10 years
Adolescent birth rate	The annual number of *live births to adolescent women per 1,000*	number of live births to adolescent women	The total number of adolescent women and multiplied by 1,000.				Every 4 to 5 years Every 10 years

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
	adolescent women.						

Family Planning Indicators

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
Contraceptive prevalence rate (modern methods)	Percentage of women aged 15-49 years who are currently using, or whose sexual partner is using, at least one modern method of contraception, regardless of the method used.	Number of women of reproductive age at risk of pregnancy who are using (or whose partner is using) a contraceptive method at a given point in time	Number of women of reproductive age at risk of pregnancy at the same point in time	36 % (All methods) 27 % (Modern Methods)	60 % (All methods) 45 % (Modern Methods)	TDHS	Every 4 to 5 years
Unmet need for family planning	Percentage of women of reproductive age, either married or in a union, who have an unmet need for family planning. Women	The number women age 15 to 49 that do not want to become pregnant but are not using contraception.	Number of women age 15 to 49 years, either married or in a union,	25.3 % 2010 TDHS		TDHS	Every 4 to 5 years

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
	with unmet need are those who want to stop or delay childbearing but are not using any method of contraception.						
Number of individuals accepting contraceptives (new acceptors)	The numbers of persons who accept for the first time in their lives any (program) contraceptive method; to be reported for a defined reference period (e.g., one year).	Counts of persons accepting any (program) method for the first time in their lives during a one-year period	NA	2,100,000	5,000,000	HMIS	Quarterly
Percent of women 15-49 years old who have heard of		Number of women aged 15-49 who have heard about at	Number of women aged 15-49 interviewed)			TDHS	*Every 4 to 5 years*

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
three or more family planning (FP) methods, modern or traditional		least three methods of FP	x 100				

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
Percent of the population who know of at least one source of modern contraceptive services and/or supplies		Number of of people surveyed/interviewed who know of at least one source of modern contraceptive services and/or supplies	Total number of people surveyed or interviewed) x 100				
Percent of facilities that experienced a stock out at any point during a given time period		Number of facilities that experienced a stock out of a product	Total number of facilities that offer product per 100			eLMIS	Quarterly
Couple-years of protection (CYP)	The estimated protection provided by family planning (FP) services during a one-year period,					HMIS	Annually

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
	based upon the volume of all contraceptives sold or distributed free of charge to clients during that period						
Number of FP service delivery points offering full range of contraceptive supplies per 500,000 populations.		Number of FP service delivery points offering full range of contraceptive supplies	500,000 per population of Tanzanians (mainland)	58	60	HMIS	Annually

Maternal Health Indicators

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
Antenatal care coverage: before 12 weeks gestational age	Percentage of pregnant women start ANC before 12 weeks of gestation age	Number of pregnant women who start ANC before 12 weeks of gestation age x 100	Estimated number of pregnant women.	15% (< 4 months TDHS 2010) 12% (HMIS 2014)	60% (< 4 months)	HMIS TDHS (< 4 months)	HMIS (Monthly) TDHS interval
Pregnant women attending ANC 4+ times	Percentage of pregnant women who received antenatal care four or more times in a given time period.	Number of pregnant women who received antenatal care four or more times x 100	Estimated number of pregnant women.	43% (TDHS 2010) 28%	80%	TDHS TDHS	Every 4 to 5 years Quarterly
HIV positive women provided with	Proportion of HIV positive women	Number of HIV positive women provided with	Total number of Number of HIV positive			HMIS	Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
ARV's during pregnancy	provided with ARV's during pregnancy	ARV's during pregnancy	women				
Pregnant women tested and treated for syphilis	Percentage of pregnant women tested and treated for syphilis	Number of pregnant women tested and treated for syphilis	Total number of pregnant women tested for syphilis			HMIS	Quarterly
Positive syphilis serology in pregnant women	Prevalence of positive syphilis serology in pregnant women	Number of positive syphilis serology in pregnant women	Total number of pregnant women tested for syphilis			HMIS	Quarterly
Pregnant women receiving two doses of SP	Percentage of pregnant women receiving two doses of SP	Number of pregnant women receiving two doses of SP	Expected number of pregnant women			TDHS HMIS	Every 4 to 5 years Quarterly
Proportion of mothers receiving Postnatal Care within 48 hours	Proportion of mothers receiving Postnatal Care within 48 hours	Number of mothers receiving Postnatal Care within 48 hours	Number of all women who delivered			TDHS HMIS	Every 4 to 5 years Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
Deliveries taking place in health facilities	Proportion of deliveries taking place in health facilities	Number of deliveries taking place in health facilities during a given period	Expected number of live births /deliveries during a given period	50%(TDHS 2010)	80%	TDHS HMIS	Every 4 to 5 years Quarterly
Births assisted by skilled attendants	Proportion of births assisted by skilled attendants	Number of births attended by skilled health personnel during a specified period	Total number of live births during the specified period	51 % TDHS 2010	80 %	TDHS HMIS	Every 4 to 5 years Quarterly
Facilities offering EmONC services (by basic and comprehensive)	Proportion of facilities offering EmONC services (by basic and comprehensive)	Number of facilities offering EmONC services (by basic and comprehensive)	Number of facilities offering delivery services			TzSPA Special Surveys HMIS	Every 4 to 5 years Varies Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
Percent of all births in EmOC facilities	The percent of all births in an area that take place in emergency obstetric and newborn care (EmONC) facilities (basic or comprehensive).	Number of women registered as having given birth in facilities classified as EmONC facilities /	Estimate of all the live births in the area, regardless of where the birth takes place x 100			TzSPA Special Surveys HMIS	Every 4 to 5 years Varies Quarterly
Met need for obstetric complications (coverage of women with obstetric complications that have received EmONC out of all women with obstetric	Coverage of met need for obstetric complications (coverage of women with obstetric complications that have received EmONC out of all women with					TzSPA Special Surveys HMIS	Every 4 to 5 years Varies Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
complications)	obstetric complications)						
Caesarean sections rate	Percentage of Caesarean sections	Number of Caesarean sections	Number of all live births			TDHS HMIS	Every 4 to 5 years Quarterly
Case fatality rate for obstetric complications	Case fatality rate for obstetric complications					HMIS	Quarterly

Neonatal Health indicators

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
Prevalence of low birth weight	Percentage of newborn registering less than 2.5 kg weight	Number of newborn registering less than 2.5 kg weight	Number of all live births				
Early initiation of breast feeding (within the first hour)	Percentage of mothers initiating early breast feeding (within the first hour)	Number of children 0 < 24 months put to the breast within 1 hour of delivery	Total number of children 0 < 24 months) x 100			TDHS HMIS	Every 4 to 5 years Quarterly
Health facilities providing essential newborn care	Proportion of health facilities providing essential newborn care	Number of health facilities providing essential newborn care	All health facilities providing delivery services			TzSPA Special surveys	Every 4 to 5 years Quarterly
Newborns	Percentage of	Number of	Projected	65%	80%	TDHS	HMIS

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
receiving postnatal care within 48 hours	mothers and babies who received postpartum care within 48 hours of childbirth (regardless of place of delivery)	mothers and babies who received postpartum care within 48 hours of childbirth x 100	number of live births	TDHS 2010		HMIS	(Monthly) TDHS interval
Perinatal deaths (still births, deaths within the first seven days of life)	Number of perinatal deaths (still births, deaths within the first seven days of life)	Number of perinatal deaths (still births, deaths within the first seven days of life)	Per 1000 live births	TDHS 2010		TDHS	HMIS (Monthly) TDHS interval
District hospitals that have functional newborn resuscitation facilities in the	Proportion of district hospitals that have functional newborn resuscitation	Number of district hospitals that have functional newborn resuscitation facilities in the	Number of all district hospitals			CHMT Supervision reports	Annual

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
delivery room	facilities in the delivery room	delivery room					
District hospitals implementing Kangaroo Mother Care for management of Low Birth Weight	Proportion of district hospitals implementing Kangaroo Mother Care for management of Low Birth Weight	Number of district hospitals implementing Kangaroo Mother Care for management of Low Birth Weight	Number of all district hospitals			CHMT Supervision reports	Annual

Child Health Indicators

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
Antibiotic treatment for pneumonia and dysentery	Percentage of children treated with antibiotic for pneumonia and dysentery	Number of children treated with antibiotic for pneumonia and dysentery	Number of all children with pneumonia and dysentery			Special surveys HMIS	Varied Quarterly
ORS and zinc treatment in management of diarrhoea	Proportion of children with diarrhoea who were given ORS and zinc	Number of children with diarrhoea who were given ORS and zinc	Number of children with diarrhoea			THDS HMIS	Every 4 to 5 years Quarterly
Health facilities with 60% of health workers trained on IMCI	Proportion of health facilities with 60% of health workers trained on IMCI	Number of health facilities with 60% of health workers trained on IMCI	Number of health facilities providing RCH services			CHMT	Quarterly
Penta 3 Immunization coverage (DTP-HepB, Hib3)	Proportion of children under one received Penta3 vaccine in	Total number of children under one year vaccinated 3 times	Total number of children under one year targeted	86% (TDHS 2010) 92%	95%	THDS	Every 4 to 5 years Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
	a given year or other period.	against DPT - Hb x 100	in the period	(HMIS 2014)		HMIS	
Measles Immunization coverage	Proportion of children under one received measles vaccine in a given year or other period.	Total number of children under one year vaccinated against measles x 100	Total number of children under one year targeted in the period	75% (TDHS 2010) 101% (HMIS 2014)	90% in 90% of districts	THDS HMIS	Every 4 to 5 years Quarterly
Fully Immunized	Percentage of Infants who received one dose of BCG, three doses each of OPV, DPT, and Hepatitis B vaccines, and one dose of measles vaccine before reaching one year of age.	Number of Infants who received one dose of BCG, three doses each of OPV, DPT, and Hepatitis B vaccines, and one dose of measles vaccine before reaching one year of age.	Number of all Infants.			THDS HMIS	Every 4 to 5 years Quarterly
HIV positive	Proportion of HIV	Number of HIV	Number of			HMIS	Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
children receiving ARV	positive children receiving ARV	positive children receiving ARV	HIV positive children				
HIV exposed infants tested for EID	Proportion of HIV exposed infants tested for EID	Number of HIV exposed infants tested for EID	Number of all HIV exposed infants			HMIS	Quarterly
HIV exposed infants receiving ARV prophylaxis	Proportion of HIV exposed infants receiving ARV prophylaxis	Number of HIV exposed infants receiving ARV prophylaxis	Number of all HIV exposed infants			HMIS	Quarterly

Adolescent Health Indicators

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
Health facilities providing Adolescent Friendly Reproductive Health Services	Percentage of health facilities providing Adolescent Friendly Reproductive Health Services	Number of health facilities providing Adolescent Friendly Reproductive Health Services	Total number of Health facilities providing RCH Services			Special surveys HMIS	Varies Quarterly
Young women aged 15–24 who have had sexual intercourse before the age of 15	Percentage of young women aged 15–24 who have had sexual intercourse before the age of 15	Number of young women aged 15–24 who have had sexual intercourse before the age of 15	All of young women aged 15–24 who had ever had sexual intercourse			TDHS	Every 4 to 5 years
New adolescent FP clients who received condoms (through health facilities, outreach,	Percentage of new adolescent FP clients who received condoms (through health facilities, outreach, CHW)	Number of new adolescent FP clients who received condoms (through health facilities, outreach, CHW)	Number of all new adolescent FP			TDHS HMIS	Every 4 to 5 years Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
CHWs)		clients					
Adolescents who received post abortion care services with MVA	Percentage of adolescents who received post abortion care services with MVA	Percentage of adolescents who received post abortion care services with MVA	Percentage of adolescents who received post abortion care services with MVA			HMIS	Quarterly
Adolescent (below 20 years) who reported for ANC services within 12 weeks gestation from among all ANC clients	Percentage of adolescent (below 20 years) who reported for ANC services within 12 weeks gestation from among all ANC clients	Number of adolescent (below 20 years) who reported for ANC services within 12 weeks gestation from among all ANC clients	Number of expected pregnancies			HMIS	Quarterly
Adolescent (below 20 years) who delivered in a health facility from among all women who	Percentage of adolescent (below 20 years) who delivered in a health facility from among all	Number of adolescent (below 20 years) who delivered in a health facility from among all	Number of all deliveries			HMIS	Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
delivered in health facilities	women who delivered in health facilities	women who delivered in health facilities					
Adolescent (below 20 years) who reported for PNC services at health facilities within 48 hours after delivery from among all women who delivered	Percentage of adolescent (below 20 years) who reported for PNC services at health facilities within 48 hours after delivery from among all women who delivered	Number of adolescent (below 20 years) who reported for PNC services at health facilities within 48 hours after delivery	Number of all women who delivered			HMIS	Quarterly
New-borns by Adolescent mothers (below 20 years) who were brought for PNC services at health facilities within 48 hours after delivery from among all	Percentage of New-borns by Adolescent mothers (below 20 years) who were brought for PNC services at health facilities within 48 hours after delivery from	Number of New-borns by Adolescent mothers (below 20 years) who were brought for PNC services at health facilities within 48 hours after delivery from	Number of all newborns			HMIS	Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
women who delivered	among all women who delivered	among all women who delivered					

Gender Based Violence and Violence Against Children Health Indicators

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
Health facilities that have integrated gender, Gender Based Violence (GBV) and Violence Against Children (VAC) services	Proportion of health facilities that have integrated gender, Gender Based Violence (GBV) and Violence Against Children (VAC) services	Number of health facilities that have integrated gender, Gender Based Violence (GBV) and Violence Against Children (VAC) services	Number of health facilities providing RCH services			HMIS	Quarterly
Female GBV clients from among all GBV clients	Percentage of female GBV clients from among all GBV clients	Percentage of female GBV clients from among all GBV clients	Percentage of female GBV clients from among all GBV clients			HMIS	Quarterly
Female VAC clients from among all VAC clients	Percentage of female VAC clients from among all VAC clients	Percentage of female VAC clients from among all VAC clients	Percentage of female VAC clients from among all VAC clients			HMIS	Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
GBV clients who experienced sexual violence from among all GBV clients	Percent of GBV clients who experienced sexual violence from among all GBV clients	Number of GBV clients who experienced sexual violence from among all GBV clients	Number of all GBV clients			TDHS HMIS	Every 4 to 5 years Quarterly
VAC clients who experienced sexual violence from among all VAC clients	Percent of VAC clients who experienced sexual violence from among all VAC clients	Number of VAC clients who experienced sexual violence from among all VAC clients	Number of all VAC clients			HMIS	Quarterly
GBV clients who experienced physical violence from among all GBV clients	Percent of GBV clients who experienced physical violence from among all GBV clients	Number of GBV clients who experienced physical violence from among all GBV clients	Number of all GBV clients			TDHS HMIS	Every 4 to 5 years Quarterly
VAC clients who experienced physical violence from among all VAC clients	Percent of VAC clients who experienced physical violence from among all	Number of VAC clients who experienced physical violence from among all	Number of all VAC clients			HMIS	Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
	VAC clients	VAC clients					
GBV clients who experienced emotional violence from among all GBV clients	Percent of GBV clients who experienced emotional violence from among all GBV clients	Number of GBV clients who experienced emotional violence from among all GBV clients	Number of all GBV clients			TDHS HMIS	Every 4 to 5 years Quarterly
VAC clients who experienced emotional violence from among all VAC clients	Percent of VAC clients who experienced emotional violence from among all VAC clients	Number of VAC clients who experienced emotional violence from among all VAC clients	Number of all VAC clients			HMIS	Quarterly
Percentage of GBV and VAC clients who were counselled from among all GBV and VAC clients	Percentage of GBV and VAC clients who were counselled from among all GBV and VAC clients	Percentage of GBV and VAC clients who were counselled from among all GBV and VAC clients	Percentage of GBV and VAC clients who were counselled from among all GBV and VAC clients			HMIS	Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
Female GBV clients who were tested for pregnancy within 72 hours after the event from among all GBV clients	Percentage of female GBV clients who were tested for pregnancy within 72 hours after the event from among all GBV clients	Number of female GBV clients who were tested for pregnancy within 72 hours after the event from among all GBV clients	Number of female GBV clients who experienced sexual violence			HMIS	Quarterly
GBV and VAC clients who arrived at a health facility within 72 hours after the event from among all GBV and VAC clients	Percentage of GBV and VAC clients who arrived at a health facility within 72 hours after the event from among all GBV and VAC clients	Number of GBV and VAC clients who arrived at a health facility within 72 hours after the event from among all GBV and VAC clients	Number of all GBV and VAC clients at health facility			HMIS	Quarterly
Intimate partner violence prevalence	Percentage of ever-partnered women 15-49 years who have experienced	Number of ever-partnered women 15-49 years who have experienced physical and/or	Number of ever-partnered women 15-49	20% (TDHS 2010)		TDHS	Every 4 to 5 years

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
	physical and/or sexual violence by an intimate partner in the last 12 months	sexual violence by an intimate partner in the last 12 months X 100	years				

Reproductive Cancers Indicators

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
New FP clients screened for breast cancer	Percentage of new FP clients screened for breast cancer	Number of new FP clients screened for breast cancer	Number of all new FP clients			HMIS	Quarterly
Screened new FP clients who were found with suspect breast cancer (lumps, bleeding nipples)	Percentage of screened new FP clients who were found with suspect breast cancer (lumps, bleeding nipples)	Number of screened new FP clients who were found with suspect breast cancer (lumps, bleeding nipples)	Number of screened new FP clients			HMIS	Quarterly
New clients screened for cervical cancer with VIA	Percentage of new clients screened for cervical cancer with VIA	Number of new clients screened for cervical cancer with VIA	Number of new clients			HMIS	Quarterly
Cervical cancer screening	Proportion of women aged 30-50 who were screened for cervical cancer	Total number of women between 30 and 50 who were screened with Visual	Number of women aged 30–50 years	11% (HMIS 2014)		HMIS	Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
	with Visual Inspection with Acetic Acid/vinegar (VIA).	Inspection with Acetic Acid/vinegar (VIA) x 100					
New clients with positive VIA results	Percentage of new clients with positive VIA results	Number of new clients with positive VIA results	Number of new clients screened with VIA			HMIS	Quarterly
Clients with cervical precancerous lesions treated with Cryotherapy	Percentage of clients with cervical precancerous lesions treated with Cryotherapy	Number of clients with cervical precancerous lesions treated with Cryotherapy	Percentage of clients with VIA positive results			HMIS	Quarterly
Clients with VIA positive results treated with cryotherapy	Percentage of clients with VIA positive results treated with cryotherapy	Number of clients with VIA positive results treated with cryotherapy	Clients with VIA positive results			HMIS	Quarterly
New clients with suspect cancer	Percentage of new clients with	Number of new clients with	Clients with VIA positive			HMIS	Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
	suspect cancer	suspect cancer	results				
Clients with VIA positive results treated with LEEP	Percentage of clients with VIA positive results treated with LEEP	Number of clients with VIA positive results treated with LEEP	Clients with VIA positive results			HMIS	Quarterly
Clients referred for large lesion	Percentage of clients referred for large lesion	Number of clients referred for large lesion	Number of clients with suspect cancer			HMIS	Quarterly
Clients referred for suspect cancer	Percentage of clients referred for suspect cancer	Number of clients referred for suspect cancer	Number of clients with suspect cancer			HMIS	Quarterly

Community Indicators

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
Communities that have set up functional emergency preparedness committees and	Proportion of communities that have set up functional emergency preparedness	Number of communities that have set up functional emergency preparedness	Number of communities			CHMT	Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
plans for MNCH including FP and nutrition	committees and plans for MNCH including FP and nutrition	committees and plans for MNCH including FP and nutrition					
Pregnant women that have birth preparedness plans	Proportion of pregnant women that have birth preparedness plans	Number of pregnant women that have birth preparedness plans	Number of pregnant women			TDHS	Every 4 to 5 years
Women who needed referral who went for referral	Proportion of women who needed referral who went for referral	Number of women who were referred	Number of women who needed referral			TDHS	Every 4 to 5 years
Children who needed referral who went for referral	Proportion of children who needed referral who went for referral	Number of children who needed referral who went for referral	Number of children who needed referral			TDHS	Every 4 to 5 years
Women with knowledge of danger signs of obstetric,	Proportion of women with knowledge of danger signs of	Number of women with knowledge of danger signs of	Number of all women			TDHS	Every 4 to 5 years

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
neonatal and child health complications	obstetric, neonatal and child health complications	obstetric, neonatal and child health complications					
District management task forces with representation from communities	Proportion of district management task forces with representation from communities	Number of district management task forces with representation from communities	Number of districts			CHMT	Quarterly
District committees with representation from communities	Proportion of district committees with representation from communities	Number of district committees with representation from communities	Number of districts			CHMT	Quarterly
Facilities with a designated staff responsible for community health services	Proportion of facilities with a designated staff responsible for community health services	Number of facilities with a designated staff responsible for community health services	Number of facilities with			CHMT	Quarterly
Villages with community	Proportion of villages with	Number of villages with	Number of villages			CHMT	Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
health workers implementing MNCH interventions	community health workers implementing MNCH interventions	community health workers implementing MNCH interventions					
Households' care-seeking rate for diarrhoea, malaria and pneumonia	Percentage of Households seeking care for diarrhoea, malaria and pneumonia	Households seeking care for diarrhoea, malaria and pneumonia	Number of all Households with for diarrhoea, malaria and pneumonia cases			TDHS	Every 4 to 5 years
Villages with community health workers offering RMNCAH services at community level	Percentage of villages with community health workers offering RMNCAH services at community level	Number of villages with community health workers offering RMNCAH services at community level	Number of all villages			CHMT	Quarterly
Villages with community health workers offering	Proportion of villages with community health workers offering	Number of villages with community health workers offering	Number of all villages			CHMT	Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
RMNCAH services at community level	RMNCAH services at community level	RMNCAH services at community level					

System Strengthening Indicators

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
MoHSW and district budget allocated to RMNCAH	Proportion of MoHSW and district budget allocated to RMNCAH	Proportion of MoHSW and district budget allocated to RMNCAH	Total MoHSW and district budget allocated to RMNCAH			Financial reports Work plans	Annual
Resources mobilized for the RMNCAH Strategic Plan	Total resources mobilized for the RMNCAH Strategic Plan	Number of resources mobilized for the RMNCAH Strategic Plan	Projected total resources for the RMNCAH Strategic Plan			Financial reports Work plans	Annual
HMIS Data completeness	HMIS Data completeness rate	Number of health facilities with HMIS data submitted that is complete	Number of health facilities using HMIS			HMIS	Quarterly
HMIS Data timeliness	HMIS Data timeliness rate	Number of health facilities with HMIS data submitted on time	Number of health facilities using HMIS			HMIS	Quarterly

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*
Councils whose data have been quality audited	Proportion of councils whose data have been quality audited	Number of councils whose data have been quality audited	Number of all councils			CHMT	Quarterly

5.2 Data Sources

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

5.2.1 Health Management Information System (HMIS)

HMIS is the system used in the health sector to collect routine data from all health facilities. The objectives of the HMIS are to provide data for measuring/monitoring the RMNCAH interventions. This information is collected daily at health facility and compiled monthly at Council level. This information is then reported monthly, quarterly, semi-annually or annually through Council Health Management Teams (CHMTs), Health Statistics Abstract, Reproductive and Child Health Reports, and Health Performance Profile Reports. Current HMIS strengthening includes timely reporting so as to accommodate data demand for specific programs, and improving the quality of data recording and reporting. Further review of the system is currently underway, with the goal of finding ways to respond to the data demands of specific programs in a timely fashion.

5.2.2 Integrated Disease Surveillance and Response Strategy (IDSR)

IDSR is a strategy that assists health workers and the RCHS to detect and respond to diseases of epidemic potential, public health importance, and those targeted for eradication and elimination. Information from this strategy is intended to enable health teams to respond quickly to outbreaks, set priorities, plan interventions, mobilize and allocate resources. RMNCAH cases reported through IDSR include maternal deaths, neonatal deaths and under 5 deaths. Although this system is currently functional, further strengthening is needed to increase the timeliness of reporting and the standardization of RMNCAH cases reported.

5.2.3 Health Facility Surveillance at Sentinel Sites

Health Facility Surveillances at Sentinel Sites is a network of health facilities that are used to track trends of some RMNCAH interventions, mostly IVD and PMTCT. The sentinel sites are selected in order to get more frequent, more in-depth and higher quality indicators than what is available through annual, aggregated HMIS reports. This type of surveillance system relies on regular health facility reports of some selected indicators from some selected facilities. Data collected from this system is used to corroborate trends identified using point estimates generated from population-based surveys, annual HMIS trends, and surveillances.

5.2.4 Tanzania Service Provision Assessments (TzSPA)

TzSPA surveys are conducted within health facilities every four years and four data collection tools are typically used to collect health facility data. These include a

Facility Audit Questionnaires to collect information on the facility infrastructure, equipment, drugs, pharmacy and laboratory services, record keeping, management, and counselling; *Observation Protocols* are completed for sick child, antenatal care, family planning, and STI consultations. Interviewers observe these client-provider interactions to assess how well service providers adhere to national and international standards of care; *Exit Interview Questionnaires* are administered to clients observed with providers and cover client's understanding and recall of provider instructions and other information, and the client's perception of the service delivery environment; and *The Health Worker/Provider Interview* collects information from providers on pre-service and in-service training, supervision, and attitudes about their work environment.

5.2.5 Tanzania Demographic and Health Surveys (TDHS)

The Tanzania Demographic and Health Survey (TDHS) have been carried out approximately every five years since the first TDHS was implemented in 1991-92. In the absence of complete vital registration and health information reporting systems, the TDHS provides valuable information on fertility and mortality data, as well as on the prevalence of childhood illnesses and utilization of health services. The TDHS collects information on fertility levels and preferences, marriage, sexual activity, awareness and use of family planning methods, maternal and child health, breastfeeding practices, nutritional and anaemia status of women and young children, childhood mortality, use of insecticide-treated-nets (ITNs) and anti-malarial, early treatment seeking behaviour for malaria, fever awareness and behaviour regarding HIV/AIDS and other sexually transmitted infections, female genital mutilation, and adult and maternal mortality. The survey includes all women, and a sub-sample of men, aged 15-49 years old in the selected households. The sample is usually designed to produce separate estimates on key indicators at the national level for urban and rural areas. National Bureau of Statistics (NBS) is conducted after every 4- 5 years. As of year 2015 five waves of TDHS have been conducted, namely the 1991/92 TDHS, 1996 TDHS, 1999 RCHS, 2004/05 TDHS and the 2010 TDHS. The planned 2015 demographic and health survey will include modules of malaria previously contained in the Tanzania HIV and Malaria Indicator Surveys (THMIS); and it will thus be known as the 2015 TDHS/MIS. The indicators that will be derived from the 2015 TDHS/MIS will also monitor progress made in the health sector and respond to the 2015 MDG's.

5.2.6 Tanzania HIV and Malaria Indicator Survey (THMIS)

In addition to the TDHS, a standard THMIS survey package for assessing the key household coverage indicators and morbidity indicators is used in Tanzania. The survey package includes a core questionnaire and data tabulation plan, as well as related materials for organizing and conducting fieldwork. This stand-alone survey is designed to be implemented in a similar manner to the TDHS surveys, producing nationally representative, population-based data from which the core HIV and Malaria indicators can be constructed for men and women of reproductive age. A two-stage cluster sampling method probability proportional to size method, similar to the TDHS, is usually used to obtain national-level population-based estimates for ITN use and parasite prevalence among those at risk for malaria. Progressively, the THMIS has

been modified to include HIV (becoming the Tanzania HIV/AIDS and Malaria Indicator Survey) to capture information specific to Tanzania malaria interventions and delivery systems The Tanzania THMIS is usually conducted during the peak malaria transmission season to provide unbiased estimates during periods of high malaria transmission. As of year 2015, three waves of THMIS have been conducted including the 2003 TMIS, the 2007 THIMIS and the 2011/12 THMIS.

5.2.7 Activity and Supervision Reports

Monitoring inputs, processes and outputs is important for tracking program performance to ensure that financial, human and other resources are available in a timely manner. Monitoring outputs is especially critical for assessing the level of service delivery achieved during implementation efforts. Program level activity reports with data will be obtained from all partners conducting RMNCAH activities on a monthly basis. These data will form the basis for tracking commodities, procurement, and implementation of activities. These data will be used at the analysis phase to assist with the interpretation of impact evaluation results.

5.2.8 Routine Monitoring Data Sources & Special Studies

- *Demographic Sentinel Surveillance (DSS)* – This data will be used to calculate mortality rates and establish denominators for key indicators within the catchment area.
- *Qualitative Studies* - Qualitative studies will address the process issues related to the operation of the information, education and communication / behaviour change communication (IEC/BCC) interventions. These special studies will use focus group interviews with community members, client exit interviews, key informant interviews and structured observations for assessing contextual factors related to the use of RMNCAH interventions and the efficacy of IEC/BCC messages.

5.2.8 National Identification Authority (NIDA)

The core functions of NIDA include Identification and Registration of Persons, Issuance and Management of Identification Cards, Management and Maintenance of Persons register, and Provision of Information from the register. In this regard, after completing the necessary prerequisites, NIDA issues to every registered Tanzania an identification card that carries a unique 20 digit individualized identification number.

The national system of identification and registration of persons is a catalyst for the development of other projects, including the National Strategy for Growth and Poverty Reduction, the civil servants information system, and the wages and government networks It also supports the concept of the Tanzania e-Government Strategy. Registration of citizens for national identification cards began in June 2012.

Currently, registration of new RMNCAH clients at health facilities in the HMIS registers on Tanzania calls for service providers to generate a three digits serial number (per month) and a unique identification number that combines the last digit of the year and the three digits serial number. Moreover, this identification number is

valid for only one year and is just unique for a given facility and service. This identification procedure for RMNCAH clients in HMIS registers thus does not provide the Ministry with a strong identifier that can be used to track clients across services, health facilities, councils and regions. The unique NIDA identification number thus is the best alternative that can be used included in the HMIS registers to identify clients. This however needs to be accompanied with some consideration to legal, data security and privacy issues to be resolved before the NIDA unique identification number can be used by health facilities.

5.2.9 Civil Registration and Vital Statistics System (CRVS)

In Mainland Tanzania, the vital registration system is governed and mandated by the Registration Insolvency and Trusteeship Agency (RITA). The Agency was officially launched in 2006 and replaces the Administrator General's Department in the Attorney General's Chambers, Ministry of Justice and Constitutional Affairs. For vital registration of births, the Agency collaborates with the President's Office Public Service Management. To facilitate performance of the system, birth and death registration is decentralized, in keeping with local government structure.

This structure facilitates establishment of the vital registration system through the hamlet (kitongoji) chairperson, with support from the village executive officer to update the village register as birth or death events occur, both at health facilities and in the community. However, according to RITA, the village registers are not well updated, reflected by the extremely low returns to the higher levels of the system. In parallel with these village registers, there are registration offices at the Council /District level for births, deaths and marriage. The success in implementation of these projects is expected to greatly move the country forward towards a complete national vital registration system. In a long term, the national identification database and the vital statistics database are expected to be of great value to the Ministry of Health and Social Welfare databases including HMIS, eLMIS, National Health Insurance etc.

5.2.10 Population and Housing Census

The National Population and Housing census data collected by the National Bureau of Statistics will be used in support of M & E activities. This will mainly be in the provision of population projections that are required for use as denominators data for RMNCAH indicators. The success in implementation of the national identification and the vital statistics projects is expected to greatly move the country forward towards a complete national vital registration system and thus put relief to the expensive National Population and Housing census that are conducted after every 10 years.

5.3 Data Flow

Using several types of tools and methods, data are collected from several levels of: household, community, health facility, and special studies. Data collected through health facility surveillance, including the HMIS, are reported monthly and quarterly and complied annually for production of an abstract. IDSR data is reported weekly and

compiled complied monthly, and reports sent to WHO and districts. The RCHS receives quarterly, semi-annual and annual reports from the councils, regions and zones, with results compiled annually for presentation at the annual RCH meeting. Data collected by implementing partners is not received by the RCHS on a regular basis. This is a key area that should be addressed through the development of a central database for the storage of all program and population-level data collected. The M & E technical working group will work towards the harmonization of data flow.

5.4 Data Quality Assurance

Data quality assurance will be done by the RCHS and implementing partners and will involve characterizing the operational definitions for HMIS indicators, documenting how these definitions may change as the needs of the HMIS change over time, and assessing the quality of data generated within health facilities. Important outcomes include recommendations on how data quality can be improved, as well as recommendations on how to maximize the use of health facility data to guide RMNCAH programming. Activities to be performed on a quarterly basis include assessments of the accuracy, completeness and timeliness of data recording and results reporting, the identification of obstacles at each tier of the health facility reporting system, cross-checking diagnosed cases, and an assessment of the current utilization strategies at each tier of the health system in Tanzania. Data quality assessments will be performed at selected health facilities quarterly. Data verification will be performed to compare the reported numbers from the health facilities to the number re-aggregated from the source documents like RMNCAH register, patient records, and monthly reports. A second strategy involves conducting random spot-checks among households and health facilities to ascertain whether or not the data recorded matches whether they have actually received specific RMNCAH intervention services and among health facilities to verify the presence of RMNCAH drugs and commodities against the data reported. As a result of these expanded data quality assurance activities, the M & E unit will be strengthened, thus increasing capacity to conduct M & E, and data management quality will be increased. Quarterly assessments and supervision visits will also provide a platform for supporting health workers at regional and council level on improving data collection procedures.

5.5 Data Validation

Data validation is the process of ensuring that a program operates on clean, correct and useful data. It uses routines, often called "validation rules" "validation constraints" or "check routines", that check for correctness, meaningfulness, and security of data that are input to the system. The rules may be implemented through the automated facilities of a data dictionary, or by the inclusion of explicit application program validation logic.

All RMNCAH data needs to be validated, and this includes survey and routine data. Validation of survey data is usually done in three stages, with the first stage is done manually in the field as part of the data collection process, the second stage is done by data editors and field supervisors as part of the daily questionnaires / data editing

process. The third stage is done electronically during data entry through validation rules and during data analysis through a data cleaning process.

For the case of RMNCAH routine data, the data validation process is done in three stages. The first stage is manual, and health facility staff as part of the primary data collection does this during service provider and client interaction. The second is also done manually during preparation of a monthly summary form by compiling facility data from multiple daily data sheets. The third stage is done electronically during data capture into the DHIS2 electronic database. The DHIS2 software has several features that can help with data validation during data entry to make sure data is captured on the right format and within a reasonable range, user-defined validation rules based on mathematical relationships between the data being captured (e.g. subtotals vs totals), outlier analysis functions, as well as reports on data coverage and completeness are then validated.

With advances adoption of information and communication technology into capture, storage, use and dissemination of RMNCAH data; use of manual data validation methods is expected to diminish with time and be replaced by electronic validation processes. This will included the use of computers (laptops, mini computers), tablets and iPad during data collection in the field and at health facilities.

5.6 Data Analysis Strategy

Analysis of RMNCAH data will focus at both community and health facility data using both monitoring and evaluation methods.

5.6.1 Monitoring of RMNCAH interventions

The primary focus of the monitoring plan is on tracking commodities, assessing coverage of key RMNCAH prevention services and control activities, and monitoring of diagnosis and treatment practices. Specifically, the RMNCAH monitoring plan focuses on assessing the coverage of selected RMNCAH-related services at health facilities and within communities. Councils, communities, households and health facilities are all part of the operational context for implementing RMNCAH prevention and control interventions. For monitoring of community-based programs, Program records from partners will form the main source of data. Special studies will be conducted generate contextual information related to the program. To track trends in facility usage, pregnant women and infant will be followed up. To track changes in RMNCAH commodities and supplies trends, a sample of health facilities will be interviewed. To assess community perceptions, understanding and use of the RMNCAH interventions focus groups will be conducted among urban and rural residents. Service provision assessments (SPA surveys) at health facilities will be used to assess diagnostic and treatment services, drug stock-outs, infrastructure, and quality of services.

The RCHS will be responsible for tracking on a monthly, quarterly and annual basis. Reports will be shared with implementing partners on a quarterly basis to assess where additional resources are needed. The RCHS will continue being the

coordinating body that brings together information from other partners implementing RMNCAH activities. Supplemental data collection using small-scale M&E systems developed by partners will be used to share information on outputs with RCHS and MOHSW.

5.6.2 Evaluation of RMNCAH interventions

To meet the evaluation objectives in Tanzania in terms of RMNCAH system constraints, the impact evaluation design will rely on the use of multiple data points in time and type to determine impact with all analyses will be conducted at the household or health facility level. Two evaluation study designs are proposed, namely a pre-post only design, stratified to capture the effect of intervention coverage on RMNCAH related morbidity and mortality at the national level; and a quasi-experimental design at the sub-national level to assess the effectiveness of different RMNCAH services delivery systems. It is hoped a robust picture will emerge that indicates how RMNCAH morbidity and mortality have changed during the intervention period, within the context of external confounding factors. The TDHS will provide most of the information for the pre-post only evaluation design. The national level pre-post evaluation will use multiple data points to strengthen the plausibility that any resultant changes in RMNCAH morbidity and mortality are attributable to the scale-up of RMNCAH interventions, and not the result of extraneous factors confounding results.

Although numerous methods can be employed to assess impact, descriptive statistics will be used to summarize evaluation outcomes and impact by year, survey round, region, and demographic characteristics of individuals and households. Chi-square and logistic regressions will be used to assess the differences between dichotomous impact and coverage indicators at baseline and the follow-up survey rounds. The potential confounders that need to control for in the regression models: age, sex, household wealth index, education, and place of residence rural/urban.

5.7 Data Management

Because of the multiple data point approach to assessing the impact of RMNCAH prevention and control interventions, and the various existing and new data collection methods that will be used, it will be essential that data for all coverage and impact indicators be compiled and stored on a monthly basis for continuous trend data and immediately following survey work for population-based data. Existing data management systems at the RCHS need to be expanded to include the additional indicators outlined in this document. MOHSW has already created a tool (HMIS Book 3) to collect among others RMNCAH data at community level. Moreover, RCHS working with partners had developed RMNCH tools to be used by Community Health workers to collect data at community level. The HMIS Book 3 is tailored to receive all data brought to the health facility by CHW using the community RMNCH tools. Data generated through this registry will be used to update the RMNCAH data in HMMIS/DHIS2.

5.8 Capacity Building Plan

Areas in need of strengthening include data recording and reporting, M & E operations, and case tracking. Specifically, systematic feedback to sub-reporting entities concerning data quality, written policy concerning late or incomplete reporting of data by sub-reporting entities, training requirements specified for staff, mechanism to verify number of staff trained or quality of the training are areas in need of strengthening. Likewise, the ZRCHCOs and the RRCHCOs; and Council level, the DRCHCos and HMIS focal people are not all trained in RMNCAH M&E. Moreover, supervisory visits do not occur at regular intervals. The M & E technical working group will also serve to bolster capacity in specific areas through technical assistance.

5.9 Operations Research Plan

Operations research is essential for monitoring program progress, establishing which RMNCAH interventions are effective, and for providing contextual information regarding the success or failure in specific areas, or among sub-groups within the population. The RCHS will work directly with the RMNCH TWG, the RMNCH M and E TWG and the MOHSW TWG to develop a national RMNCAH operations research framework based on the country needs. The end of 2016 will develop a working draft of the operations research framework. The RMNCAH M & E Working group will lead the drafting of the framework in conjunction with the RMNCH TWG, with technical assistance from external sources as needed. It is envisioned that the national RMNCAH operations research framework will provide a strategic plan for developing research questions relevant for monitoring programs; the results of which will assist with the identification of factors that influence the successful implementation of RMNCAH interventions. An essential step in developing the national operations research framework will be the development of a core set of agreed-upon priorities, both present and future.

5.10 Coordination of RMNCAH and M & E Activities

The RCHS is organized into nine units, and each unit is under the leadership of a Coordinator or Program Manager. To coordinate and direct actions, the RCHS have established various TWG and task forces. The National RMNCAH Advisory Committee meets four times a year. Its purpose is to offer to the RCHS appropriate technical advice. There is another 9 TWG that address various aspects of the program, namely: Family Planning, SMI, ARH, MIS/R, GBV/VAC, PMTCT, IVD, Reproductive Cancers, NBCH, and IEC/BCC. Overall supervision of partner activities is performed by the RCHS with support from RHMT. The RMNCAH TWG and the MOHSW M and E TWG will guide monitoring and Evaluation of RMNCAH activities; and they meet once quarterly with their agenda guided by prevailing RMNCAH M and E activities and focus.

5.11 M & E Review Process, Dissemination of Results and Expected Products

Annual reviews will take place to ensure key activities are rolling out as planned. Programmatic reviews will take place as part of this process. The purpose of the review process is to inform the RMNCAH monitoring and evaluation process. At the conclusion of each annual review RCHS will compile a draft report of the current

status of the RMNCAH interventions that need further strengthening, the status of M & E activities, and recommendations for plan or program modification. This report will be presented to the National RMNCAH Advisory Committee RMNCAH program information and the current status of RMNCAH interventions will be disseminated through media briefs (as needed), quarterly reports (electronic and print) to stakeholders, presentations and workshops, annual RMNCAH review meetings, publications, web sites and other documentation. Importantly, zonal review meetings will be held annually; these meetings create an opportunity for engaging partners who normally don't report about their activities and also promote evidence-based practices.

5.12 RMNCAH Scorecard for Accountability

The RMNCAH scorecard is a tool designed based on national health priorities and populated with best available data. President Dr Kikwete launched the Tanzanian RMNCAH Scorecard on 15 May 2014, along with the Sharpened One plan 2014 to 2015. It is a tool built on existing data sources, strategic and operational plans. It is developed to track progress, produces reports for accountability and action; and fosters an environment of accountability at all levels. Using HMIS data, it generates a progress report every three months, where improvements in key interventions for maternal, newborn and child survival can be monitored, and leaders can be held to account. This card has up and down arrows to show changes (+/-5 %) as compared to previous quarter. The RMNCAH scorecard uses traffic lights colour codes: red (bad), yellow (intermediate), green (good), and it shows performance at national and regional level for indicators, presents National, Regional and Council performance on each indicator, and has action item tracker lists action items and progress against them. This card shows the current status of key RMNCAH interventions for each region with colour codes showing which indicator is doing well or lagging behind each quarter, all regions and councils are supposed to assess their respective RMNCAH scorecards and take note of areas where they have made successes and where there were shortfalls towards the set target.

5.13 Opportunities and Challenges for RMNCAH M & E

The RMNCAH programs have clear goals and objectives, and well-established indicators for measuring program performance and impact. As such, there exists synergistic opportunities for capacity building and system strengthening in M & E. The following is a list of key strengths that should be used as a platform for further M & E strengthening.

- There is adequate experience in collecting and managing data at the national and sub- national level
- M&E leadership exists within RCHS
- Data inconsistencies are recognized and can be addressed
- Good oversight of annual sub-reporting activities
- Numerous data collection exercises are planned; these activities could be harmonized to increase efficiency, cut costs, and ensure standardized approaches are used to produce point estimates.

The following is a list of priority areas in need of strengthening:

- A small percentage of the RMNCAH budget is allocated to M&E activities
- Dissemination plans should be developed further
- Use of partner strengths and existing internal systems to collect and report data for M&E purposes should be incorporated into the MOHSW strategic action plans
- Data quality assessment training and supervision should be expanded
- Updating and standardizing guidelines for data entry and processing
- Increase data management staffing
- Increase data management staffing within RCHS
- Increase use of the private sector for RMNCAH activities and reporting; this includes assuring that the private sector adheres to the One Plan II strategy.
- Expand linkages with HMIS
- Establish system for providing periodic M & E training and continual resources for in-country health staff to access
- Improve coordination of partners for the collection of monitoring and evaluation data.

CHAPTER 6: COSTING OF STRATEGIC OBJECTIVE ACTIVITIES

6.1 Costing of the One Plan II activities

For the purpose of costing all activities prioritised in the One Plan II; each program was required to identify key interventions activities that were required to be costed. The costing of the activities was then projected to cover the period from 2016 to 2020. The costing of the One Plan II activities was conducted in a two-stage process. Stage one involved using the Lives Saved Tool (LiST) which is an evidence-based tool for estimating intervention impact. This new computer-based tool allows users to set up and run multiple scenarios to look at the estimated impact of different intervention packages and coverage levels for their countries, states or districts. These scenarios, developed with the LiST tool, provide a structured format for program managers or ministry of health personnel to combine the best scientific information about effectiveness of interventions for maternal, neonatal and child health with information about cause of death and current coverage of interventions to inform their planning and decision-making, to help prioritize investments and evaluate existing programs. The LiST tool is meant to be used as part of the planning process not as a replacement for planning. The second stage involved using the financial projections required to address the identified priorities and implement planned activities was done following the principles of UN One Health Costing Tool. This is a tool for medium term strategic health planning (3-10 years) at national level. It estimates the costs by health program and the implications for health system components, it also estimates health impact achieved by scale-up, using UN-approved epidemiological and impact models. This tool is thus for or joint planning, costing, budgeting, impact analysis, and financial space analysis and disease programs and health systems; and it is aligned with Joint Assessment of National Strategies (JANS).

6.2 Assumptions made

During costing, the total cost of each health program is split by direct costs (preventive or curative interventions or health services, drugs and commodities); and indirect costs (program management and support activities). The budgeting assumptions included Service delivery and activity targets *by zone, n*ew government per diems beginning July 2015, no inflation, and harmonized budget template for meetings, workshops, assumed the national and zonal perspective of service delivery and/or trainings. The costing process does not include: freight and clearance (17%) for commodities, distribution cost (22%) for commodities, malaria and HIV interventions for mothers and children, human resources for health (number and pay package), and renovation of health facilities. The scenarios; identification of what can be funded under each scenario (e.g. how the target level of coverage or which element of

the essential package will change if there is less funding available for RMNCH); and prioritization of the critical interventions and actions to strengthen systems in ways that address the highest priority issues (including improving equity) when resources are tight (done using the LiST tool described earlier).

NEWBORN AND CHILD HEALTH								
SN	**STRATEGIC OBJECTIVE**	**ACTIVITIES**	**TIME FRAME**					**TOTAL RESOURCES NEEDED IN US DOLLARS**
			2016	**2017**	**2018**	**2019**	**2020**	
			RESOURCES NEEDED IN US DOLLARS					
6.1	Strategic Objective 1: Essential newborn care services provided at all facilities conducting deliveries by 2020.	Activity 1.1:Conduct Essential Newborn Care Training (ENC) to build capacity of health care workers to provide quality ENC	770,686	770,686	770,686	770,686	770,686	3,853,430
		Activity 1.2:Procurement of newborn resuscitation equipment (ambu bags/mask sizes 0 & 1, suction devices, Resuscitation tables with Radiant warmer)	-	-	-	-	-	-
6.2	Strategic Objective 2: Management of preterm and low birth weight babies improved by 2020.	Activity 2.1:Conduct needs assessment site visit for Kangaroo Mother Care (KMC) service establishment	24,000	0	0	0	0	24,000
		Activity 2.2:Conduct KMC training to build capacity of health care providers to provide quality care to preterm babies.	928	77,276	86,935	48,297	28,978	242,414

		Activity 2.3:Establish KMC sites at all District hospitals (equipped with KMC beds, beddings, weighing scales, low reading thermometers, calibrated feeding cups)		17,997	20,247	11,248	6,749	56,241
6.3	Strategic Objective 3: Management of sick newborn improved by 2020.	Activity 3.1: Integrated Management of Childhood Illnesses (IMCI) Training (Distance Learning mode) which includes management of sick newborns.		-	-	-	-	-
		Activity 3.2: Advocacy meetings for establishment of Neonatal Care Units/Room at district hospitals	115,551	90,790	-	-	-	206,341
		Activity 3.3: Procurement of essential equipment for care of sick newborn (Oxygen concentrators, Phototherapy machines, Suction machines, Low reading thermometers, room thermometers, room heaters, etc.)	215,612	173,479	-	-	-	389,091
6.4	Strategic Objective 1: Management of common childhood illnesses improved by 2020.	Activity 1.1: Train health care workers on Integrated Management of Childhood Illnesses (IMCI) Training (Distance Learning mode).	3,738,185	4,205,458	2,336,365	1,401,819	-	11,681,827
		Activity 1.2: Train health care workers on Emergency Triage Assessment and Treatment (ETAT) to manage pediatric emergencies at hospital and health center level.	1,352,777	1,521,874	845,485	507,291	-	4,227,427

		Activity 1.3: Procurement of Pediatric emergency equipment for hospitals and health centers (Oxygen concentrators, Pulse Oxymeters, Nebulizers, Glucometers, Haemoques, Suction machines, Ambu bags/masks, Infusion pumps)	2,939,705	2,787,651	2,965,048	2,289,253	-	10,981,657
		Activity 1.4: Conduct Clinical Mentoring at hospital and health center level	393,200	931,451	931,451	931,451	931,451	4,119,004
		Activity 1.5: Conduct Supportive Supervision for quality pediatric and nutrition care to hospitals and health centers	237,259	237,259	237,259	237,259	237,259	1,186,295
6.5	Strategic Objective 2: Routine Under Five vaccination sustained with equitable coverage by 2020	Activity 2.1: Implement Reach Ever District/Child (RED/REC) Strategy activities in all councils						
		Activity 2.2: Intensify surveillance of vaccine preventable diseases						
		Activity 2.3: Develop, print, and disseminate immunization policy guidelines						
		Activity 2.4: In-service, refresher, and mid-level management (MLM) training at all levels						
		Activity 2.5: Distribution, cold chain supply and vaccine management						
		Activity 2.6: Develop, print, disseminate and implement communication strategy (mass media, IEC, immunization week)						
		Activity 2.7: Supportive supervision for immunization						
		Activity 2.8: Improve data management						
		Activity 2.9: Introduce new and under used vaccine						
		Activity 2.10: Coordination meetings at all levels						

6.6	Strategic Objective 3: Improve breastfeeding rates and practices by 2020	Activity 3.1: Capacitate health care providers in assisting women to initiate breast feeding within 1 hour, and exclusive breastfeeding at all levels	538,973	538,973	538,973	538,973	538,973	2,694,865
		Activity 3.2: Train community health care workers at all levels on importance of early breastfeeding initiation and breast feeding techniques	560,971	280,486	280,486	280,486	280,486	1,682,915
6.7	Strategic Objective 4: Infant and Young Child Feeding (IYCF) practices and nutrition status improved by 2020.	Activity 4.1: Train health care workers at all levels on new growth monitoring standards and tools	546,400	546,400	546,400	546,400	546,400	2,732,000
		Activity 4.2: Procure and distribute length/height boards and MUAC tapes to all health facilities offering under five growth monitoring services	344,501	344,501	344,501	344,501	344,501	1,722,505
		Activity 4.3: Print under 5 growth monitoring booklets (sex specific)	2,285,174	2,285,174	2,285,174	2,285,174	2,285,174	11,425,870
		Activity 4.4: Training health care workers and CHWs on adequate meal frequency and food diversity for pregnant women and children	932,285	735,628	735,628	735,628	735,628	3,874,797
6.8	Strategic Objective 5: Coverage of Management of Severe Acute Malnutrition (SAM) through the national health system increased by 2020	Activity 5.1: Train health care workers (including nutrition officers) and community health workers on management of MAM and SAM	1,378,114	1,097,629	1,097,629	1,097,629	1,097,629	5,768,630
		Activity 5.2: Conduct regular screening for malnutrition among all U5 attending at health facilities	344,501	344,501	344,501	344,501	344,501	1,722,505

		Activity 5.3: Procure essential supplies (therapeutic milk and food) to all district, regional, and referral hospitals for SAM treatment	-	-	-	-	-	-
		Activity 5.4: Equip hospitals to manage nutritional rehabilitation	85,640	130,343	171,998	206,293	168,951	763,225
6.9	Strategic Objective 6: Improved community and household practices for child survival by 2020	Activity 6.1: Conduct Quarterly Village Child Health Days	-	-	-	-	-	-
6.10	Strategic Objective 7: Improved accountability for U5 deaths by 2020	Activity 7.1: Conduct Under-five Death Reviews	71,813	56,346	0	0	0	128,159
		Activity 7.2: Orientation to standard pediatric treatment guideline and facility assessment for pediatric quality of care	2,356,663	3,534,994	1,472,915	883,749	0	8,248,321

ADOLESCENT REPRODUCTIVE HEALTH

SN	**STRATEGIC OBJECTIVE**	**ACTIVITIES**	**TIME FRAME**					**TOTAL RESOURCES NEEDED IN US DOLLARS**
			2016	**2017**	**2018**	**2019**	**2020**	
			RESOURCES NEEDED IN US DOLLARS					

6.1	Strategic objective 1: Adolescent and Youth Friendly Sexual and Reproductive Health (AYFSRH) including HIV service coverage and FP increased by 2020	Activity 1.1: Conduct rapid assessment of health programmes with integrated adolescent and youth friendly services based on the national standards.	1,274,171	0	0	0	0	1,274,171
		Activity 1.2 Survey on barriers to accessing and using adolescent and youth friendly health services	1,277,943	0	0	0	0	1,277,943
		Activity 1.3: Develop, adapt, and print tools for integrated supportive supervision of adolescent and youth friendly service provision at service delivery points.	56,738	0	0	0	0	56,738
		Activity 1.4: Develop, adapt, and operationalize a system for outreach, effective referral and networking for adolescent and youth SRH and HIV services.	44,782	4149	12069	12251	7314	80,565
		Activity 1.5: Procure essential equipment, materials and supplies for adolescent and youth friendly SRH and HIV services.	62,357	62,357	62,357	62,357	62,357	311,785
		Activity 1.6: Use Social marketing initiatives to provide SRH and HIV services and to adolescents and youth.	46,400	0	0	0	0	46,400

		Activity 1.7: Disseminate the National Standards for Adolescent and Youth Friendly Reproductive Health Services to policy/decision makers, programme managers, supervisors and development partners at national, regional, district and community levels.	163,547	0	0	0	0	163,547
		Activity 1.8: Review, develop, adapt, and print training materials including a training plan to roll-out implementation of the national standards for adolescent friendly SRH Services.	50,569	0	0	0	0	50,569
		Activity 1.9: Assess the in-service training needs among various service providers on provision of adolescent and youth friendly SRH and HIV.	142,857	0	0	0	0	142,857
		Activity 1.10: Build capacity of human resource in public and private health facilities to implement the national standards for adolescent friendly SRH services	644,373	232,966	537,197	77,655	0	1,492,191
		Activity 1.11: Develop and outline a national minimum package of services for adolescents to be provided at each level of service delivery (job aid, SOP, and supervision checklist	318,528	0	0	0	0	318,528

		Activity 1.12: Integrate adolescent health into the pre-service training curriculum	158,629	0	0	0	0	158,629
		Activity 1.13: Develop framework for monitoring implementation of adolescent and youth friendly SRH and HIV services in service delivery points	20,991	219,633	58,752	208,608	58,752	566,736
		Activity 1.14: Review meetings semi-annually and annually	86,377	86,377	86,377	86,377	86,377	431,885
6.2	Strategic Objective 2: Comprehensive knowledge, skills and positive behaviors on sexuality and reproductive health education improved among adolescent by 2020	Activity 2.1: Review, develop, adapt, print, disseminate and distribute adolescent and youth SRH and HIV rights advocacy messages and materials.	545,049	239,143	494,743	239,143	0	1,518,078
		Activity 2.8: Review, adapt, harmonize, print, and distribute national IEC/BCC materials related to adolescent and youth SRH (peer education, life skills, parent guide, para professional counseling, sermons guide).	104,883	3,798,318.00	-	3,466,889	-	7,370,090
		Activity 2.3: Roll out adolescent SRH communication interventions delivered by CORPS e.g. lay counsellors, peer educators, village health workers using national guidelines and standards.	6,720,280	5,917,457	6,366,291	5,917,457	5,917,457	30,838,942

6.3 **5.3**	Strategic objective 3: Linkage and capabilities among various stakeholders in the government, private sector and CSOs dealing with adolescent SRH strengthened by 2020	Activity 3.1: Conduct Stakeholders analysis and map key partners in advocating for adolescent SRH at all levels.	145,522	0	0	0	0	145,522
		Activity 3.2: Facilitate formation of adolescent SRH and rights coalition at all levels	0	0	0	0	0	-
		Activity 3.3: Build capacity of national, regional, district core teams and interested CSOs on advocacy on investing in adolescent and youth SRH and HIV	518,272	0	0	0	0	518,272
		Activity 3.5: Advocate for resource mobilization and allocation for adolescent SRH interventions at all levels.	-	-	-	-	-	-
6.4	Strategic objective 4: Institutionalize policies and supportive laws to improve access to information, education and services for adolescents by 2020	Activity 4.1: Review existing national policies and laws to conform to international/ regional conventions on adolescent sexual and reproductive health and rights.	-	-	-	-	-	-
		Activity 4.2: Advocate for formulation of relevant national laws, district and village by-laws to promote adolescent SRH and rights.	-	-	-	-	-	-

6.5	Strategic objective 5:Knowledge, understanding and healthy practice for sexual and reproductive health and rights (SRHR)as well as socio-economic situation of adolescents and youth improved by 2020	Activity 5.1: Conduct rapid assessment and map existing community-based activities related to the National Youth Adolescent Parent Community Alliance (NYAPCA)	142,857	0	0	0	0	142,857
		Activity 5.2: Establish and strengthen National Youth Adolescent Parent Community Alliance (NYAPCA) in selected districts for provision of SRH information, education, and services (clinical and non-clinical SRH services, recreational activities, small library/learning services, and livelihood activities).	418,929	775,500	1,132,071	1,488,643	1,845,214	5,660,357
		Activity 5.3: Scale-up supervision of community based National Youth Adolescent Parent Community Alliance (NYAPCA) activities.	240,371	240,371	240,371	240,371	240,371	1,201,855
		Activity 5.4: Support implementation of innovative information, education, and services for adolescent and youth SRH and HIV, including those with disabilities	709,471	709,471	709,471	709,471	709,471	3,547,355

		Activity 5.5: Support utilization of existing community structures (religious leaders, parents, community and government leaders) to reach young people with age-appropriate sexual and reproductive health information and link them to services.	0	0	0	0	0	0
		Activity 5.6: Design and advocate on use of culturally appropriate mass media communication strategies for ASRH/FP.	0	0	0	0	0	0
		Activity 5.7: Build capacity of LGAs (CHMTs) on integration of youth issues into planning processes.	0	0	0	0	0	0
		Activity 5.8: Liaise with other sectors (CSOs, MDAs etc) to support out of school youth access to income generating activities, business skills training, resource mobilization skills training and capacity building for youth led organization.	0	0	0	0	0	0
FAMILY PLANNING								
								TOTAL RESOURCES NEEDED IN US DOLLARS
Contraceptive utilization improved by 2020			**2016**	**2017**	**2018**	**2019**	**2020**	

Strategic objective 1:Family Planning (FP) services and utilization improved by 2020	Activity 1.1: Train skilled health care providers to provide method mix with special focus on long term methods	1,044.44	1,003,184	1,003,184	1,073,241	1,003,184	4,083,837.44
	Activity 1.2: Train on preceptorship, mentoring and coaching on FP	33,614	67,227	67,227	33,614	33,614	235,296.00
	Activity 1.3: Update FP contents of pre-service curriculum of different cadre/ health training institutions	0	19,295	7,103	7,103	0	33,501.00
	Activity 1.4: Conduct Contraceptive Technology Update for pre-service tutors	22,309	44,617	44,617	44,617	0	156,160.00
Strategic objective 2: Integration of FP into other maternal, newborn, child, adolescent health (MNCAH) programs improved by 2020	Activity 2.1: Train skilled health care providers to provide integrated FP/HIV, FP/Postpartum/Immunization outreach and cPAC/FP services	33,033	33,033	33,033	33,033	33,033	165,165.00
	Activity 2.2: Establish integrated outreach RMNCAH clinics to promote uptake of FP services	5,052,069	5,052,069	5,052,069	5,052,069	5,052,069	25,260,345.00
Strategic objective 3: Contraceptive coverage at community level improved by 2020	Activity 3.1: Train skilled health care providers to provide male friendly FP services.	121,746	121,746	121,746	121,746	121,746	608,730.00
	Activity 3.3: Investigate challenges influencing male involvement and participation in FP services.	0	100,000	0	0	0	100,000.00

	Activity 3.4: Conduct FP outreach services to reach males in workplaces such as mining, constructions and fishing camps	291,600	353,328	445,920	445,920	445,920	1,982,688.00
	Activity 3.5: Ensure youth/young people access and use of contraception services	978,665	1,319,328	1,679,897	1,619,127	1,554,213	7,151,230.00
	Activity 3.6: Partner with private companies to increase accessibility and utilization of FP	601,705	768,224	893,273	818,487	753,573	3,835,262.00
Strategic Objective 4: Procurement and distribution of FP commodities improved by 2020	Activity 4.1: Procure and distribute FP commodities.	74,932,000	74,932,000	74,932,000	74,932,000	74,932,000	374,660,000.00
	Activity 4.2: Supervise zonal contraceptive stocks	118,400	118,400	118,400	118,400	118,400	592,000.00
	Activity 4.3: Publicize and re-launch Green star	108,640	108,640	108,640	108,640	108,640	543,200.00
Strategic Objective 5: Contraceptive coverage at community level improved by 2020	Activity 5.1: Train CHW to increase scope of FP service provision at community level.	17,440	2,094,121	1,545,079	2,317,618	515,026	6,489,284.00
	Activity 5.2: Train community mobilizers/champions on how to influence people on FP	0	853,248	639,936	959,904	213,312	2,666,400.00
	Activity 5.3: Engage religious leaders to promote family planning	78,546	164,679	141,045	207,285	141,045	732,600.00
Strategic Objective 6: Demand for FP improved by 2020	Activity 6.1: Hold annual FP Day across the country	23,090	23,090	23,090	23,090	23,090	115,450.00

	Activity 6.2: Radio and TV spots for demand creation	3,301,160	3,302,182	3,301,160	3,301,160	3,301,160	16,506,822.00
Strategic Objective 7: M&E and management of FP service provision improved by 2020	Activity 7.1: Implementation of Costed Implementation Plan	64,515	29,573	29,573	29,573	29,573	182,807.00

Gender Based Violence and Violence Against Children								
SN	**STRATEGIC OBJECTIVE**	**ACTIVITIES**	**TIME FRAME**					**TOTAL RESOURCES NEEDED IN USD**
			2016	**2017**	**2018**	**2019**	**2020**	
			RESOURCES NEEDED IN USD					
5.1	Strategic objective 1:Gender, GBV, VAC and male involvement guidelines and strategies in RMNCAH developed, updated and disseminated by 2017	Activity 1.1: Develop guidelines on integration of gender in RMNCH by 2017	25,231	22,734	-	17,143	-	65,108
		Activity 1.2: Develop gender, GBV and VAC advocacy strategy	25,231	22,734	0	17143	0	65,108
		Activity 1.3: Operationalize and roll out male involvement guidelines in RMNCH interventions	21,287	42,574	42,574	21,287	21,287	149,009

		Activity 1.4: Review other RMNCAH and HIV guidelines to include Gender, GBV and VAC issues	0	17,500	-	-	-	17,500
		Activity 1.5: Mobilize resources for GBV/VAC prevention and response activities	28,940	45,505	45,505	28,944	28,944	177,838
5.2	Strategic objective 2: Gender, GBV and male involvement integration into RMNCAH and HIV improved by 2020.	Activity 2.1: In-service training of gender, GBV, VAC and male involvement among health care providers	77,002	77,002	38,501	38,501	38,501	269,507
		Activity 2.2: Integrate GBV and VAC one stop centers at referral hospital level	23,712	41,709	59,707	77,705	95,703	298,536
		Activity 2.3: Inclusion of Gender, GBV, VAC and male involvement in Pre-service Curricula	-	28,000	-	-	-	28,000
5.3	Strategic objective 3: Community and households empowered with knowledge and information in understanding of harmful gender norms, male involvement, and prevention and response to GBV and VAC by 2020.	Activity 3.1: SBCC interventions for addressing harmful GBV, VAC, gender norms and promoting male involvement and improving health seeking behaviors	30,954	987	13,913	987	987	47,828
		Activity 3.2: Orient CHWs on Gender, GBV and VAC prevention interventions using national guidelines and standards	33,966	33,966	33,966	33,966	33,966	169,830
		Actvity 3.3: Intergrate GBV/VAC into pre - exixting RMNCAH outreach services	-	4,000	6,000	8,000	10,000	28,000

		Activity 3.4: Develop and roll out school based and community curriculum and training package on prevention of harmful gender norms, GBV and VAC, and its implications on health	127,869	87,260	70,117	87,260	70,117	442,623

ZONAL AND REGIONAL COORDINATION

SN	STRATEGIC OBJECTIVE	ACTIVITIES	TIME FRAME					TOTAL RESOURCES NEEDED IN US DOLLARS
			2016	2017	2018	2019	2020	
			RESOURCES NEEDED IN US DOLLARS					
	Strategic objective 1: Monitoring evaluation framework for RMNCH improved by 2020	Activity 1.1: Conduct Annual National RCHS Meeting	203,206	203,206	203,206	203,206	203,206	1,016,030
		Activity 1.2: Conduct Annual Zonal RCHS Meeting (Northern)	135,759	135,759	135,759	135,759	135,759	678,795
		Activity 1.2: Conduct Annual Zonal RCHS Meeting (Central)	135,759	135,759	135,759	135,759	135,759	678,795
		Activity 1.2: Conduct Annual Zonal RCHS Meeting (Southern Highland)	135,759	135,759	135,759	135,759	135,759	678,795
		Activity 1.2: Conduct Annual Zonal RCHS Meeting (Lake)	135,759	135,759	135,759	135,759	135,759	678,795
		Activity 1.2: Conduct Annual Zonal RCHS Meeting (Eastern)	135,759	135,759	135,759	135,759	135,759	678,795

		Activity 1.2: Conduct Annual Zonal RCHS Meeting (Southern)	135,759	135,759	135,759	135,759	135,759	678,795
		Activity 1.3: Conduct RMNCH Intergrated supportive supervision at national level	38,528	38,528	38,528	38,528	38,528	192,640
		Activity 1.3: Conduct RMNCH Intergrated supportive supervision at national level(Northern zone)	0	0	57,792	57,792	57,792	173,376
		Activity 1.3: Conduct RMNCH Intergrated supportive supervision at national level(Central zone)	0	57,792	57792	57792	57,792	231,168
		Activity 1.3: Conduct RMNCH Intergrated supportive supervision at national level(Southern Higland)	0	115,584	115,584	115,584	115,584	462,336
		Activity 1.3: Conduct RMNCH Intergrated supportive supervision at national level	115,584	115,584	115,584	115,584	115,584	577,920
		Activity 1.3: Conduct RMNCH Intergrated supportive supervision at national level	0	0	57,792	57,792	57,792	173,376
		Activity 1.3: Conduct RMNCH Intergrated supportive supervision at national level	0	0	38,528	38,528	38,528	115,584
	Strategic objective 2: Quality assurance and management (supervision) strengthened by 2020	Activity 2.1: Print orientation package for appointed regional and district RCHS coordinators on RMNCAH package(National)	45,714	0	0	0	0	45,714
		Activity 2.1: Conduct and update orientation package for appointed regional and district RCHS coordinators	25,465	25,465	25,465	25,465	25,465	127,325

		on RMNCAH package(Western)						
		Activity 2.1: Conduct and update orientation package for appointed regional and district RCHS coordinators on RMNCAH package(Northern zone)	25,465	25,465	25,465	25,465	25,465	127,325
		Activity 2.1: Conduct and update orientation package for appointed regional and district RCHS coordinators on RMNCAH package(Central zone)	25,465	25,465	25,465	25,465	25,465	127,325
		Activity 2.1: Conduct and update orientation package for appointed regional and district RCHS coordinators on RMNCAH package(Southern Highlands zone)	25,465	25,465	25,465	25,465	25,465	127,325
		Activity 2.1: Conduct and update orientation package for appointed regional and district RCHS coordinators on RMNCAH package(Lake)	25,465	25,465	25,465	25,465	25,465	127,325
		Activity 2.1: Conduct and update orientation package for appointed regional and district RCHS coordinators on RMNCAH package(Lake zone)	25,465	25,465	25,465	25,465	25,465	127,325
		Activity 2.1: Conduct and update orientation package for appointed regional and district RCHS coordinators on RMNCAH package(Eastern zone)	25,465	25,465	25,465	25,465	25,465	127,325

		Activity 2.1: Conduct and update orientation package for appointed regional and district RCHS coordinators on RMNCAH package(Southern zone)	25,465	25,465	25,465	25,465	25,465	127,325

References

Aga Khan Foundation, MOHSW (2013). *"A baseline survey report for Joining Hands Initiative (JHI) project: improving MNCH in Morogoro, Dodoma, Mwanza, Iringa and Mbeya Regions of Tanzania".* Presented on 25th October, 2013.

Black RE, Victora CG, Walker SP, et al (2013). *Maternal and child undernutrition and overweight in low-income and middle-income countries*. Lancet 382; 427 -451.

Bongaarts J, Cleland J, Townsent JW, et al (2012). *Family Planning Programs for the 21st Century: Rationale and Design (*New York: The Population Council, 2012).

Catalyst Consortium/TAHSEEN Project (2003). *"Integration of Family Planning/Reproductive Health and Maternal and Child Health Services: Missed Opportunities and Challenges."* USAID, 2003.

de Benoist B, McLean E, Egli I, & Cogswell, M. (2008) *Worldwide prevalence of anaemia 1993-2005: WHO Global Database on Anaemia.* Geneva: World Health Organization.

Edmond KM, Zandoh C, Quigley MA, et al (2006). *Delayed breastfeeding initiation increases risk of neonatal mortality.* Pediatrics; e380 - e386.

Finlayson K, Downe S (2013). *Why do women not use antenatal services in low- and middle-income countries? A meta-synthesis of qualitative studies.* PLoS medicine, 2013. **10**(1): e1001373.

GLOBOCAN (2008). Ferlay J, Shin HR, Bray F, et al. *Cancer incidence and mortality worldwide: IARC Cancer Base No 10.* International Agency for Research on Cancer, Lyon, France.

Gupta G, Mpembeni R, Yamada G, et al (2013). *Factors associated with four or more antenatal care visits and its decline among pregnant women in Tanzania: Results from Tanzania DHS surveys1999, 2004/05 and 2010.* Manuscript submitted for publication.

Hindin JM, Kishor S, Ansara DL (2008). *Intimate Partner Violenceamong Couples in 10*

DHS Countries: Predictors and Health Outcomes. DHS Analytical Studies No 18.

Calverton, Maryland, USA: Macro International.

IHI, American Red Cross, WHO (2011) *"Integrated Measles and Routine Immunization: Post Campaign Coverage Evaluation Survey 2011 Post Campaign Evaluation Report"* Dar es Salaam, April, 2012

Li XF, Fortney JA, Kotelchuck M, et al, (1996). *The post-partum period: the key to maternal mortality.* Int J Gynecol Obstet 54: 1-10.

Lewycka S, Mwansambo C, Rosato M, et al (2013). *Effect of women's groups and volunteer peer counseling on rates of mortality, morbidity, and health behaviors in mothers and children in rural Malawi (MaiMwana): a factorial, cluster-randomized controlled trial.* Lancet, 381(9879): 1721-1735

Lassi ZS, Kumar R, Mansoor T, et al (2014a). *Essential interventions: implementation strategies and proposed packages of care.* Reproductive Health, 11(Suppl): S5

Lassi ZS, Mansoor T, Salam RA, et al (2014b). *Essential pre-pregnancy and pregnancy interventions for improved maternal, newborn and child health.* Reproductive Health, 11(Suppl): S2

Kruk ME, Mbaruku G, McCord CW, et al (2009). *Bypassing primary care facilities for childbirth: a population-based study in rural Tanzania.* Health Policy Plan; 24: 279-288.

Lancet (2014). Every Newborn: An Executive Summary for the Lancet's Series. May 2014

Magoma M, Requejo J, Campbell OM, et al (2010). *High ANC coverage and low skilled attendance in a rural Tanzanian district: a case for implementing a birth plan intervention.* BMC Pregnancy Childbirth; 10: 13

Mbeba RM, Mkuye MS, Magembe GE, et al (2012). *Barriers to sexual reproductive health services and rights among young people in Mtwara district, Tanzania: a qualitative study.* Pan Afr Med J; 13(Supp 1): 13

Mfinanga GS, Kimaro DG, Ngadaya E, Massawe S, Mtandu R, et al. (2009). *Health facility-based active management of the third stage of labor. Findings from a national survey in Tanzania.* Health Research Policy and Systems, 7 (6). doi:10.1186/1478.4505.7.6

MOHSW (2008). *The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania: 2008-2015. One Plan.* RCHS, Directorate of Preventive Services, United Republic of Tanzania, Dar es Salaam, April, 2008.

MOHSW (2008). *Human Resource for Health Strategic Plan, 2008-2013.* United Republic of Tanzania, Dar es Salaam, Tanzania

MOHSW (2010). *National Communication Strategy for Maternal, Newborn and Child Health: 2011 – 2015.* RCHS, Directorate of Preventive Services, Dar es Salaam, Tanzania

MOHSW (2011a). *National Cervical Cancer Prevention and Control Strategic Plan 2011 - 2015.* Ministry of Health and Social Welfare, Dar es Salaam, Tanzania, December, 2011.

MOHSW (2011b). *National Policy Guideline for the Health Sector Prevention and Response to Gender-Based Violence.* Ministry of Health and Social Welfare, Dar es Salaam, Tanzania, September, 2011.

MOHSW (2012). *National Guidelines for Comprehensive Care of Prevention of Mother-to-Child Transmission of HIV Services.* Ministry of Health and Social Welfare, Dar es Salaam, Tanzania, 2012.

MOHSW (2013). *Tanzania Service Availability and Readiness Assessment (SARA) 2012: Final Report.* Dar es Salaam, Tanzania, March 2013.

MOHSW (2013). *Midterm Analytical Review of Performance of the Health Sector Strategic Plan III 2009 – 2015:* Dar es Salaam, Tanzania, September 2013

MOHSW (2014a). *Mid Term Review of the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania: 2008-2015. One Plan.* RCHS, Directorate of Preventive Services, United Republic of Tanzania, Dar es Salaam, April, 2014.

MOHSW (2014b). *The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania: 2008-2015.* ***Sharpened One Plan****.* RCHS, Directorate of Preventive Services, United Republic of Tanzania, Dar es Salaam, April, 2014.

MOHSW (2014c). *Women and Children First: Countdown to Ending Preventable Maternal, Newborn and Child Deaths in Tanzania.* RCHS, Directorate of Preventive Services, United Republic of Tanzania, Dar es Salaam, April, 2014.

MOHSW and USAID (2012) *''Assessment of Reproductive and Child Health Integration in Tanzania: challenges and opportunities"* GH Tech Bridge II Project, October 2012.

MOHSW and USAID (2013) *''Tanzania: Strategic Review of the National Supply Chain for Health Commodities".* April 2013

Mpembeni RN, Killewo JZ, Leshabari MT, et al (2007). *Use pattern of maternal health services and determinants of skilled care during delivery in Southern Tanzania: implications for achievement of MDG-5 targets.* BMC Pregnancy Childbirth; 7: 29

Mselle LT, Moland KM, Mvungi A, et al (2013). *Why give birth in health facilities? Users' and providers' accounts of poor quality of birth care in Tanzania.* BMC Health Service Research; 13: 174.

Msemo G, Massawe A, Mmbando D, et al (2013). *Newborn Mortality and Fresh Stillbirth Rates in Tanzania After Helping Babies Breathe Training.* Pediatrics; 131; e353

Mushi D, Mpembeni R, Jahn A (2010). *Effectiveness of community based safe motherhood promoters in improving the utilization of obstetric care. The case of Mtwara district in Tanzania.* BMC Pregnancy and Childbirth; 10: 14.

Mwandali B (2013). *Availability, range and utilization of sexual and reproductive health services by adolescents at Kinondoni Municipality, Tanzania.* MPH Dissertation, Kilimanjaro Christian Medical University College, 2013

Nyamtema AS, Urassa DP, Massawe S, et al (2008). *Partogram use in the Dar es Salaam perinatal care study.* Int J Gynaecol Obstet; 100: 37-40.

Nyamtema AS, Bartsch-de Jong A, Urassa DP, et al (2012). *The quality of antenatal care in rural Tanzania: what is behind the number of visits?* BMC Pregnancy and Childbirth; 12: 70

Pembe AB, Urassa DP, Carlstedt A, et al (2009). *Rural Tanzanian women's awareness of danger signs of obstetric complications.* BMC Pregnancy Childbirth; 9: 12.

Printz N, Amenyah J, Serumaga B, and Van Wyk D (2013). *Tanzania: Strategic Review of the National Supply Chain for Health Commodities.* Supply Chain Management Systems Project and the USAID | DELIVER PROJECT, April 2013.

Prytherch H, Kakoko DVC, Leshebari MT, et al (2012). *Maternal and newborn health care providers in rural Tanzania: in-depth interviews exploring influences on motivation, performance and job satisfaction*. Rural and Remote health; 12: 2072.

RCHS (2013). *Preliminary report of RMNCH partners mapping and resource tracking 2013*. MOHSW, Dar es Salaam, Tanzania

Ronsmans C, Graham WJ, on behalf of The Lancet Maternal Survival Series Steering Group (2006). *Maternal mortality: who, when, where, and why.* Lancet; 368; 1189-1200.

Sarker M, Schmid G, Larsson E, et al (2010). *Quality of antenatal care in rural southern Tanzania: a reality check.* BMC Research Notes; 3: 209

Sikika (2010). *Human resources for health in Tanzania: deployment tracking survey*. November, 2010

Stockl H, Filippi V, Watts C, Mbwambo JKK (2012). *Induced Abortion, Pregnancy Loss and Intimate Partner Violence inTanzania: A Population Based Study.* BMC Pregnancy & Childbirth 12: 12.

TDHS (2004/05). Tanzania Demographic and Health Survey, 2004/05. National Bureau of Statistics, Dar es Salaam, Tanzania and ORC Macro, 2005.

TDHS (2011). *''Tanzania Demographic and Health Survey, 2010".* National Bureau of Statistics, Dar es Salaam, Tanzania and ORC Macro.

THMIS (2008). *"Tanzania HIV/AIDS and Malaria Indicator Survey 2007/08."* National Bureau of Statistics, Dar es Salaam, Tanzania and ORC Macro, 2008

THMIS (2011/12). *"Tanzania HIV/AIDS and Malaria Indicator Survey 2011/12*: National Bureau of Statistics, Dar es Salaam, Tanzania and ORC Macro, 2012.

Tylleskar T, Jackson D, Meda N, et al (2011). Exclusive breastfeeding promotion by peer counsellors in sub-Saharan Africa (PROMISE-EBF): a cluster-randomised trial. Lancet, 378(9789): 420-7. doi: 10.1016/S0140-6736(11)60738-1.

UNAIDS (2011). *"Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive: 2011-2015,"* 2011.

UNFPA (2013). *State of World Population 2013: Motherhood in childhood: Facing the challenges of adolescent pregnancy*. New York: UNFPA.

UNICEF (2011). *Adolescence in Tanzania*. United Nations Children's Fund, September 2011, Dar es Salaam, Tanzania.

URT (2011) *Government Budget for Financial Year 2011/2012: Citizens Budget Edition.* Ministry of Finance & Policy Forum, Tanzania.

URT (2012) *Government Budget for Financial Year 2012/2013: Citizens Budget Edition.* Ministry of Finance & Policy Forum, Tanzania.

USAID, MCHIP, SHOPS (2012). "*Report of the Tanzania Assessment of Community Services for Childhood Illness*". Draft Report, September 2012.

USAID & MOHSW (2013). *''MAISHA quality of maternal and newborn care study key findings: Essential Newborn Care 2010–2012".*

USAID & MOHSW (2013). *''MAISHA quality of maternal and newborn care study key findings: screening, prevention and management of preeclampsia and eclampsia 2010–2012".*

von Both BC, Flessa S, Makuwani A, et al (2006). *How much time do health services spend on antenatal care? Implications for the introduction of the focused antenatal care model in Tanzania.* BMC Pregnancy Childbirth; 6: 22

WHO (2004). *Making pregnancy safer: the critical role of the skilled birth attendant. A joint statement by WHO, ICM, and FIGO*. Geneva, WHO.

WHO (2009) *Monitoring emergency obstetric care: a handbook.* WHO Press. Geneva. http://www.who.int/reproductivehealth/publications/monitoring/9789241547734/en/index.html

WHO (2011) *World health statistics 2011.* Geneva: World Health Organization.

WHO(2012) *Recommendations for prevention and treatment of PPH.*
Available:http://apps.who.int/iris/bitstream/10665/75411/1/9789241548502_eng.pdf. Last accessed 30th December 2014.

WHO (2014) *Every Newborn: an action plan to end preventable deaths.* Geneva: World Health Organization. Available at www.who.int

WHO & UNICEF (2012). *''Countdown to 2015 Report; Maternal, Newborn and Child Survival; Building a Future for Women and Children,"* June, 2012. http://www.hoffmanpr.com/world/PMNCH/ CountDown2015/

WHO & UNICEF (2014). *"Countdown to 2015 Report (2014); Maternal, Newborn and Child Survival; Fulfilling the Health Agenda for Women and Children"* May, 2014. http://www.countdown2015mnch.org/

ANNEX 1:

Global Initiatives signed by Tanzania in commitment to improve RMNCH (2009-2013)

	Year	Declaration
1	**2009**	Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA); launched by African Union. It was launched in Tanzania in 2011
2	**2010**	Every Woman Every Child; by UN Secretary General • UN Commission on Information and Accountability (COIA) of Women and Children's Health • UN Commission on Life Saving Commodities (COLSC)
3	**2012**	London Summit commitment on Family Planning 2020 Partnership
4	**2012**	Scaling Up Nutrition (SUN) Interventions
5	**2012**	Global Plan for Elimination of Mother-to-Child Transmission (eMTCTC) of HIV 2011-2015
6	**2012**	Child Survival Call to Action: A Promise Renewed
7	**2013**	Global Vaccine Action Plan 2011-2020

8	**2013**	Every Newborn Action Plan (ENAP)

Source: Sharpened One Plan, April 2014

ANNEX 2: Ending Preventable Maternal Mortality (EPMM) – Targets beyond 2015

Global Targets	
Global target	Reduce global Maternal Mortality Ratio (MMR) to less than 70 maternal deaths per 100,000 live births by 2030
Secondary global target	By 2030, no country should have MMR greater than 140, a number twice the global target
Country Targets	
For countries with MMR < 420 in 2010	Reduce the MMR by at least two-thirds from the 2010 baseline by 2030
For countries with MMR > 420 in 2010	The rate of decline should be greater and in 2030, no country should have MMR over 140. Countries will need to reduce their MMR at an annual rate of reduction (ARR) greater than 5.5%.

Source: *WHO & USAID, 2014*

ANNEX 3: Ending Preventable Neonatal, Stillbirths and Child Mortality (EPCD) Targets beyond 2015

U5MR		
Global target	Reduce U5 Mortality Rate to less than 20 per 1,000 live births by 2035 *(A promise renewed, 2012)*	
NEWBORN DEATHS *(Every Newborn, 2014)*		
	Country targets	**Global targets**
2020	Follow national target	NMR of 15 per 1000 live births
2025	Follow national target	NMR of 12 per 1000 live births
2030	NMR of < 12 per 1000 live births	NMR of 9 per 1000 live births
2035	NMR of < 10 per 1000 live births	NMR of 7 per 1000 live births
NEWBORN DEATHS *(Every Newborn, 2014)*		
	Country targets	**Global targets**
2020	Follow national target	SBR of 14 per 1000 total births
2025	Follow national target	SBR of 11 per 1000 total births
2030	SBR of < 12 per 1000 total births	SBR of 9 per 1000 total births
2035	SBR of < 10 per 1000 total births	SBR of 8 per 1000 total births

ANNEX 4: Assumptions in calculating MMR, U5MR, NMR and SBR targets for beyond 2015

Ending preventable Maternal Mortality (EPMM) targets beyond 2015 set a goal that by 2030, no country should have MMR > 140/100,000 live births and countries should have < 100 maternal deaths /100,000 live births by 2035, see Annex 1. The stakeholders meeting of TWG for MNCH and other organizations working in field was held in Dar es Salaam on 18th December 2014 decided on different ARR for MMR from 2015 – 2020, 2021 – 2025 and from 2026 – 2030 to achieve the MMR recommended for 2035. Tanzania decided that it will make efforts to increase ARR from the current rate of 4.8% to the recommended rate - ARR of 5.5% from 2016 – 2020. From 2021 – 2025 the country will accelerate the ARR to 6.5%, and from 2026 – 2030 the country would like to have ARR of > 7% in order to achieve the 2035 goal of having MMR < 100 per 100,000 live births, see Table xx.

Table 4.1: MMR reduction following different average annual rate of reduction (ARR) to meet the 2035 goals of EPMM (2014 – 2035)

ARR%	Period	2014	2015	2020	2025	2030	2035
5.5%	2015-2020	410	387	292			
6.5%	2021 – 2025			292	209		
7%	2026 -2030				209	145	
7.5%	2031 – 2035					145	98

Underfive Mortality Rate reduction estimates

A goal of achieving U5MR < 20/ 1,000 live births by 2035 was proposed in the ''Child Survival: A promised Renewed'' publication (WHO, 2013). Tanzania will achieve that goal by having an ARR of 5% between 2014 – 2033. If the country can keep the current pace of 7% ARR of U5MR, then the country will achieve the goal of having < 20 U5 deaths/ 1,000 live births by 2028, Table 4.2.

Table 4.2: Rates to be reached by year following the 2030 and 2035 global goals

	2014	2015	2020	2025	2030	2035	ARR% required
U5MR	54	51	40	31	24	18	5%
NMR	21	20	16	13	10	8	4.3%
SBR	26	25	19	15	11	9	5%

Newborn Mortality Rate estimates

According to ''Every Newborn: An Action Plan to End Preventable Deaths'' an accelerated ARR of 4.3% is reccommended to achieve the 2030 target of NMR of 12 or less and < 10 newborn deaths/1,000 live births in 2035. Tanzania should be able to achieve the target by following the recommended ARR of 4.3% , and in fact by 2026 the country would have achieved NMR of 12/ 1,000 live births.

Stillbiths Rate

According to the 2014 reports, stillbirth rate (SBR) is 26 per 1,000 total births in Tanzania (Countdown Report, 2014). In order to end preventable stillbirths by 2030, it is recommended that countries should at least have an average annual rate of reduction of 3.5% (WHO, 2014). The SBR proposed target for 2020 is 14/1,000 total births and < 12/ 1,000 total births in 2030. With the an ARR of 3.5%, the country will not reach the 2030 goal of < 12 stillbirths/ 1,000 total births. Thus an accelerated ARR of 5% is required. Further the 2020 recommended goal of SBR of 14/1,000 livebirths is difficult to achieve even with ARR of 8%. It is therefore recommended that the country should follow the trajectory of achieving the 2030 goal by having 5% ARR. Thus by 2020 the country should aim to reduce stillbirths to 19/total births.

ANNEX 5: Key Evidence Based Interventions in MNCH and level where they should be offered

5.1 Pre-pregnancy, pregnancy and child birth interventions (Lassi et al, 2014a & b)

	Intervention	Method/Evidence	Level to be offered
Pre-pregnancy	Family planning	Male and female condoms, oral contraceptives, emergency contraceptives and hormonal injections	Community (C), Primary (P), Referral (R)
		All of above plus implants, intrauterine devices	Primary (P)
		All of above plus surgical contraception	Referral (R)
	Prevent & manage STIs, HIV and syphilis	Counseling, condoms & antibiotics	C, P, R
		All of the above laboratory testing HIV/STIs,ARVs	P, R
	Folic acid fortification and/or supplementation for preventing neural tube defects		C, P, R
Pregnancy & adolescents	ANC Essential care	• Iron and folic acid supplementation • Tetanus immunization in pregnancy • Prophylactic antimalarial for preventing malaria in pregnancy • ITN for preventing malaria • Counseling on birth and emergency preparedness • Screening for hypertensive disorders of pregnancy • Screening for anemia • Screening for HIV/syphilis • Screening of Gestation Diabetes • Prevention and management of HIV including ART	C, P, R C, P, R C, P, R C, P, R C, P, R P, R P, R P, R P, R P, R P,R
	Prevention and Management of pre-eclampsia	• Low dose Asprin for prevention of pre-eclampsia in high risk women • Use of antihypertensive drugs to treat severe hypertension in pregnancy	P, R P, R
	Magnessium sulphate for eclampsia	-	P, R
	Corticosteroid to prevent respiratory distress syndrome		R
	Antibiotics for preterm rupture of membranes	-	P, R
Child birth	Skilled birth attendance	-	P, R

	Basic Emergency Obstetric and newborn care		P, R
	Comprehensive Emergency Obstetric Care		R
	Prophylactic antibiotics for caesarean section		R
	Active management of third stage of labour to prevent postpartum hemorrhage		P, R
PNC	Advice and provision of FP		C, P, R
	Prevent and treat maternal anemia		P, R
	Detect and treat postpartum sepsis		P, R

5.2: Key interventions for newborn health

	Intervention	**Evidence**	**Level to be offered**
Routine foe all newborns	Essential Newborn Care *Skin-to-skin care* *Drying and wrapping* *Sterile instrument for cord cutting* *Cord, eye, skin care* *Initiate breastfeeding early*	- Provision of quality, routine care during time of birth for all women and newborns could prevent estimated 531,000 stillbirths and 1.325 million newborn deaths (Lancet, 2014) - Skin-to-skin care reduce risk of hypothermia by 91% especially in preterm/LBW newborns weighing < 2000 grams (Salam et al, 2014)	Community (C) Primary Health (P) Referral (R)
	Breastfeeding within 1 hour	Early breastfeeding initiation associated with; - 44% reduction in all-cause neonatal mortality (Debes et al, 2013; Black et al, 2013) - 42% reduction in mortality among LBW babies (Debes et al, 2013) - 45% reduction in infection-related neonatal mortality (Debes et al, 2013)	C, P, R
Complications at birth	Neonatal resuscitation with bag and mask for do not breath spontaneously at birth	- Meta-analysis showed decreased intra-partum related neonatal deaths with training by 30% (Lee et al, 2011; Salam et al, 2014) - In Tanzania training in HBB showed 47% reduction in early neonatal mortality (Msemo et al, 2011)	P, R
Small and sick babies	Kangaroo mother care for preterm and babies weighing < 2000 grams	- 51% reduction in mortality for newborns weighing < 2000 grams (Lawn et al, 2010; Salam et al, 2014) - 43% - 60% reduction in severe morbidity (Conde-Agudelo et al, 2011; Salam et al, 2014)	P, R
	Management with antibiotics of	Treatment of sepsis and pneumonia in newborns	P, R

	neonatal sepsis, pneumonia or meningitis	lead to; (Zaidi et al, 2011; Salam et al, 2014) - 25% reduction in all-cause neonatal mortality - 42% reduction in pneumonia-specific mortality	
	Focusing on care of small and sick newborn could further prevent 600,000 newborn deaths by 2025 (Lancet, 2014)		
	NCU	Case management of jaundice, safe oxygen therapy, I/V fluids, extra support VLBW and management of babies with respiratory distress at district/higher level may avert 20% neonatal mortality (Salam et al, 2014)	R
	PNC visit	Meta-analysis of home visits by CHWs during postnatal period especially in rural for home deliveries showed a reduction of 12% (95% CI 5–18) of newborn mortality (Kirkwood et al, 2013)	C

5.3: Key interventions for Child Health

	Intervention	**Evidence**	**Level to be offered**
Routine for all children	Exclusive breastfeeding for 6 months	Lack of exclusive breastfeeding initiation associated with; - Contributes to 804,000 child deaths - which represent 11.6% of the 6.9 million child deaths that occurred globally (Black et al, 2013).	Community (C) Primary Health (P) Referral (R)
	Appropriate IYCF to reduce stunting and anemia	-	C, P, R
	Routine immunization	-	C, P, R
Severely sick 2° under	Treatment of SAM	-	P, R
Sick children	Comprehensive care of childhood pneumonia	-	P, R
	Case management of diarrhea	-	C, P, R
	Comprehensive care of children exposed or infected with HIV		P, R
	Management of childhood malaria		C, P, R

Community platforms	Community promotion of EBF, nutrition counseling and care seeking behavior		C

ANNEX 6: Other Monitoring and Evaluation Indicators of RMNCAH

Indicators for Maternal Health Interventions

Table 6.1: Indicators depicting level and targets for 2020 of care provided during pregnancy in Tanzania

Indicator	Current level 2013 -2014	Target by 2015	2020 Target
ANC at least once	96%	100%	100%
ANC at least 4 times	43%	90%*	90%
ANC before 16 weeks of gestation	15%	60%	60%
IPT $_2$	32%	80%	80%
ITN Use in pregnancy	75%	80%	90%
TT $_{2+}$ Lifetime protection	88%	90%	100%
Anemia in pregnancy	53%		37%
% of pregnant women screened for syphilis	38%	80%	80%
% pregnant women screened for HIV	90%	90%	> 95%
PMTCT			
Site coverage (RCH facilities with PMTCT services)	94%	100%	100%
% pregnant reached at ANC with PMTCT services	95%	80%*	100%
% HIV positive receive ART recommended in option B+	79%	90%	100%
% HIV exposed infants receive ARV prophylaxis	56%	80%	>90%

Table 6.2: Level and trends of indicators to monitor progress during childbirth

Indicator	Current level 2013-2014	2015 Target	2020 Target
Proportion of deliveries taking place in health facilities (TDHS, HMIS 2011)	50% - 56%	80%	80%
Proportion of births assisted by a skilled attendant (TDHS, NPS 2011)	51% - 62%	80%	80%
Proportion of facilities offer BEmOC (SARA)	20 % dispensaries 39 % Health centers	70 % dispensaries 70% Health Centre	70%
Proportion of facilities offer CEmOC	73% Hospitals	100%	100%
Proportion of facilities offer CEmOC	9 % Health centers	50%	50%
C/S rate	4.5%	5-15%	5-15%

Met need for Obstetric Complications	*Complications not recorded in HMIS*		100%
Case Fatality Rate (CFR) for obstetric complications	*Complications aren't recorded*		< 1%

Indicators for Newborn Interventions

Table 6.3: Current levels and target for 2020 - newborn indicators

Indicator	Current level 2013-2014	2015 Target	2020 Target
NMR (per 1,000 live births)	21	19	16
SBR (per 1,000 total births)	26	-	19
Postnatal care visit (within 48 hours)	31 %	80 %	80 %§
Postnatal visit at home within 1st week	-		80%§
Early initiation of breastfeeding (within 1 hour after birth)	49%	90%	90%§
Prevalence of low birth weight (LBW)	7%		< 2%*
Prevalence of preterm births/delivery	-		
% HIV exposed children who receive ARV prophylaxis	56%	80%	90%§
Proportion of health facilities with deliveries perform newborn resuscitation (NR)	-		50%‡
% of babies without spontaneous breathing at birth who were resuscitated with bag and mask			50%‡
% of health facilities with deliveries providing essential newborn care (ENC)	-	75%	75%
% of district hospitals and health centers with designated area for Kangaroo Mother Care (KMC)// or implementing KMC	-		100%
% of preterm and babies weighing < 2000 grams who received KMC	-		50%‡
% of district hospitals with functional neonatal care unit (NCU)	-		100%
% of health facilities with RCH services with corticosteroids to reduce preterm births	-		90%
% health facilities where there are deliveries have recommended NR commodities (bag &mask, suction)	15-32% PHC 90% Hospitals		90%

% health facilities deliveries with recommended antibiotics for newborn infections (I/M ampicilin & gentamycin)	-		90%
Proportion of newborn with possible serious bacterial infection who received antibiotic therapy			50%‡
Proportional of district hospitals that are accredited baby friendly (BFHI)			100%
Birth registration	16%	60%	60%*

§ = target from previous policy documents

‡= recommended targets for 2020 in every newborn, WHO, 2014

*= suggestions and inputs are required from TWG

- = No data

PHC = Primary health care (dispensary & health centres)

Indicators for child health

Table 6.4: Current Level and Targets for 2020 in Child Health and Nutrition Indicators

Indicator	Current level 2013 - 2014	2015 Target	2020 Target
U5MR (per 1,000 live births)	54		40
Measles 1 Immunization Coverage	95%	90% in 90% of districts	90% in 90% of the districts*
DPT- HiB 3 (Penta 3) coverage	95%		
Vitamin A supplementation (U5)	60%	70 % dispensaries	90%§
Exclusive Breastfeeding @ 6M	50%	80%	80%§
Timely complementary feeding rate	93%	100%	100%
Under-weight prevalence	16%	14%	11%
Stunting prevalence	42%	22%	22%§
Wasting prevalence	5%	< 5%	< 5%§
Anemia prevalence	59%		41%
ART coverage among children with advanced HIV infection	23%		60%
% HIV exposed children who receive ARV prophylaxis	56%	80%	90%§

% HIV exposed children who receive Cotrimoxazole prophylaxis	34%	80%	90%§
% of HIV-exposed children tested at 6 weeks or 12-18 months	30%	80%	90%§
Mother-to-child HIV transmission rate	12.7%		< 5%§
ITN use in children	73%	80%	90%*
Malaria/fever care seeking	77%		90%*
% of children with malaria Rx with recommended drug (ACT)	34%		60%*
ARI/ pneumonia care seeking	71%		90%
% of children with pneumonia treated with recommended antibiotics	-		50%*
Care seeking for diarrhea	53%		90%
ORS and zinc used for treatment of diarrhea	59%		90%
% sick children correctly identified and treated following IMCI guideline	-		50%*
% health facilities with at least one trained staff in IMCI	44%		80%

§ = target from previous policy documents

‡= recommended targets for 2020 in every newborn, WHO, 2014

*= suggestions and inputs are required from TWG

- = No data

PHC = Primary health care (dispensary & health centres)

Indicators for Adolescent health

Table 6.5: Current Level and Targets for 2020 in Adolescent Health Indicators

Indicator	Current level 2013 -2014	2015 Target	2020 Target
Adolescent Fertility Rate AFR (15-19) years	128 per 1,000 women	< 100 per 1,000 women	< 100 per 1,000 women
Adolescent birth rate (have started childbearing by age 19)	44%%	39%	30%
Proportion of HF provide AFSRH services	30%	80%	80%
Proportion of service delivery points outside HF provide youth friendly services	-	-	50%

Sexually active adolescents (15-19)			
CPR	12%	-	20%
Unmet need for FP	16%		10%
Demand of FP satisfied	48%		60%
% use condom at last sex	50%		65%
HIV testing among 15-24 years			
Young women	39%		60%
Young men	25%		60%
% 15-19 who are married/ cohabiting	18%		30%