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MCH PROGRAM DESCRIPTION

Tanzania



Overall MCH and health sector situation

Tanzania has a population of about 40 million people; 88 percent are poor and live in rural areas. The country was ranked 159 out of 177 countries in the 2005 United Nations Human Development Index. Tanzania embarked on a fundamental political and economic transformation in the early 1990s and now sustains annual economic growth rates that are among the highest in sub-Saharan Africa. Life expectancy was 65 in 1990 and is now 44, and is expected to drop to 37 by 2010, largely due to a 7 percent HIV/AIDS infection rate and endemic malaria. On the Tanzania mainland and on Zanzibar, the MMR has remained high for the last 10 years without any decline (578 per 100,000 live births). Although infant and child mortality have been reduced by an impressive 31 percent and 24 percent, respectively, in just 5 years, neonatal mortality remains high (32 per 1,000 live births) and accounts for 47 percent of the IMR. The TFR is 5.7.

Over the past year and a half, the Ministry of Health and Social Welfare (MOHSW), the president of Tanzania, and the donor community have performed a great deal of advocacy and policy efforts both nationally and internationally to accelerate achievement of the MDGs for reducing maternal, newborn, and child deaths in Tanzania. As a result, two key strategies are in place: Tanzania Vision 2025, the National Strategy for Growth and Reduction of Poverty (NSGRP-MKUKUTA), and the Primary Health Services Development Program (PHSDP-MMAM) (2007–2017) to ensure fair, equitable, and quality services at the community level. Also, the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn, and Child Death in Tanzania (2008–2015) was developed and outlines a strategic framework with activities and numerical goals for maternal, newborn, and child health “to improve coordination of interventions and delivery of services” with the following objectives:

- To reduce MMR from 578 to 193 per 100,000 live births
- To reduce neonatal mortality from 32 to 19 per 1,000 live births

The Government of Tanzania is decentralizing the health sector by delegating planning, budgeting, and implementation to districts. An essential package of health interventions is funded by both the government and donors by a sectorwide approach, including government agencies, the donor partner group for health (USG is an active member), and civil society. Most donors have switched modalities to basket funding or general budget support, leaving USG as the major bilateral donor of projects.

MCH interventions at the Mission level

The range of interventions currently supported by the Mission include FANC, IMCI, vitamin A supplementation, malaria control, zinc and ORT for diarrhea treatment, and family planning. All of these programs – with the exception of in-service training through zonal training centers, which cover half the country – provide national coverage or are in the process of being scaled up to national coverage. The biggest impacts on reducing maternal and child mortality are being provided by the family planning and malaria programs, as malaria is the largest killer of children in Tanzania.

As a new MCH priority country, the Mission is preparing a new 5-year strategy to introduce components of basic emergency obstetric care and immediate newborn care in health centers and dispensaries. Potential activities are 1) advocacy for national policies supportive of emergency obstetric care at lower-level facilities; 2) integrated immediate newborn care and safe birth practices in preservice and in-service training programs; and 3) logistical support for equipment and supplies for maternity services. The Mission's water supply and sanitation programs will expand and build on activities previously achieved under the Water and Development Alliance (USAID and Coca-Cola Foundation GDA) by expanding safe water access and basic sanitation services for schools and health facilities.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

The Mission focuses on training and supporting supervision of the decentralized health systems at the district (hospital) level for FANC and subdistrict levels (health centers and health posts) for all other activities. For capacity building and sustainability, the Mission works with zonal training centers and also upgrades midwifery preservice training. The Mission's public-private partnerships include social marketing for contraceptives, zinc and ORS, and ITNs. Additional planned activities include community outreach through support to a national community-based primary health care program.

Specific actions supported as part of the MCH approach

The MOHSW decentralized health system is being strengthened in areas of planning, budgeting, supervision and monitoring. The Mission supported the development of a quality improvement system for FANC that will be adapted for other areas. The Norwegian government has been providing support to the MOHSW to adopt an incentive-based scheme to improve performance of providers in support of attaining the MDGs for maternal and child survival. This system is in an early stage of development.

The USAID program's geographic focus

The FANC program is being scaled up nationwide in a phased approach. Most of the regions and districts have been covered. Other child survival activities have also been supported at the national level. Direct support to three zonal training centers covers half the country for training of health care providers in MCH, FP/RH, and malaria.

The Mission program's relationship to the country's health sector and development plans and strategies

The Mission supports the MOHSW health sector strategies listed above.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

The FANC program is co-funded with malaria funds as it addresses malaria in pregnancy. The leveraging of PMI monies to support a national program in FANC is synergistic as two of the main PMI interventions – ITNs and IPTp – can be successfully promoted through a strong antenatal care program.

The new maternal and child health activity is being designed with and will receive support from the PEPFAR program as well as PMI. The Mission will harness synergies of funds in maternal and newborn survival especially through PMTCT and postnatal care-type interventions that could cross the continuum of maternal and newborn vulnerabilities through postnatal life.

Investments and initiatives of other donors and international organizations

Other donor-funded projects include UNICEF and Canadian support for vitamin A; Danish support for health logistics; Japanese support for systems development; Dutch and German support for contraceptive social marketing; and Norwegian support for health workers via pay for performance. Other donors support health basket funding that is leveraged by the Mission's interventions.

Planned results for the Mission's MCH investments over the next 5 years

Within the next 5 years, results will include reduction of MMR (currently 578/100,000) by 10 percent and U5MR (currently 112/1,000) by 25 percent, and increase in contraceptive prevalence (currently 20 percent) by 1 percent per year.

MCH COUNTRY SUMMARY: TANZANIA	VALUE
MCH FY08 BUDGET	5,693,000 USD
Country Impact Measures	
Number of births annually*	1,418,000
Number of under-5 deaths annually	159,000
Neonatal mortality rate (per 1,000 live births)	32
Infant mortality rate (per 1,000 live births)	68
Under-5 mortality rate (per 1,000 live births)	112
Maternal mortality ratio (per 100,000 live births)	578
Percent of children underweight (moderate/severe)	22%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	97%
Percent of women with at least four antenatal care (ANC) visits	59%
Percent of women with a skilled attendant at birth	46%
Percent of women receiving postpartum visit within 3 days of birth***	13%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	25%
Immunization	
Percent of children fully immunized at 1 year of age	62%
Percent of DPT3 coverage	86%
Percent of measles coverage	80%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	61%
Percent of children receiving adequate age-appropriate feeding	91%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months****	92%
Percent of children under 6 months exclusively breastfed	41%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	70%
Percent of children with diarrhea treated with zinc	0%
Percent of children with pneumonia taken to appropriate care	57%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	55%
Percent of population with access to improved sanitation**	33%
<p>* Census International Database ** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report *** This number is based only on mothers whose last live birth occurred outside a health facility in the 5 years preceding the survey. **** TNFC/HKI database on vitamin A coverage in mainland Tanzania, updated March 2008 (Unless otherwise noted, the data source is the 2004 Demographic and Health Survey.)</p>	