



ASSESSMENT OF REPRODUCTIVE AND CHILD HEALTH INTEGRATION IN TANZANIA

CHALLENGES AND OPPORTUNITIES

OCTOBER 2012

This publication was produced at the request of the Tanzania Ministry of Health and Social Welfare. It was prepared independently by Lauren Mueenuddin and Sia Msuya through the GH Tech Bridge II Project.



USAID
FROM THE AMERICAN PEOPLE



**THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH AND SOCIAL WELFARE**

Cover Photo: © 2006 Ashley Pinsent, Courtesy of Photoshare.

ASSESSMENT OF REPRODUCTIVE AND CHILD HEALTH INTEGRATION IN TANZANIA

CHALLENGES AND OPPORTUNITIES

OCTOBER 2012

Global Health Technical Assistance Bridge II Project (GH Tech) USAID Contract
No. AID-OAA-C-12-00027

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

This document (Report No. I2-02-009) is available in printed or online versions. Online documents can be located in the GH Tech website at www.ghtechproject.com. Documents are also made available through the Development Experience Clearinghouse (<http://dec.usaid.gov>). Additional information can be obtained from:

GH Tech Bridge II Project
1725 Eye Street NW, Suite 300
Washington, DC 20006
Phone: (202) 349-3900
Fax: (202) 349-3915
www.ghtechproject.com

This document was submitted by Development and Training Services, Inc., with CAMRIS International to the United States Agency for International Development under USAID Contract No. AID-OAA-C-12-00027.

ACKNOWLEDGEMENTS

We would like to thank the Reproductive and Child Health Section, Ministry of Health and Social Welfare, Regional Medical Officers, and Regional Reproductive and Child Health Coordinators of Dar es Salaam and Kigoma for their support and collaboration in the implementation of this assessment. We would also like to thank the district RCH Coordinators of Kigoma Ujiji municipality and Temeke for their input.

We thank the health care providers working at the RCHS, laboratory, pharmacy and maternity wards at the following facilities: Maweni Regional Hospital, Kasulu District Hospital, Bitale, Nyakitonto and Kiganamo health centers, Mwandiga and Rusimbi dispensaries in Kigoma, as well as providers at Sinza Hospital, Kigamboni Health Center and Tandale Dispensary in Dar es Salaam.

Sincere thanks to the women who participated in client exit interviews at the health facilities in Kigoma and Dar es Salaam.

Special thanks to Dr. Elizabeth Mapella for her preparatory work and to Dr. Ahmad Makuwani and Mr. Martin K. Magogwe of Reproductive and Child Health Section for logistical and technical support, material input and participation during the planning and execution of the assessment.

Lastly, we thank all the support staff at Reproductive and Child Health Section and in the districts for their work and patience during the assessment.

CONTENTS

ACRONYMS.....	v
EXECUTIVE SUMMARY	vii
Major Findings	viii
Next Steps	ix
I. MAJOR OBJECTIVES OF THE ASSESSMENT	1
II. METHODOLOGY OF ASSESSMENT	3
Review of Key Documents.....	3
Organization/Logistics of Stakeholder Interviews.....	3
Health Facility Assessment.....	3
Limitations of the Assessment.....	4
III. SITUATION ANALYSIS OF REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD HEALTH IN TANZANIA	5
IV. INTERNATIONAL TRENDS IN SUPPORT TO MNCH AND POPULATION HEALTH ACTIVITIES.....	7
V. INTEGRATION.....	9
VI. TANZANIA HEALTH SYSTEMS	11
Ministry of Health And Social Welfare and Reproductive and Child Health Services Policies.....	11
Donor Community Support to Tanzanian Health System.....	11
Regional-Based Implementing Partners Working on the Delivery of Integrated Health Service Packages.....	13
VII. FINDINGS FROM INTERVIEWS AND FIELD SITE VISITS	15
Findings from Stakeholder Interviews	15
Findings from Meetings with Reproductive and Child Health Services Section.....	16
Findings from Visits to Health Facilities	16
VIII. OPPORTUNITIES	21
Focus on Key Topics in Integration	21
Service Entry Points for Integration.....	22
IX. NEXT STEPS	35
Identify Desired Health Outcomes of Integration	35
Detail Required Inputs for Integration	36

ANNEXES

ANNEX 1: SCOPE OF WORK.....	39
ANNEX 2: REFERENCES	45
ANNEX 3: DEVELOPMENT PARTNERS, IMPLEMENTING PARTNERS AND UN AGENCIES.....	47
ANNEX 4: HEALTH FACILITIES VISITED	49
ANNEX 5: IN-SERVICE TRAININGS ATTENDED BY RCH STAFF IN THE PAST FIVE YEARS BY REGION AND LEVEL	51
ANNEX 6: INTERVIEW GUIDES	53
ANNEX 7: EXAMPLES OF CLIENT FLOW PATTERNS FOR ANC, FP AND IMMUNIZATION SERVICES OBSERVED AT FACILITIES.....	77

FIGURES

Figure 1: Client Flow Patterns for Baby-well Clinics	77
--	----

TABLES

Table 1: Opportunities/Requirements for Integration at the Health Facility Level	25
Table 2: Framework Major Challenges for Integration of RCH Services and Possible Solutions Identified by Stakeholder in the Annual RCH Meeting:	29
Table 3: GHI Results Framework for Integration.....	34

ACRONYMS

ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretroviral
BCC	Behavior change communications
BEmOC	Basic emergency obstetric care
CEmOC	Comprehensive emergency obstetric care
CHMT	Council Health Management Team
DFID	Department for International Development
FANC	Focused antenatal care
FP	Family planning
GBV	Gender based violence
HIV	Human Immune-Deficiency Virus
HEID	HIV early infant diagnosis
HMIS	Health Management Information System
IEC	Information, education and communication
IMCI	Integrated Management of Childhood Illness
MDG	Millennium Development Goals
MMR	Maternal mortality ratio
MNCH	Maternal, newborn and child health
MOHSW	Ministry of Health and Social Welfare
MRDT	Malaria rapid diagnostic test
MSD	Medical Stores Department
NVP	Nevirapine
NMCP	National Malaria Control Programme
PAC	Post abortion care
PITC	Provider initiated counseling and testing for HIV
PMORALG	Prime Minister's Office Regional Administration and Local Government
PMTCT	Prevention of mother-to-child transmission (of HIV)
RCH	Reproductive and child health
RCHS	Reproductive and Child Health Services
RHMT	Regional Health Management Team
RMNCH	Reproductive, maternal, newborn and child health

RTI	Reproductive tract infections
SBA	Skilled birth attendant
SRH	Sexual and reproductive health
STIs	Sexually transmitted infections
TFNC	Tanzania Food and Nutrition Centre
TOT	Training of trainers
TWG	Technical Working Group
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization

EXECUTIVE SUMMARY

The Millennium Development Goals (MDG) deadline of 2015 is fast approaching and many countries continue to have difficulty in their delivery of an adequate volume of health care services. This is needed to truly “turn the tide” in key areas of health, such as maternal and newborn mortality, contraceptive use and mother-to-child transmission of HIV. In response, the international public health community is calling for a shift away from the vertical service delivery platforms of maternal, newborn and child health (MNCH) services and HIV, and more toward an “integrated” health services delivery system. Integration is understood as a process of breaking down programming and funding silos of HIV and sexual and reproductive health (SRH) that have developed over the years, and returning to a more holistic, client-focused health care delivery model. This model focuses on continuum of care and caters to the multiple and diverse health needs of women and their children throughout their lifespans.

The push behind integration also recognizes that there are deep and inseparable connections between HIV and SRH needs. Most HIV infections are sexually transmitted (the risk of which is increased by the presence of other sexually transmitted infections). Transmission is often closely associated with pregnancy, childbirth and breastfeeding—defining moments in a women’s sexual and reproductive life. It is also clear that sexual and reproductive ill-health and HIV share root causes, including economic inequality, limited access to appropriate information, gender inequality, harmful cultural norms and social marginalization of the most vulnerable populations.¹ Integrated services can provide a complete range of maternal, child, sexual and reproductive health services, including HIV testing and treatment, under the same roof and by a coordinated group of health professionals or within a strong referral network.

In order to explore these issues in the Tanzanian context, the Ministry of Health and Social Welfare (MOHSW) called for an assessment on the current existing challenges and opportunities for the integration of reproductive and child health (RCH) services at the national and health service delivery levels. The findings in this report, researched in-country during September and October of 2012, identify gaps and opportunities for the delivery of a more efficient, effective and integrated health service set.

Consultants conducted discussions with key stakeholders in Dar-es-Salaam, including RCH staff, members of the donor community and members of several international non-governmental agencies (NGOs) to discuss the feasibility and desirability of integration. Consultants also conducted a rapid assessment of health facilities in five districts: two districts in Dar-es-Salaam (Kinondoni and Temeke) and three districts in Kigoma (Kigoma Ujiji Municipality, Kigoma District Council, and Kasulu District) in order to ascertain system readiness for integration and to elicit opinions of providers and clients on the potential benefits and/or obstacles to integration.

¹“Sexual and Reproductive Health (SRH) Services with HIV Interventions in Practice” Background Paper presented at the 26th Meeting of the UNAIDS Programme Coordinating Board, Geneva, Switzerland, June 22-24, 2010).

MAJOR FINDINGS

- Clinics face severe challenges in the provision of the *basic* RCH services packages. These include major staff shortages, lack of adequate infrastructure, stock-outs of drugs, poor provider knowledge and skills, and poor supervision. *Addressing current health system weaknesses is a critical first step before beginning the process of integration.*
- Stakeholders cited *the shortfall in financial and human resources as a major stumbling block for integrating services.* With core RCH provision under strain, stakeholders expressed concern about the MOHSW's ability to efficiently and effectively integrate additional services to the core package.
- Health care providers felt that the delivery of multiple reproductive, maternal, newborn and child health (RMNCH) services by one provider, at one visit, would improve service quality, client satisfaction and service efficiency. *However, providers cautioned that integration might also pose a threat to provider efficiency and the quality of services if staff shortages and drug/supply stock-outs are not addressed as an integral part of the process.*
- Numerous entry points and missed opportunities were identified, such as *expanding the availability of family planning (FP) services at all service points* (well-baby clinics, antenatal care, postnatal care and post abortion care). Further, *expanding the availability of sexually transmitted infection (STI) screening and treatment at antenatal care visits, including HIV counseling, testing and antiretroviral therapy (ART) would be highly productive*, as well as increasing the availability of health education materials on various health topics. Special focus on the specific health needs of adolescent girls is also a critical area of need.
- *There is a great need to conduct further investigations on the feasibility/cost effectiveness of integrating additional services from within the RCH Section (RCHS).* Regional and district-based models of integrated services are important to serve as test cases for the study of integration feasibility and effectiveness. Careful documentation of successful models and implementation challenges, including collection and analysis of data on increased uptake of key services, would be highly productive for guiding the MOSHW on choices of integration.
- Furthermore, *a complete mapping of current resources, activities, and pilots at the regional and district levels would be helpful for locating a starting point for integration.*
- *Systems “readiness analysis” is critical* before integrating services across sections. Detailed analyses of facility readiness, including an inventory of human resources, provider skills, physical infrastructure and availability of key drugs and supplies are a precursor to integration.
- There is a need for better harmonization and coordination of efforts among partner agencies working in collaboration with the MOHSW and the RCHS Unit. There is duplication of services and the management of disparate health initiatives and donor priorities takes up valuable staff time and energies.
- Given current financial and human resource constraints in Tanzania, *it will be necessary for the RCHS to prioritize interventions and services to be integrated over the short and medium term.* RCHS will need to select across areas of topical focus as well as a combination of services that would accelerate progress in meeting MDG 4 and 5.

- Prioritized services over the short and medium term will also help serve as a test case for managers and providers to begin to address the issue of inter-sectional (within RCHS) and cross-sectional (between RCHS and National AIDS Control Programme [NACP], National Malaria Control Programme NMCP, Medical Stores Department [MSD], Prime Minister's Office Regional Administration and Local Government [PMORALG]) coordination.
- Unwanted pregnancies are a major cause of poor health outcomes for women.⁵ Expanding the availability of FP services at all entry points, both within RCHS and NACP (the integration of FP into HIV service provision), should be prioritized. Priority actions should include scaling up *the availability of a full range of FP options including long-term methods at all service entry points, information and counseling for antenatal clients, male involvement and outreach to adolescents.*
- A second priority should focus on *addressing the special health needs of adolescent girls and boys*, including the development of a comprehensive outreach and communications strategy.
- Given severe resource constraints in Tanzania, the RCHS needs to build integration efforts on the successful foundation of disease-specific health programs such as the President's Emergency Plan for AIDS Relief (PEPFAR), and the President's Malaria Initiative (PMI).

NEXT STEPS

Policy and Governance

- The MOHSW must take on a strong national leadership role in articulating the definition of, need for and steps to developing an integrated RCH services package, including potential integration across health sections and programs such as RCHS and NACP.
- Need of high-level coordination/cooperation between the MOHSW and other levels of government such as PMORLG.
- Need for high-level advocacy on budget and human resource requirements for RCH services.
- Better coordination across different MOHSW departments (such as quality of care unit, diagnostics, education unit, MSD, NACP, Training Unit, HR, Health Management Information System [HMIS] unit, Tanzania Food and Nutrition Centre [TFNC]).
- Harmonization and better planning among partner organizations.
- Harmonization of activities, better information sharing and joint planning between different programs of the RCHS.

Health Systems Functions

- **A basic integrated package of essential RCH services needs to be defined and drafted:** Using existing guidelines and protocols across units within RCHS, develop a set of additional "integrated" guidelines, protocols and job aids from MOHSW. Based on the package, other important elements can be integrated such as curricula, clinical guidelines, job aids, quality standards or supervision tools.
- **Training:** Develop training packages and curriculum for integrated service provision for pre-service and in-service providers. Staff will need to be introduced to an essential package and be trained to offer multiple services (e.g., counseling, ART care, Focused Antenatal Care

[FANC], FP, screening using rapid tests, syndromic management, basic emergency obstetric care [BEmOC], infant and young child feeding counseling). Phased training and refresher courses will be needed, as well as a strong mentoring system through training of trainers (TOT). The development of an on-site training mechanism for providers is also necessary.

- **Personnel and staffing issues:** Staff shortage, turnover and uneven geographic coverage need to be addressed. Ways to maximize deployment of existing staff should be explored and integrated incentives may help. Performance-based compensation and task shifting of may be another way of addressing staffing issues.
- **Logistic and supply chain system:** An enabling environment where providers have a regular supply of essential drugs and supplies is key to integration. Integrated procurement and supply of essential drugs and commodities for multiple services is necessary. Strategies to curb frequent stock-outs need to be in place.
- **Integrated and simplified monitoring tool for RCH services:** An electronic record system based on the basic integrated package needs to be in place. A simplified and user-friendly integrated version will minimize the record keeping burden and eliminate the need for separate reporting and evaluation systems. It will be necessary to develop indicators for tracking integration of RCH services that can be captured within HMIS.
- **Service quality standards:** Quality standards need to be developed based on the basic package. Providers will need *integrated service delivery guidelines* to guide them on how to offer care as well job aids materials. Quality of care committees should be present at districts and facilities during the process of integrating RMNCH services. These committees should document gaps, develop action plans and evaluate over time whether integration of services weaken or strengthen the existing RCH services at the facilities.
- **Infrastructure:** Must be reorganized or rebuilt to allow for the addition of other services and better client flow. It will be important to explore the realistic burden on time and cost of such a process and to ensure that the system developed is appropriate to the capacity of individuals within the system.
- **Integrated supervision system:** While the individual units within RCHS may remain, there is a need for integrated supportive supervision so that a provider is mentored in multiple areas and topics.

Planning and Management

- Study results of pilots of integrated packages, with documentation of successes and sharing of findings.
- Identify and prioritize a few key areas for integration across existing units (FP, care and outreach to adolescents, prevention of mother-to-child transmission [PMTCT] of HIV).
- Engage in “modeling” exercises with experts to inform the process (e.g., how many providers need to be in place; level of skill needed before integration of RCH services can be considered).
- Initiate analysis of economic and opportunity costs of integrated services for clients, providers and programs.

- Conduct needs assessment of facility readiness for delivery of “integrated” service deliver.
- Demonstrate implementation flexibility. After integration policies and guidelines are in place, there should be room for districts and facilities to decide on the “best” integrated package for their local areas. This will help with ownership of the process, implementing what is possible while thinking of better linkages to other established services.

Demand Creation

- Integrate Behavior Change Communication (BCC) campaigns.
- Promote health behaviors in combination (e.g., nutrition and FP).
- Address barriers to health seeking in a coordinated and integrated manner.

I. MAJOR OBJECTIVES OF THE ASSESSMENT

The Tanzanian Ministry of Health and Social Welfare (MOHSW) has called for an assessment of the current existing challenges and opportunities for the integration of Reproductive and Child Health (RCH) services at the national and health service delivery levels. The Global Health Technical Assistance Project (GH TECH) Bridge II, with support from USAID, conducted the assessment during September and October 2012.

The purpose of this report is to support the MOHSW and more specifically, the Department of Reproductive and Child Health Services (RCHS) in identifying gaps and opportunities for the delivery of a more efficient, effective and “integrated” health services set, one that focuses on the multiple and diverse health needs of Tanzanian women and children. These services include antenatal care; family planning (FP); labor and delivery; prevention and treatment of sexually transmitted infections (STI), including Human Immune-Deficiency Virus (HIV); prevention of malaria in pregnancy; immunization; growth monitoring; nutrition; and management and treatment of childhood illnesses. The report will also serve to assist the United States Government (USG) in Tanzania to prioritize its health programming in-country for the promotion of better integrated maternal, newborn and child health (MNCH) and HIV/AIDS services in accordance to the guidance provided by the administration’s Global Health Initiative (GHI).

This report will hopefully act as a catalyst for further thinking and planning on the need and necessary conditions for quality, client-focused RCH services given the depth and diversity of health needs, and given the human and material resource constraints within the Tanzanian preventive and curative health service system. The report presents recommendations for next steps for a process to assess needs, resources and practical guidelines for service integration.

Specifically, the rapid review examines:

- RCH services integration efforts in Tanzania.
- Existing policies and guidelines on integration within the MOHSW and the RCHS.
- Current technical working groups’ efforts and available materials and guidelines on integration.

This assessment also examines current thinking on “integrated” RCH services desirability and feasibility in Tanzania through interviews with stakeholders within the Department of Reproductive and Child Health Services, several of the lead donor agencies in Tanzania (USAID, GIZ, CIDA), representatives from the United Nations (One UN), and several of the lead implementing partners working on regional- and district-based models of RCH services integration.

The consultation team also engaged in discussions with RCH managers and providers from health facilities in two regions (Dar-es-Salaam and Kigoma) to elicit opinions on the opportunities and challenges for delivering more integrated services.

Questions for RCH policymakers and the donor community/implementing partners focused more on higher-level systems issues such as:

- What changes would need to be made at the policy level so that the RCHS can develop a more integrated approach?
- What role can the donor community/implementing partners play in supporting the development of a plan to have better integration of services?
- What conditions (policy, financial, planning) are necessary to develop a more integrated approach?
- Who can/should lead this effort?
- What level of effort is required to develop a minimum essential package of services that would serve as a model for various levels of health facilities?
- What resources could be leveraged through further integration?

Discussions with RCH managers/providers focused on questions related to health care delivery systems and current practice:

- What RCH services are currently provided at different levels of the health system and what is the accompanying client flow?
- What are key challenges in the provision of *core* RCH services?
- What opportunities exist at different levels of care to add additional services that would constitute a more integrated package?
- What modifications (structural/infrastructure/human resource/training) would be necessary at the facility level to provide a more integrated package (i.e., audio and visual tools, privacy, supplies, drugs, skills)?
- What kinds of materials could be developed to improve providers' and clients' access to health information (information, education and communication [IEC] materials/job aids)?

II. METHODOLOGY OF ASSESSMENT

REVIEW OF KEY DOCUMENTS

Before arrival to Tanzania, consultants were provided with background reading materials from the MOHSW for preparation of on-site visits. These documents included “The National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008–2015;” “National Package of Essential Reproductive and Child Health Interventions in Tanzania;” “Maternal and Child Health Atlas;” “Tanzania Demographic and Health Survey, 2010;” and the “Tanzanian Health Strategy, Primary Health Services Development Programme, MMAM 2012–2017.” Other materials, including guidelines of individual RCH services units, national strategies (human resources development, communications, drug supply chain and logistics), assessment reports from previous studies, descriptions of projects and programs working on integrated models were gathered by the consultants in-country (see Annex 2 for a complete list of documents referenced). Consultants also referenced international literature on integration research and on-going pilot efforts.

ORGANIZATION/LOGISTICS OF STAKEHOLDER INTERVIEWS

Administrators from the RCHS provided material support to consultants, including appointment setting with stakeholders in Dar-es-Salaam, and organizing interviews and logistics of site visits to RCH health facilities in Dar-es-Salaam and Kigoma. The RCHS also provided support to the consultancy through technical support of two staff members.

Consultants developed a series of interview guides for different stakeholders (see Annex 6), which were submitted to the RCHS for comments during the first week on-site.

Key stakeholders interviewed included heads of units at the RCHS, acting head of the National AIDS Control Programme (NACP), donors (USAID, CIDA, GIZ), the World Health Organization (WHO) and several development partners, (see Annex 3 for a complete list). Other stakeholders include reproductive child health coordinators (RCH-CO) at regional and district levels and members of the regional and district health management teams in Dar-es-Salaam and Kigoma regions. Due to difficulty in scheduling appointments and the unavailability of certain key respondents in Dar-es-Salaam, consultants were unable to conduct a comprehensive set of discussions.

HEALTH FACILITY ASSESSMENT

Consultants conducted a rapid assessment of health facilities in the two regions of Dar-es-Salaam and Kigoma. Five districts participated in the assessment: the two districts of Kinondoni and Temeke in Dar-es-Salaam, and the three districts of Kigoma Ujiji Municipality, Kigoma District Council and Kasulu in Kigoma. (see Annex 4 for complete list of the name of health facilities visited).

Convenience sampling of 10 health facilities include three hospitals, four health centers and three dispensaries. Through a series of qualitative interview guides, consultants engaged in discussions with health care providers working at RCH maternity units, laboratories and pharmacies, as well as with clients accessing RCH services. Observations and checklist supplemented the in-depth interviews at the facility level in assessing overall availability of RCH

services and associated commodities, client flow and opportunities for further integration of RCH services.

A local consultant and the RCHS program officer, both experienced Tanzanian physicians and MNCH experts, conducted interviews with health care providers and clients. Although the number interviewed was small (24 and 22 respectively), these discussions constituted the richest source of information on the challenges and opportunities to integration, as well as the recommendations provided in this report. These on-site interviews provided the team with the opportunity to conduct more in-depth discussions with providers and to observe daily challenges and opportunities for RCH service providers and clients.

Upon finishing field work at the end of September 2012, the team presented its initial findings to the RCHS Annual Meeting (October 4, 2012), which included all the RCHS unit heads, directors of preventive and diagnostic services, directors of the referral hospitals, and national, zonal and regional RCH coordinators. The team also presented findings at the MNCH Technical Working Group (TWG) Meeting (October 9, 2012). Both of these presentations allowed for a group discussion on current issues in RCHS service delivery, as well as a discussion of challenges, opportunities, and gaps. These opportunities to interact with this level of RCHS management have significantly enriched the analysis in this report.

LIMITATIONS OF THE ASSESSMENT

The findings of this report constitute a snapshot of integration efforts and issues in Tanzania. This report should be seen as a baseline assessment to inform a process of strategy development for RCH integration in the country. A short amount of time for the assessment limited the ability for comprehensive observations at the facilities, including an in-depth look at systems readiness and acceptability. This is a critical piece in the development of priority actions for integration. Also missing are potentially informative interviews with individuals within MOHSW, the MSD, the Health Education Unit, the PMORALG. These discussions could have provided important perspective on programming priorities within departments and on concrete ways to move forward the integration agenda.

Consultants also did not have time to meet with all the development partners who are contributing important material and technical support to MNCH programming in Tanzania. Any process for moving forward the integration agenda needs to work in close collaboration with all the members of the donor community.

Not all interview respondents were highly conversant on RCH integration issues. There seems to be a lack of clarity on the definition and process of integration. Sharing current thinking, ongoing international operations research and emerging best practices on integration would be highly beneficial for policymakers, administrators and implementing partners on integration issues.

III. SITUATION ANALYSIS OF REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD HEALTH IN TANZANIA

As a signatory of the Millennium Development Goals (MDG), Tanzania has committed to reducing child mortality (Goal 4) and improving maternal health (Goal 5) by 2015. The country has made significant progress in reducing under-5 mortality from 157 deaths per 1,000 live births in 1990 to 81 per 1,000 in 2010.² This is partly due to increased immunization rates for children (three out of four children in Tanzania are fully vaccinated);³ increased use of Insecticide Treated Nets (ITN) by 72%;⁴ and increased coverage of the Integrated Management of Childhood Illness program (93%) and coverage of Prevention of Maternal to Child Transmission of HIV (PMTCT) (ARV prophylaxis 71%).⁵

However, Tanzania still faces challenges in reaching Goals 4 and 5. The maternal mortality rate has remained high over the past 15 years (454 maternal deaths per 100,000 live births, down from 578 in 2004–05).⁶ And while neonatal mortality has decreased from 32 deaths per 1,000 live births in 2004–2005 to 26 per 1,000, it still remains high. Further, 42% of Tanzanian children under age 5 are stunted, according to the “2010 Tanzanian Atlas on Maternal Health, Child Health and Nutrition.”

Tanzania also faces challenges in achieving progress on other key maternal and reproductive health indicators. Skilled birth attendance stands at 50% of all births. Modern methods of contraceptive use among all women remains at 28% and 25% of married women have an unmet need for FP. Almost a quarter of all girls between the ages 15 and 19 are mothers or have begun childbearing, with 23% of all maternal deaths occurring among pregnant girls.⁷ Women in Tanzania are particularly affected by HIV and AIDS and comprised over 60% of the population with HIV in 2008. HIV prevalence is higher among women as compared to men, at 7% and 5%, respectively. Only 33% of pregnant women received the recommended two doses of the antimalarial, Sulphadoxine Pyrimethamine (SP), during an antenatal care visit, which is a slight increase from 22% in 2004–05.⁸

In some instances, key service provision has worsened. The number of pregnant women attending four antenatal visits has dropped from 64% in 2004–2005 to 43% in 2010.⁹ In Tanzania,

² TDHS. “Tanzania Demographic and Health Survey, 2010.” National Bureau of Statistics, Dar es Salaam, Tanzania and ORC Macro. 2010.

³ TDHS. “Tanzania Demographic and Health Survey, 2010.” National Bureau of Statistics, Dar es Salaam, Tanzania and ORC Macro. 2010.

⁴ THMIS. “Tanzania HIV/AIDS and Malaria Indicator Survey 2011/12.” National Bureau of Statistics, Dar es Salaam, Tanzania and ORC Macro. 2012.

⁵ MOHSW. “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.

⁶ TDHS. “Tanzania Demographic and Health Survey, 2004/05.” National Bureau of Statistics, Dar es Salaam, Tanzania and ORC Macro. 2005.

⁷ World Health Organization Strategy on Adolescent Health.

⁸ THMIS. “Tanzania HIV/AIDS and Malaria indicator survey—preliminary report.” 2010.

⁹ TDHS. “Tanzania Demographic and Health Survey, 2010.” National Bureau of Statistics, Dar es Salaam, Tanzania and ORC Macro. 2010.

just 21% of all children aged 6 to 23 months are fed in accordance with Infant and Young Child Feeding (IYCF) practices,¹⁰ and six in 10 children are anemic. Nutrition status among women of reproductive age (15 to 49) needs improvement, with 40% of women anemic and 11% undernourished with a BMI of less than 18.5kg/m².

¹⁰ Tanzania Maternal Child Health and Nutrition Atlas, 2010.

IV. INTERNATIONAL TRENDS IN SUPPORT TO MNCH AND POPULATION HEALTH ACTIVITIES

Over the past 25 years, there has been global action in advocating and garnering support for a comprehensive set of health services for women and children, starting with the International Conference on Population and Development (ICPD) and culminating most recently with the MDG Declaration and Plan of Action. The UN, international and regional development banks, bilateral agencies, non-governmental organizations (NGOs), public/private partnerships and alliances, and private foundations have worked to develop the technical expertise and “know how” to address the particular health needs of women and children. Much work and effort has gone into defining packages of core RMNCH services, operational guidelines, monitoring and evaluation tools, communications strategies and program costing tools. Many field-based implementation projects and pilots have shown promising results.

The international community has struggled however to deliver a comprehensive package of services for women and children in many countries and will be hard pressed to meet the ambitious goals set for maternal and child health by 2015. One factor is competing international health priorities, chiefly the rise in the prevalence and incidence of infectious diseases, particularly HIV/AIDS, tuberculosis and malaria. International financial assistance and technical focus has shifted to this global crisis and vertical programming platforms. This shift is evidenced by dramatic increases in financial support for infectious disease prevention and control over the past 20 years, which now dwarfs support to MNCH and FP activities.¹¹ The FY 2012 funding of \$610 million for FP represents more than a 30% cut from US spending 1995.¹²

In recognition of these trends and in response to the global need for more effective and efficient solutions to meet international and local goals, there is growing interest in focusing on the diverse and multiple health needs of women and children (including the sexual and reproductive health of adolescent girls), with an emphasis on HIV/PMTCT.¹³ Linkages and integration with other services like FP, MNCH and HIV care and treatment is vital to meet this goal as it will reduce loss to follow-up and ensure mothers and infants get continuous care after pregnancy and the breastfeeding period.

¹¹Support is channeled through numerous mechanisms, such as the Global Fund for AIDS, TB, Malaria (GFATM); United States Government support through President’s Plan for AIDS Relief (PEPFAR) and the President’s Malaria Initiative (PMI).

¹² Population Action International, 2012.

¹³ In line with the UNAIDS, Tanzania PMTCT goal is virtual elimination of MTCT of HIV by 2015. This will be realized by reducing the number of new HIV infection among children by 90% and reducing the number of AIDS-related maternal deaths by 50%.

V. INTEGRATION

The discussion on “integrated services” is not new. It is in part a call to return to the concepts espoused in the Declaration of Alma Ata on primary health care for “bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.”¹⁴ However, the renewed interest in integration seeks to address the perceived “verticalization, territorialism, and duplication of effort”¹⁵ that has developed in HIV and SRH programming in recent years (at the national and service delivery levels as well as in donor funding priorities). Integration is understood as a process of breaking down the programming and funding silos of HIV and SRH that have developed over the years, and returning to a more holistic, client-focused health care delivery model that focuses on continuum of care catering to the multiple and diverse health needs of women and their children throughout their lifespans.

The push behind integration also recognizes deep and inseparable connections between HIV and sexual and reproductive health needs. Most HIV infections are sexually transmitted (the risk of which is increased by the presence of other sexually transmitted infections). Transmission is often closely associated with pregnancy, childbirth and breastfeeding—defining moments in a women’s sexual and reproductive life. It is also clear that sexual and reproductive ill-health and HIV share root causes, including economic inequality, limited access to appropriate information, gender inequality, harmful cultural norms and social marginalization of the most vulnerable populations.¹⁶

As such, there is an urgent need to plan for health service delivery mechanisms that cater to these interconnected health needs, providing women of reproductive age access to a full range of SRH services, including HIV testing, treatment and care, as well as other vital services such as FP. It also means ensuring that women (and men) living with HIV, have access to a complete range of SRH and MNCH services provided in a single place by a coordinated group of health professionals or within a strong referral network.

Developing an integrated service set is thought to have a number of clear benefits for clients and health systems and gives “added value” to service delivery mechanisms.¹⁷ Some of these benefits include a reduction in HIV-related stigma and discrimination; improved coverage of underserved, vulnerable or key populations; greater support for dual protection; improved quality of care; decreased duplication of efforts and competition for scarce resources; better understanding and protection of individuals’ rights; mutually reinforcing complementarities in legal and policy frameworks; enhanced program effectiveness and efficiency; and better utilization of scarce human resources for health.¹⁸

¹⁴“Sexual and Reproductive Health (SRH) Services with HIV Interventions in Practice Background Paper” (presented at the 26th Meeting of the UNAIDS Programme Coordinating Board, Geneva, Switzerland , June 22-24, 2010).

¹⁵ Ibid

¹⁶ Ibid

¹⁷ The Integra Project (2008-2012) is a partnership between Population Council, International Planned Parenthood Federation (IPPF) and London School of Hygiene and Tropical Medicine (LSHTM). It has been leading an effort to develop conceptual frameworks and evaluation tools to assess different models of service integration. This “added value” notion was borrowed from their work.

¹⁸ Ibid

However, to support these assertions there is a need for “rigorous research comparing integrated with non-integrated services, including cost, cost-effectiveness, and health outcomes such as HIV and STI incidence, morbidity and mortality.”¹⁹ The research findings are vital to inform programs and policy. Key issues to address include:

-
-
-
- one-stop shop model, co-location of services, referral models) ?
- What is the benefit of integrated service delivery compared with community standard of care in terms of coverage and access, client acceptability, responsiveness and quality, efficiency, service use and uptake?
- Is there a tipping point in which adding extra services might be more harmful than beneficial?²⁰

There is a lack of robust evidence to show either the positive or negative effects of integration on impact indicators, such as unmet need, HIV incidence or reduced mortality. Studies on the cost effectiveness of integration are also lacking, as are modeling exercises in resource constrained settings. In response to this knowledge gap, the Cochrane Collaboration conducted a review of 22 peer-reviewed articles (2012) describing results from 19 different MNCH-FP and HIV/AIDS intervention strategies. The review’s findings show that integrated HIV/AIDS and MNCH-FP services “are feasible to implement and show promise towards improving a variety of health and behavioral outcomes. However, significant evidence gaps remain.” The study calls for “rigorous research comparing outcomes of integrated with non-integrated services, including cost, cost-effectiveness, and health outcomes such as HIV and STI incidence, morbidity and mortality are greatly needed to inform programs and policy.”²¹

The Integra Project (2008–2012), a partnership between the Population Council, International Planned Parenthood Federation (IPPF), and the London School of Hygiene and Tropical Medicine (LSHTM) has been leading an effort to address this gap in knowledge. The project is currently evaluating the costs and benefits of using different models of HIV and SRH service integration in different African countries. The results will come out in early 2013 and inform policy on costs and best models of integration.¹⁶ While the Integra Project is looking at HIV and SRH integration, there is little literature available on integration of other reproductive, maternal, newborn, child and nutrition health programs.

¹⁹ The Cochrane Collaboration. *Integration of HIV/AIDS Services with Maternal, Neonatal and Child Health, Nutrition, and Family Planning Services* (John Wiley & Sons, Ltd, 2012).

²⁰ USAID Global Health Bureau Integration Learning Group product.

²¹ The Cochrane Collaboration. *Integration of HIV/AIDS Services with Maternal, Neonatal and Child Health, Nutrition, and Family Planning Services* (John Wiley & Sons, Ltd, 2012).

VI. TANZANIA HEALTH SYSTEMS

MINISTRY OF HEALTH AND SOCIAL WELFARE AND REPRODUCTIVE AND CHILD HEALTH SERVICES POLICIES

Tanzania's MOHSW has several policy documents that touch on the issue of integration, although a specific policy on integration within RCHS itself was not found.

- **The Tanzanian One Plan/National Road Map Strategic Plan Maternal and Newborn Health 2008–2015** states the following in regard to the need for integration. “All efforts will be made to implement the proposed priority interventions at various levels of the health system in a coherent and effective manner that is responsive to the needs of the mother, the newborn and the child.” It further notes that the plan will “ensure provision of the continuum of care from pregnancy, childbirth and neonatal period through childhood and across all services levels from family/household, community, and primary facility to referral care.”
- **The Tanzanian National Health Policy Document of 2003 states as its goal:** “Reduce the burden of disease, maternal and infant mortality and increase life expectancy through the provision of adequate and equitable maternal and child health services, facilitate the promotion of environmental health and sanitation, promotion of adequate nutrition, control of communicable diseases and treatment of common conditions.”
- **The Tanzania National Package of Essential Reproductive and Child Health Interventions (2000) states:** “The vision of RCHS is “A healthy and well informed Tanzanian population with access to quality reproductive and child health services that are accessible, affordable, and sustainable and which are provided through an efficient and effective support system.” Furthermore, the document states that in “planning for RCH services, the unique needs of adolescents must be considered” and “in conjunction with RH services, integrated services for child survival should be provided, with particular emphasis on the prevention and management of the main causes of childhood illness.” The national package of RCH services has specific guidelines developed for each level of care including the regional hospital, health center, dispensary and community levels.

The MOHSW has taken concrete steps over the past few years to assess the need for and feasibility of integrating services. These include a “Rapid Assessment of Sexual and Reproductive Health and HIV Linkages in Tanzania 2009,” the formation of a technical working group on MNCH, and a sub-technical working group on HIV/FP integration. Other work has included an “Assessment of the Integration of PMTCT within MNCH Services at Health Facilities in Tanzania” (PEPFAR, AIDSTAR-One Sept 2012), and the ongoing development of National Operational Guidelines on MNCH/HIV Integration supported by USAID and GIZ. Furthermore, the RCHS has developed two new sets of service guidelines: the “National Integrated Community Maternal, Newborn and Child Health Guideline” and the “National Postpartum Care Guideline.”

DONOR COMMUNITY SUPPORT TO TANZANIAN HEALTH SYSTEM

Tanzania has a complex international assistance environment, with numerous players and many different activities taking place at different levels of the health system—at the national, regional

and district levels and within individual health facilities. Efforts to improve the health of women and children are being supported at the highest levels, through major bilateral contributions to the “Tanzanian Poverty Reduction Strategy” and country-level sector-wide approaches (SWAp) mechanisms. Financial and technical support for RMNCH is also channeled through the ONE UN (WHO, UNFPA, UNICEF, UNAIDS) and through core support to MOSHW budgets. Bilateral assistance also provides technical assistance and guidance to the MOHSW on key health systems strengthening activities related to human resources development, supply chain and commodities management, health management information systems, as well as health financing and governance.

In the field of MCH, the USG has been a key contributor and supporter to the Government of Tanzania’s health activities. Through USAID, the USG has provided substantial and sustained support to the Government’s response to the HIV/AIDS crisis through the President’s Emergency Plan for AIDS Relief (PEPFAR). The President’s Malaria Initiative (PMI) has also been an important source of support and assistance to mothers and children by increasing the availability of malaria prevention and treatment options. Several partners, including Canada, Denmark, Germany, Netherlands, Norway and Switzerland development agencies, also provide substantial direct support to the Tanzanian Health Basket and further support to MNCH through several technical assistance mechanisms.

USAID’s Health Office has supported the work of several leading international agencies working on field-based implementation projects. These include projects that improve MCH, including pre- and in-service training for ANC and BEmONC; improve of RCH service quality by supporting the development of standards of care and approaches to strengthen supervision and mentorship; track and procure contraceptives and essential MCH supplies and equipment; reposition and revitalize FP/RH. USAID also supports the strengthening of cross-cutting health building blocks as part of an approach to improve key health systems functions (adequate human resources; sustainable financing options; available commodities and logistics; accountable governance and management approaches; and effective monitoring and evaluation).

USAID/Tanzania supports the concept of integration, guided in part by the principles articulated in the USG’s Global Health Initiative (GHI) Framework. The GHI strategy calls for aligning USG-supported programs in HIV/AIDS, malaria, nutrition, FP/RH and MNCH, and to scale up integrated programs that “work.” The USAID/Tanzanian Health Office will be building its strategy for integration in part based on the USAID Global Health Bureau’s current work on integration issues, which addresses the different dimensions of “physical, temporal provider and functional integration.” USAID/Tanzania will also be looking closely on how best to leverage the well-funded PEPFAR supported PMTCT platform to co-locate other key MNCH services such as FP, antenatal care and labor and delivery, given the current scarcity of key inputs in the Tanzanian health system, such as human resource shortages, health commodity stock-outs, poor infrastructure and management and governance challenges.

As noted, this assessment does not offer an in depth exploration of the full range of international and bilateral support to the Tanzanian government in the area of MNCH, HIV and field-based integration efforts. All future mapping and planning exercises should include the resources and technical expertise of all agencies working in the field of MNCH in Tanzania.

REGIONAL-BASED IMPLEMENTING PARTNERS WORKING ON THE DELIVERY OF INTEGRATED HEALTH SERVICE PACKAGES

In support of the MOHSW's interest in better service integration, the international donor community (USAID, GIZ, DFID) has been working to support the rollout of more integrated service delivery models and pilots at the regional and district levels.

As noted above, USAID through its Global Health Initiative Framework, is looking to “leverage the robust delivery platforms strengthened under PEPFAR and PMI”²² to ensure the delivery of more effective MNCH, nutrition, sanitation and hygiene, and FP/RH interventions to help address the major causes of maternal and under-5 mortality. Examples of field-based “integrated services packages” supported by USAID and others are noted below.

PEPFAR-supported partners, such as the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) and ICAP, with strong regional platforms for the delivery of comprehensive HIV/AIDS services for children and adults have been asked to “roll out” a more comprehensive package of MCH services developed under Mothers and Infants Safe Healthy Alive (MAISHA) program managed by JHPIEGO. This more integrated package includes support to FANC, BEmONC, postpartum care, cervical cancer screening and post-abortion care. This rollout of integrated services is in the early stages, but will constitute an interesting case study of leveraging existing HIV/AIDS service delivery platforms for other MNCH services.

EngenderHealth's ACQUIRE Project has been integrating FP services at PMTCT and CTC sites at the district level. ACQUIRE has also been integrating FP services into decentralized post-abortion care services with positive initial results.

Marie Stopes provides a range of sexual and reproductive health services through a network of 14 clinics and mobile outreach teams. Marie Stopes' teams have had success in providing comprehensive FP services, health screenings, maternal health services, post-abortion care along with voluntary counseling and testing (VCT) services in rural communities.

The Ifakara Health Institute, through the Connect Project, is also working on testing interventions that seek to strengthen the continuum of care for women and children between health facilities and communities. The Connect Project seeks to demonstrate improved health outcomes for women and children through the introduction of community health workers linked with an emergency referral system.

These regional- and district-based models of integrated services serve as important test cases to study the feasibility and effectiveness of integration. Careful documentation of successful models and implementation challenges, including collection and analysis of data on increased uptake of key services, would be valuable in guiding the MOHSW on choices of integration.

²² Tanzania Global Health Initiative Strategy 2011.

VII. FINDINGS FROM INTERVIEWS AND FIELD SITE VISITS

FINDINGS FROM STAKEHOLDER INTERVIEWS

Discussions with numerous stakeholders (donors, UN, implementing partners) revealed that the MOHSW needs to take on a strong national leadership role in articulating, defining and outlining the necessary steps for developing an integrated RCH service package. Better coordination across different MOHSW Directorates and Sections (such as Quality of Care Unit, Diagnostics, Education Unit, MSD, NACP, Training Unit, HR, HMIS Unit, TFNC) was deemed vital to address some of the major gaps identified at the health facility level, to improve core service delivery and to further address the additional needs and requirements of an integrated package. The government also needs to coordinate efforts and align priorities with others, such as the MOHSW and the PMORALG. These two bodies need to develop a common vision and definition on need for and direction of health service integration by supporting district plans and prioritizing the health sector in district budgets.

Stakeholders said that the MOHSW needs to designate a “lead agent” to take a proactive role in working with the RCH Section to operationalize a package of integrated services. This lead agent would be expected to develop a working definition of “integrated services;” to conduct a comprehensive assessment of readiness of health facilities and staff to provide integrated services based on their current training and skills sets; to develop a framework to evaluate the costs of integrated service; and to assess the acceptability of integrated services to providers and clients once packages have been developed.

Analyzing the readiness of the health system to integrate is crucial. Experience in other countries has shown that the development of an “integrated package” is usually not straightforward. If improperly managed, it can place strain on the underlying logistics, training, supervisory and management systems—especially if the services are provided through a vertical system—and may overtax service providers with limited skills and support.²³

All stakeholders reported that the shortfall in financial and human resources to provide even the core package of RCH services was cited as a major stumbling block for integrating services. With core RCH service provision under strain, stakeholders expressed concern about the MOHSW’s ability to efficiently and effectively integrate additional services to the core package.

Stakeholders also said that better coordination of the multiple programs within RCHS itself—especially on training and other activities like drugs procurement, reporting and data collection—would be an important step towards overall integration and improved management of RCH service delivery.

Stakeholders also reported the need for better harmonization and coordination of efforts among partner agencies working in collaboration with the MOHSW through the RCH Section. Duplication of services and the management of disparate health initiatives and donor priorities take up valuable staff time and energy. Furthermore, a complete mapping of current resources, activities and pilots, at the regional and district levels, is needed to identify a starting point for developing a strategy of integration and effective use of meager resources.

²³ Catalyst Consortium. “Integration of Family Planning/Reproductive Health and Maternal and Child Health Services: Missed Opportunities and Challenges.” USAID, 2003.

FINDINGS FROM MEETINGS WITH REPRODUCTIVE AND CHILD HEALTH SERVICES SECTION

The heads of RCHS units were asked via questionnaire about levels of current integration between units, where integration was already occurring at the service delivery levels and areas where services could be added for better integration.

Overall, they reported a lack of a clear policy or guidelines on integration of reproductive, maternal, newborn and child health services at the MOHSW level. Coordination between different units in RCHS could be improved through better information sharing on activities in the field and better coordination of activities across units that are funded by the same donor agency. Many heads of units said that training guidelines and manuals for health providers at each unit within the RCHS were too subject specific and did not address health components of other units.

In addition, heads of the RCHS units said that before beginning “integration of additional services,” there is a need to develop a supportive supervision methodology for current services within the core RCHS package—an integrated monitoring tool and coordinating mechanism for different sections within MOHSW that have a stake in RCH service provision. At this time RCHS has started development of an integrated supervision guideline.

FINDINGS FROM VISITS TO HEALTH FACILITIES

Consultants surveyed available RCHS services when visiting health facilities. The purpose of the site visits was not to exhaustively document available human and material resources and service delivery, but rather get a quick feel for challenges in current service delivery and identify some possible missed opportunities as well as entry points for the introduction of integrated services.

Consultants assessed health facilities in two regions, Dar-es-Salaam and Kigoma. Convenience sampling of 10 health facilities was undertaken including three hospitals, four health centers and three dispensaries (see Annex 4 for a complete list of facilities).

Available Services in the Reproductive and Child Health (RCH) Facilities

The core packages of RCH services, as described in the MOHSW’s “National Package of Essential Reproductive and Child Health Interventions of 2000,” include a wide range of services that are theoretically provided at each level of care and each service delivery point. However, observations of current clinical practice at the surveyed facilities showed real challenges in the provision of basic currently recommended RCH service packages.

Antenatal care, PMTCT (counseling, testing and ARV prophylaxis), vaccination, growth monitoring, FP and delivery services were available in all observed facilities.

The core antenatal care package in most facilities included monitoring progress of pregnancy, PMTCT (counseling, testing and ARV prophylaxis), syphilis screening, malaria prevention (IPTp and ITN), anemia prevention (iron, folic supplementation and de-worming), and tetanus toxoid immunization. Routine counseling on breastfeeding, nutrition, FP, postnatal care and danger signs of mother and infants in pregnancy and delivery were available in a limited number of facilities. In some facilities, staff did not have time to address the diverse needs of pregnant women due to staff shortages and high client loads. In other facilities, there was a lack of relevant technical knowledge and/or skills among providers. Providers cited a lack of guidelines on care, such as postpartum care, as a reason for the failure to offer comprehensive services. Antiretroviral

treatment for HIV positive women, tested in antenatal clinics, were available in two hospitals (the service was newly offered, one to two months prior to the assessment).

In under-5 clinics (well-baby clinics), standard childhood immunizations and growth monitoring services were offered in all of the assessed facilities. HIV early infant diagnosis (HEID) was offered during vaccination in five out of the 10 facilities; NVP prophylaxis in two facilities; and provider initiated counseling and testing for HIV (PITC) services for mothers in two health facilities.

Nutrition counseling and care was generally not available, apart from offering supplements (iron, folic acid or Vitamin A) during antenatal care and child growth monitoring. The combination of observations and client interviews showed that very few women received infant and young child feeding counseling apart from HIV-positive women.

For labor and delivery services, PITC for women with unknown HIV status, PMTCT prophylaxis and Vitamin A supplementation were universally available. Some facilities reported that they offered postpartum care, however they neither had registers to record women and newborns nor technical guidelines on how to offer services. RCHS leaders indicated that this service is just recently starting to be formalized within the RCHS.

Comprehensive emergency obstetric care (CEmOC) was available in all of the assessed hospitals, while Integrated Management of Childhood Illness (IMCI), newborn resuscitation, BEmOC, screening for cervical cancer and PITC were available in only one third of lower-level facilities. Adolescent care was available in one dispensary only. Care for victims of gender based violence (GBV), care and treatment for STIs and reproductive infections, and services for the disabled were not available at the facilities visited.

Staffing Levels and Previous Training

A severe staffing shortage was observed in all facilities assessed, a finding echoed in many reports.^{20, 21} Consultants found a range of four to seven providers of different cadres working in the RCH department at health facilities in Dar-es-Salaam and between one and three providers in Kigoma region. These providers were attending an average of 50 to 200 clients daily when a combination of ANC, FP, immunization, growth monitoring and PMTCT clients were included. The regional medical officer in Kigoma Region stated that there was a health staff shortage of nearly 65%.²⁴

Service providers were questioned about their recent in-service training in RMNCH. Providers in both regions have received more training in HIV care and PMTCT as compared to other RMNCH topics (see Annex 4). Providers in Kigoma attended in-service training with more RMNCH components compared to Dar-es-Salaam. Through interviews and observation during service delivery, this assessment shows that some providers have poor MNCH knowledge and skills; inadequate training in RMNCH topics may be a contributing factor.

Observed Challenges in RCH Service Delivery

- **Staff shortages exist.** In most facilities, the team observed a severe shortage of staff present on the day of the visits or lower-level staff (medical or nurse attendants) performing functions of higher-level providers. For example, in several facilities visited, a single nurse attendant performed multiple tasks including ANC visits, FP services, labor and delivery.

²⁴ Kigoma Annual RCH Report, 2011.

Staff shortages resulted in congestion of clients and long wait times. In congested clinics, the few staff who did offer specific RCH services did not screen women or children for multiple health needs—leading to missed opportunities for comprehensive care. Lack of time, staff burn-out, low motivation, and excessive administrative duties may be contributing factors.

- **Poor integration of service delivery points and irrational client flow** (see Annex 7, Figure I). A client is required to move to two or three different rooms/departments to receive essential care stipulated in the guidelines. For example, core ANC services were fragmented and offered in multiple locations, which required patients to move within and outside the RCH section, and resulted in long wait times (up to six hours in some places), loss to follow-up, and missed opportunities for care at first contact. Different RCH services were offered in different rooms/locations. For example, ANC, FP services and well-baby care and immunizations were all offered in separate places, which resulted in inefficient use of time for those needing multiple services. Clients for FP had the longest wait time as priority was given to antenatal and under-5 patients.
- **Lack of adequate infrastructure for clients.** Most antenatal and well-baby clinics were overcrowded and uncomfortable, with little seating for mothers and children. Overall, there was a lack of space for individual consultations and counseling, especially in growth monitoring and vaccination sections, posing problems for client privacy and confidentiality. In some facilities, there was limited space to offer FP services so FP clients had to wait until antenatal clients were seen before accessing services. In most facilities, IMCI, adolescent and nutrition services didn't have designated room or space, which affected quality of care, including confidentiality and privacy.
- **Lack of adequate infrastructure for providers.** Providers often worked in very small confined rooms. Lack of space limited providers' ability to deliver a wider set of services on-site (urinalysis, hemoglobin, or syphilis and HIV testing) as well as private, confidential counseling for clients on other topics.
- **Stock-out of drugs, commodities and supplies.** In most of the facilities visited, there were shortages of basic drugs, commodities and supplies (e.g., syphilis kits, HIV kits, dipsticks for urine testing, magnesium sulfate, ANC and growth monitoring cards, and gloves). Simple, inexpensive drugs like SP, Mebendazole or iron tablets were lacking in some facilities. Necessary equipment to offer emergency care like an MVA kit or ambu bags and masks for newborn resuscitation were missing in several facilities.
- **Lack of multiple skills/knowledge for providers.** Many providers did not have thorough knowledge of core RCH services issues (e.g., enrolled nurses and even some nurse midwives at FP clinics reported that they were able to offer contraceptive pills and injectable contraceptives for clients, but many were unable to offer implants or the intrauterine contraceptive device (IUCD) because they lacked the knowledge and skills despite that the commodities were available). In one facility, when the single nurse who offered PMTCT was out, patients had to access care at another time because other nurses were not knowledgeable. In another dispensary, HIV pregnant women were referred to a regional hospital because of a lack of "know-how in patient management," despite availability of ARV drugs and trained personnel like clinical officer and an enrolled nurse.

- **Lack of guidelines and job aids in many RCH services.** Most providers did not have guidelines or job aids available at the time of the assessment. There was no clinical protocol available for reference by providers on the basic topics of RCH services. Furthermore, there were no guidelines available for newer services areas, such as adolescent services, postpartum care or nutrition care.
- **Lack of IEC materials.** No printed health information materials were available for clients on core topics such as danger signs in pregnancy, maternal nutrition, exclusive breast-feeding, infant and young child feeding, FP, immunization, importance of delivery with a skilled attendant or postnatal care. There was also no information for men, inviting them to participate in different RCH services with their partners.
- **Disintegrated recording system.** Providers spent much of their time recording patient data in multiple registers. For example, providers recorded antenatal information in four different registers and information for HIV-positive pregnant women in three other different registers. Lack of standardized RCH cards was observed (e.g., four versions of ANC cards in use, two different versions of FP cards and two different versions of parto-graphs, sometimes within the same facility.). The existing MTUHA-HMIS tools do not capture whether or not a client received comprehensive/multiple RCH services, a fact that should be taken into consideration when planning for integration of RCH services.
- **Inappropriate/unnecessary data collection.** Providers spend time capturing data that is not used in quarterly reporting thereby wasting valuable time that could be spent in better service provision or supervision. District and regional RCH coordinators highlighted this problem, calling for the need to streamline the tool and remove unnecessary data required by the RCH section.
- **Lack of regular supportive supervision.** There is infrequent, if non-existent, clinical mentoring on site. Supervision was lacking from the national level to the region/district level, as well as at the facilities.
- **Lack of incentive strategy for staff.** Many providers work many hours for little pay and with little or no recognition from the higher-ups, which leads to lack of motivation. Staff reported that there is no routine system for compensation, overtime pay or promotion. Payment for performance may motivate staff, but currently does not exist.

Attitudes and Perceptions of Providers and Clients on RCH Services Integration

In interviews, health providers said that they believed in theory that the delivery of multiple RMNCH services, by one provider during a single visit, could improve service quality, client satisfaction and service efficiency. Service delivery would be more efficient by reducing excessive staff and client movement between different service delivery points and by decreasing the likelihood of losing clients for whom multiple visits is inconvenient, expensive and time consuming.

However, providers cautioned that integration might also pose a threat on provider efficiency and the quality of services if staff shortages and drug/supply stock-outs are not addressed as an integral part of the process. Some feared increased workloads and responsibilities. One informant questioned that integrating services might simply mean adding duties and responsibilities for already over-loaded, over-worked and under-compensated staff. Other staff pointed to the need for improved infrastructure (number and quality of rooms), clear service

delivery guidelines on integrated RCH care, and clear job descriptions on which services to offer within each cadre.

Clients echoed the same concern. Ultimately, the limited number of providers is the primary challenge to integration. And unless solved, integration will have a negative impact on quality of care and wait times. However, patients expressed optimism that integration of services, if properly managed, would reduce wait time, movement and unnecessary referrals.

VIII. OPPORTUNITIES

FOCUS ON KEY TOPICS IN INTEGRATION

Given the current financial and human resource constraints in Tanzania, it will be necessary for the RCHS to *prioritize interventions and services to be integrated over the short and medium term*. The RCHS will need to select several areas of focus and a combination of services that would accelerate progress in meeting MDG Goals 4 and 5. Prioritizing specific services over the short and medium term will also serve as a test case for managers and providers to begin to address inter-sectional (within RCHS) and cross-sectional (between RCHS and NACP, NMCP, MSD, PMORALG) coordination.

Two key strategies are critical for achieving improved MCH now and for future generations of women and children: FP and outreach and service provision for adolescents. A third strategy is the integration of antiretroviral treatment and care, which easily can be integrated in the RCH with current resources. However integration of HIV within MNCH is addressed by another group, hence not included here.

Family Planning

Unwanted pregnancies are a major cause of poor health outcomes for women. Contraceptive prevalence in Tanzania is low (28%), while the fertility rate remains high at 5.4 children per woman. This rate has remained largely unchanged since 1999. The use of contraception offers a number of benefits for all women. It allows women to delay first births, lengthen birth intervals, reduce the total number of children born to a woman, prevent unintended pregnancies and reduce the need for unsafe abortions. Family planning is one of the top WHO recommended interventions for improving overall maternal and infant health, and it can also be offered in a variety of settings and at different levels of care. The evidence base for the effectiveness of FP in improving health outcomes is well established:

- Studies have clearly shown that easy availability and accessibility of modern contraceptive methods have a potential to reduce maternal deaths by 22% to 30%.²⁵
- Globally, about one third of 358,000 maternal deaths every year could be averted if women had access to reliable FP methods.²²
- One third of the 190 million unintentional pregnancies could be avoided with availability of FP methods.
- Fifty million abortions, of which, 19 million are performed under unsafe conditions, could be prevented with reliable reproductive health services. In Tanzania unsafe abortions contribute to 9% of maternal deaths. The population-based adult morbidity and mortality study (AMMD) which was conducted in Hai, Kilimanjaro, Morogoro and Dar-es-Salaam showed that unsafe abortions contributed to between 9% and 31% of maternal deaths.²⁵

²⁵ Setel, P. H. Kitange, KGMM Alberti and C. Moshiri. "The Policy Implications of Adult Morbidity and Mortality in Tanzania: From Data Analysis to Health Policy-preliminary Experiences" (paper presented at the Global Forum for Health Research (Forum 2), Geneva, June 25-26, 1998.

Family Planning in the Prevention of HIV

Preventing unwanted pregnancies among HIV-positive women is also an important strategy to improve women's and children's health, particularly in countries with a high HIV burden. Studies have shown that the provision of FP services reduces rates of MTCT of HIV. However, the majority of resources for PMTCT are directed toward the provision of ARVs—such as the Nevirapine regimen for HIV-positive pregnant women and their newborns. In contrast, preventing unintended pregnancies among HIV-positive women—by increasing the voluntary use of contraception—has been undervalued and little-used. Improving service provision for FP within the HIV/AIDS Care and Treatment Centers and in tandem with PMTCT efforts would be highly beneficial.

Adolescent Health

Health service and health education outreach to adolescents is a critical strategy for improving the health of women and children. The Tanzanian population is young, with 44% below age 15. For many adolescents, pregnancies are unplanned and associated with many negative health consequences, including the high risk of illness and death for both the mother and child.

- In Tanzania, teenage pregnancy is a major problem as 44% of women are either mothers or pregnant with their first child by age 19.
- Nearly 25% of all unsafe abortions in Africa, including in Tanzania, are among women aged 15 to 19. The AMMD study showed that more than six in 10 abortion deaths were adolescents.
- 23 percent of all maternal deaths are among young pregnant girls. Unmarried adolescent girls are far more likely to become pregnant unintentionally and thus pregnancies are more likely to end in induced abortion.²⁶
- Adolescents also suffer more obstetric and long-term complications (e.g., 65% of fistula cases admitted at major hospitals in Tanzania are among adolescents). Younger women also have a higher risk of contracting HIV because of biological and social factors. In Tanzania, young women are 1.5 times more likely to acquire HIV as compared to boys of similar age
- Women with more education are more likely than uneducated women to utilize life-saving interventions (e.g., use a skilled attendant during birth, seek postnatal care, seek care early when children have pneumonia or diarrhea).

The RCHS has developed a specific strategy on the provision of adolescent care. But even if FP and other key health services are available, adolescent girls may lack the skills and negotiation and decision-making power to use these services. A special effort to reach out to girls and involve them in the health care delivery system is necessary.

SERVICE ENTRY POINTS FOR INTEGRATION

The following lists some missed opportunities for integrated care and may be potential entry points for offering a wider range of services. The RCHS will need to decide where to focus its efforts on integration and take a step-by-step approach.

²⁶ Bongaarts J, J. Cleland, JW Townsend, et. al. *Family Planning Programs for the 21st Century: Rationale and Design* (New York: The Population Council, 2012).

Antenatal Care

Antenatal care is an important entry point for integrating other services as it is universally available at all health facilities, is highly attended (96%) and offers an opportunity to introduce many preventive and curative services for pregnant women and unborn children. The delivery of the core antenatal care package however needs to be strengthened by addressing staff shortages, limited staff skills and knowledge and drug/commodities stock-outs, before adding additional services. Antenatal services to be strengthened include offering tetanus toxoid; screenings for syphilis, hemoglobin and protein in urine during ANC; PMTCT (ART care and treatment); screening and treatment for cancer; and offering IEC on core components including danger signs during pregnancy, hospital delivery, FP, breastfeeding, postpartum care and nutrition.

Women seeking ANC services could also

- Receive information/counseling on vaccination status of their children.
- Receive counseling/advice for their plans for FP use after delivery.
- Receive counseling on maternal and child nutrition.
- Receive IEC materials for important subjects like danger signs during pregnancy, importance of delivery with a skilled attendant, postpartum care, FP, nutrition or breastfeeding.
- Be screened for STI and HIV. And in the case of positive test results, receive treatment at ANC instead of an HIV Care and Treatment Clinic.

Well-baby Clinics

Growth monitoring and child immunization services is a good entry point to integrate RCH services because it is a highly attended service (DPT 3 > 90%), is accepted by the community and offers an opportunity to attend mother and their children together. Well-baby clinics, immunization and under-5 growth monitoring services could integrate TT for women, IEC on core components and links with IMCI. Mothers who visit a health unit for growth monitoring and child immunization could also

- Receive counseling about FP use (currently, women must visit an FP clinic to receive contraceptive services).
- Receive PITC services.
- Be screened and treated for anemia.
- Receive guidance on exclusive breastfeeding.
- Receive IEC materials on nutrition, early recognition of growth problems and complementary feeding.
- Receive infant and young child feeding counseling.
- Receive HEID or ART and care.
- Be asked about their progress if attending CTC for ART.
- Receive IEC material or information on FP, STIs/RTIs, screening for cervical cancer, infant and young children nutrition, or on childhood infections by being provided links with IMCI.

Family Planning Clinics

FP is a good entry point because services are universally available at all the health facilities. FP services could integrate STI screening and treatment, PITC, IEC on the importance of other child services like immunization and nutrition. It is also a good opportunity to build services for adolescents by providing VCT, condoms, emergency contraceptives and other methods, pregnancy testing, STI screening and testing.

Women who visit FP clinics could also

- Receive provider initiated counseling and testing and +/-ARV prophylaxis /treatment.
- Be asked about signs or symptoms of STIs/RTIs (e.g., syphilis screening and treatment).
- Be offered syndromic treatment if RTIs symptoms are present (currently women are referred elsewhere).
- Be asked about vaccination status of their children.
- Be screened for cervical or breast cancers and/or informed about screening possibilities.
- Be provided with FP methods of choice because the providers lacked the skill to offer wider selection of methods (e.g. surgical method, IUCD or Depo-Provera)
- Receive IEC materials about other RMNCH services.

Labor and Delivery

Labor and delivery is an important entry point for the provision of integrated services as 50% of Tanzanian women deliver their babies in a health facility.

Many women who deliver in a health facility also could

- Receive provider initiated counseling and testing and +/-ARV prophylaxis /treatment.
- Receive potentially life-saving information about possible health dangers tied to the postpartum period.
- Be offered newborn resuscitation if needed, especially in BEmOC facilities.
- Receive routine eye prophylaxis for the newborns.
- Participate in “Kangaroo Care” and counseling for premature babies.
- Receive counseling on breastfeeding, nutrition, PNC and danger signs of mother and infants.
- Be counseled on postpartum FP and receive services for immediate postpartum IUDs, or permanent contraceptive methods (tubal ligation).
- Be provided IEC materials on danger signs, PNC, postpartum FP, nutrition, infection prevention and care for newborns.

Post Abortion Care

Post abortion care services offer an important entry point and opportunity to reach women of reproductive age with preventive and curative services. Post abortion care services could integrate FP, STI screening and management, PITC and cervical cancer screening.

Women in need of post abortion care could also

- Receive FP counseling.
- Be offered PITC services.
- Be asked about signs and symptoms of STIs/RTIs.
- Be offered information or services on cervical and/or breast cancer screening.

Table 1: Opportunities/Requirements for Integration at the Health Facility Level

Service Entry Point	Observed Challenges	Opportunities	Requirements
Antenatal care (ANC)	<ul style="list-style-type: none"> • Not offered daily in some facilities. • Investigations (syphilis, hemoglobin, urine) done at OPD laboratory or outside the facility. • Syphilis treatment and STI/RTI. • Treatment not offered in RCH, only at OPD. • TT offered only in Vaccination Unit not at ANC. • PMTCT in another room. • ART care in CTC clinic. • Stock-outs of HIV kits, hemoglobin tests, urine stick, essential drugs like SP, anti-hypertensive drugs, magnesium sulphate and ANC cards. • Syphilis kits out of stock for prolonged periods in nearly 50% of the facilities. • Multiple ANC cards used within one facility. • Job aids were missing. • IEC materials (danger signs, breastfeeding, 	<ul style="list-style-type: none"> • Strengthen the basic package. • TT immunization in ANC. • Routine testing syphilis, hemoglobin, urine in ANC. • Provide treatment for syphilis and STIs/RTIs. • Other services which can be added: <ul style="list-style-type: none"> – ART care and treatment. – MRDT. – GBV. – Adolescent care. • IEC materials in core topics. • Job aids. 	<ul style="list-style-type: none"> • Training on essential package. • Train HCP to offer multiple services (e.g., ART care, screening using rapid tests, syndromic management, FP). • Regular drugs and supplies. • Infrastructure restructured to allow addition of other services. • Side laboratory within RCH for routine tests may be more efficient (tried in IHF). • Address staff shortage by using available HCPs/task shifting. • Integrated monitoring tool. • Guidelines. • Invest in IEC and job aids materials. • Quality of care assessments.

Service Entry Point	Observed Challenges	Opportunities	Requirements
	<p>importance of delivery with skilled provider and PNC, nutrition) were not available.</p> <ul style="list-style-type: none"> • Male involvement is poor except in three facilities. • Skills of providers were low in some facilities when interviewed in multiple RCH topics (e.g., PMTCT, FANC, FP,) limiting ability for integrated services and leading to unnecessary referrals. 		
Childbirth (L and D)	<ul style="list-style-type: none"> • Most of BEmOC facilities did not perform assisted vaginal delivery or newborn resuscitation. • Lack of ambu bag and mask for resuscitating women in the labor ward. • Low clinical resuscitation skills (e.g., ABC) despite training. • Lack of guidelines, protocols or job aids in the labor ward. • Many do not have or offer eye prophylaxis. • M&E tools: multiple versions of parto-graphs were found in the facilities. • Stock-outs of supplies and drugs. • Magnesium sulphate OS in some facilities. • Gloves and disinfectant was an issue in some facilities. • Infrastructure: small rooms will need modification. 	<ul style="list-style-type: none"> • Other services which can be added: <ul style="list-style-type: none"> – PITC. – PMTCT prophylaxis. – FP. – Nutrition counseling and care. – Breastfeeding. – STI prevention and management. • IEC materials in core topics. • Job aids. 	<ul style="list-style-type: none"> • Training in EmOC and newborn care. • Protocols and job aids in the labor ward. • Essential equipment. • Essential supplies and drugs (e.g., parto-graphs, gloves). • Quality of care assessments.

Service Entry Point	Observed Challenges	Opportunities	Requirements
Postpartum care (PNC)	<ul style="list-style-type: none"> • Space to offer care. Few who came at seven days were seen at different places: labor ward, vaccination room, FP or ANC room. • Lack of guidelines on what to offer and what to record regarding the service. • Not understood by many providers. 	<ul style="list-style-type: none"> • Other services that can be added: <ul style="list-style-type: none"> – Postpartum FP. 	<ul style="list-style-type: none"> • Guidelines and protocols. • Training. • Monitoring tools.
Family planning (FP)	<ul style="list-style-type: none"> • Few health care providers (HCP), high volume. • Lack of wider choice of methods in some health facilities (condoms, COCs and Depo-Provera). • Stock-outs of commodities is common (e.g., Depo-Provera) and some lack basic equipment like speculums or sterilizers. • Lack of skills to offer full range of services (e.g., few HCPs can place implants or IUCDs even when available). • Clients required multiple visits or referred to another facility. • Symptomatic for STIs/ RTIs, referred to OPD, which leads to queues, loss of clients and missed opportunity to offer treatment on spot. • Space was a major problem. Many share room with ANC and had to wait for a long time. Providers give priority to ANC clients. • No time or skills for adolescents care. • Lack of job aids and displayed guidelines. 	<ul style="list-style-type: none"> • Several services may be added: <ul style="list-style-type: none"> – PITC. – Syphilis screening. – Screen and management of STIs/RTIs. – Screening for cervical and breast cancers. – Adolescent care. • Link with immunization, nutrition, growth monitoring services. • IEC materials on nutrition, infections, child growth, child spacing, FP methods. • Reposition FP by integrating into other services. • ANC counseling. • Childbirth counseling and methods. • Immunization and growth monitoring. • PMTCT, ART and CTC services. • IMCI, in-patient at pediatrics and gynecology wards. • PAC. • STI clinics. 	<ul style="list-style-type: none"> • Training available to all HCPs to offer full range of methods except surgical methods. • Train HCP on other integrated services to offer multiple care. • Supplies, commodities and equipment. • Internal: arrangement of drugs, kits, vaccines and accountability mechanism. • Space – input rooms for FP and addition services. • Integrated registers for all services. • Guidelines on how to implement services.

Service Entry Point	Observed Challenges	Opportunities	Requirements
Post abortion care (PAC)	<ul style="list-style-type: none"> • Lack of FP counseling or commodities. • STI screening and management was lacking. • PITC not routinely offered. • MVA was used, some still use D & C. • Misoprostol was not used for incomplete abortion < 12 weeks while available, especially at lower level. • Lack of skills in some providers on use of MVA or misoprostol for management of incomplete abortion. 	<ul style="list-style-type: none"> • Several services may be added: <ul style="list-style-type: none"> – Misoprostol to manage incomplete abortion, especially at the lower level facilities. – PITC. – FP. – Screen and management of STIs/RTIs. – Cancer screening. • IEC materials on STIs, infections, child spacing, FP methods. 	<ul style="list-style-type: none"> • Training all cadres of nurses, clinical officers, AMOs and MOs to PAC. • Train HCP on other integrated services according to package. • Place misoprostol in the list essential MNCH drugs. • Guidelines and job aids on how to implement services. • Legislation for task shifting to nurses.
Baby-well clinics	<ul style="list-style-type: none"> • Space to offer care. Care is currently offered in an open space, with lack of privacy to offer counseling or discuss problems. No single facility had a side room for private counseling. • Shortage of staff has led to local arrangement—immunization is offered once a week in some facilities. • Supplies: problem with growth cards, polio vaccine. 	<ul style="list-style-type: none"> • Other services that can be added: <ul style="list-style-type: none"> – ART care and treatment. – FP services. – PITC. – HEID. – Cervical cancer screening at 28 days. – Nutrition counseling and care. • IEC materials in core topics. • Job aids. 	<ul style="list-style-type: none"> • Infrastructure improvement to have counseling rooms within service. • Training of staff on other services (e.g., HIV counseling and testing, HEID for integrated care).
Adolescent care	<ul style="list-style-type: none"> • Although RCHS strategy exists for adolescent care, only one facility (dispensary) had functional clinic for adolescent girls and boys. • Privacy and confidentiality for counseling and services are rare. • Health providers were not comfortable or confident in offering care to adolescents. • No community outreach with information on to available services. 	<ul style="list-style-type: none"> • Develop specific information and outreach policies targeting youth. Several services can be packaged together. These include negotiating skills and how to cope with peer pressure, counseling and provision of condoms and contraceptives, STI screening and management, HIV counseling and testing, GBV including sexual assault, PAC and other psycho-social services. 	<ul style="list-style-type: none"> • Training providers on special needs of adolescents. • Training of other adolescents as peer educators. • Create safe private spaces for adolescents, as well as flexible clinic hours. • Drugs, supplies and commodities.

Table 2: Framework Major Challenges for Integration of RCH Services and Possible Solutions Identified by Stakeholder in the Annual RCH Meeting:

Challenge	Possible Solutions or Steps	Best Practice
Lack of specific policy and guidelines at the national level on integration.	<p>Formulation of integration policies and guidelines.</p> <ul style="list-style-type: none"> • Start an integration unit placed within the MOHSW to lead the process. • Harmonization of training curriculum (pre and in-service) to reflect integrated package. • Harmonization of M&E tools. • Integration of supportive supervision at the national level. • Coordination and supervision of donors and developing partners working at the facilities. • MOHSW/ RCHS need to develop integrated package, which partners will need to adhere when supporting MNCH programs at facilities. • Regional and district RCH coordinators should be fully members of RHMT and CHMT (e.g., enable plans to be sustainable supporting HF). • Establish budget for zone coordinators and zone training centers to support with supervision and mentoring. • Last operation definition of integration is needed. 	
Shortage of staff.	<ul style="list-style-type: none"> • Motivation and retention strategy of scarce providers who are already working in the facilities. • Pay extra duty allowance on time. <ul style="list-style-type: none"> – DHMT allowed to put in the basket fund extra duty allowance (Kasulu district). • Enabling environment. • Prepare support package for newly posted HCPs. <p>Source Form IV leavers locally and put a system to train and develop them to serve at their localities.</p> <p>Address misuse of human resource for RMNCH by central level.</p>	<ul style="list-style-type: none"> • <i>Tabora: “If money from MOHSW for extra duty or call is late, we use money from another basket, like insurance money to pay on time and replace when the Government has paid.”</i> • <i>Iringa: “We make sure there are solar to all HCPs houses in the districts and water, helped by an Italian NGO.”</i> • <i>Rukwa: “We find houses for all new posted staff, we purchase basic household things, money to settle in and making sure the houses have electricity and water.”</i>

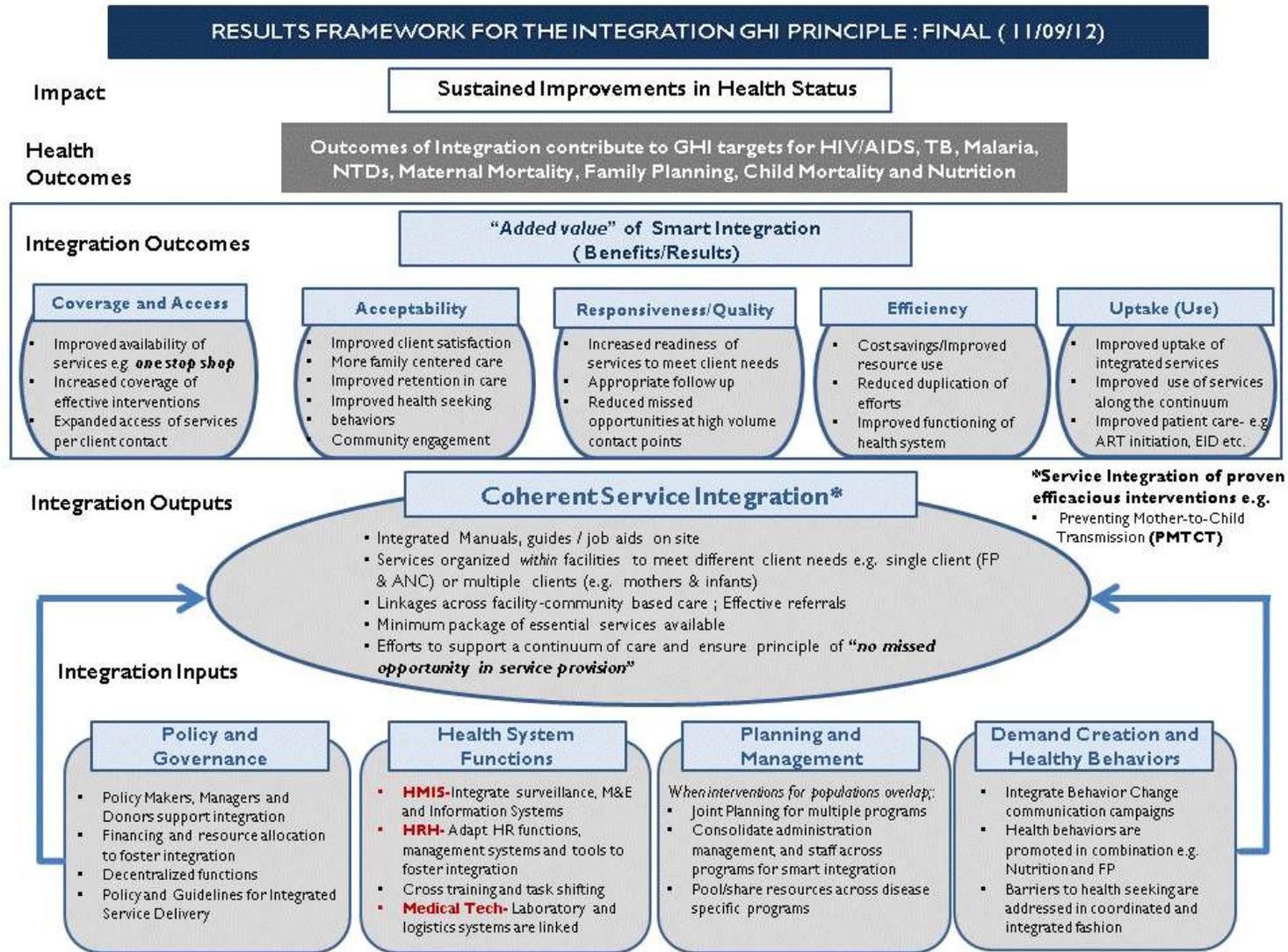
Challenge	Possible Solutions or Steps	Best Practice
	<ul style="list-style-type: none"> • MCHA were trained in midwifery for 18 months, but were forced to either upgrade or demoted. Those demoted are currently medical attendants and wearing green uniforms for attendants. Some have refused to offer RCH care except following TOR for attendants. <i>“I have 290 MCHA who have been demoted, and not working at RCH, how can if fill the shortage?”</i> — Regional RCH-CO • Auxiliaries (one year course): There was a clear carrier pathway and auxiliaries were trained at regional hospitals. Then they were removed. Now some other donors are bringing CHW into HF to cover shortages, others are training CHW for nine months who will end in HFs. <i>“Rethinking of our HR is needed.”</i> <p>Employment and deployment.</p> <ul style="list-style-type: none"> • Government services should employ according to requests from the regions and districts. <ul style="list-style-type: none"> – Better communication between MOHSW and PRMORALG. – Reception at the districts (take them even though letter from central has not arrived). <p>Task shifting when supervised (need legal back-up and to redefine roles).</p> <ul style="list-style-type: none"> • PAC – Clinical officers and nurse midwives who are trained can perform. • Surgical FP methods – Clinical officers and theater nurses. • Nurses to do HIV care and treatment. <p>Long term: increase output from training institutions.</p>	
<p>Low or insufficient knowledge and skills of providers to offer multiple RCH services.</p>	<p>Invest in HCPs locally to provide integrated services.</p> <ul style="list-style-type: none"> • Attach staff at different departments within facility (e.g., pediatric to FP or CTC). • Attach staff from lower facilities to the district or regional hospital where they have trained providers in several RCH topics. 	

Challenge	Possible Solutions or Steps	Best Practice
	<ul style="list-style-type: none"> • Zonal centers, regional and district RCH-CO should be trained first, then they in turn train at health facilities (invest in frequent supportive supervision). <p>Design and have an integrated induction training package for one week on RH and MNCH for all new health providers. This can be organized at the regional or zone level.</p> <p>Integrated in-service training.</p> <ul style="list-style-type: none"> • Vertical programs (e.g., PMTCT or BEmOC should add other RCH topics in trainings, after MOHSW has defined essential integrated package). <p>Long term solutions.</p> <ul style="list-style-type: none"> • Training (pre-service), should focus on imparting integrated knowledge and skills in RMNCH. 	
<p>Low staff motivation.</p>	<ul style="list-style-type: none"> • Improve working environment. • Improve infrastructure. • Ensure adequate supplies, commodities, equipment and even furniture. • Ensure no stock-outs of drugs. • Staff housing, utilities (water, electricity). • Staff uniform. <p>Meaningful annual salary increments.</p> <p>Timely staff promotion (right not privilege).</p> <p>Staff recognition (certificates).</p> <p>Performance based financing for facilities, individual HCPs.</p> <p>Staff incentives (extra duty, hard-to-reach-area-allowance).</p> <p>Refresher on-job trainings to be up to date.</p> <p>Supportive supervision.</p> <ul style="list-style-type: none"> • Respect for lower level staff when giving guidance <p>Need for staff <u>job descriptions</u> now and when integrated guidelines comes out.</p>	<ul style="list-style-type: none"> • Dar-es-Salaam: “There are 80 to 100 deliveries at big hospitals. Labor ward staff are given special extra duty allowance for motivation, depending on number of deliveries ranging from 20,000 to 50,000 Tsh per month. Budgeted this in the CCHP Plan.” • Another: “We have friendly competition among facilities and we have several indicators they have to meet. We give awards like certificates, recognition and prizes both to staff and facilities that do well.” • Tabora: “We make sure we provide house, bed, mattress, household equipment, plus 500,000 Tsh as a start pack for new employees. We have been very successful because they know we care and they stay.”

Challenge	Possible Solutions or Steps	Best Practice
Problems with frequent stock-outs of essential drugs, commodities and supplies.	<p>Integrate at MSD procurement of cross cutting issues (guidelines are needed from MOHSW).</p> <ul style="list-style-type: none"> • ART drugs, RCH, STI drugs, etc. <p>MSD</p> <ul style="list-style-type: none"> • Ensure availability of essential commodities and drugs (RCHS, regions and districts should give MSD an updated list of essential drugs). <p>Train both staff at MSD and at facilities on “planning, quantifying and forecasting.”</p> <p>MSD should identify a reliable partner where districts or facilities can purchase commodities if they are out of stock in the MSD.</p> <p>Locally, facility-HMT teams should be convinced to allow independent purchasing if drugs that are OS at MSD.</p>	<ul style="list-style-type: none"> • <i>Dar-es-Salaam: “A dispensary staff convinced and oriented the HMT team about the problem of supplies from MSD. The HMT allowed purchasing from other suppliers once the drugs are not in the MSD. We have forgotten the problem of gloves, or SP stock-outs since that decision was taken.”</i>
Infrastructure issues.	<ul style="list-style-type: none"> • Review the physical facilities and either renovate or completely rebuild, while adhering to required infrastructure plan by the ministry. • Upgrading plans need to be in CCHP. • Electricity with generators or solar in all HF with deliveries or perform surgery. <p>Communication:</p> <ul style="list-style-type: none"> • For referral and sending data, mobile technology can be used from lower level to districts. • Reliable transport for referral at all health centers. 	
Monitoring tools (M&E).	<p>Integrated monitoring tools to capture most indicators to reduce multiple registers.</p> <p>Use mobile technology to capture and send data from lower facilities to the districts.</p> <p>Develop indicators to monitor integration of RCH services.</p>	

Challenge	Possible Solutions or Steps	Best Practice
Supervision.	<p>Integrated supportive supervision.</p> <ul style="list-style-type: none"> • Proper staff mentoring. • Effective two-way communication and feedback from and to all levels. • Respect for lower level staff when they come to higher levels to bring issues/problems. <p>Broaden the base of skilled, experienced content experts at the regional level so that the RCH CO can draw on a team of senior staff in districts to perform supervision, mentorship and collect reports from facilities.</p>	
Training.	<p>Integrated training courses for RMNC health.</p> <ul style="list-style-type: none"> • Develop integrated in-service training package. • Appropriate pre-training courses in RMNCH that addresses a holistic approach to treatment instead of treating a disease or condition alone. <p>To facilitate integrated care at facilities, introduce history taking tools which facilitate identification of multiple health needs of clients (checklist).</p>	<ul style="list-style-type: none"> • Post training mentorship.

Table 3: GHI Results Framework for Integration²⁷



²⁷ USAID Global Health Bureau, Washington DC 2012

IX. NEXT STEPS

The process of developing and operationalizing an integrated health service set in Tanzania should be conceptualized in keeping with the principles and ideas articulated in the Results Framework for Integration GHI Principle (see Table 8.2 above). Strategic decisions regarding the types and models of integration should be organized around the ideas of desired health outcomes and required inputs.

IDENTIFY DESIRED HEALTH OUTCOMES OF INTEGRATION

Coverage and Access

- Improved availability of services (e.g., one-stop-shop).
- Increased coverage of effective interventions.
- Expanded access of services per client contact.

Acceptability

- Improved client satisfaction.
- More family-centered care.
- Improved retention in care.
- Improved health-seeking behaviors.
- Community engagement.

Responsiveness and Quality

- Increased readiness of services to meet client needs.
- Appropriate follow-up.
- Reduced missed opportunities at high volume contact points.

Efficiency

- Cost savings/improved resource use.
- Reduced duplication of efforts.
- Improved functioning of health system.

Uptake

- Improved uptake of integrated services.
- Improved use of services along the continuum.
- Improved patient care (e.g., ART initiation, EID).

DETAIL REQUIRED INPUTS FOR INTEGRATION

Policy and Governance

- The MOHSW must take on a strong national leadership role in defining and articulating the need and developing the steps for an integrated RCH service package. This includes potential eventual integration across health sections such as RCH and NACP.
- There is a need for high level coordination/cooperation between the MOHSW and other levels of government such as PMORLG.
- There is a need for high level advocacy on budget and human resource requirements for RCH services.
- There is a need for better coordination across different MOHSW departments (such as Quality of Care Unit, Diagnostics, Education Unit, MSD, NACP, Training Unit, HR, HMIS Unit, TFNC).
- There is a need for harmonization and better planning among partner organizations.
- There is a need for harmonization of activities, better information sharing and joint planning between different departments of the RCH services.

Health Systems Functions

- **A basic integrated package of essential RCH services need to be defined and drafted.** Using existing guidelines and protocols across units within RCHS, the MOHSW must develop a set of additional “integrated” guidelines, protocols and job aids. Based on the package, other important elements can be integrated such as curricula, clinical guidelines, job aids, quality standards or supervision tools.
- **Development of training packages and curriculum for integrated service provision is needed.** This is needed for pre-service and in-serve providers. Staff will need to be oriented on an essential package and trained to offer multiple services (e.g., counseling, ART care, FANC, FP, screening using rapid tests, syndromic management, BEmOC, IYCF counseling). Also needed are phased training and refresher courses as well as a strong mentoring system provided by TOTs. Development of an on-site training mechanism for providers is also needed.
- **Personnel and staffing issues must be addressed.** Staff shortages, turnover and geographic distribution must be addressed. Maximizing the use of existing human and physical resources as well as deployment of existing staff should be explored; integrated incentives system may help. Performance-based compensation may be another way of addressing staffing issues. Task-shifting of certain tasks may help in staff issues.
- **Logistic and supply chain system must be developed.** An enabling environment where providers have regular supply of essential drugs and supplies is key to integration. An integrated procurement and supply of essential drugs and commodities for multiple services is necessary. Strategies to curb frequent stock-outs need to be in place.
- **Integrated and simplified monitoring tool for RCH services is necessary.** An integrated record system based on the basic integrated package need to be in place. A simplified and user-friendly version will minimize the record keeping burden and eliminate

the need for separate reporting and evaluation systems. Indicators for tracking integration of RCH services that can be captured within HMIS are also needed.

- **Service quality standards need to be developed based on the basic package.** Providers will need integrated service delivery guidelines and job aid materials for direction on how to offer care. There should also be quality of care committees at districts and facilities that are in the process of integrating RMNCH services. These committees should document gaps, develop action plans and evaluate over time whether integration of services weaken or strengthen existing RCH services at the facilities.
- **Infrastructure needs to be re-organized or rebuilt.** This will allow for the addition of other services and better client flow. It will be important to explore the realistic burden on time and cost of such a process and ensure that the system developed to conduct the supervision is appropriate to the capacity of the individual in that system.
- **Integrated supervision system.** While the individual units within RCHS may remain, there is a need for integrated supportive supervision so that a provider is mentored in multiple areas and topics.

Planning and Management

- Study results of pilots of integrated packages, with documentation of successes and sharing of findings.
- Identify and prioritize a few key areas for integration across existing units (FP, care and outreach to adolescents, PMTCT of HIV).
- Engage in “modeling” exercises with experts to inform the process (e.g., how many providers needs to be in place, level of skills and at which level before integration of RCH services can be considered).
- Analyze the economic and opportunity costs of integrated services for both clients, providers and programs.
- Conduct a needs assessment of facility readiness for delivery of integrated services.
- Demonstrate implementation flexibility. After integration policies and guidelines are in place, there should be room for districts and facilities to decide on the best package for their local area. This will help with ownership of the process, implementing what is possible while thinking of better linkages to other established services.

Demand Creation

- Integrate BCC campaigns.
- Health behaviors should be promoted in combination (e.g., nutrition and FP).
- Barriers to health seeking are addressed in a coordinated and integrated manner.

ANNEX I: SCOPE OF WORK

GLOBAL HEALTH TECHNICAL ASSISTANCE BRIDGE II PROJECT

GH Tech

Contract No. AID-OAA-C-12-00027

I. TITLE:

Assessment of Integration in Reproductive and Child Health Services, Tanzania

Contract: Global Health Technical Assistance Bridge II Project (GH Tech)

II. PERFORMANCE PERIOD:

o/a 6 Sept to 16 Oct (approximately 28 days LOE for international consultant and 19 LOE for local consultant)

III. FUNDING SOURCE:

USAID/Tanzania.

IV. PURPOSE OF ASSIGNMENT

In partnership with the Tanzanian Ministry of Health and Social Welfare (MOHSW), a team composed of an international and a local consultant will lead an assessment to identify opportunities for and conditions necessary to further integrate reproductive and child health services. This assessment will result in the development of a draft framework to enable the Reproductive and Child Health Section (RCHS) of the MOHSW to achieve efficiencies that have a multiplier effect on improving health outcomes of women and children in Tanzania. For USG in Tanzania, the study will help efforts in prioritization of its health programming in country and will promote further integration of maternal newborn and child health (MNCH) and HIV/AIDS services along the guidance provided by the administration's Global Health Initiative.

V. SCOPE OF WORK

The International Consultant together with a Local Consultant will:

- I. Through meetings with key stakeholders and field visits to all levels of the health system (elaborated upon in points 2&3, respectively), the consultants will assess meaningful opportunities for greater integration of reproductive and child health services (RCHS) within the health sector (e.g. FP and HIV). Illustrative questions to map-out the current situation and develop recommendations that would enhance opportunities for integration include, but are not limited to:
 - a) Very brief history of integration efforts, any relevant technical working groups, and up-date of current organization, efforts and materials available
 - b) How a better integrated RCH program might look, what could easily be integrated where? How much effort would it take to develop a minimum essential package of services that would serve as a model for various levels of health facilities?

- c) What structural/infrastructure changes would be necessary within RCH services, (e.g. changes to accommodate needs for audio and visual privacy (including men as well as women, youth / adolescents, and possibly even women who may have been victims of gender based violence) be an issue)?
- d) What is the current flow of services and client flow? How can these be modified/ changed to improve integrated service provision for all clients (see list in c) and consider others such as people with disabilities)?
- e) What human resource changes could be needed to support the types of integration specified i.e. where a lower level provider is in place what new skills would s/he need and what task shifting options should be considered?
- f) What job aids and IEC materials could support this process so that both providers and clients are facilitated in their access to health information?
- g) What policy changes would need to be made so that the RCHS policies are in support of a more integrated approach?
- h) Who can/ should lead this effort?

What comparative leadership advantage would specific institutions under the MOHSW (e.g. Zonal Health Resource Centers or centers of medical education) have versus institutions in other parts of the government (e.g. under the Prime Minister's Office of Regional Authority and Local Government)

- i) What changes would be implied when the National RCH Policy Guidelines and National Essential Health Package of MNCH services will be revised?
 - j) What resources could be leveraged through further integration?
2. Desk review of RCHS service delivery assessments with a focus on understanding opportunities for and the current status of integrated programming.
 3. Meet with key stakeholders to assess integration opportunities. As feasible, stakeholders include, but are not limited to, the following:
 - a) Ministry of Health and Social Welfare (MOHSW)
 - Reproductive and Child Health Section (RCHS)
 - National AIDS Control Program (NACP)
 - Health Education Unit
 - b) USAID/GIZ FP/HIV integration team members
 - c) Medical Stores Department
 - d) USAID Health Officer and Technical Advisors
 - e) Implementing partners (EngenderHealth, Jhpiego, Elizabeth Glazer Pediatric AIDS Foundation (EGPAF), FHI and FHI360's PROGRESS Project, Marie Stopes Tanzania, SAVE, AMREF, World Vision, ICAP.)
 - f) Donors (One United Nations (e.g. UNFPA, WHO), CIDA, DFID)
 - g) Health Center, Dispensary and Hospital staff as approved

- h) Members of District and Regional Health Management Teams (including Reproductive Child Health Coordinators) as well as Zonal RCH Coordinators.
4. Field visits to 1-2 regions to include hospitals, health centers and dispensaries as well as other institutions as needed (e.g., Zonal Health Resource Centers). These should provide a survey of the realities on the ground and how they would be affected (negatively or positively) by integration. Per the above, conversations with key staff and observations should be included in the assessment.

VI. CONSULTANT SELECTION AND LEVEL OF EFFORT (LOE)

Consultant Selection

The Mission will work with GH Tech to identify 2 consultants who have the requisite skill set, knowledge of Tanzanian health systems, and critical relationships to work with key stakeholders in Tanzania.

An international consultant will work with a local consultant who will ensure that the effort is grounded in a firm understanding of the country context.

Level of Effort (LOE)

An illustrative table of the LOE is found below. Dates may be modified based on availability of consultants and key stakeholders, and amount time needed for field work.

Activity	International Consultant	Local Consultant
Review materials relating to MOHSW operations and services as well as other examples of effective integration	1	1
Travel to Tanzania	2	0
In-country meetings	4	4
Field visits to 1-2 regions	5	5
Reviewing/writing/presentation creation	5	3
Debrief with MOHSW, MNCH TWG	1	1
<i>USAID assessment review (5 days)</i>	0	0
Depart Tanzania	2	0
Prepare final report	5	3
Develop draft framework	3	2
Total LOE	28	19

A six-day work week is approved while in Tanzania

VII. LOGISTICS

MOHSW together with USAID/Tanzania will provide overall direction to the consultant.

GH Tech Bridge will provide all logistical arrangements such as flight reservations and tickets, country cable clearance, in-country travel funds, airport pick-up, as appropriate. GH Tech

Bridge will provide transport to field sites (as required), assist in setting up appointments, and arranging lodging as necessary.

VIII. DELIVERABLES AND PRODUCTS

Specific objectives and deliverables are:

- The assessment will result from key stakeholder meetings, research, and field visits. These findings should be presented in the form of a Word Document and should not exceed 30 pages in length (not including appendices). The first draft will be submitted before departing Tanzania. USAID will review this and provide feedback. Consultant will submit a final draft within five days of receiving comments from Mission.
- A draft framework including recommendations for key steps necessary to improve integration of RCH services internally as well as within the Tanzanian Health System based on opportunities and challenges gleaned from the assessment conducted in Tanzania.
- A debrief with MOHSW and USAID with a Power Point presentation and notes around key findings from the in-country work. These will be further elaborated upon in the final assessment document.
- Weekly updates submitted by email to GH Tech Bridge.

IX. RELATIONSHIPS AND RESPONSIBILITIES

GH Tech will recruit and hire the consultant (with input from MOHSW and USAID/Tanzania) and will be responsible for consultant travel logistics as needed.

MOHSW in consultation with USAID/Tanzania will provide overall technical leadership and direction for the consultant throughout the assignment and will provide assistance with the following tasks:

Before In-Country Work

- SOW. Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CVs for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them to GH Tech, preferably in electronic form, at least one week prior to the inception of the assignment.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation)

During In-Country Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the consultant's work.

After In-Country Work

- Timely Reviews. Provide timely review of draft/final report and approval of deliverables.

X. MISSION CONTACT PERSON

Raz Stevenson

USAID/Tanzania

Email: rstevenson@usaid.gov

Phone Number: 255-22-2294490

Mobile: +255 789 788102

XI. COST ESTIMATE

GH Tech will provide a cost estimate for this activity.

ANNEX 2: REFERENCES

- Askew, I. "Achieving Synergies in Prevention through Linking Sexual and Reproductive Health and HIV Services" (paper presented at the International Conference on Actions to Strengthen Linkages Between Sexual and Reproductive Health and HIV/AIDS. Mumbai, India, February 4-8, 2007.
http://www.popcouncil.org/pdfs/frontiers/reports/2007MumbaiProceedings_Askew.pdf
- Bongaarts J, J. Cleland, JW Townsent, et al. *Family Planning Programs for the 21st Century: Rationale and Design* (New York: The Population Council, 2012).
- Catalyst Consortium/TAHSEEN Project. "Integration of Family Planning/Reproductive Health and Maternal and Child Health Services: Missed Opportunities and Challenges." USAID, 2003.
- Church, K. and S. Lewin. "Delivering integrated HIV services: time for a client centered approach to meet the sexual and reproductive health needs of people living with HIV?" *AIDS*. 24 (2010):189–193.
- 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/>
- GHI. Tanzania Global Health Initiative Strategy, 2010-2015.
- Hogan MC, KJ Foreman, M Naghavi, et al. "Maternal Mortality for 181 countries, 1980-2008: A Systematic Analysis of Progress Towards Millennium Development Goal 5," *Lancet*. (2010): 8:375(9726):1609-23.
- IPPF, LSTHM, Population Council. Integra Project. "Strengthening the Evidence Base for Integrating HIV and Sexual and Reproductive Health (SRH) Services." Newsletter 1: March 2012.
- Kigoma. Annual Reproductive and Child Health Report, 2011.
- MOHSW. "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.
- NIMR, FHI, MOHSW. "Rapid Assessment of Sexual and Reproductive Health and HIV Linkages in Tanzania." Dar-es-Salaam, Tanzania, 2010.
- NOGI
- Setel, P. H. Kitange, KGMM Alberti and C. Moshiri. "The Policy Implications of Adult Morbidity and Mortality in Tanzania: From Data Analysis to Health Policy-preliminary Experiences" (paper presented at the Global Forum for Health Research (Forum 2), Geneva, June 25-26, 1998.

- Smit AJ, K. Church, C. Milford, et al. "Key Informant Perspectives on Policy-and Service-level Challenges and Opportunities for Delivering Integrated Sexual and Reproductive Health and HIV Care in South Africa." *BMC Health Serv Res*, (2012):12:48.
- TDHS. "Tanzania Demographic and Health Survey, 2004/05." National Bureau of Statistics, Dar-es-Salaam, Tanzania and ORC Macro, 2005.
- TDHS. "Tanzania Demographic and Health Survey, 2010." National Bureau of Statistics, Dar-es-Salaam, Tanzania and ORC Macro, 2010.
- The Cochrane Collaboration. *Integration of HIV/AIDS Services with Maternal, Neonatal and Child Health, Nutrition, and Family Planning Services* (John Wiley & Sons, Ltd, 2012).
- THMIS. "Tanzania HIV/AIDS and Malaria Indicator Survey 2007/08." National Bureau of Statistics, Dar-es-Salaam, Tanzania and ORC Macro, 2008
- THMIS. "Tanzania HIV/AIDS and Malaria Indicator Survey 2012: Preliminary Report." National Bureau of Statistics, Dar-es-Salaam, Tanzania and ORC Macro, 2012.
- UNAIDS. "Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive: 2011-2015," 2011.
- UNFPA and PATH. "Reducing unmet need for family planning: Evidence based strategies and approaches for addressing," 2008.
- USAID, T-MARK Project. "Knowledge, Perception and Behaviour of Tanzanians towards PMTCT and Available Services in Tanzania," 2010.
- WHO. "Atlas of African Health Statistics 2012: Health Situational Analysis of the African Region." Regional Office for Africa, Brazzaville, Congo, 2012.
- WHO/UNFPA. *Pregnant Adolescents: Delivering on Global Promises of Hope*. (Geneva:WHO/UNFPA, 2006).
- WHO, UNFPA, IPPF, UNAIDS, UCSF. *Linkages: Evidence Review and Recommendations*. (Geneva: UNAIDS, 2008).

ANNEX 3: DEVELOPMENT PARTNERS, IMPLEMENTING PARTNERS AND UN AGENCIES

Name	Number of people interviewed	Place of interview
WHO	2	Dar-es-Salaam
USAID	3	Dar-es-Salaam
CIDA	1	Dar-es-Salaam
GIZ	2	Dar-es-Salaam
JHPEIGO	3	Dar-es-Salaam
ENGENDER HEALTH	3	Dar-es-Salaam and Mwanza
EGPAF	2	Dar-es-Salaam
FHI	1	Dar-es-Salaam
ICAP	2	Kigoma
Marie Stopes	2	Dar-es-Salaam
IHI	3	Dar-es-Salaam

ANNEX 4: HEALTH FACILITIES VISITED

Level	Dar-es-Salaam	Kigoma
Hospitals (N = 3)	Sinza Hospital	<ul style="list-style-type: none"> • Maweni Regional Hospital • Kasulu District Hospital
Health Centers (N = 4)	Kigamboni Health Centre	<ul style="list-style-type: none"> • Bitale Health Centre • Kiganamo Health Centre • Nyakitonto Health Centre
Dispensaries (N = 3)	Tandale Dispensary	<ul style="list-style-type: none"> • Mwandiga Dispensary • Rusimbi Dispensary

ANNEX 5: IN-SERVICE TRAININGS ATTENDED BY RCH STAFF IN THE PAST FIVE YEARS BY REGION AND LEVEL

Level	Dar-es-Salaam	Kigoma
Hospitals (N = 3)	<ul style="list-style-type: none"> • PITC/HIV counseling and testing • Home Based Care (HIV) • CBHC (TB, vaccination, ARV) • PMTCT • Adolescent care • EPI • FP 	<ul style="list-style-type: none"> • ART basic course • ART advanced course • PITC/HIV counseling and testing • PMTCT • Adolescent care • FANC • BEmOC • Cancer screening • Nutrition counseling
Health Centers N = 4)	<ul style="list-style-type: none"> • PITC/HIV counseling and testing • PMTCT • HEID (DBS) • BEmOC • ENC/ NR • FP (1980'S, 2007) 	<ul style="list-style-type: none"> • ART basic course • ART advanced course • PITC/HIV counseling and testing • PMTCT • MRDT (Malaria) • BEmOC • FANC • Infant feeding (trained at refugee camp) • Cancer screening
Dispensaries (N = 3)	<ul style="list-style-type: none"> • PITC/HIV counseling and testing • PMTCT • HEID (DBS) • Pediatric HIV testing • CTC • TB for children • BEmOC • FANC • FP (2007) 	<ul style="list-style-type: none"> • ART basic course • ART advanced course • PITC/HIV counseling and testing • PMTCT • HIV/TB Training • MRDT (Malaria) • BEmOC • FANC • FP (Long time)

ANNEX 6: INTERVIEW GUIDES

RCHS UNIT HEADS

MINISTRY OF HEALTH AND SOCIAL WELFARE

RCHS HEADS of UNIT INTERVIEW GUIDE

RAPID ASSESSMENT FOR INTEGRATION OPPORTUNITIES OF REPRODUCTIVE AND CHILD HEALTH SERVICES

September 2012

IDENTIFICATION		
INSTITUTION		
NAME OF RCHS UNIT		
NAME AND TITLE OF RESPONDENT		
INTERVIEW SUMMARY		
DATE OF INTERVIEW: Day ____ Month ____ Year: _____		____/____/____
DATA QUALITY CONTROL		
TITLE	NAME	CODE
INTERVIEWER		
INTRODUCTION TO THE INTERVIEWEE		
<p>Hello. My name is _____. We are carrying out an assessment on behalf of the Ministry of Health and Social Welfare to identify opportunities and necessary conditions to further integrate reproductive and child health services at the national and health facility level. The results are intended to help to develop a DRAFT framework which will guide the MOHSW in designing and implementing a more efficient/effective set of integrated RCH services. This assessment aims to collect views on integration models currently being implemented in Tanzania, and to elicit opinions from a wide variety of stakeholders on policies, procedures, training needs, supply chain and health facility-based issues/changes which will be needed to achieve the integration of RCH services.</p>		

Q1. Could you please describe the specific services that your Unit within RCHS is responsible for at the national and field level?

Q2. Does the RCHS Department have an overall stated policy on the benefits and advantages of integration of Reproductive, Maternal, Newborn and Child Health Services? Are there any specific policy statements/guidelines for your specific Unit on integration of services with other RCHS Units?

Q3. Do you have examples of how the services from your Unit have been integrated with other RCHS Unit services at regional/district levels? (If Yes, please briefly describe which programs offer services in an integrated manner and where)

Q4. What in your opinion are the steps that need to be taken in order for the process of integration of RCHS services to be realized? (Probe: what needs to be addressed/what conditions need to be met at following levels):

- MOHSW level
- RCHS Department level
- Individual RCHS Unit level
- Facility level
 - Dispensary
 - Health Center
 - Hospital
- Human resources level
- Training level (pre-service, in-service)
- Commodities &supplies
- Physical Infrastructure
- M&E tools and Reporting
- Supportive Supervision

Q5. What, in your opinion, would be the most readily available/exploitable OPPORTUNITIES for better integration of RMNCH services at the facility level in the short/medium term?

Facility based Issues:

- Human resources availability/knowledge/skills
- Infrastructure
- Commodities and supplies
- Data collection and Reporting

Q6. Can you describe the greatest CHALLENGES serving to constrain the strengthening of integration of RMNCH services programs?

Q7. Who do you think would be the most likely agency to lead to effort towards integration?

Q8. Do you think the donor community is ready to support integration of RMNCH services?

WE HAVE COME TO THE END OF THE INTERVIEW. I WOULD LIKE TO THANK YOU FOR YOUR TIME, COOPERATION AND VALUABLE INFORMATION.

DEVELOPMENT PARTNERS ASSESSMENT TOOL

MINISTRY OF HEALTH AND SOCIAL WELFARE

DEVELOPMENT PARTNERS and FIELD BASED NGO INTERVIEW GUIDE

RAPID ASSESSMENT OF OPPORTUNITIES FOR INTEGRATION OF REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD HEALTH SERVICES

September 2012

IDENTIFICATION	
INSTITUTION	
NAME AND TITLE OF RESPONDENT	
INTERVIEW SUMMARY	
DATE OF INTERVIEW: Day ____ Month ____ Year: _____	____/____/____
TITLE	NAME
INTERVIEWER	
INTRODUCTION TO THE INTERVIEWEE	
<p>Hello. My name is _____. We are carrying out an assessment on behalf of the Ministry of Health and Social Welfare to identify opportunities and necessary conditions to further integrate reproductive and child health services at the national and health facility level. The results are intended to help to develop a DRAFT framework which will guide the MOHSW in designing and implementing a more efficient/effective set of integrated RCH services. This assessment aims to collect views on integration models currently being implemented in Tanzania, and to elicit opinions from a wide variety of stakeholders on policies, procedures, training needs, supply chain and health facility-based issues/changes which will be needed to achieve the integration of RCH services.</p>	

Q1. Can you briefly describe reproductive, maternal, newborn and child health programs that your organization is supporting/implementing in Tanzania?

List programs and districts or region where they are implemented

Q2. In what ways are you working in collaboration with the Ministry of Health and Social Welfare? And at which level?

Q3. Is your program supporting an integrated set of RCH services in the region/districts? (If Yes, please describe which programs offer services in an integrated manner and where)

Q4. Has your program developed guidelines or best practices on integrated services?

Q5. Has your program been able to generate data showing improved service quality, better service uptake as a result of integration of services? Can you share this data with our team?

Q6. From your experience, what conditions need to be met in order for the process of integration to be realized? (Probe: what needs to be addressed at MOHSW level, at facility level, policy, training, commodities & supplies, infrastructure, M&E tools and supportive supervision)

Q6a. Despite the challenges, what do you consider to be the opportunities for better integration of RCH services? At central and at facility levels?

Q6b. From your experience of health facilities, which services could be easily integrated first and where?

Q7. Which RCH services are missing at the facilities? Where should they be provided?

Q8. What are some of the policies and procedures in place that serve as the greatest challenges/opportunities for strengthening for integration of RCH services programs including HIV?

Q9. Do you think the donor community is ready to support integration of RCH services? (Probe: Are donors a strength or a stumbling block in the process)

WE HAVE COME TO THE END OF THE INTERVIEW. I WOULD LIKE TO THANK YOU FOR YOUR TIME, COOPERATION AND VALUABLE INFORMATION.

REGIONAL AND DISTRICT RCH COORDINATORS

MINISTRY OF HEALTH AND SOCIAL WELFARE

Regional and District RCHS Coordinator INTERVIEW GUIDE

RAPID ASSESSMENT FOR INTEGRATION OPPORTUNITIES OF REPRODUCTIVE AND CHILD HEALTH SERVICES

September 2012

IDENTIFICATION	
NAME OF DISTRICT/REGIONAL RCHSco	
NAME OF RESPONDENT	
TITLE OF RESPONDENT	
REGIONAL AND DISTRICT NAME	
DATE OF INTERVIEW: Day ____ Month ____ Year: _____	____ / ____ / ____
INTERVIEWER	
TITLE	NAME
INTRODUCTION TO THE INTERVIEWEE	
<p>Hello. My name is _____. We are carrying out an assessment on behalf of the Ministry of Health and Social Welfare to identify opportunities and necessary conditions to further integrate reproductive and child health services at the national and health facility level. The results are intended to help to develop a DRAFT framework which will guide the MOHSW in designing and implementing a more efficient/effective set of integrated RCH services. This assessment aims to collect views on integration models currently being implemented in Tanzania, and to elicit opinions from a wide variety of stakeholders on policies, procedures, training needs, supply chain and health facility-based issues/changes which will be needed to achieve the integration of RCH services</p>	

Q1. Can you please tell me what RCH services are provided at the Regional/District level? (Are they available at each level of care?)

Q2. Does the RCHS Department at the regional/district level have any specific policy statements/guidelines on the benefits and advantages of integration of Reproductive and Child Health Services?

Q3. We understand that in some of the places in the country, there are examples of integration of RCH services, such as FP and HIV counseling and testing. In this district, do you have any similar examples? (If Yes, please briefly describe which services are integrated, who was the responsible partner and which tools/guidelines did they use?)

Q4. In your opinion, do you think that integration of some of the RCH services will be beneficial for improving the quality of services for women and children?

Q5. What services do you think could be most easily integrated and at what level? (dispensary, health center, hospital)

Q6. In your opinion, what would be the OPPORTUNITIES for better integration of RCH services at the facility level in the short/medium term?

- Human resources (PROBE: task shifting, new skills, in-service training)
- Infrastructure (PROBE: shared space, increased privacy/confidentiality, integrated service delivery points)
- Commodities and supplies (PROBE: more IEC materials available, better drug availability, equipment)
- Data collection and Reporting (PROBE: integration of data collection tools)
- Supervision (PROBE: combined supervisory visits)

Q7. Can you describe the greatest CHALLENGES for the integration of RCH services?

WE HAVE COME TO THE END OF THE INTERVIEW. I WOULD LIKE TO THANK YOU FOR YOUR TIME, COOPERATION AND VALUABLE INFORMATION.

SERVICE PROVIDERS

MINISTRY OF HEALTH AND SOCIAL WELFARE

SERVICE PROVIDERS INTERVIEW GUIDE

RAPID ASSESSMENT OF OPPORTUNITIES FOR INTEGRATION OF REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD HEALTH SERVICES

September 2012

IDENTIFICATION	
ITEM	CODE
REGION	
DISTRICT	
HEALTH FACILITY	
TYPE OF FACILITY: 1=Hospital, 2=Health Centre, 3=Dispensary	
FACILITY OWNERSHIP: 1=Government, 2=Faith Based, 3=Private, 4=NGO	
FACILITY LOCATION: 1=Urban/Peri Urban, 2=Rural	
INTERVIEW SUMMARY	
DATE OF INTERVIEW: Day ____ Month ____ Year: _____ Interviewer Name: _____	
INTRODUCTION TO THE INTERVIEWEE	
<p>Hello. My name is _____. We are carrying out an assessment on behalf of the Ministry of Health and Social Welfare to identify opportunities and necessary conditions to further integrate reproductive and child health services at the national and health facility level. The results are intended to help to develop a DRAFT framework which will guide the MOHSW in designing and implementing a more efficient/effective set of integrated RCH services. This assessment aims to collect views on integration models currently being implemented in Tanzania, and to elicit opinions from a wide variety of stakeholders on policies, procedures, training needs, supply chain and health facility-based issues/changes which will be needed to achieve the integration of RCH services.</p>	
Cadre of respondent <i>Please circle</i>	1=Specialist, MD, AMO, CO 2=Nursing Officer, Asst. Nursing Officer, Enrolled Nurse 3=Public Health Nurse 4=MCHA 5=Other (specify)
For how many years have you been working as a health care provider?	
For how many years have you been working at this health facility?	

SECTION 2: MNCH & REPRODUCTIVE HEALTH SERVICES		
Core Service	Which of the following essential MNCH & reproductive health services are provided at this facility?	Among the services mentioned, which ones have you offered yourself in the past 3 months?
<ol style="list-style-type: none"> 1. Focused Antenatal Care 2. Delivery Care (normal) 3. Delivery Care (BEmOC or CEmOC) 4. Essential Newborn Care 5. Postpartum Care 6. Growth Monitoring of the children 7. Immunization of the children/ women 8. Family planning 9. STI management & prevention 10. PMTCT Care 11. HIV counseling and testing (VCT) 12. Care for Abortion Complications (CPAC) 13. Cervical and Breast cancer screening 14. Nutrition care- assessment & counseling 15. Care of the sick child (IMCI) 16. Adolescent health care 17. Prevention and management of gender based violence 18. Others (specify) 		
<p>Have you attended any course in MNCH & RH care in the past 3-5 years?</p> <p><i>List the courses attended</i></p>		

When a woman comes for the following; which services are routinely given/offered in this facility? <i>Circle all the services offered</i>						
Core Service	Services expected to be offered by guidelines (Expected)	Services offered on the ground (Actual, fill in this column)	Availability of Drugs, Supplies and Equipment	Availability of Staff	What RCH Core services need to be strengthened and what services need to be added for a more integrated package?	Needed Resources (Job aids? Guidelines? Additional Staff? Task Shifting? New Skills? Drugs and supplies? Space? Privacy? Time?)
ANC	<ol style="list-style-type: none"> 1. Weighed & height 2. History & Pregnancy Monitoring 3. Screening for blood pressure, diabetes, anemia, STI/RTIs symptoms 4. Laboratory screening for HIV, Syphilis, Hemoglobin and urine for protein/sugar 5. IPT with SP for Malaria (DOT) 6. De-worming (mebendazole) 7. Immunization - TT 8. Counseling on Danger signs, Birth Preparedness, Maternal Nutrition, Family Planning, Exclusive Breast Feeding 9. PITC-Group Counseling for HIV testing 10. PMTCT Services 11. Issuing voucher for ITNs 12. HIV/AIDS Care & Treatment Services (Refer to clinician for ARV) 13. STI Management- RPR positive, refer to clinician 14. Counseling and support to women with disabilities 15. Follow up appointment 		<ol style="list-style-type: none"> 1. Ferrous supplementation 2. Folic acid tablet supplementation? 3. HIV kits for HIV testing 4. Syphilis kits for screening at ANC 5. Haemoque for checking Hb 6. Dipstick for urine tests (protein, albumin, sugar) 7. Tetanus vaccination 8. SP for malaria prophylaxis 9. IEC materials on various health topics 10. ANC cards 		<p>PROBE for examples of Integrated Service:</p> <p>ANC services + HIV testing/ counseling+ ARV treatment + STI testing/treatment + TT + cancer screening + health information sessions and IEC materials on birth preparedness, danger signs in pregnancy, maternal nutrition, post partum family planning, exclusive breast feeding</p>	

When a woman comes for the following; which services are routinely given/offered in this facility? <i>Circle all the services offered</i>						
Growth Monitoring and Immunization	<ol style="list-style-type: none"> 1. Immunization 2. Assessment of nutritional status 3. Assessment of Child wellbeing and referral 4. Family planning counseling for mothers 5. PITC 6. Early infant diagnosis of HIV/AIDS 7. Infant & young child feeding counseling 8. Issuing vouchers for ITNs 9. Issuing Vitamin A and Mebendazole 		<ol style="list-style-type: none"> 1. Weighing Machine 2. Vaccines 3. Growth Monitoring Cards 4. HIV Kits 		PROBE For Examples of integrated package: Growth Monitoring + immunization+ Family Planning services+ PMTCT services+PITC+ Counseling on Exclusive Breast feeding+ Referral for Cancer screening	
FP/STI	<ol style="list-style-type: none"> 1. Counseling about family planning methods & Dual Protection 2. Family Planning Services (pills, injections, IUCD, Implants, condoms) 3. Screening/Treatment for STIs 4. PITC for HIV 5. Screening for Chronic Diseases 		<ol style="list-style-type: none"> 1. Pills 2. Injectable 3. Condom 4. Implants 5. IUCD 6. HIV Kits 7. Drugs for Treating STIs 8. IEC Materials 		PROBE For Examples of integrated package: Family Planning+ STI Treatment + Breast and Cervical Cancer screening and treatment + PITCand ARV Treatment, IEC Materials (immunization, nutrition)	
Delivery (BEmOC)	<ol style="list-style-type: none"> 1. Monitoring labor (partograph) 2. PITC 3. PMTCT services 4. Prevention & Management of PPH (Uterotonic drugs) 5. Manual Removal of Placenta/MVA 6. Assisted vaginal delivery 		<ol style="list-style-type: none"> 1. Parto-graph 2. Oxytocin 3. Misoprostol 4. Mag Sulphate 5. Broad spectrum 6. Antibiotics 7. IV fluids (NS/RL) 8. Protocols or guidelines on walls? 		PROBE For Examples of integrated package: BEmONC + PITC + PMTCT/treatment	

When a woman comes for the following; which services are routinely given/offered in this facility? <i>Circle all the services offered</i>						
	<ul style="list-style-type: none"> 7. Neonatal Resuscitation 8. Essential Newborn care 9. Referring complications 10. Infant feeding counseling 		<ul style="list-style-type: none"> 9. New born resuscitation (ambu bags and mask) 10. MVA kits 11. Vacuum Extractor 			
PNC (24hrs, 7 days, 28, 42)	<ul style="list-style-type: none"> 1. Care of the woman: lochia, uterus involution, BP, Temp, mental health 2. Essential Newborn Care services 3. Counseling on danger signs for mother/baby 4. Counseling on Infant Feeding [EBF] & Maternal Nutrition 5. Family Planning counseling 6. Family Planning Services 7. Early infant diagnosis of HIV/AIDS 8. PMTCT services 9. Cervical cancer screening 10. Birth registration 11. Ferrous Sulphate, folic 12. Vitamin A 13. Special counseling and support to mothers with disabilities 14. Follow up appointment 		<ul style="list-style-type: none"> 1. Room for offering care 2. FP commodities 3. IEC Materials 4. HIV Test Kits 		<p>PROBE For Examples of integrated package: Postpartum Family Planning + PMTCT + Counseling on infant feeding + STI/sepsis screening and treatment</p>	
PAC	<ul style="list-style-type: none"> 1. Post abortion care (MVA or misoprostol) 2. Post Abortion Family Planning and Counseling 3. Screen for STI symptoms and treat (refer for treatment) 4. Treatment or prevention of infection 		<ul style="list-style-type: none"> 1. MVA 2. Family Planning 3. STI Kits 		<p>PROBE For Examples of integrated package: Family Planning services + STI Screening and treatment+ PITC</p>	

When a woman comes for the following; which services are routinely given/offered in this facility? <i>Circle all the services offered</i>						
Cervical cancer screening	<ol style="list-style-type: none"> 1. Examination and visual inspection with acetic acid 2. Cryotherapy 3. Refer to district hospital for LEEP for those with problems 		<ol style="list-style-type: none"> 1. Acetic Acid 2. Cryotherapy Guidelines 		PROBE For Examples of integrated package: <ol style="list-style-type: none"> 1. Screen and treat for STIs/RTIs 2. Offer FP counseling and methods 3. PITC for HIV 	
Care of the sick child (IMCI)	<ol style="list-style-type: none"> 1. Management of Childhood Illness (IMCI Case management) 2. Nutrition and immunization assessment 3. PITC 4. Refer to FP room for IUCD & Implants, surgical contraception. 5. Refer to higher level 		<ol style="list-style-type: none"> 1. Antibiotics 2. ORS 3. Malaria Rapid diagnostic 4. ARV treatment for HIV+ children 		PROBE For Examples of integrated package: <ol style="list-style-type: none"> 1. Family Planning services for Mother 2. Care & Treatment for HIV positive children 3. Link to Immunization and Growth Monitoring 	

<p>The MOHSW is considering on further integration of services offered in RCH services.</p> <p>(definition: multiple services provided by one provider at one client visit) In your opinion which challenges should be addressed before doing integration of services?</p>	
<p>In your opinion which MNCH & RH services can be easily integrated and why?</p>	
<p>Which additional MNCH & RH would you like to see being offered at this facility?</p>	
<p>What do you think may be some of the benefits of a client receiving all multiple services from the same facility or unit and same provider at one time?</p>	
<p>What do you think may be some of the possible disadvantages of the above model?</p>	

RCH CLIENTS

MINISTRY OF HEALTH AND SOCIAL WELFARE

CLIENT EXIT INTERVIEW

ASSESSMENT OF OPPORTUNITIES FOR INTEGRATION OF REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD HEALTH SERVICES

IDENTIFICATION
NAME OF THE HEALTH FACILITY:
DISTRICT:
REGION:
TYPE OF FACILITY: 1=Hospital 2=Health Centre 3=Dispensary
FACILITY OWNERSHIP: 1=Government 2=Faith Based 3=Private 4=NGO
FACILITY LOCATION: 1=Urban 2= Peri Urban 3=Rural
INTERVIEW SUMMARY
DATE OF INTERVIEW: Day _____ Month _____ Year: _____ Name of the person collecting the data: _____
INTRODUCTION TO THE INTERVIEWEE
<p>Hello. My name is _____. We are carrying out an assessment on behalf of the Ministry of Health and Social Welfare. The MOHSW wants to have ideas from clients who are using health facilities on how to improve integration of reproductive and child health services in general. The MOHSW wants a client to get multiple services, by one provider, in a single visit, when they come for services. Your views and advice are therefore very important and we will appreciate your participation.</p> <p>The information we collect is strictly confidential. If I ask you any question you don't want to answer, just let me know and I will go on to the next question or you can stop the interview at any time.</p> <p>Do you have any questions?</p> <p>May I begin the interview now?</p> <p><i>Habari. Jina langu ni _____. Tunatafanya utafiti kwa niaba ya Wizara ya Afya na Ustawi wa Jamii. Wizara inataka kupata maoni toka kwa wananchi hasa wale wanaotumia vituo vya afya ni nini wafanye na kwa jinsi gani ili kuwezakuwawezesha wahudumu wa afya waweze kutoa huduma zenye ubora na huduma nyingi(tofauti) na kwa wakati mmoja pale mteja wahuduma za afya ya uzazi, mama na mtoto anapohudhuria. Maoniyakonaushaurikamamdauwaafyakuhusuchangamotonaninikifanyikenimuhimunatutashukurukamautashi riki.</i></p> <p><i>Taaarifa/maelezo tutakayoyopata toka kwako ni siri. Iwapo nitakuuliza swali ambalo hutaki kujibu, naomba unieleze niendelee na maswali mengine. Unaweza kusimamisha usahili huu saa yoyote unayotaka. Kushiriki kwako ni hiari.</i></p> <p><i>Je una swali lolote unalotaka kuniuliza?</i></p> <p><i>Je ninaweza kuanza dodoso?</i></p>

SECTION 1: Background			
Q	QUESTIONS AND FILTERS	CATEGORY CODES	
100	Sex of respondent/ <i>jinsia</i>	1 = Female 2 = Male	
101	Age of respondent <i>Umrikwamiaka</i>		
103	Education Level of Client <i>Kiwango cha elimu</i>	1= No Education 2= Primary 3= Secondary 4=University 5=Other (specify)	
104	Parity <i>Namba ya watoto</i>		
105	Is this your first visit to this facility? <i>Je hii ni mara yako ya kwanza kupata huduma katika hiki kituo?</i>	1 = Yes 2 = No	
106	For how many years have you been coming to this health facility for services? <i>Je ni kwa miaka mingapi umekuwa ukipata huduma za afya katika kituo hiki?</i>		
SECTION 2: Reproductive, Maternal, Newborn & Child Health Services			
Q	QUESTIONS AND FILTERS	CATEGORY CODES	GO TO
201	What services did you come for today? (<i>Circle all the services that apply</i>) <i>Leo umekuja kliniki ili kupata huduma ipi/zipi?</i>	1. Antenatal Care 2. Delivery Care 3. Postpartum Care 4. Growth Monitoring of the child 5. Immunization of the Child 6. Family planning 7. STI management & prevention 8. PMTCT Care 9. HIV counseling and testing (VCT) 10. HIV Care & Treatment Clinic 11. Care of Abortion Complications (CPAC) 12. Care of pregnancy with complications 13. Care of Postpartum complications 14. Care of the sick child 15. Cervical and breast cancer screening 16. Prevention and management of gender based violence Others (specify)	

202	<p>What services did you receive today (exclude those provided outside the facility by referral)</p> <p><i>Je umepata huduma zipi katika kliniki hii leo?</i></p>	<ol style="list-style-type: none"> 1. Antenatal Care 2. Delivery Care 3. Postpartum Care 4. Growth Monitoring of the child 5. Immunization of the Child 6. Family planning 7. STI management & prevention 8. Screened for Syphilis, Hemoglobin, Urine in the laboratory 9. PMTCT Care 10. HIV counseling and testing (VCT) 11. HIV Care & Treatment Clinic 12. Care of Abortion Complications (CPAC) 13. Care of pregnancy with complications 14. Care of Postpartum complications 15. Care of the sick child 16. Cervical and breast cancer screening 17. Prevention and management of gender based violence 18. Counseling in (<i>mention topics</i>) 19. HE (<i>mention topi</i>) 20. IEC materials to take home (<i>Topics</i>) <p>Others (specify)</p>
203	<p>Were you given other services other than those for which you came for?</p> <p><i>Umepata huduma nyingine zaidi ya hiyo/hizo ulizokuwa unahitaji kwa leo?</i></p>	<p>1 = Yes 2 = No</p> <p>List other services given</p>
204	<p>Were you referred to other departments/ outside the facility for services which you came for?(List the services she was referred for)</p> <p><i>Je imekubidi kwenda nje ya kituo au kwenye idara nyingine nje ya RCH ili kupata huduma?</i></p>	<p>1 = Yes 2 = No</p>
205	<p>Did you get all services you wanted today? <i>Je umepata huduma zote ulizokuwa unahitaji leo?</i></p>	<p>1 = Yes 2 = No</p>
206	<p>What other services would you have liked from this facility today, but were not offered? Please list</p> <p><i>Je ni huduma gani za ziada ambazo ungependa upate katika kituo hiki lakini hazipo kwa sasa?</i></p>	
207	<p>Apart from services, were you given counseling? If Yes, about what? List all the topics received counseling on</p> <p><i>Je zaidi ya huduma, umepewa ushauri kuhusu mada yoyote? Ipi?</i></p>	<p>1 = Yes 2 = No</p>

208	<p>Were you given any IEC (<i>vipeperushi</i>) materials to take home? If Yes in which subject matter? Please list <i>Je umepewa vipeperushi ili kwenda kujisomea nyumbani? Katika mada gani?</i></p>	<p>1 = Yes 2 = No</p>
209	<p>Which MNCH & RH services will you like to be offered in an integrated manner/ in a package (multiple services offered by one provider, in one place and on the same day when you come to the clinic) <i>Je ni huduma zipi ambazo ungependa zitolewe kwa pamoja (m hudumu mmoja ato huduma zaidi ya moja katika sehemu moja)</i></p>	
209 b	<p>Probe in detail which services she wanted integrated with examples from a client and reasons for that particular choice <i>Dodosa kwa undani na akupe mifano. Vile vile chunguza sababu za chaguo lake</i></p>	
210	<p>What major challenges need to be addressed in this facility before integration of services can be realized? <i>Je ni changamoto zipi zinazohitaji kutafutiwa ufumbuzi kabla wizara haijaanza kutoa huduma mchanganyiko?</i></p>	
210	<p>Which of the MNCH & RH services will you like to continue to be offered in the same manner and why? <i>Je ni huduma gani za uzazi, mama na mtoto ungependa ziendelee kutolewa bila kuchanganywa? Sababu?</i></p>	
211	<p>Do you have any suggestions about the integration of MNCH & RH services? <i>Je ni nini maoni yako au ushauri kuhusu mfumo wa uchanganyaji huduma tuliokuwa tunaujadili?</i></p>	
212	<p>Do you think there will be benefits of receiving RCH services in integrated manner? Which ones? <i>Je unadhani kutakuwa na faida iwapo huduma zitolewa kwa pamoja/mchanganyiko? Ni zipi?</i></p>	

213	<p>Do you think there will be disadvantages when RCH services are integrated? Which ones?</p> <p><i>Je unadhani kutakuwa na hasara/shida iwapo huduma zitachanganywa na kutolewa kwa pamoja? Zitaje tafadhali</i></p>	
<p>WE HAVE COME TO THE END OF THE INTERVIEW. I WOULD LIKE TO THANK YOU FOR YOUR TIME, COOPERATION AND VALUABLE INFORMATION.</p>		
	<p>TIME INTERVIEW ENDED</p>	

HEALTH FACILITIES ASSESSMENT TOOL

MINISTRY OF HEALTH AND SOCIAL WELFARE

Assessment Tool for Health Facilities

ASSESSMENT OF OPPORTUNITIES FOR INTEGRATION OF REPRODUCTIVE AND CHILD HEALTH SERVICES

IDENTIFICATION	
Health Facility Name:	
District:	
Region:	
Type of Health Facility: 1=Hospital, 2=Health Centre, 3=Dispensary	
Facility Ownership: 1=Government, 2=Faith Based, 3=Private, 4=NGO	
Facility Location: 1=Urban 2= Peri Urban, 3=Rural	
INTRODUCTION	
<p>Hello. My name is _____. We are carrying out an assessment on behalf of the Ministry of Health and Social Welfare to identify opportunities and necessary conditions to further integrate reproductive and child health services at the national and health facility level. The results are intended to help to develop a DRAFT framework which will guide the MOHSW in designing and implementing a more efficient/effective set of integrated RCH services. This assessment aims to collect views on integration models currently being implemented in Tanzania, and to elicit opinions from a wide variety of stakeholders on policies, procedures, training needs, supply chain and health facility-based issues/changes which will be needed to achieve the integration of RCH services.</p> <p>Thank you.</p> <p>Do I have consent to continue with these questions? Yes / No</p> <p>Date.....</p> <p>Name of interviewer.....</p> <p>Name of interviewee(s)..... Designation.....</p>	

A. Availability of Human Resource and Their Skills in the MNCH & RH Services				
Staffing		Indicate no. of staff available for RCH/Maternity Care		
What staff are available in the health facility to offer MNCH & RH Services?			For hospital specific department	
No.	Cadre	Total ()	Maternity	Other RCH Units
1.	Registered Nurse Midwives			
2.	Enrolled Nurse			
3.	Public Health Nurse			
4.	Nurse Assistants			
5.	MCHA			
6.	Clinical Officers (Cos)			
7.	Assistant Medical Officer (AMOs)			
8.	Medical Officer (MDs)			
9.	Obstetricians			
10.	Medical attendants			
11.	Others			
	TOTAL (no. offer RH & MNCH Service)			

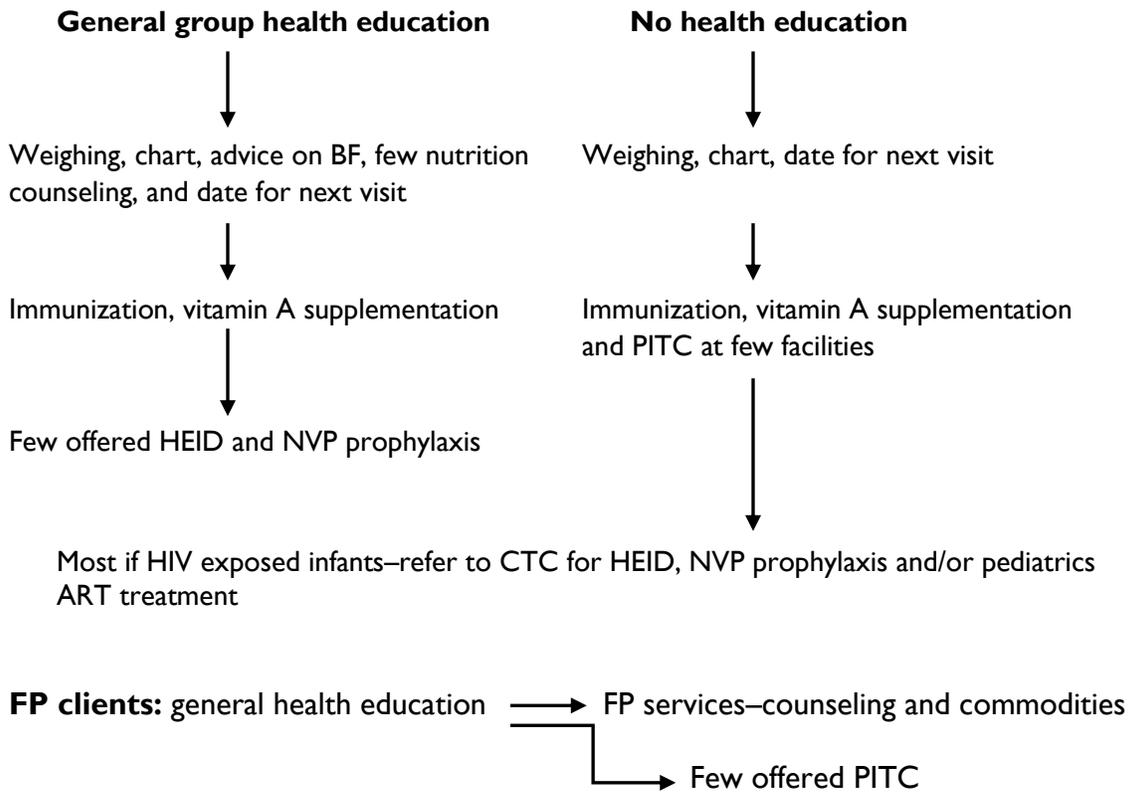
B. Services provided at the facility	Tick if any staff trained in the indicated field		
	Available (Yes/No)	Available staff trained (Yes/No)	Cadre providing the service
1. Focused antenatal care (FANC)			
2. Immunization			
3. Lifesaving skill in EmOC&NC			
4. Post abortion care including MVA (PAC)			
5. Postpartum Care			
6. Essential Newborn Care			
7. Kangaroo mother care (KMC)			
8. Family planning			
9. VCT for HIV/PITC			
10. PMTCT			
11. Infant and Young Child feeding counseling			
12. Exclusive Breast Feeding counseling and support			
13. Syndromic Management of STIs/RTIs			
14. Cancer of the cervix screening and management			
15. Nutrition assessment and counseling			
16. HIV Care and Treatment			
17. Adolescent care			
18. IMCI			
19. Infection Prevention Control (IPC)			
20. Lab services and Pharmacy			
21. Other (specify)			

C. Number of clients received care at MNCH & RH services in past 3 months				
Service	Number of clients			
	June	July	August	Total ()
Deliveries				
KMC				
ANC				
Postpartum care 24 hours				
Postpartum care 7 days				
Vaccination (Infants) [OPV, BCG, Penta, Measles]				
Growth monitoring				
Family planning				
PMTCT				
PITC				
Cancer of the cervix screening				

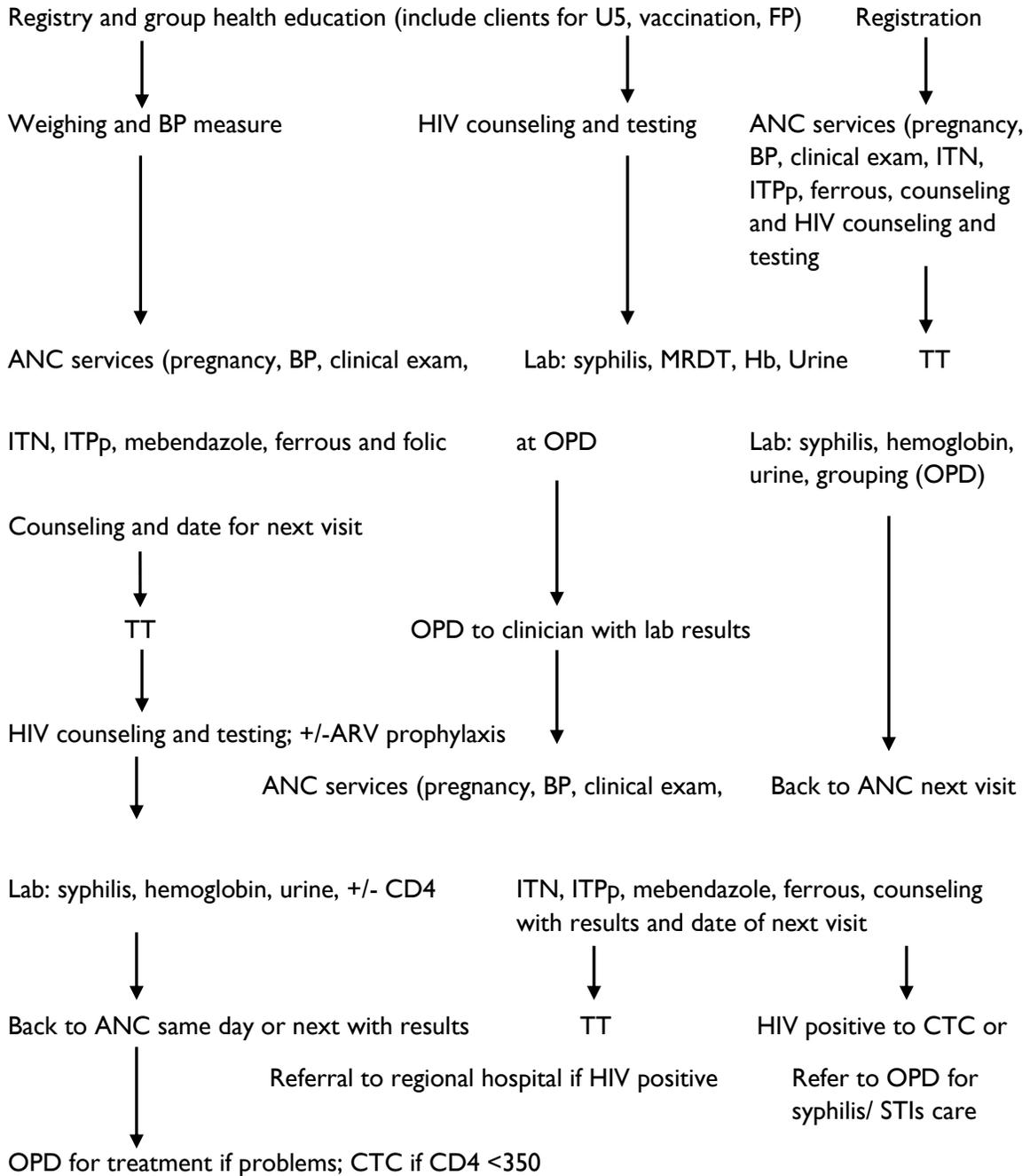
D. Availability of Drugs, Supplies and Equipment				
	ANC Card (MCH 4)	Availabl		Comments
		(Yes/No		
ANC	Ferrous supplementation			
	Folic acid tablet supplementation?			
	HIV kits for testing at ANC			
	Syphilis kits for screening at ANC			
	Hemocue for checking Hb			
	Dipstick for urine tests			
	Tetanus vaccination			
	SP for malaria prophylaxis			
	Condoms for HIV/STI prevention			
	Drugs for PMTCT prophylaxis			
	Drugs for ART treatment			
	IEC materials			
	Delivery	Parto-graph being used?		
Oxytocin available				
Misoprostol				
Magnesium sulphate				
Broad spectrum antibiotics				
IV fluids (NS or RL)				
New born resuscitation (ambu bag and mask)				
Drugs for PMTCT prophylaxis				
KMC (postpartum room)				
PAC	Protocols/ Job aids			
	MVA kits			
PNC	Misoprostol			
	Room for offering care			
	FP commodities			
FP	IEC Materials			
	Room for offering care			
	Pills, Depo-Provera, Condoms			
	Implants			
	IUCD			
	IEC Materials			
	HIV Kits			
Immunization and Growth Monitoring	Room for advice or counseling			
	Growth monitoring cards (MCH 1)			
	Vaccines			
	Weighing machine			
	Vitamin A			
	HIV kits for PITC			

ANNEX 7: EXAMPLES OF CLIENT FLOW PATTERNS FOR ANC, FP AND IMMUNIZATION SERVICES OBSERVED AT FACILITIES

Figure 1: Client Flow Patterns for Baby-well Clinics



ANC clients:



For more information, please visit
<http://www.ghtechproject.com/resources>

GH Tech Bridge II Project
1725 Eye Street NW, Suite 300
Washington, DC 20006
Phone: (202) 349-3900
Fax: (202) 349-3915
www.ghtechproject.com