Tanzania Country Summary, March 2017

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Tanzania—Selected Demographic and Health Indicators					
Indicator	**Data**	**Indicator**	**Data**	**Indicator**	**Data**
Population (3)	44,928,923	U5MR (per 1,000 live births) (1)	67	SBA (1)	64%
Live births/year (1)	37.2 Per 1000 population (CBR)	TFR (births per woman) (1)	5.2	IPTp2 (4)	35%
MMR (per100,000 live births) (2)	410	CPR (modern methods) (1)	45.8%	DTP3 (1)	97%
NMR (per 1,000 live births) (1)	15	ANC +4 (1)	50.7%	Stunting (height for age <5) (1)	34.4%

Sources: 1. DHS 2015/16; 2. WHO, 2016; 3. Tanzanian Population Census, 2012; 4. 2015-16 Tanzania DHS-MIS.

Strategic Objectives

- Improve the environment for RMNCAH services through technical leadership and coordination to roll out high-impact, integrated RNMCAH interventions at scale.
- Strengthen key health systems to deliver quality RMNCAH services.
- Strengthen involvement of civil society and supporting institutions and improve uptake of innovations.

Program Dates	June 2014 – March 2019		
Financial Status	Expenditures through PY2: [redacted]; PY3 Budget: [redacted] (still to be finalized) Total budget through end of PY3 : [redacted]		
Geographic Scope	National, Regional (Mara and Kagera) and 16 Districts in these Regions Limited scope of work in an additional six regions: Zanzibar, Tabora, Simiyu, Shinyanga, Iringa and Njombe		
Geographic Presence	**No. of Regions (%)**	**No. of Districts (%)**	**No. of Facilities (%)**
	2/30 (6.67%)* *limited scope of work in additional 6 regions	16*/168 (9.5%) *100% of districts in Mara and Kagera	221*/8,327 (2.6%) *40% (563) of all health facilities in Mara and Kagera

Technical Interventions	 PRIMARY: community health and civil society engagement, immunization, malaria, maternal health, newborn health, reproductive health OTHER: gender, health systems strengthening, HIV, pre-service education

Key Accomplishments

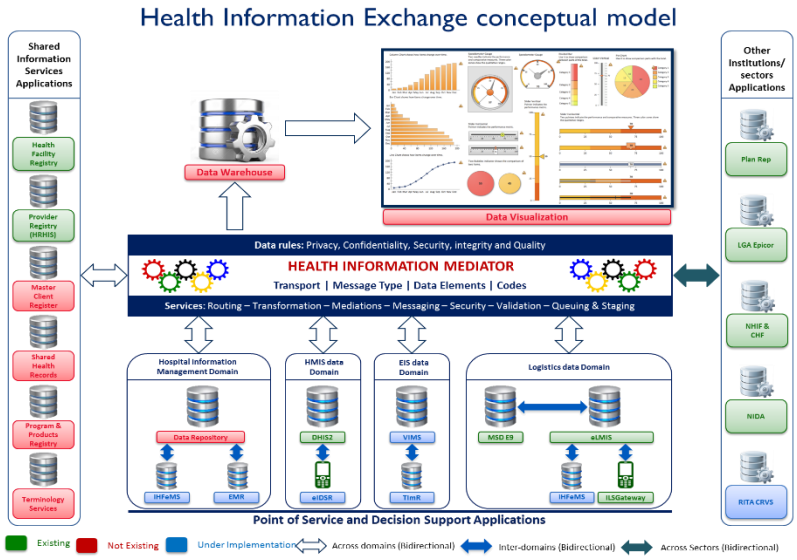
MCSP Tanzania continues to increase access to and population coverage of quality RMNCH services by contributing to the scale-up and rollout of high impact interventions to reduce maternal and newborn morbidity and mortality. The program focuses on supporting the MOHCEGEC (MOH) to develop national-level guidelines, to strengthen skills of health providers for provision of quality RMNCH services, reinforce knowledge and skills learned during trainings through the implementation of supportive supervision and mentorship at the facility level and increase knowledge and understanding of immunization services management and strengthening routine immunization in workstations. MCSP also continues to advance the development of the National HIS architecture to streamline and link existing information systems, improve data visualization for data use in decision-making and provide technical assistance to build the capacity of other PEPFAR partners in RMNCAH.

National-level Policy Development and Technical Assistance: MCSP supported the development and dissemination of the CEmONC LRP to facilitate national and MCSP-supported trainings, and advocated for the reduction of disrespect and abuse (D&A) at health facilities by working with national-level RMC core working group to develop a logic framework to outline how to improve and facilitate smooth implementation of RMC during labor, delivery and within 24 hours post-delivery to promote gender-equitable services across the continuum of care and gender mainstreaming efforts in the health workers curriculum and community-based outreach work. The MOH also approved midwifery competencies supported by MCSP that will guide midwifery educators, curriculum developers, practicing midwives, supervisors, mentors, managers and decision-makers on midwifery education, care and research.

For lasting impact, MCSP provided technical assistance to reproductive health cancer (RHCa) units to harmonize and include RHCa sessions that embrace the CECAP component in the Comprehensive National RMNCAH CHW Guidelines and LRP and incorporated the latest updates on additional FP methods and approaches in the FP procedure manual. Together with ACNM, MCSP supported the development of RMNCH practicum site standards and skills lab checklists to be utilized by MCSP-supported HTIs. MCSP supported the technical review of the integrated community MNCH package in collaboration with MOH/RCHS to incorporate updates on technical content (immunization, Option B+ and FP, RHCa, male involvement gender and GBV), and collaborated with IVD, WHO, UNICEF, CHAI and other partners to develop the National Immunization Comprehensive Multi-Year Plan (cMYP), which includes the strategic direction for the IVD program for 2015-2020.

MCSP supported the MOHCDGEC-ICT and HMIS units to develop a national health information exchange (HIE) framework under the leadership of the MOH, following the Enterprise Architecture approach. To guide and facilitate development and improvement of interoperability and information exchange, MCSP supported the development of functional requirements and phase I implementation use cases for the Health Information Mediator (HIM), Visualization & Analytics as sub-components of the HIE. The following conceptual model, approved by the MOH, displays the interaction of health information systems, noting where data will be shared and integrated within the domain and where data from others domains will be facilitated by the HIM. MCSP will continue to assist the MOH to implement the HIM, program registry, and data warehouse and visualization.

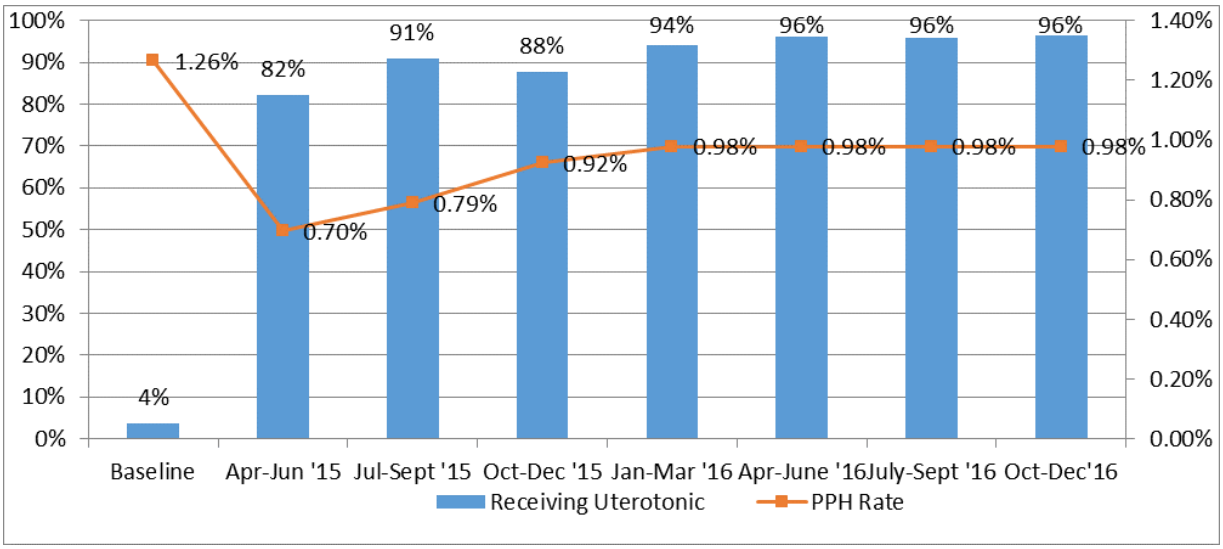
Figure 1: Health Information Exchange Conceptual Model



Subnational Planning and Management for Health Systems Strengthening: MCSP worked with health administrators in all 17 district councils in Mara and Kagera to apply systems thinking to local planning through the Comprehensive Approach to Health System Management (known by MTUMA). The MTUMA pilot was based on the hypothesis that if managers identify the root causes of health systems challenges, mobilize assets and tools to address those challenges, and integrate solutions across technical areas, the effectiveness and efficiency of local systems will increase. After MCSP led planning workshops in April 2016 to conduct root causes analyses and develop action plans for 4 priority areas (supply chain & commodities, referral networks, safe blood supply, and health financing), district councils implemented these plans with MCSP technical support. A process assessment, conducted in December 2016, showed that MTUMA helped stakeholders think more strategically about planning and management, especially in terms of data use and service integration and increased CHMT accountability and motivation. Numerous district councils noted that the approach would be used in the 2017-18 CCHP development process.

Clinical Competence, Readiness, and Service Delivery Improvements: MCSP supported the MOH to train 40 service providers from 14 HFs in Mara and Kagera to improve clinical skills on CEmONC, oriented CEmONC teams on the use of biomedical gas and other new theater equipment for CEmONC centers, and trained a total of 53 service providers on safe collection and utilization of safe blood to form district blood collection teams. As a result of these efforts, the blood collection superseded the monthly targets in Mara by 32%. MCSP supported additional training of 24 service providers on BEmONC to increase the number of skilled providers trained and to improve quality of delivery care; and by end of PY2, SBM-R scores from baseline to the first internal assessment increased by 29% to 35% in Kagera and 22% to 43% in Mara. In addition, provision of uterotonic to prevent PPH also increased greatly from the baseline to the present under MCSP support (see Figure 2). The updated register did not include a column for uterotonic; thus, MCSP supported the strengthening of reporting this indicator by adding this indicator in each of the supported sites along with onsite coaching and mentoring, data review meetings and routine data quality audits.

Figure 2: Percentage of women who delivered at MCSP-supported facilities who received prophylactic uterotonic and incidence of PPH in Kagera and Mara Regions, April 2015 – Sept. 2016

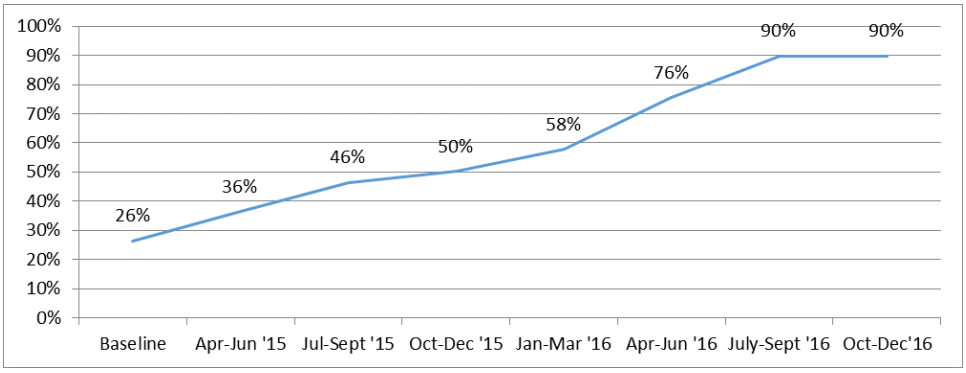


Observations: Baseline is low due to missing data, stock-outs and under-reporting.

In collaboration with AGOTA, MCSP conducted on-site clinical mentorship for 28 providers in 6 newly established CEmONC sites in Mara and Kagera. Providers mentored included doctors, anesthetists and nurse midwives working at labor wards, post-natal wards, antenatal clinics and theatre. Areas mentored in include proper documentation, evidence based skills on maternal and newborn care including use of partographs during labor and delivery, childbirth and decision making based on the findings from the partograph, AMTSL, post-natal care, management of obstetric complications, safe surgical skills such as caesarean section, post-partum hysterectomy, and laparotomy for ectopic pregnant using WHO safe surgery checklist, and other areas including newborn resuscitation and ante-natal care.

BEmONC trainings and supportive supervision on technical and data recording have contributed to the increase of newborns seen within two days of birth from 26% at baseline to 90% by the end of June 2016.

Figure 3: Proportion of deliveries where newborns were seen for postnatal care within two days of birth



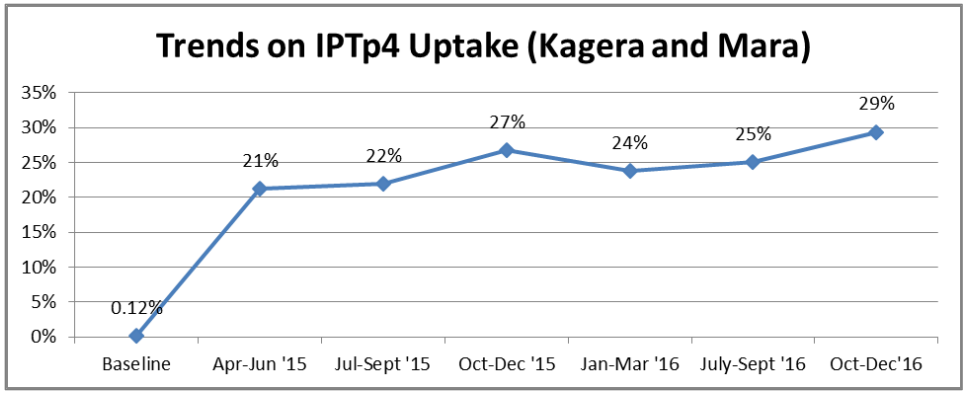
Denominator: Total deliveries as reported from the labor ward and PNC (this includes TBA, home and BBAs) in supported 226 sites.

MCSP trained 48 providers from 48 MCSP-supported dispensaries in Mara region on PPFP counseling to increase family planning uptake. Now, all 226 MCSP-supported sites provide PPFP counseling for all PPFP methods and refer women who choose PPFP to facilities that offer methods of their choice. MCSP also supported MOH efforts by rolling out clinical mentorship and facilitating the TOT for 21 participants from six regions of the Lake Zone. To monitor and reduce maternal and perinatal death, MCSP conducted regional

MPDSR meetings in Mara and Kagera. These meetings prompt reporting at all levels and develop actions to reduce number of home deliveries, improve management of obstetric complications and facilitate sufficient monitoring of post-delivery mothers through increased periodic supportive supervision and clinical mentorship at all implementation levels plus community sensitization of RMNCAH services.

MCSP provided support to district mentors in Kagera and Mara to conduct onsite mentoring and provide MIP updates for ANC providers on a quarterly basis. In addition, CHWs trained during PY1 conducted home visits to identify pregnant women and refer them for early ANC. A total of 198,197 (newborns, 1 month to 1 yr, 1-5 yrs) and 33,268 mothers were visited by 743 CHWs. These two interventions resulted in an increase in the number of pregnant women attending ANC prior to 12 weeks from 11% at baseline to 32% and an increase in both IPTp2 and IPTp4. However, in PY2 there was a decrease in IPTp uptake corresponding to the national SP stock-outs.

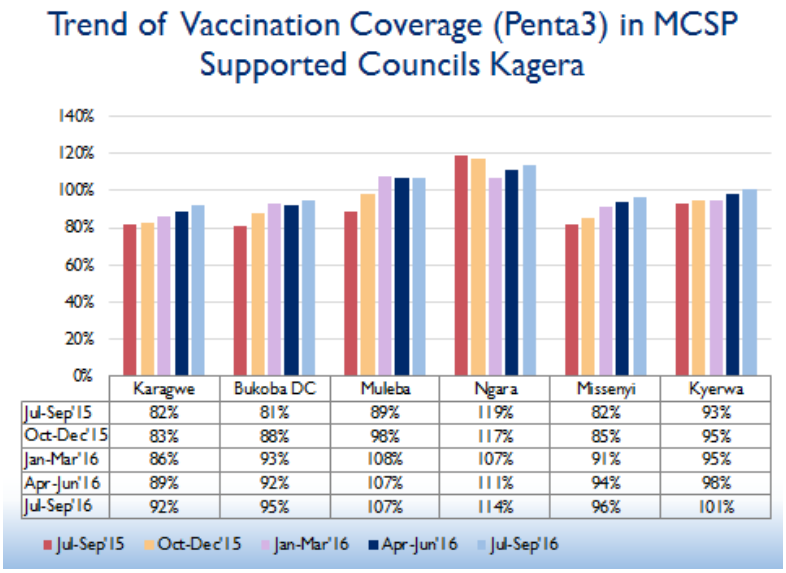
Figure 4: IPTp4 Uptake in Kagera and Mara Regions



MCSP established KMC services in 25 hospitals in Mara and Kagera regions, initiated KMC to a total of 2,382 LBW babies, trained a total of 288 HCPs in KMC and 39 HCPs in ENC, and mentored a total of 383 HCPs. Although this was a smaller number trained compared to the program target, their commitment and leadership has contributed much to the improvement in performance standard scores as seen from the internal QI assessments and external verification results. In the past two years, a total of 2,484 (7.7%) of newborns received resuscitation and 2,066 (8.3%) newborns not breathing at birth were resuscitated achieving the target of 15%. MCSP successfully ensured that 23,359 (94%) out of 24,947 total deliveries were put to the breast within one hour of birth in MCSP-supported health facilities in Mara and Kagera.

To equip PSE HTIs with updated technical RMNCH teaching materials, MCSP loaded and distributed 18 tablets to 9 HTIs (two tablets per school) and trained 24 tutors on their use. Immediately after training, tutors and preceptors were able to access and use updated resourceful information in the tablets for refreshing their knowledge and teaching.

MCSP continued to provide technical support focusing on monitoring supportive supervision, strengthening microplans and improving data quality checks in immunization focus regions and councils. In support to improve the immunization coverage, MCSP facilitated mid-level managers (MLM) trainings for 41 health managers (RIVOs, DIVOs and Medical Officers) in the Arusha Zone Health Resource Centre (ZHRC) and 79 health managers in the Iringa ZHRC. The MLM course focused on strengthening managers' skills to better plan, manage monitor and evaluate their health programs. MCSP advocated for immunization activities among 796 Health Facility Governing Committee members in Kaliua, Tabora MC, Maswa, Bariadi TC, Bariadi DC, Itilima, Muleba, Ngara, Karagwe and Kyerwa by providing orientation on needs for better immunization coverage, defaulter tracing and how better to support planning and resource allocation for immunization activities. The orientations, coupled with targeted supportive supervision following REC guidelines and defaulter tracing follow-ups has led to the increase in the proportion of vaccinated children by 13.2% in the previous 12 months.



	Karagwe	Bukoba DC	Muleba	Ngara	Missenyi	Kyerwa
Jul-Sep'15	82%	81%	89%	119%	82%	93%
Oct-Dec'15	83%	88%	98%	117%	85%	95%
Jan-Mar'16	86%	93%	108%	107%	91%	95%
Apr-Jun'16	89%	92%	107%	111%	94%	98%
Jul-Sep'16	92%	95%	107%	114%	96%	101%

As planned in Tanzania's Learning Agenda, MCSP conducted follow-up visits in Ngara and Muleba districts after implementing the REC microplanning tool and providing technical assistance to the CCHP process at council and health facility levels. Following implementation of the tool in December 2015, Muleba council received 100% of requested operational funds for 2016/2017 and is expected to see improvement in implementation of planned activities. During the Vaccine Information Management System (VIMS) pilot, MCSP observed districts ran into the challenge of not being able to use the new system when the district's only trained DIVO was out of the office. In response, MCSP provided technical assistance in the training of 44 assistant DIVOs from the 44 pilot councils, where trainees were oriented on how to use the system and generate reports for routine immunization activities, stock management and cold chain inventory. During routine supervision visits in Tabora, MCSP continues to monitor uptake of the system to ensure data is collected and reports flow in a timely manner.

Quality Improvement: To identify best performing health facilities on SBM-R standards, MCSP supported the MOH to conduct external verification assessments using the nationally approved BEmONC standards in 35 health facilities (19 in Mara, 14 in Kagera, and 2 in Zanzibar). These sites scored above 70% during the 2nd internal assessment, calling for an external verification by the MOH QI team. Out of 5 facilities that received MCSP support in implementing the SBM-R approach for improving quality of MNH services in Zanzibar, Wete Hospital achieved 81% achievement rate (level 1) and Makuduchi HC achieved 73% (level 2). MCSP also supported recognition ceremonies for the top 3 performing nursing and midwifery schools from Kagera (Rubya, Ndolage and St. Magdalena) to recognize QI achievements as well as serve as motivation for other colleges to improve performance on CQI standards.

Technical Assistance to PEPFAR Partners: Utilizing HIV/RMNCH integration funds, MCSP provided TA to TUNAJALI by supporting the planning and execution of BEmONC trainings conducted in Iringa and Morogoro regions, where a total of 25 health care providers from 25 facilities were trained. MCSP also provided TA to EGPAF in planning for a BEmONC services baseline assessment and supported modifications to their facility readiness assessment tools to improve BEmONC services.

Way Forward

In PY3, MCSP will continue with a limited scope focusing on CECAP, PSE, Immunization, HIS and the learning agenda, while the other key technical areas will transition to the new USAID bilateral, Boresha Afya. MCSP will continue national level CECAP support in addition to support in the Iringa and Njombe regions and will intensify PSE work in Mara and Kagera to improve the skills of tutors and preceptors, strengthen the linkages between HTIs and clinical practicum sites and track graduate outcomes. MCSP also will continue to provide TA and intensify implementation in immunization support and will improve immunization coverage and uptake of new vaccines in all poor performing districts in supported regions. Following the VIMS pilot, MCSP will conduct implementation research to assess its effects on immunization-related information functions which will inform the national rollout. MCSP will also finalize the HIS work that has been done to date by adapting, installing and developing test cases with the Health Information Mediator that will operationalize the newly integrated national HIS. MCSP will continue to engage R/CHMTS and ZHRCs in day-to-day implementation of program activities and will place a major focus on documenting achievements and lessons learned to date to disseminate and share with the Government, USAID and other program

stakeholders, prioritizing the areas that have transitioned to the bilateral and were initially disseminated during program review meetings held PY3 Q1.

Selected Performance Indicators for PY2 and PY3 Qtr 1	
MCSP Global or County PMP Indicators	**Achievement**
Number of (national) policies drafted with US Government (MCSP) support	• ANC, labor and delivery, PNC performance standards updated to include gender and respectful maternity care. Draft available. • CEmONC LRP • ANC LRP • Gender and Respectful Maternity Care LRP for facility based staff • RMNCAH Client Service Charters to accommodate gender-sensitive respectful maternity care in 4 selected districts • Integrated Supportive Supervision Learning Resource Package • Compiled the Malaria in Pregnancy (MiP) Learning Resource Package (LRP) based on the revised 2013 National Guidelines on Diagnosis and Treatment of Malaria (NGDTM) • Provided technical assistance and reviewed training package materials (training guide, facilitator's manual and participants' manual) for Malaria Rapid Diagnostic Testing Accuracy Quality Control (mRDT TA QC) • PPFP Learning Resource Package • CEmONC LRP • Midwifery competencies to guide midwifery educators, curriculum developers, practicing midwives, supervisors, mentors, managers and decision-makers on midwifery education, care and research. • National CECAP VIA based QI guideline • Practicum standards and Checklists for RMNCH competencies • National RMNCAH CHW Guidelines and LRP • National immunization comprehensive Multi-Year Plan (cMYP) which includes the strategic direction for the IVD program for 2015-2020
Number of MCSP-supported health facilities actively implementing a quality improvement approach	226
Number of districts that have introduced new vaccines with MCSP program support	13
[1]Percentage of children aged <12 months who received Penta3 vaccine in MCSP-supported areas	102%
Percentage of women receiving uterotonic in the third stage of labor in MCSP-supported areas	96%
Percentage of babies born in health facilities who received newborn resuscitation	10%
Number of civil society organizations receiving US government (MCSP) assistance engaged in health advocacy to promote RMNCH	8