Tanzania EOP Summary & Results

Geographic Implementation Areas

Regions
- 9/28 (32% of country total)—Iringa, Kagera, Mara, Njombe, Shinyanga, Simiyu, Tabora, and Tanga, plus Zanzibar

Districts
- 52/169 (30.7% of country total)

Facilities
- 1,639

Population

Country
- 55.5 million

MCSP-supported areas
- 12.4 million

Technical Areas:

Program Dates

June 1, 2014–June 30, 2019

Total Funding through Life of Project

$36,973,267 (including $1,000,000 GHSA Ebola funds—Pillar IV)

Demographic and Health Indicators

Indicator	# or %
MMR (per 100,000 live births)	556
NMR (per 1,000 live births)	25
U5MR (per 1,000 live births)	67
TFR	5.2
CPR (modern)[1]	32%
Children ages 12-23 months who received all basic vaccinations	75%
ANC 4+	51%
SBA	64%
IPTp2 IPTp3	35% 7.7%

Source: Tanzania DHS 2015/16

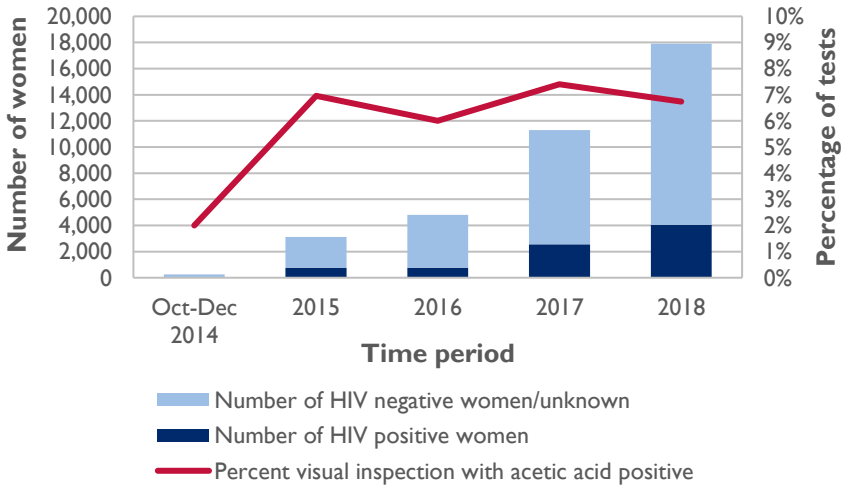
Strategic Objectives through the Life of Project

- Improve the environment for RMNCAH services through technical leadership and coordination to roll out high-impact, integrated RMNCAH 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.

Highlights through the Life of Project

- Strengthened prevention of MiP by increasing IPTp2 coverage from 32% to 62% in MCSP-supported regions.
- Increased the percentage of women delivering in MCSP-supported health facilities from 63% to 95% and uterotonic use in the third stage of labor from 4% to 96%.
- Reached over 42,948 women with cervical cancer screening services in Iringa and Njombe regions over the life of the program.
- Supported nursing midwifery institutions, which scored an average of 80% on QI standards compared to 68% from schools without MCSP support.
- Deployed the Health Information Mediator to enable the flow of data between multiple systems and organizations, and improve data use for decision-making.
- Successfully facilitated budget allocations to self-sustain immunization activities in 19 MCSP-supported councils/sites.

Figure 1. Women newly screened using visual inspection with acetic acid in MCSP-supported facilities



Tanzania

Background

MCSP's goal in Tanzania was to increase the accessibility, coverage, and utilization of high-quality RMNCAH services by contributing to the scale-up and rollout of high-impact interventions across the continuum of care to reduce maternal and newborn morbidity and mortality. At the request of USAID Washington and the Mission in Tanzania, the project also helped strengthen the health system to improve security against global health threats. MCSP worked closely with the Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC) and its Reproductive and Child Health Section, regional health management teams, and council health management teams to reduce maternal, newborn, and child deaths by expanding and improving the quality of BEmONC and comprehensive EmONC, with a focus on the day of birth; strengthening MiP services; increasing the contraceptive prevalence rate, particularly voluntary use of LARCs and PPFP; integrating maternal, newborn, and FP services into HIV interventions, including cervical cancer screening and treatment; strengthening PSE, with a focus on midwifery training; increasing the engagement of communities and CSOs in health; increasing immunization coverage in areas with large numbers of unimmunized children, introducing new vaccines, and testing the electronic vaccine information system; strengthening the national HIS, particularly the standardization and interoperability of existing systems and use of data for decision-making at all levels; and addressing cross-cutting health systems issues, such as equity, gender, respectful care, supply chain management/commodity security, district microplanning, digital health solutions, and accountability for results at the national, regional, district, facility, and community levels.

MCSP transitioned leadership in some technical areas in PY3 while continuing support in others (see Figure 2). Specifically, MCSP continued to provide technical assistance to improve PSE; deliver high-quality, sustainable CECAP services; strengthen immunization systems in high-priority regions; and further develop the national HIS architecture to streamline and link existing information systems and improve the quality and use of data for decision-making at all levels. MCSP transitioned its implementation support for MNH, FP, MiP, community, and other HSS field-level activities to the MOHCDGEC and the USAID-funded bilateral Boresha Afya project in Lake and Western zones.

Figure 2. MCSP project timeline in Tanzania

Key Accomplishments

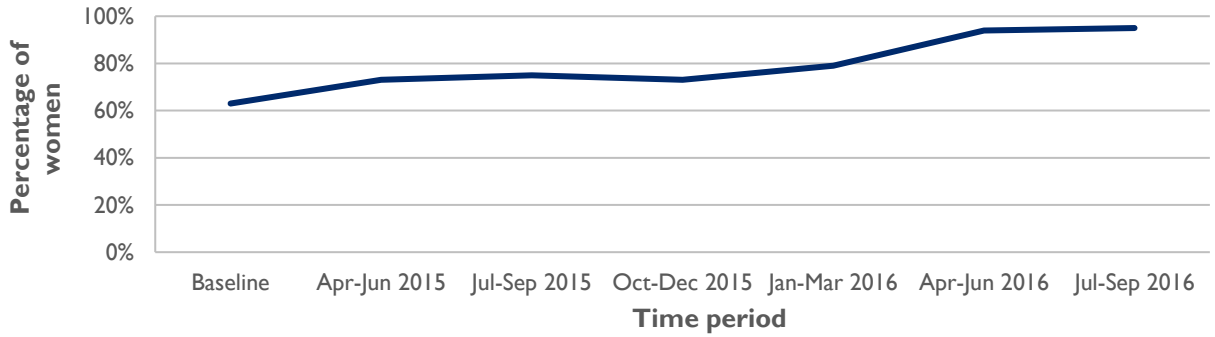
Improved MNH

MCSP worked with the Government of Tanzania to increase access to high-quality RMNCAH services by introducing and scaling up high-impact interventions along the continuum of care. These interventions included ANC, labor and delivery care (including routine, integrated MNH services on the day of birth), ENC, and respectful maternity care mainstreaming to reduce preventable maternal and newborn morbidity and mortality. MCSP supported the introduction and scale-up of BEmONC in 226 facilities and comprehensive EmONC in seven facilities in Mara and Kagera regions and strengthened comprehensive EmONC services in an additional 37 facilities. These efforts resulted in an increase in institutional deliveries at MCSP-supported sites from 63% to 95% (see Figure 3). The percentage of women receiving a uterotonic immediately after birth in MCSP-supported sites also increased from 4% (baseline) to 96%. Baseline data were very low due to missing data and underreporting. MCSP worked to strengthen reporting of these

indicators through onsite coaching and mentoring, data review meetings, and routine data quality assessments.

MCSP established a QI team at each of 226 facilities, in which the team oversaw adherence to performance standards. By the end of MCSP, 33 sites were verified, and 25 were recognized for high performance. The program also helped establish MPDSR committees at the regional, district, and facility levels. These committees facilitated identification, review, notification, and response to recommendations on improving quality of care. MCSP additionally contributed to the development of national MPDSR guidelines and disseminated those guidelines and tools to all comprehensive EmONC sites in Mara, Kagera, and Zanzibar.

Figure 3. Percentage of women who delivered in a facility



Prevented MiP

In Tanzania, MiP services within ANC services are aligned with those recommended in WHO's three-pronged approach: use of long-lasting insecticidal nets, IPTp, and prompt diagnosis and treatment. MCSP worked to increase early uptake of integrated ANC services to reduce maternal and neonatal morbidity and mortality due to malaria, though stock-outs of SP, diagnostic tests, and artemisinin-based combination therapy were an ongoing challenge. MCSP endeavored to help decrease the frequency of stock-outs of SP by organizing orientations, advocacy meetings, and council discussions about funding sources such as the National Insurance Health Fund, user fees, and basket funds to procure malaria commodities. Trends in IPTp2 uptake in Mara and Kagera regions improved over the life of the project in Tanzania. In Kagera, IPTp2 uptake increased from 36% in 2014 to 69% in September 2016. An increase from 27% to 54% was observed in Mara Region. IPTp4 uptake in Kagera increased from 0% to 29% and in Mara increased from 0% to 20%.

Increased Access to FP and PPFP

MCSP focused on increasing contraceptive prevalence among Tanzanian women by making high-quality PPFP/FP services more accessible and equitable through the integration of FP into other RMNCAH services. MCSP supported the MOHCDGEC to scale up the availability of PPFP counseling services from 23 to 221 health facilities within 6 months and increase the availability of postpartum LARCs in 46 additional facilities, from 23 to 69 facilities (34 in Mara, 30 in Kagera, and five in Zanzibar). At the national level, MCSP supported the standardization of the national learning resource package for comprehensive PPFP counseling and service delivery, including postpartum insertion of implants and IUDs, and updated the national Integrated Community MNCH Learning Resource Package to include PPFP, which is now used by the MOHCDGEC and all implementing partners. (For more information, see MCSP's formative report on FP and immunization service integration and its manuscript on MIYCN and FP service integration.)

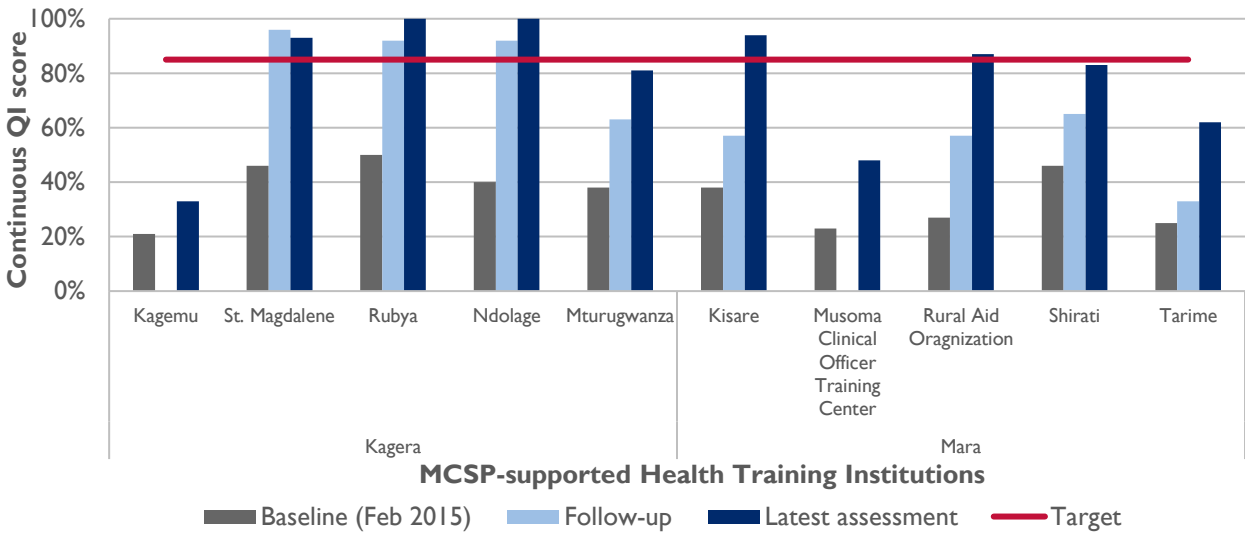
Strengthened PSE

MCSP provided technical assistance to the MOHCDGEC to strengthen PSE systems and improve governance and midwifery training. MCSP's work in PSE takes place nationally and within the regions of Mara and Kagera in Lake Zone. MCSP's work in PSE focused on improving direct and indirect factors that

influence graduate competence. MCSP applied this framework in Tanzania, integrating it with HSS approaches to ensure midwives were competent and prepared for deployment.

To assess the impact of MCSP's contributions on midwifery competency and education system strengthening efforts, MCSP facilitated a nursing and midwifery competency assessment in Mara and Kagera regions to measure implementation outcomes of seven MCSP-supported nursing and midwifery schools. Results showed a significant improvement in midwifery competencies from baseline; graduating students from MCSP-supported schools showed an average improvement of 80%, whereas students from non-MCSP-supported schools demonstrated an average improvement of 68%. The difference in newborn resuscitation was most marked, at 80% average performance for MCSP-supported schools versus 56% for non-MCSP-supported schools. The introduction and implementation of continuous QI approaches facilitated self-reflection among institutions for further improved performance; these efforts resulted in high-quality education standards among graduates, particularly nurse-midwives (see Figure 4 for continuous QI over time). This initiative serves as a key sustainability strategy to ensure high-quality education standards, minimize duplication of efforts across governing bodies, and build the capacity of the National Council for Technical Education and the Tanzania Nursing and Midwifery Council to continue educational quality efforts following MCSP.

Figure 4. Improvement against continuous QI standards within MCSP-supported health training institutions



Prevented Cervical Cancer

In collaboration with the MOHCDGEC, MCSP worked to strengthen CECAP implementation by building local capacity among national-, regional-, and facility-level staff to execute a comprehensive, sustainable, high-quality, and results-based program. At the national level, MCSP developed and distributed a national CECAP training package that included technical updates on IPC and supported the orientation of 25 national CECAP trainers. MCSP also improved the capacity of skilled providers to offer quality CECAP services in Iringa and Njombe regions. At the four facilities where the intervention was introduced, 42,948 clients were reached with screening services using visual inspection with acetic acid, and more than 97% of identified precancerous lesions were treated on the same day. As part of its sustainability strategy, MCSP focused on strengthening regional-level capacity in program management, quality control, data quality, and data use for decision-making to enhance regional ability to support district- and facility-level CECAP activities, and to strengthen regional-level outreach activities and referral systems to provide CECAP services to hard-to-reach populations. MCSP actively provided ongoing clinical mentorship to 65 providers and supported 13 districts to actively plan for CECAP activities in district-level budgets to sustain CECAP activities following MCSP.

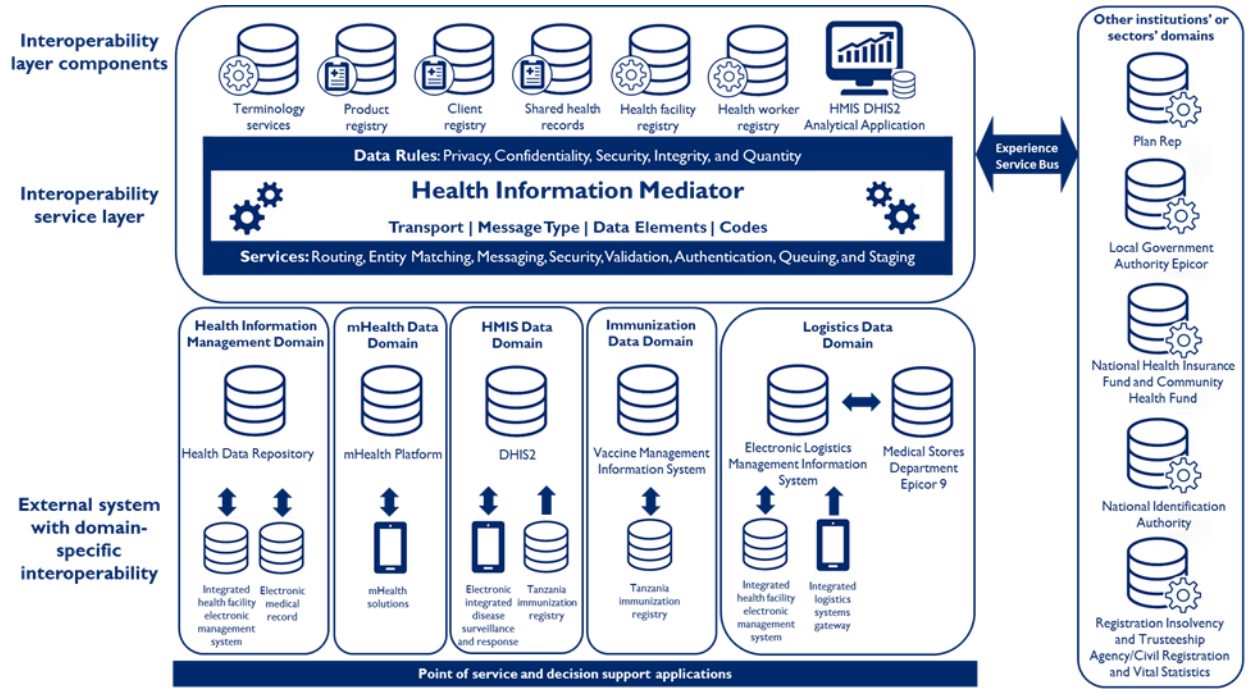
Developed HISs

With technical assistance from MCSP, the MOHCDGEC led significant progress toward deploying a national HIS. A major achievement was going live with the Health Information Mediator, the interoperability layer, and starting to exchange data among 13 data systems, including the electronic logistics management information system, Vaccine Information Management System, health data repository, and health facility registry (Figure 5). The health data repository, currently supported by the Health Information Mediator, is exchanging patient data, such as reason for admission, services received, cause of death, bed occupancy rate, and revenue, with seven of the largest hospitals in the country, intended to improve decision-making for management.

Strong government leadership and the establishment of a multipartner TWG were critical for the success and sustainability of the national health system. The Tanzania Health Information Exchange TWG, a diverse set of stakeholders, including public and private institution representatives, USAID, MCSP, and other development and implementing partners, were involved at every step of planning, designing, and implementing the mediator, leading the government to take ownership and increase its capability to maintain the system independently.

With support from MCSP, the Government of Tanzania created one of the most advanced health information exchanges in sub-Saharan Africa, automating and exchanging tens of thousands of health records every month. The Tanzania Health Information Mediator allows managers to understand their data to better inform decision-making at all levels of the health system.

Figure 5. Tanzania health information exchange conceptual model



Increased Immunization Coverage

From 2014–2018, MCSP worked hand in hand with the MOHCDGEC Immunization and Vaccine Development Program and President's Office for Regional Administration and Local Government to strengthen the delivery of Tanzania's RI services and introduce new lifesaving vaccines. Partnering at the national level and within its four focused regions of Kagera, Tabora, Shinyanga, and Simiyu, MCSP supported the Immunization and Vaccine Development Program to increase the technical and management skills of its workforce and strengthen immunization service delivery aimed at reducing the number of unvaccinated and undervaccinated children, especially those living in hard-to-reach areas. MCSP supported 19 councils at the

district level between 2013 and 2018, through which over 35,000 children's lives were saved by protecting communities from vaccine-preventable diseases. With fewer unvaccinated children, communities are more protected against over 13 vaccine-preventable diseases and outbreaks.

As a result of the program, the MOHCDGEC Immunization and Vaccine Development Program is equipped to influence global and regional strategies, guidelines, plans, and tools aimed at enabling the national immunization system to reach every child with high-quality RI services. The immunization data management subworking group also became functional and self-sustaining at the national level. Immunization program staff are better prepared to manage and deliver high-quality immunization services and to sustain high levels of equitable and timely immunization coverage levels. New vaccines, including measles second dose, measles-rubella, inactivated polio vaccine, and human papillomavirus, were successfully introduced and integrated into the national RI system. Pre-service curricula and other training reference materials were updated and used nationally by environmental health schools and zonal health resource centers.

Immunization data quality and use improved in the four supported regions after adoption of the national, streamlined Vaccine Information Management System and recommendations for strengthening the Comprehensive Council Health Plan planning process, including use of the electronic microplanning tool. Figures 6 and 7 compare use of the microplanning tool in Muleba council to the control council, Ngara. While immunization budget allocations in Muleba increased with use of the microplanning tool, the number of children vaccinated increased as well.

Figure 6. Immunization budget allocations in Comprehensive Council Health Plans in Muleba versus Ngara councils

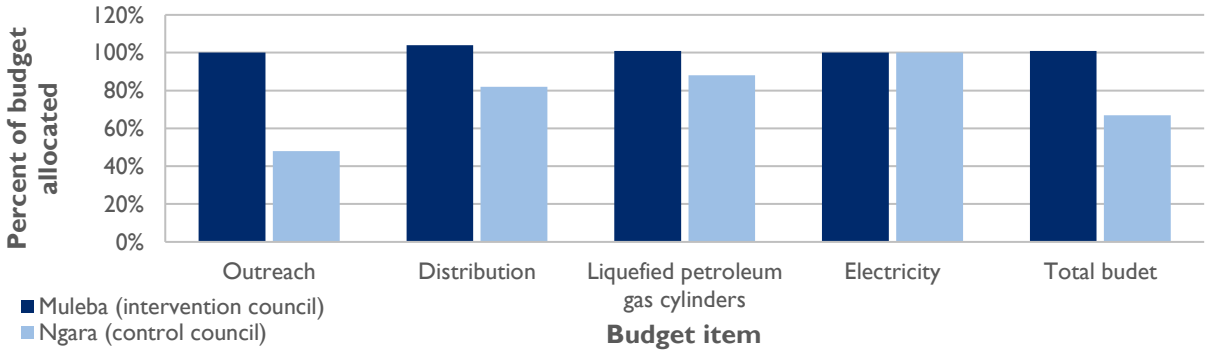
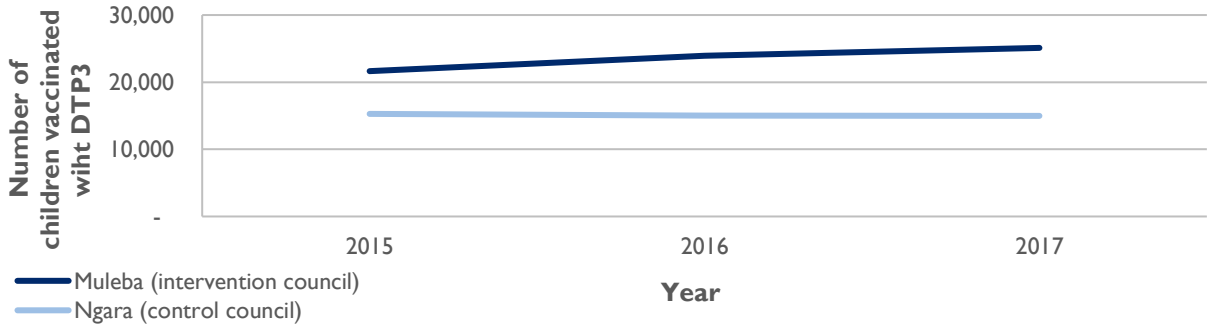


Figure 7. Number of children vaccinated with diphtheria-tetanus-pertussis vaccine (DTP3) in Muleba versus Ngara councils



Improved Disease Surveillance

Vaccine-preventable diseases in Tanzania have been monitored by two systems and managed by two MOHCDGEC offices: the Epidemiology Department and the Immunization and Vaccine Development Program. At the request of USAID Washington and the Mission, over the course of 1 year, MCSP utilized GHSA funding to help improve disease surveillance by guiding the MOHCDGEC to develop a transition plan to harmonize the parallel systems, establishing ownership of a national surveillance TWG with engaged

stakeholders from both the Immunization and Vaccine Development Program and the Epidemiology Department, and rolling out the electronic IDSR system in five regions of Tanga, Simiyu, Shinyanga, Njombe, and Tabora. This brought the total number of regions trained in the country to 25 of 26 (96%). The electronic IDSR system is an unstructured, supplementary service database system designed to assist reporting from the facility level to the national level and link with DHIS2. Health facilities in the trained regions started to report data using the system and immediately observed improvements in timeliness, completeness, and accuracy.

Recommendations for the Future

These promising results would not have been achieved without the leadership and commitment of the Government of Tanzania, specifically the MOHCDGEC and MOH of Zanzibar; the President's Office for Regional Administration and Local Government; and regional, district, and zonal health management teams to strengthen the capacity of the health workforce in Tanzania and increase access to and coverage of quality RMNCAH services. Recommendations to the government and partners to sustain these efforts include:

- **Implement strategies to address the critical shortage of human resources for health in order for the country to meet its long-term RMNCAH goals.** During PSE, providing tutors, instructors, and preceptors with updated knowledge and skills can help create a more supportive learning environment and ensure that graduates are ready to provide high-quality health care services in their own settings.
- **Develop innovative strategies to increase local resource allocation to ensure financial stability at the regional, district, and facility levels, and scale up microplanning tools to assist budgeting for ongoing QI processes at all facilities.** Using documented lessons from MCSP's scale-up, capacity-building, and QI approaches, it is recommended that MOHCDGEC ensure resources are allocated to scale up these approaches countrywide with robust measurement to monitor progress.
- **Continue efforts to improve immunization program data and disease surveillance systems such as the national Vaccine Information Management System and electronic IDSR.** Scale-up of such interventions must be paired with complementary capacity-building, supervision, monitoring, and review activities in order for health workers to be equipped to manage and maintain these systems.

Selected Performance Indicators	
Global or Country Performance Monitoring Plan Indicators	**Achievement (Target)**
Number of MCSP immunization-focused councils in Tabora, Kagera, Shinyanga, and Simiyu with Penta3) coverage > 80%	19 (target: 19; target achieved)
Number of councils with Penta1 to Penta3 dropout rate ≤ 10% in MCSP-focused councils in Kagera, Tabora, Shinyanga, and Simiyu region	12 (target: 19; 63% achieved)
Percentage of children aged <12 months who received DTP3/Penta3	90% (target: 100%; 90% achieved)
Percentage of districts/councils using RED/REC approach for immunization microplanning in Kagera, Tabora, Shinyanga, and Simiyu	100% (target: 100%; target achieved)
Number of health training institutes with PSE material strengthened to improve immunization services with MCSP support	13 (target: 10; target exceeded)[1]
Number of health workers graduated from pre-service training institutions	2,861 (target not defined)
Percentage of pregnant women who received IPTp2	62% (target: 60%; target exceeded)
Percentage of women who delivered at a health facility	95% (target: 80%; target exceeded)
Percentage of women who received a uterotonic immediately after birth	96% (target: 100%; target 96% achieved)
Percentage of babies delivered at a facility breastfed within 1 hour of birth	92% (target: 100%; target 92% achieved)
Percentage of newborns who received PNC within 2 days of delivery	90% (target not defined)
Number of CSOs receiving USG (MCSP) assistance engaged in health advocacy to promote RMNCH	4 (target: 4; target achieved)

Selected Performance Indicators	
Global or Country Performance Monitoring Plan Indicators	**Achievement (Target)**
Total number of clients screened with visual inspection with acetic acid	42,948 (target: 40,000; target achieved)[1]
Number of clients VIA+ results treated with cryotherapy on same day	2,781 (97%, target: >95%; target achieved)
Number (percentage) of new clients referred for suspect cancer	142 (0.36%, target: <1%; target achieved)[3]
Number of health facilities supported to offer CECAP services	4 (target: 4; target achieved)

[1] This is a new indicator that was not implemented in PY1–3. PY4/5 target includes 10 health training institutes supported in PSE interventions, plus another 15.

[2] This target was a program goal, rather than an official Performance Monitoring Plan target.

For a list of technical products developed by MCSP related to this country, please click here.