



United Republic of Tanzania

**Ministry of Health and
Social Welfare**

WOMEN AND CHILDREN FIRST

**Countdown
to ending
preventable
maternal,
newborn
and child
deaths in
Tanzania**

"Improving the health of women and children is a matter that is very close to my heart. I am very passionate about getting the opportunity to do something to help save the lives and improve the living conditions of many innocent children and mothers..."

President Jakaya Kikwete of Tanzania, co-chair for the United Nations Commission on Information and Accountability for Women and Children's Health, May 2011.



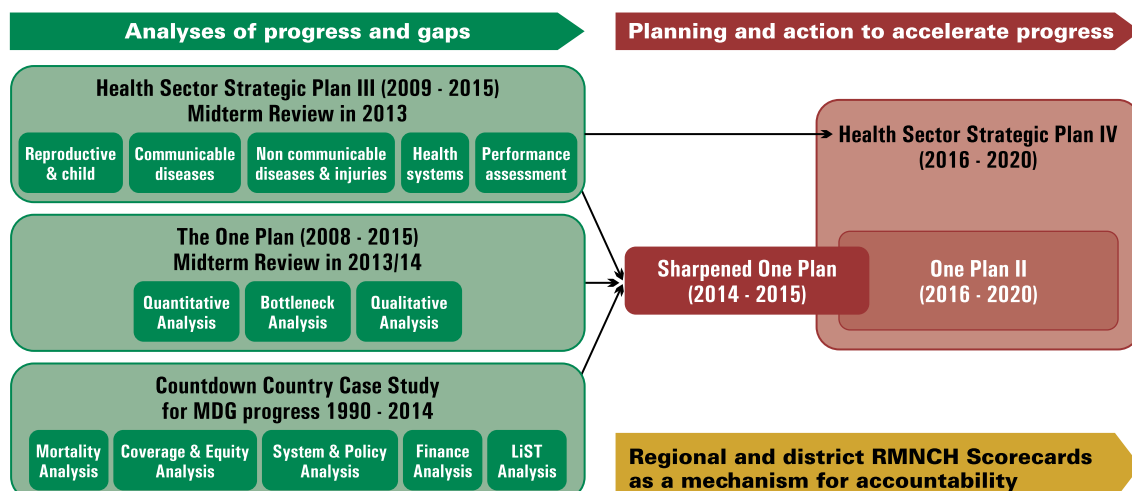
Photo: WHO

WOMEN AND CHILDREN FIRST presents an overview of the current status of Reproductive, Maternal, Newborn, and Child Health (RMNCH) in Tanzania. It identifies gaps in coverage, equity, and quality for essential care, and outlines practical solutions and strategies that Tanzania can implement now. Tanzania must build on this foundation of evidence. We must prioritise policies and programmes that target the most vulnerable women and children; invest in equitable coverage of health interventions that are proven to work; and move faster to deliver on our commitments in order to save lives. We must work together, learning from successes and failures in the past, boldly addressing the challenges we face today, and sharpening our planning for the future. We must ensure that all of us - partners in and outside of government - are held accountable for keeping our promises. By taking action now, we can accelerate progress on the Millennium Development Goals (MDGs), and put Tanzania on track to achieving the targets set for women and children in the One Plan II (aligned to the Health Sector Strategic Plan (HSSP) IV) by 2020. The ultimate aim is to end all preventable maternal, newborn and child deaths by 2035.

This policy brief outlines a collaborative effort to analyse progress so far for Tanzania's women and children, and to develop focused national priorities for further action. The Tanzanian Countdown to 2015 Country Case Study,¹ along with other important analyses of Tanzania's health and development progress, including the HSSP III Midterm Review² and the One Plan Midterm Review,³ have their findings summarized in these pages. Together, and in full alignment with A Promise Renewed,⁴ these analyses shed light on what is working and what is not, on which Tanzanians are being reached and who is being left behind. They enable policymakers to focus planning, action, and resources – as defined in the Sharpened One Plan (2014 – 2015) and the One Plan II (2016 – 2020) – where they will be most effective in saving lives of women and children. Accountability for effective implementation will be strengthened through the regional and district RMNCH scorecards, which allow transparent monitoring and evaluation.

Together, let us hold ourselves, and each other, accountable for keeping our promises to Tanzania's women and children. Let us show that, for Tanzania, WOMEN AND CHILDREN COME FIRST.

Figure 1:
Analyses that have informed the priorities for Reproductive, Maternal, Newborn and Child Health in Tanzania and sharpening of future plans, and accountability mechanism



Key Messages

The Situation: *Where We Stand*

Tanzania is poised for increasing economic progress, but a country's successful, sustainable development ultimately depends on the health of its people.

Remarkable achievements have been made for child survival, and Tanzania has already reached its target for MDG 4. Still, far too many children are dying from preventable causes and very little progress has been observed for maternal and newborn survival.

Whilst contraceptive prevalence has improved, including for rural women, unmet need for family planning remains high and has not improved in 20 years. Coverage of some high impact health interventions - such as immunisation and bed nets for malaria - have improved rapidly, but coverage of other interventions, especially care around the time of birth, remains low, and large inequities persist.

Each year:

- Almost 7,900 Tanzanian women die due to complications of pregnancy and childbirth.⁵
- Nearly 40,000 Tanzanian babies die during the first 28 days of life.⁶
- Almost 100,000 Tanzanian children die before reaching their fifth birthday.⁶
- Nearly 50,000 babies are stillborn, almost half of them dying during delivery.⁷

The Solutions: *What We Must Do*

Building on the policies and plans that are already in place, we must work together, in Tanzania, to accelerate progress for women and children. We must:

PRIORITISE, set policies and build programmes on a foundation of evidence.

INVEST, mobilise and leverage resources.

DELIVER, ensuring that programmes, health workers, and essential supplies are available when and where they are most needed. We must take action now to reach the women, newborns and children who are being left behind.

The evidence shows that accelerated action for the three priority strategies below will SAVE LIVES:

1. Address unmet need for family planning, particularly for adolescents and women through avoiding stock-outs, greater choice of long acting methods, community distribution and community mobilisation.



Photo: Jordi Matas/Save the Children

2. Address the gaps for coverage and quality of care at birth (including postnatal care), particularly for the rural, poor women and newborns, and ensure that every woman and every newborn delivered in a facility during 2015 receives essential care.

3. Continue the progress for child health, particularly prevention and management of pneumonia, diarrhoea, malaria and HIV, as well as newborn care, and prevention of under-nutrition.

Every Tanzanian has a role to play in ending preventable maternal, newborn and child deaths. Government officials, policymakers, health managers, healthcare providers, and communities must all work together and be accountable for the progress of health and wellbeing of Tanzanians.

THE GOAL: ENDING PREVENTABLE DEATHS FOR WOMEN, NEWBORNS AND CHILDREN

If these three priority strategies are accelerated – family planning, quality care at birth and the continuing the progress for child health – in the whole country, then 18,400 Tanzanian lives could be saved by the end of 2015.

With universal coverage of all RMNCH care by 2035, deaths of Tanzanian mothers, newborns, children as well as stillbirths would be reduced by more than 80%, saving over 60,000 lives that year alone.

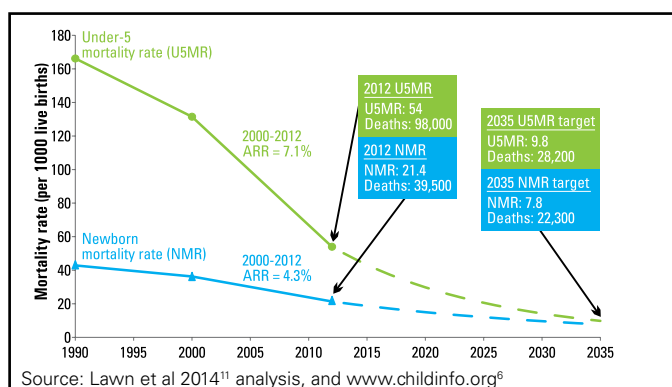
Progress towards MDGs 4 & 5 in Tanzania

In comparison with other sub-Saharan countries, Tanzania has enjoyed decades of political stability and economic growth. But the population has almost doubled – from 25 million in 1990 to 45 million in 2012⁸ - bringing challenges in maintaining high-quality social services in healthcare and education. Seventy percent of Tanzanians continue to live in rural areas⁹ and approximately 30% of women of reproductive age are illiterate.¹⁰ Figures 2-4 show Tanzania's mixed progress for MDGs 4 and 5.

MDG 4: Reduce under-five mortality rate (U5MR) by two-thirds by 2015

Tanzania has achieved remarkable progress in child survival, and has already reached its target for MDG 4. The decline in child mortality rate accelerated significantly between 2000 and 2012, with an average annual rate of reduction (ARR) of 7.1%.¹¹ However, similar progress in newborn survival has not been achieved: neonatal mortality – deaths in the first 28 days of life – has declined at only about half the speed as child mortality (Figure 2). Newborn deaths now make up 40% of all deaths in under-five children.¹²

Figure 2: MDG 4 is achieved but more progress is required to end preventable newborn and child deaths in Tanzania by 2035 for A Promise Renewed and Every Newborn Action Plan

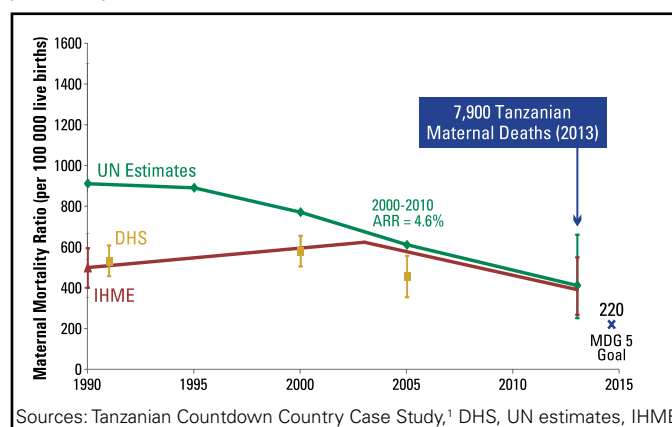


Almost 100,000 Tanzanian children, including nearly 40,000 newborns, die each year⁶

MDG 5a: Reduce maternal mortality ratio (MMR) by three quarters by 2015

Tanzania has made insufficient progress in maternal survival between 1990 and 2013 (Figure 3). Approximately 7,900 women still die each year from complications of pregnancy and childbirth.⁵ Despite a modest increase in the ARR between 2000 and 2010, the ARR between 1990 and 2013 was only 3.5%.⁵ Tanzania is therefore off target to achieving MDG 5a.

Figure 3: Progress towards reducing the MMR by three quarters (MDG 5a) in Tanzania

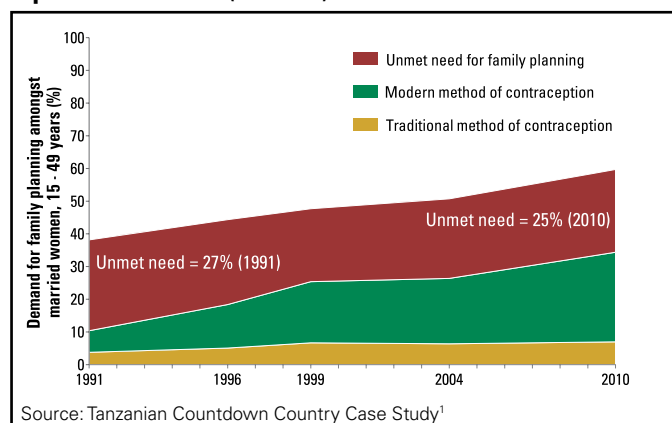


Almost 7900 Tanzanian mothers die each year due to pregnancy⁵

MDG 5b: Provide universal access to family planning and reproductive health services

Tanzania has increased the modern contraceptive prevalence rate (CPR) from 7% in 1991 to 27% in 2010,¹ with the increase between 2005 and 2010 largely attributable to an increase amongst rural women.^{1,10} However, the unmet need for family planning – the proportion of all women whose family planning needs are not satisfied – has remained constant¹ (Figure 4). By addressing the unmet need for family planning, Tanzania can achieve the One Plan CPR target of 60%.

Figure 4: Progress towards achieving universal access to reproductive health (MDG 5b) in Tanzania



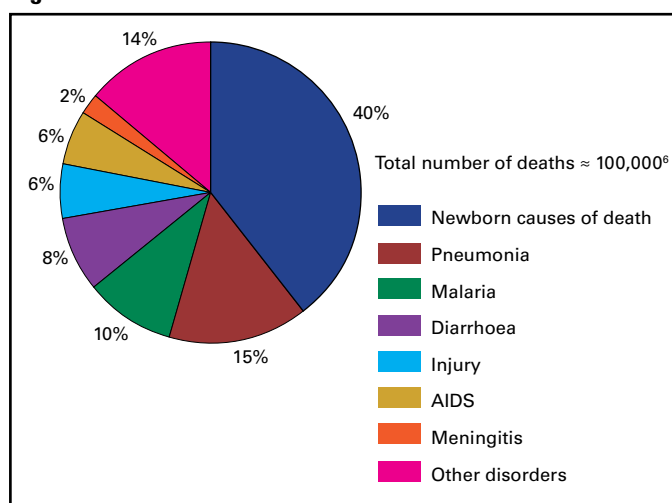
The unmet need for family planning has remained constant for 20 years in Tanzania¹

Why do Tanzanian women and children die?

Why do Tanzanian children die before their 5th birthday?

After the first month of life, approximately half of all child deaths are due to pneumonia, diarrhoea or malaria. Malnutrition is also important as it increases the risk of children dying from infections. The proportion of Tanzanian children under five that are stunted remains high (41% in 2010) and has not improved significantly since 1991.¹³ In addition to focusing more attention on newborn care, Tanzania must continue the progress for child health through strengthened nutrition programs; prevention and improved management of pneumonia, diarrhoea and malaria; and continuing the countdown to zero for HIV in children.

Figure 5a

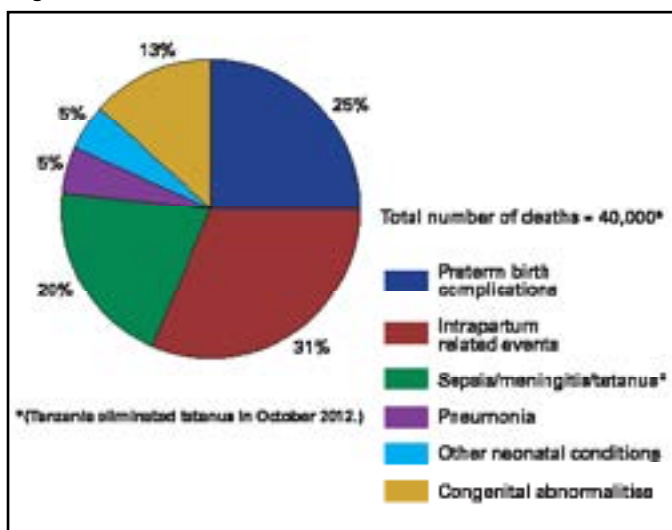


WHO and CHERG 2014¹²

Why do Tanzanian newborns die?

Around one in three deaths in children under five (40%) occurs during the neonatal period – the first 28 days of life.¹² This proportion is increasing as progress in newborn survival is slower than progress for children under five. Three conditions account for more than three-quarters of newborn deaths: preterm birth complications, intrapartum-related events (birth asphyxia), and sepsis.¹¹ More than 80% of newborn deaths occur in babies that are small, especially those that are born preterm.^{10,11} Newborn deaths can be prevented through quality care at birth, care of small and sick newborns, use of antenatal steroids for preterm labour, neonatal resuscitation, Kangaroo Mother Care (KMC) and sepsis case management, which Tanzania is poised to scale up.

Figure 5b

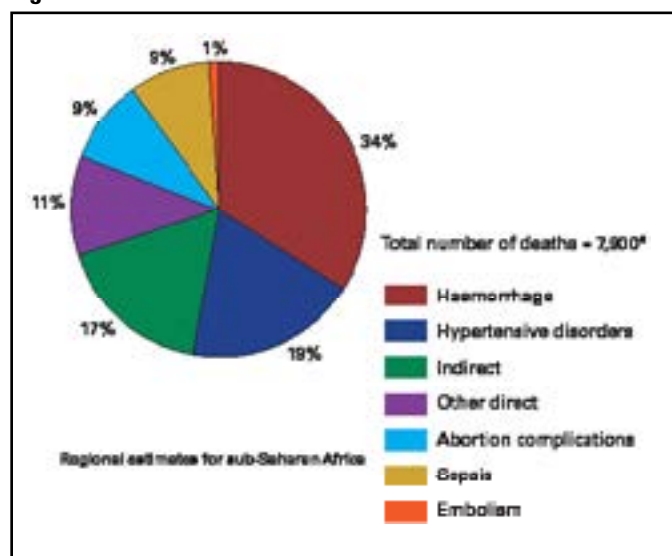


WHO and CHERG 2014^{11,12}

Why do Tanzanian mothers die?

The majority of maternal deaths in Tanzania are due to direct obstetric complications, which occur at the time of birth and during the postnatal period. Obstetric haemorrhage and hypertensive disorders account for more than 50% of all maternal deaths. These deaths can be reduced by preventing unwanted pregnancies through effective family planning programmes, ensuring high coverage of quality care at birth and during the postnatal period, provision of emergency obstetric care services and availability of skilled birth attendance. Family planning is one of the most cost effective ways to reduce deaths, and disability as well as empowering women.¹⁶

Figure 5c



Countdown Report 2012¹³

What is required for essential care for mothers, newborns and children?

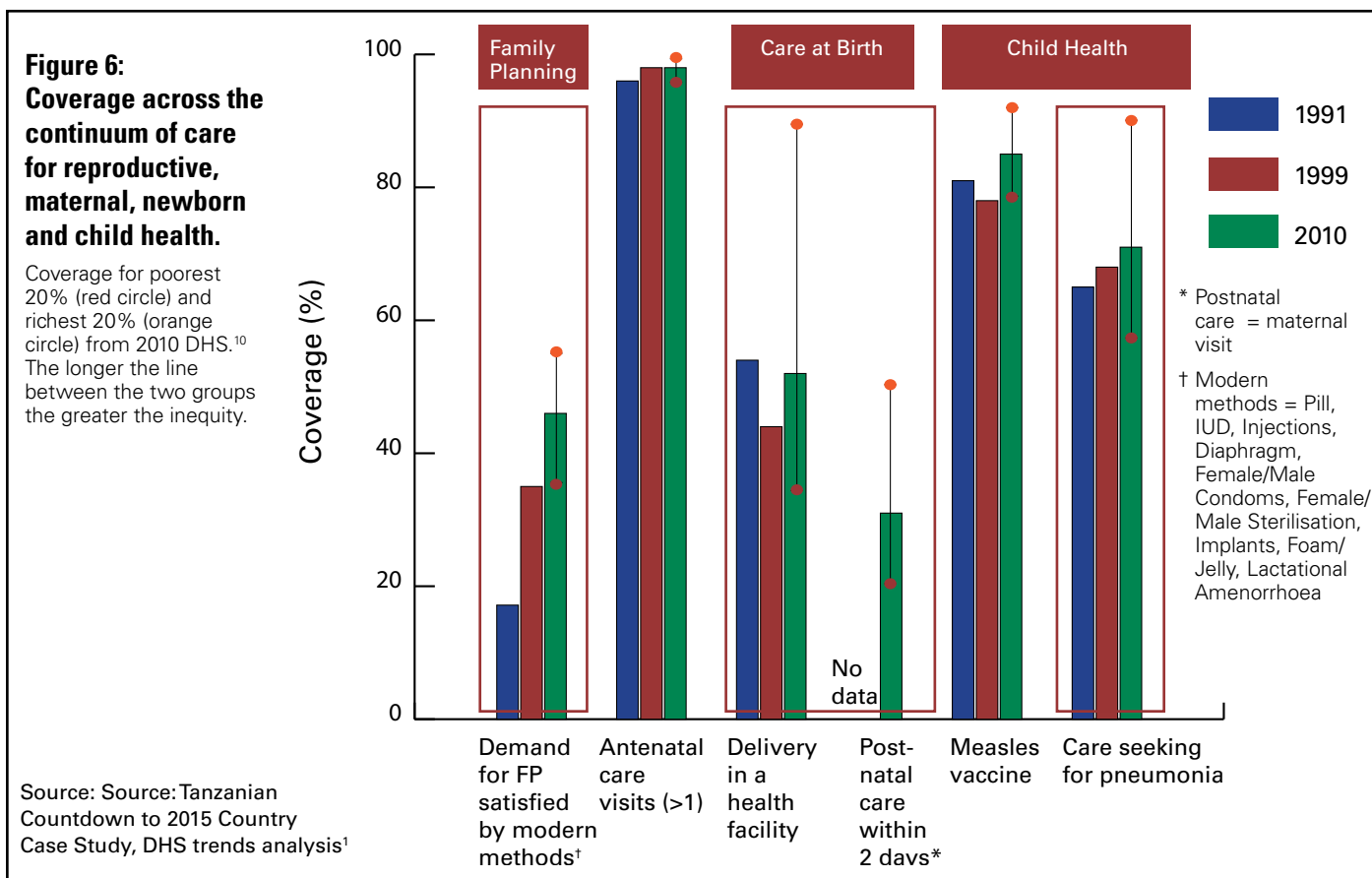


The continuum of care emphasises the seamless linkages required between reproductive, maternal, newborn and child healthcare across time and at all levels of the health system. Both coverage and quality of care need to be high to save lives. Tanzania's ultimate aim is to achieve universal coverage and high quality care in all essential interventions across the continuum of care, and to end all preventable maternal, newborn and child deaths.

Achieving universal coverage means reaching every mother, newborn and child with essential interventions. Providing high quality services means doing the right thing, at the right time. Figure 6 depicts coverage and equity by socio-economic status along the continuum of care. Each indicator in this figure shows a single contact point for women, newborns and children as tracked by the Commission for Information and Accountability through Countdown to 2015.¹ The narrow 'error bars' extending above and below the 2010 data show the equity gaps between the poorest and richest, a stark indicator of who is being left behind. Current coverage of interventions across the continuum of care varies widely, with women from the lowest socioeconomic group often being left behind.

Quality care requires the availability of people with the rights skills, and an enabling environment (including essential equipment and medicines). Quality of care is critical to saving lives but often is not measured in a standard way. The lack of real-time nationally representative information for tracking coverage, equity and quality of care makes it challenging to accurately assess and plan for the future, and highlights the need for better data for decision-making. It is hoped that the Tanzanian Health Management Information System (HMIS), scaled up nationally in 2013, will fill this gap.

Intersectoral solutions, such as improvements in water and sanitation and socio-economic conditions, also make essential contributions to improving nutrition, improving quality of life and saving lives.



Who's being left behind in Tanzania?

COVERAGE GAP – Does care reach everyone?

The coverage gap is the difference between the current coverage of a service (or package of services), and reaching everyone who needs it. Tanzania has achieved high national coverage for many preventive child health interventions. However, coverage levels for demand for family planning satisfied and care at birth remain too low and have not improved much in the last 20 years (Figure 6). Curative child care has made less progress and data, especially for newborn care interventions, are limited.

EQUITY GAP – Who receives care and who does not?

National averages conceal gaps in coverage between rich and poor, between the most educated and least educated, between urban and rural families, and between regions. In Tanzania, the largest inequities along the continuum of care, between rich and poor, are in demand for family planning satisfied, care at birth, and care-seeking for pneumonia.

Compared to women from the poorest 20%, women from the wealthiest 20% are:

- TWICE as likely to have their demand for family planning satisfied,
- THREE times more likely to deliver in a health facility,
- TWICE as likely to receive postnatal care, and
- TWICE as likely to seek care for their child with suspected pneumonia (Figure 6).

QUALITY GAP – Is the right care provided at the right time?

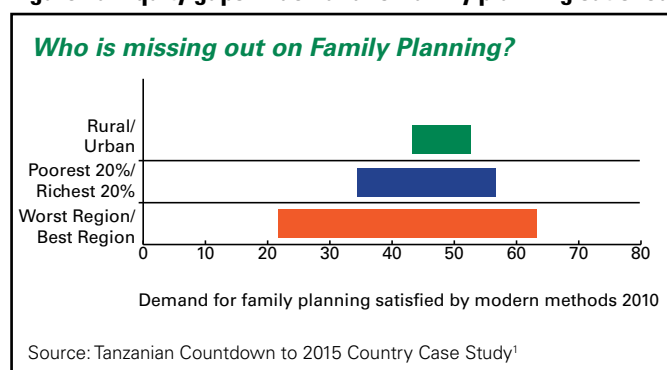
The quality gap is the percentage difference between those who simply make contact with the health system (the 50% of women who gave birth in a facility in 2010¹⁰, for example), and those receiving the right interventions at the right time. Quality care is particularly important at birth, the riskiest time for mothers and babies and a time when a delay of even minutes can cost lives. This is the main focus of the *Every Newborn Action Plan*.¹⁵

Family planning, care at birth (including postnatal care) and curative child health care have the lowest coverage and the largest equity and quality gaps.

Equity gaps by residence, wealth status and region

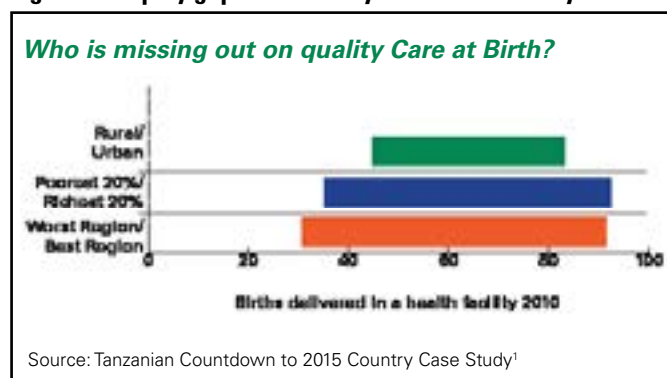
NOTE: In these equity gap charts, the wider the bar, the greater the inequity.

Figure 7a: Equity gaps in demand for family planning satisfied



Women from the **WESTERN** and **LAKE** zones, specifically **Mara, Mwanza, Shinyanga, Kigoma and Tabora**, are being left behind for family planning!

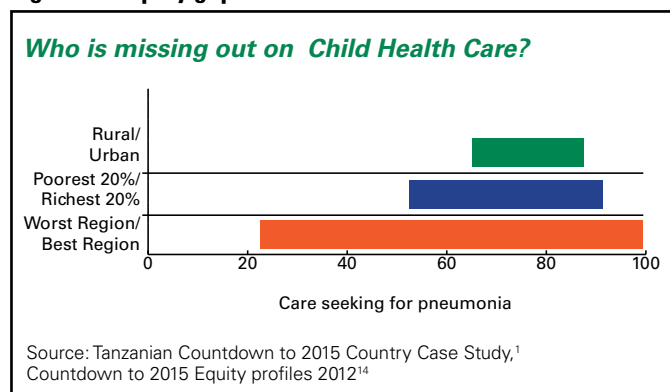
Figure 7b: Equity gaps for delivery in a health facility



POOR, RURAL women are being left behind for care at birth!

Most of the poorest families in Tanzania live in rural areas, so the rural poor are the largest group that is not being reached.

Figure 7c: Equity gaps in Child Health Care



Children from **Tabora, Mbeya, Singida and Kagera** are being left behind for curative child health care!

Solutions exist to save lives in Tanzania

Tanzania has many of the policies and plans in place to bring about substantial and rapid change. Now is the time for Tanzania to prioritise, invest and deliver fast to save lives by the end of 2015 and beyond. The solutions lie in real investment, action, and implementation of evidence-based plans targeting women, newborns and children, focusing on those who are not being reached by the essential interventions. The One Plan Midterm Review³ identified solutions to both supply and demand bottlenecks in the healthcare system for all interventions along the continuum of care, including family planning, care at birth and for maintaining progress for child health.

"My Government is committed to double the number of family planning users from the current 2.1 million to 4.2 million towards achieving the national contraceptive prevalence rate target of 60 per cent by 2015..."

President Jakaya Mrisho Kikwete of Tanzania, London Summit on Family Planning, July 2012.

Family Planning

Tanzania has made progress in reducing the urban/rural equity gap for modern methods of family planning from 2.8 in 1991 to 1.4 in 2010.¹ Now the biggest gap remains for women in the Western and Lake Zones, specifically women from Mara, Mwanza, Shinyanga, Kigoma and Tabora¹ (including the new regions of Simiyu and Geita). Adolescents across Tanzania are still being left behind for family planning provision and other sexual and reproductive health services. Tanzania needs to address the unmet need for family planning in order to reach the One Plan goal for CPR of 60%. As a commitment to Family Planning 2020, Tanzania has committed to doubling the number of women using family planning.¹⁶

Supply solutions for Family Planning

- Prioritise family planning in district health budgets.
- Bring outreach services closer to the community through Community Health Workers (CHWs).
- Expand family planning services to reach adolescents and young people.
- Increase the skills of healthcare workers to provide the full range of family planning methods, including mentorship and supervision.
- Ensure the availability of management protocols and guidelines on the provision of family planning, linked to supportive supervision and professional bodies to ensure accountability.
- Provide better availability of the range of family planning methods, including long-term methods, especially in lower-level facilities.
- Strengthen the supply chain and avoid stock-outs of family planning commodities.
- Include contraceptive indicators in the HMIS register.



"Yes, family planning services are available and people are being educated but this has not been enough. Not all have knowledge on family planning."

One Plan Midterm Review, Qualitative Analysis³

Photo: Mamaye!

Demand solutions for Family Planning

- Well-designed social engagement approaches, including male involvement, family planning days and events.
- Mass media campaigns to increase access to information on sexual and reproductive health and family planning, especially among adolescents and youth.

Solutions exist to save lives in Tanzania

Care at Birth

Rural, poor women across Tanzania, are currently missing out on life-saving care at birth, for themselves and their newborns. The One Plan Midterm Review³ reports that an increase in the availability of basic emergency obstetric and newborn care (BEmONC) services at dispensaries and health centres, and scaling up of rural health centres to perform caesarean sections and blood transfusions (comprehensive obstetric and newborn care (CEmONC)), is urgently needed to save lives.

Supply solutions for health system management and health professionals:

- Increase recruitment and invest in the technical competency of rural health providers, especially midwives, with specific incentives to work in hard-to-serve areas.
- Ensure scale-up of BEmONC at lower-level facilities, and CEmONC provision at health centres and hospitals, including sustainable financing in district health budgets.
- Ensure use of management protocols and guidelines for emergency obstetric and newborn care.
- Address management and oversight to ensure continuous availability of maternal and newborn care commodities and equipment.
- Improve provider competencies for BEmONC and CEmONC, and newborn care practices (including essential newborn care and KMC).
- Strengthen the blood transfusion system, including satellite collection centres in regional hospitals.



- Strengthen anaesthetic services, including investing in training and recruitment of anaesthetists.
- Conduct regular assessment of the provision of BEmONC and CEmONC signal functions, and link indicators for HMIS.
- Conduct maternal and perinatal death surveillance and response in every facility where births occur and strengthen accountability processes to link to responsive action for continuous quality improvement.

Demand solutions and community level:

- Build community awareness of the need to give birth in a facility, and community planning and accountability for access to facilities for women, newborns and children during emergencies.
- Increase public awareness - including male involvement - of danger signs, care-seeking, and postnatal visits, with special emphasis on adolescent girls, pregnant women and young couples.
- Scale up community health worker programmes especially for home visits during pregnancy and postnatally.
- Improve blood transfusion supply through community sensitisation to voluntary blood donation.



Solutions exist to save lives in Tanzania

Child health

Completing the task, tackling the remaining challenges

The biggest gaps in child health are insufficient access to curative care for sick children and newborns, and lack of progress in addressing stunting and under-nutrition, especially among the poorest. Case management of pneumonia and diarrhoea, including hospital care, shows large inequalities.¹⁴ Care for small and sick newborns is also critical, and yet lacks coverage data.

Stunting remains high and is a critical risk factor for child deaths. Increasing exclusive breastfeeding to six months is an essential

intervention in which Tanzania has made less progress than some other African countries. Improving young infant nutrition, as well as addressing low birth weight and preterm birth, are crucial. More attention is required for prevention of preterm birth and small-for-gestational-age, which together account for at least one-third of stunting.

It is important to continue to invest in maintaining the ongoing high coverage and increasing the quality of preventive child care services such as use of insecticide treated nets to prevent malaria, vitamin A supplementation, Prevention of Mother to Child Transmission (PMTCT) of HIV, and immunisation, to ensure continued progress.



Photo: Colin Cowley / Save the Children

Accelerating in the 500 days to the end of 2015

The Countdown to 2015 is well underway, MDG 4 has been met but there are critical areas of need in which Tanzania must accelerate efforts in order to save lives and improve health outcomes for women and children. We know the solutions! We need to prioritise, invest and deliver faster to save lives.

The Sharpened One Plan (2014 – 2015) underlines the focus of and leads the way for the One Plan II (2016-2020) which will be aligned to the HSSP IV and longer term activities to support A Promised Renewed⁴ and Every Newborn Action Plan.¹⁵ The Sharpened One Plan, whilst advocated for all of Tanzania, will especially target the geographical inequity for women and children from the WESTERN and LAKE zones who are being left furthest behind.



Table 1: Priority strategies to accelerate change in the short term and inform sharpened action in the medium term

Priority Areas	Sharpened One Plan (2014-2015)	One Plan II (2016 – 2020) Aligned with HSSP IV
Family Planning	1. Prevent stock-outs of family planning commodities, increase access to long-acting methods.	These three strategic priorities (family planning, quality care at birth, and addressing the challenges in child health) will form major thrusts for action in the One Plan II and within the HSSP IV, to be detailed during 2014.
	2. Capacity building for healthcare providers.	
	3. Bring outreach services closer to the community through CHWs.	
Care at Birth (Including postnatal care)	1. Prevent stock-outs of essential commodities for EmONC, case management of newborn sepsis and preterm births.	
	2. Capacity building for healthcare providers.	
	3. Strengthen postnatal care services for women and babies, including home visits.	
Child Health	1. Prevent stock-outs of essential commodities for case management of children with pneumonia, diarrhoea and malaria.	
	2. Capacity building for healthcare providers.	
	3. Bring outreach services closer to the community through CHWs.	
Implementation and ACCOUNTABILITY for action at all levels of health management.		

Sharpening and accelerating action – what will it take and how many lives will be saved?

Lives Saved Tool (LiST) Analysis

Based on data from Tanzania Demographic and Health Surveys, as well as baseline data of health status, mortality rates, and causes of death, analyses were undertaken using the Lives Saved Tool (LiST) version 5.03, a computer-based module, to estimate impact on deaths of scaling up intervention coverage.¹⁷ The results reflect accelerated progress between now and the end of 2015 for the following interventions:

- Family planning increases with longer term methods and use of community-based distribution so that the current change rate for CPR (at 2-3% per year) is doubled next year.
- Targeting births already happening in facilities so that every woman and every newborn receives effective essential obstetric and newborn care, and the current coverage gap for CEmONC (caesarean sections and blood transfusion) is halved.
- Halving the current coverage gap in care for small and sick newborns in facilities including KMC and injection antibiotics for neonatal infections.

Impact

If the goals in this Sharpened One Plan are realised by the end of 2015, then the One Plan target of 54 under-five child deaths per 1000 live births would be exceeded. Similarly, the national

target for NMR of 19 per 1000 live births will be exceeded, but not the MMR of 193 per 100,000 live births. Scaling up CPR reduces births by 16% in 2015, further reducing the number of deaths (Table 2).

Approximately 14,500 under-five deaths would be prevented in 2015, with the majority of this reduction coming from the neonatal period. This reflects the lack of prior progress for newborns, but also the fact that these interventions are poised for scale-up but are at low coverage, so that concerted action could result in rapid change. In addition there would be an estimated 1,400 maternal deaths and 2,500 stillbirths prevented, mainly through improved obstetric care and increases in modern contraceptive use.

Care at birth accounts for half of the total reduction; curative care after birth, especially for small and sick newborns and for malaria, accounts for 43%. The interventions that show the highest impact in this analysis include: improved labour and delivery management (13%), clean birth practices (11%), antenatal corticosteroids (10%), neonatal resuscitation (9%), KMC (9%), case management of neonatal infection (7%), oral rehydration solution for diarrhoea (7%), antibiotics for pneumonia (7%), and Artemisinin-based combination therapies for malaria (10%).

Table 2: Estimated lives saved by the end of 2015 if the accelerated plan is acted on nationally and by 2030 with universal coverage¹⁷

	SHARPENED ONE PLAN By end of 2015 with faster progress for the 3 priority strategies at national level			UNIVERSAL COVERAGE By 2030 with 95% coverage of MNCH care + family planning demand satisfied	
	Reduction (%)	Mortality rate	Lives saved	Reduction (%)	Lives saved
Under-five deaths	25%	46	14,500	84%	45,000
• Neonatal deaths	31%	16	9,400	89%	22,000
• Deaths 1-59 months	21%	30	5,100	80%	23,000
Maternal deaths	30%	382	1,400	83%	3,600
Stillbirths	22%	20	2,500	76%	11,400
Total lives saved			18,400	81%	60,000

Call to ACTION for National Leaders and Parliamentarians

"My government is committed to make sure that all children in this country have access to affordable and high quality health services"

**President Jakaya Mrisho Kikwete of Tanzania,
Paediatric Meeting, 22nd February 2014**

National leaders and parliamentarians must together increase efforts to deliver on existing commitments to women and newborns, and to maintain and build on progress for children. A healthy start to life for every newborn is a sensitive marker of the health of the country, and the function of the health system. The successful, sustainable development of Tanzania is dependent on the health of its people.

National leaders, parliamentarians and councillors must:

- Generate and sustain political will and momentum to achieve great progress for RMNCH Plans.
- Prioritise, invest and be accountable to ensure that adequate resources are available to provide high impact evidence-based solutions to women and children that are being left behind, notably for family planning, care at birth and curative child health care.
- Ensure that the national health accounts and council planning reflect priorities in national strategies, and develop systems to better track these funding streams. A health finance analysis conducted as part of the Countdown to 2015 Country Case Study highlighted that donor funding for RMNCH remains substantially lower than for HIV¹⁸ and dependable government funding is critical.
- Ensure timely disbursement of allocated funding to reduce the burden of out-of-pocket spending at the local level. Household spending accounts for the majority of RMNCH expenditure despite the government's commitment to free healthcare for mothers and children under-five.¹⁸
- Ensure that RMNCH priorities remain prominent in the post-2015 era, including the HSSP IV and National Strategy for Growth and Reduction of Poverty (NSGRP/MKUKUTA).

Call to ACTION for Health System Leaders

Tanzania has many good policies and strategies that address RMNCH. The task is to sharpen the focus and accelerate implementation, to deliver health-care to the families most in need, especially to the poor and those living in rural areas. The role of good leadership and management is critical to their successful implementation.



Photo: Mamaye!

Health system leaders must:

- Engage regional and district executive and administrative officers to place priority on RMNCH and the three evidence-based strategic priorities highlighted in this policy brief, namely family planning, care at birth including postnatal care, and the child health challenges, up to 2015 and beyond.
- Implement and manage the national plan for RMNCH, through accountable leadership and good stewardship at both national and local government, and support regional and council health management teams to develop context-specific implementation strategies.
- Strengthen and invest in human resources for health - increase their availability and improve their competencies, especially for the life-saving skills.
- Create and maintain an enabling environment, including incentives to motivate health care workers to work in rural areas.
- Ensure essential commodities are consistently available, especially in rural areas.
- Promote research and evidence-based decision making that results in implementation of RMNCH interventions. Encourage increased collection and use of high quality local data, for example through the use of subnational scorecards and maternal and perinatal death surveillance and response.

Call to ACTION for Healthcare Providers

"We have been sending out staff to the regional hospital to learn Emergency Obstetric Care services"

One Plan Midterm Review, Qualitative Analysis³

The individuals providing services at every level are the front line workers in saving the lives of mothers, newborns and children in Tanzania. Healthcare providers can take specific actions to improve services by increasing availability of high quality care.

Healthcare providers must:

- Ensure continuous professional development and demonstrate a high level of competency in evidence-based medicine and life-saving skills, especially for care at birth and for small and sick newborns.
- Be accountable for continuous quality improvement by undertaking regular maternal and perinatal death surveillance and response and prioritising evidence-based decisions.
- Provide good clinical mentoring to improve quality of care provision for mothers and newborns.
- Be respectful and ethical to all women, adolescents and children, including the poor.
- Work with managers to monitor stocks of essential commodities for family planning and EmONC services and to plan ahead to reduce stock-outs.
- Promote healthy home behaviours and appropriate care-seeking among families including family planning, four or more antenatal care (ANC) visits, deliver in a health facility and early postnatal care.
- Keep good medical records for individual patients and be accountable for reporting accurate data and using these data to improve services.



Photo: UNFPA

Call to Action for Communities

Local councillors, local government, and civil society (including parents' and women's groups) must work with their communities to hold healthcare providers and managers to account for providing accessible, high quality reproductive, maternal, newborn and child health care.

Communities and their representatives must work together to:

- Raise expectations – ensure that women and their families know that they have a right to skilled, respectful care; free treatment, medicines and supplies; timely and correct care in an emergency.
- Help shift social norms – women should not die while giving birth, no baby is born to die, and no child should die needlessly.
- Promote uptake of family planning methods to safely plan and space pregnancies, and encourage women to deliver at a health facility with skilled providers.
- Encourage men to play their role in ensuring the survival of women, newborns and children.
- Mobilise local resources such as transport and food, so as to ensure that women and children can access the care they need at a health facility, especially if they have to stay there a long time.
- Encourage communities to advocate for and join the Community Health Fund so as to increase the local resources available to ensure free treatment, medicines and supplies.
- Raise the voice of the community especially via the health facility governing committees – represent the community view and demand accountability for better care that ensures greater survival!

Abbreviations

ARR	Average annual rate of reduction
ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
DHS	Demographic Health Survey
EmONC	Emergency Obstetric and Newborn Care
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
KMC	Kangaroo Mother Care
LiST	Lives Saved Tool
MDG	Millennium Development Goal
MKUKUTA	National Strategy for Growth and Reduction of Poverty
MOHSW	Ministry of Health and Social Welfare
MMR	Maternal Mortality Ratio
NMR	Neonatal Mortality Rate
PMTCT	Prevention of Mother to Child Transmission
RMNCH	Reproductive, Maternal, Newborn & Child Health
U5MR	Under-Five Mortality Rate
WHO	World Health Organization

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References

- ¹ Countdown to 2015 Country Case Study, including DHS trends and equity analysis from 1985 – 2010. 2014 (forthcoming).
- ² MoHSW et al. Midterm Analytical Report of Performance of the Health Sector Strategic Plan III (2009 – 2015). September 2013.
- ³ MoHSW et al. Midterm Analytical Report of Performance of the One Plan (2008 – 2015), including the Bottleneck Analysis and Qualitative Analytical Review. April 2014.
- ⁴ UNICEF. Committing to Child Survival: A Promise Renewed. Progress Report 2013.
- ⁵ Countdown to 2015. Accountability for Maternal, Newborn and Child Survival. The 2013 Update.
- ⁶ Trends in Maternal Mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Cited 06 May 2014. Available from: <http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en>
- ⁷ Lawn JE, Blencowe H, Pattinson R, et al. Stillbirths: Where? When? Why? How to make the data count? Lancet 2011; 377: 1448–63.
- ⁸ United Nations Department of Economic and Social Affairs. Population Division, Population Estimates and Projections Section. UN World Population Prospects. Cited 18 March 2014. Available from: <http://esa.un.org/wpp/Excel-Data/population.html>.
- ⁹ National Bureau of Statistics (Tanzania). 2010. Population projections, 2010. Dar es Salaam, Tanzania: NBS.
- ¹⁰ National Bureau of Statistics of Tanzania, ICF Macro. Tanzania Demographic and Health Survey 2010. Calverton, Maryland: ICF Macro; 2011.
- ¹¹ Special analysis for Tanzania based on Lawn JE, Blencowe H, Oza S, et al. Every Newborn: Survival and Beyond. Lancet 2014; In press.
- ¹² WHO and CHERG neonatal and child cause of death estimates. WHO Global Health Observatory – To be released May 2014. [online]. Available from: www.who.int/gho.
- ¹³ Countdown to 2015. Building a Future for Women and Children. The 2012 Report.
- ¹⁴ Countdown to 2015. Equity Profiles 2012. Cited 10 March 2014. Available from: http://www.countdown2015mnch.org/documents/2012Report/2012Equity/full_equity_profiles_2012.pdf.
- ¹⁵ Every Newborn Action Plan. Available from: <http://www.everynewborn.org/>.
- ¹⁶ Family Planning 2020. Available from: <http://familyplanning2020.org>.
- ¹⁷ LiST analyses conducted by Francis Levira, Victoria Chou, Kate Kerber, Hoviyeh Afnan-Holmes, Joy Lawn in collaboration with Countdown to 2015 Case Study and APR analyses teams. 2014.
- ¹⁸ Finance analysis conducted by Melisa Martinez-Alvarez, Josephine Borghi, Peter Binyaruka in collaboration with Countdown to 2015 Case Study. 2014.



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