



**A REPORT ON THE STATUS OF INTEGRATION
OF MATERNAL, NEWBORN AND CHILD HEALTH
(MNCH) INTO AIDS, TUBERCULOSIS AND
MALARIA (ATM) IN TANZANIA,**

Policies, Strategies and Financing

Dar es Salaam
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This Report of MNCH/ATM integration has been prepared by:

Human Development Trust
P O BOX 65147
Dar es Salaam
Tanzania
Email: *info@hdt.or.tz*

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Table of Contents

ABBREVIATIONS AND ACRONYMS	III
LIST OF TABLES	IV
LIST OF FIGURES	IV
GLOSSARY	V
ACKNOWLEDGEMENT	VI
EXECUTIVE SUMMARY	VII
A: Introduction	1
B: Goal and Objectives of the Assessment	4
CHAPTER 1: MNCH POLICIES, STRATEGIES AND INTERVENTIONS	5
1.1. MNCH in Policies and Strategies	5
1.2. MNCH integration at Policy level:	12
CHAPTER 2: MNCH BUDGET ANALYSIS	15
2.1. Macro-Budget Analysis	15
2.2. Health Sector Financing	15
2.3. Financing for Maternal Newborn and Child Health	16
2.4. Functional Classification of MNCH Budget	19
2.5. Conclusions:	20
CHAPTER 3: DISCUSSION AND RECOMMENDATIONS	21
3.1. Discussions:	21
3.2. Recommendations	22
ANNEX:	24
1. MNCH TARGETS FROM DIFFERENT NATIONAL DOCUMENTS	24
2. REFERENCES	25

Abbreviations & Acronyms

AMREF	Africa Medical Research Foundation
ANC	Ante Natal Clinic
ATM	AIDS, Tuberculosis and Malaria
ARV	Anti-Retroviral drugs
BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Obstetric and Newborn Care
CTC	Care and Treatment Clinic
EID	Early Infants Diagnosis
EmONC	Emergency Obstetric and Newborn Care
EPI	Expanded Program for Immunization
FDC	Fixed Dose Combination
HBB	Help Babies Breath
IMCI	Integrated Management of childhood Illness
IPT	Intermittent Preventive Treatment
ITN	Insecticide Treated Nets
MDG	Millennium Development Goal
MMAM	Mpango wa Maendeleo ya Afya ya Msingi
NSGPR	National Strategy for Growth and Poverty Reduction
PHSDP	Primary Health Services Development Program
PMI	President Malaria Initiative
MNCH	Maternal and Newborn Child Health
SMI	Safe Motherhood Initiatives

List of Tables

Table 1: Interventions classified as MNCH	3
Table 2: Areas of MNCH per budget allocation	18

LIST OF FIGURES

Figure 1: Percentage utilization of MNCH integrated services	2
Figure 2: Percentage of health sector spending in Tanzania	15
Figure 3: Spending on Reproductive Health (MNCH); On budget Tsh-Bln	16
Figure 4: Malaria and MNCH budget including off-budget; Tsh Biln	17
Figure 5: Functional spending on MNCH in Tsh. Bln	19

Glossary

1. **Budget classification:** the way the budget is broken down to show by whom, or on what, the money will be spent. Common classifications include:
 - i) *Administrative*, which is defined in terms of who will spend the money e.g. government departments or regions
 - ii) *Functional*, presented in terms of what the money will be spent on e.g. on EPI or Family planning.
2. **Consolidated debt services (CDS):** are debts that the country has accumulated through overseas loans, which are required to be repayed within a certain period of time. Each year the government allocates a certain amount of money to service its debts.
3. **Discretionary expenditure:** Refers to the funds available to be spent by government after paying consolidated debt services.
4. **Nominal values:** the actual value of money, disregarding inflation.
5. **Real values:** the value of money taking the inflation index into consideration.
6. **Recurrent spending:** spending on wages, salaries, operations and maintenance that is not of an investment nature.
7. **Development expenditure:** Spending that involves investment in new services, skills, beneficiaries or programmes or a significant scale-up of ongoing activities.
8. **Off-budget:** This refers to the expenditure that is not captured under Government's own budget system (Medium Term Expenditure Framework (MTEF) but the government knows how much is being spent and for what. On budget is therefore that which is captured in Government budget and is approved by the parliament.

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Jaliath Rangi
Program Officer
Human Development Trust
P.O. Box 65147, Dar es Salaam
Tanzania.

Executive Summary

The main objective of conducting this Rapid Assessment was to understand the policy context, programming and financing of MNCH in Tanzania and how the services are integrated in ATM. This was accomplished by undertaking policy review and budget analysis for MNCH. The results will be used to influence enforcement of MNCH policies and enhance integration of MNCH into AIDS, TB and Malaria. The assessment will also be useful to advocate for increased resource allocation for integrated MNCH services from both donors and Government's own funds.

Literature review indicates that, Tanzania has prioritized Maternal, Newborn and Child Health in its policies and strategies in order to meet MDG 4 and 5 through provision of free primary health care services to pregnant women and children aged below five years. This prioritization ranges from development policies such as MKUKUTA and the recent Five Years Development Plan. The Health Policy and Health Sector Development Plan (III) both prioritize MNCH. Specifically, the National Road Map Strategic Plan 2008-15 (One Plan) stipulates various strategies to guide stakeholders to meet the MDGs' target, but the two policies do not specify integration. The Health Sector Strategic Plan III (2009-2015) focuses on partnership for delivering the MDGs through two major programs: Primary Health Services Development Program 2007-2017 (PHSDP or MMAM in Swahili) and the Human Resources for Health Strategic Plan. National policies for MNCH commit to ensure fair, equitable and quality services to the community.

An analysis of financing for MNCH indicates that the health sector share has been decreasing for years; it peaked in year 2007 at 10.8% then declined and now (2011/12) stands at 8.9% of the total national budget including consolidated fund. In year 2011/12, the government of Tanzania's budget increased by 16.6% from the previous year, but MNCH budget decreased from 229.2 billion to 98.7 billion for year 2011/12. This decrease was mainly due to ending of universal coverage for ITN and is likely to affect attainment of the targets set in national targets for MNCH (see annex).

In conclusion, the analysis indicates that, there are policies and strategies developed to address maternal and child health even though they

don't spell out integration. MNCH is integrated mostly in HIV and Malaria interventions, but not in TB. Because of MNCH integration to HIV, when a pregnant mother is found to be HIV positive, she is referred to a TB clinic. Financial resources available have not increased, and have mostly been coming from donors, with the trend of meeting the targets not matching the needs towards achieving the MDGs.

Clarity of integration at policy level is needed and reasonable financing for MNCH to meet MDG targets. Integration in TB is needed in order to address childhood TB.

A: Introduction

Three years remain to assess the extent to which countries have met the Millennium Development Goals (MDGs). The Global Fund Board Decision Point: GF/B22/DP15 encouraged countries, where applicable, to strengthen the MNCH content of their Global Fund-supported investments, maximizing existing flexibilities for integrated programming. To exemplify that GFATM also integrated the MNCH in its five years strategy. USAID has also been supporting Safe Motherhood by strengthening Basic Obstetric and Neonatal care and voluntary family planning services. Child health programs supported by USG include those to support improvement of child health through improved diagnosis and treatment of febrile illnesses and improved nutrition. In addition, it also supports maternal health supplies under USA | DELIVER project mainly focusing on (1) Forecasting and supply of maternal commodities (2) Monitoring stock out and (3) Support supervision at service delivery points.

In this context, Population Action International (PAI) initiated The Integration Partnership (TIP) to support advocacy efforts to advance RH/HIV and MNCH/ATM integration within US investments and the Global Fund. As such, Human Development Trust (HDT), spent part of its grant from TIP to assess policy and financing for MNCH and how MNCH is integrated in ATM. To understand the extent of integration, a separate assessment at health facilities was done by MEWATA (another TIP partner) and findings were presented in a separate report.

Whereas policies and strategies may show high priority on MNCH, the actual priority is often determined by the amount of funds allocated and actually spent on MNCH. In other words it's the resource envelope that determines the priority and whether supportive policy can be translated to quality services; hence discussions and conclusions will be made based on comparison of strategies and budget allocation. Budgeting for MNCH is important, but actual spending represent more reality as re-allocation can occur, but expenditure analysis for the 2011-12 year could not be done since expenditure reports were not available and in addition it was beyond the scope of this analysis.

In Tanzania, the estimated annual maternal mortality rate is 454 per 100,000 live births, infant Mortality rate is 68 per 1,000 live births, new born Mortality rate is 32 per 1,000 live birth, these mortality rates are associated by diseases which are HIV/AIDS, Tuberculosis and Malaria. Review shows that only 8% of children required to be on ARVs are actually on ARVs. Mortality rate among Patients with AIDS within three years of starting ART is 8.5%, with highest mortality (over 10%) occurring in the first year¹. The prevalence among men is 4.6% compared to 6.6% in women of this age group. HIV prevalence among ANC is higher than that of general population, recorded at 8.2%.

An estimated 64% HIV+ mothers received ARVs for PMTCT, 19% of pregnant women with advanced HIV were put on ARVs for life and 56% of HIV+ babies were put on ARVs. 49% of infants were started on exclusive breast feeding within one hour after birth and significant proportion (98%) are breastfed up to six months with half on exclusive breast feeding (50%)². The table below shows the percentage utilization of MCH services as integrated in HIV and AIDS.

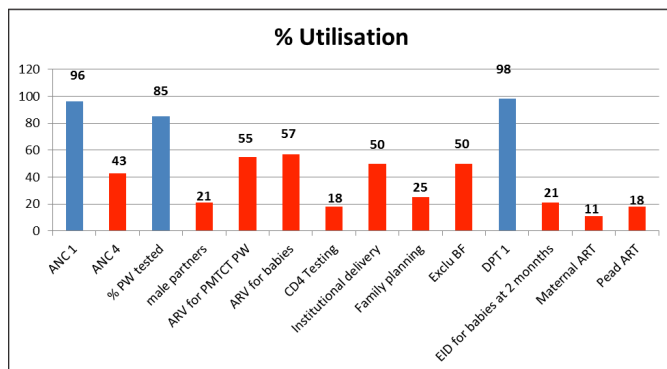


Figure 1: Percentage utilization of MNCH integrated services

Malaria also is another cause to these high mortality rates, annual malaria deaths in Tanzania are estimated to be 60,000, with 80% of these deaths among children fewer than five years of age. Campaign to Accelerate Reduction of Maternal Mortality was launched in Tanzania 6th June 2011, with a theme “No woman dies while giving life” which was a call to meet the already existing commitment. Morbidity related to TB is high among PLHIV, but the TB- related mortality is recorded at 78 per 100,000 per year. Given that the combined the mortality and morbidity caused by AIDS, Malaria and TB, integration of these services will not only reduce money invested but will maximize the human resource for health available.

¹HIV and AIDS Final evaluation of NMSF- care and treatment September 2012

²Final evaluation of NMSF – Prevention September 2012

To that effect, Tanzania has developed the MNCH Strategic Plan to accelerate reduction of maternal and child mortality in response to the MDGs and the New Delhi Declaration of April 2005. The mission of the plan is to promote, facilitate and support in an integrated manner, the provision of comprehensive reduction of maternal, newborn and child morbidity and mortality.

The table below summarizes the MNCH interventions that are financed in the Budget system of Tanzania referred to as Medium Term Expenditure Framework (MTEF).

Table 1: Interventions classified as MNCH

S/N	MNCH intervention	S/N	MNCH Interventions
1	Malaria initiatives	6	Contraceptive supply
2	Training of RCH, C-IMCI ¹	7	Immunization for mother and child
3	Cancer of cervix	8	Maternal Mortality Reduction
4	Delivery kits procurement	9	Macro-nutrient and malnutrition
5	Vaccine & monitoring	10	Child protection and C-IMCI

Although Malaria initiatives are classified as MNCH, it is important to note it is not entirely targeting MNCH; they target the whole country. For example, the fund budgeted for malaria campaign (free long lasting ITNs and indoor residual spraying) was done for all Tanzanians. This is to say when analysis of resource is made, it has to be noted that some of the resources goes to general population.

³C-IMCI refers to Community Integrated Management of Childhood Illness (IMCI)

B: Goal and Objectives of the Assessment

The goal: To undertake assessment MNCH policies, strategies and financing and how they are integrated in ATM.

Objectives:

1. To establish policy commitment on MNCH through existing policies and strategies towards maternal newborn and child interventions;
2. To determine the extent at which maternal newborn and child health is integrated in existing AIDS, TB and Malaria interventions;
3. To establish financial commitment towards achieving maternal newborn and child health interventions

This report therefore presents the findings of the assessment of the policies and strategies and financing for MNCH in interventions in Tanzania. It also analyzes the financial allocation trends for MNCH for two consecutive years 2011-2012. It is divided into three parts: Chapter one highlights on the existing MNCH policies strategies and interventions; Chapter two gives the Budget Analysis on Financing MNCH; and Chapter three outlines the conclusions and recommendations.

Chapter 1:

MNCH Policies, Strategies And Interventions

1.1. MNCH in Policies and Strategies

Tanzania has mainstreamed maternal, newborn and child survival into its National Health Policy 2007. In policy statements, the Tanzanian government, in collaboration with other stakeholders, commits to provide free services for maternal, newborn and children under-five years. This is sometimes hindered by stock out, adherence to guidelines, infrastructure, community participation through positive health seeking behaviors etc.

The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015 (One Plan) stipulates various strategies to guide all stakeholders for Maternal, Newborn and Child Health (MNCH). Stakeholders include the government, development partners, non-governmental organizations, private health sector, faith-based organizations and communities.

The National Health Policy was also translated into Health Sector Strategic Plan III (2008-2015), Primary Health Services Development Programme 2007-2017, Human Resource for Health Strategic Plan 2008-2013 to mention a few. Improving MNCH is also a major priority area in the National Strategy for Growth and Poverty Reduction (NSGPR/MKUKUTA) 2010-2015 which has three major interlinked clusters. Goal three (Improving survival, Health, Nutrition and Wellbeing, Especially for Children, Women and Vulnerable Groups) is clearly outlined in the second cluster of the strategy. Under this goal, there are five operational targets of importance to MNCH are Fertility, Maternal and Neonatal Health, Infant, Child Health and Nutrition. These contribute to monitoring progress towards achieving MDG 4 and 5. The strategy further states, Operational targets and strategic interventions for achieving this goal which were identified based on the strategic areas and targets defined in the National Health Policy 2007.

The Health Sector Strategic Plan III (2009 – 2015) focuses on ‘partnership for delivering the MDGs through two major programmes Primary Health

Services Development Programme 2007 – 2017 (PHSDP or MMAM in Swahili) and the Human Resources for Health Strategic Plan. The PHSDP addresses the delivery of health services to ensure fair, equitable and quality services to the community and is envisioned to be the springboard for achieving good health for Tanzanians. The programme has 17 components which contribute to the attainment of objectives, whereby Maternal, Newborn and Child Health is one of them.

The Five Year Development Plan (FYDP 2011/12-2015/16) which is to be used as a budgeting tool for the government in the next five years also includes maternal and child health. It projects to reduce maternal mortality from 454 to 175 per 100,000 live births and the under-five child mortality from 112 to 45 per 1,000 live births by the year 2017. The FYDP is one third of a Long Term Perspective Plan (LTPP 2011/2012 -2025/2026). In both of these documents MNCH is one of the strategic interventions for health related goals.

In conclusion, the national policies and strategies acknowledge the need for prioritizing MNCH and include both targets and strategies towards meeting MDG 4 and 5. However there are differences in the targets set under each as compared to MDG targets (see Annex 1).

MNCH Interventions

Within the policies above, a number of interventions are presented. Below we summarize interventions planned towards MDG 4 and 5 and we classify them into Pre-pregnancy, pregnancy and post-delivery.

Pre-Pregnancy Interventions:

There are several interventions under this category including adolescent sexual reproductive health which also supports prevention of early pregnancies that contributes to the burden of maternal and neonatal deaths. A National Adolescent Reproductive Health Strategy 2011-15 has been developed to facilitate adolescent sexual reproductive health. The goal is to improve reproductive health of all adolescents in Tanzania through four strategic objectives namely:

- Strengthened policy and legal environment to support provision of sexual reproductive health information, services and life skills for adolescents;
- Increased adolescent's access to and utilization of quality reproductive health services;

- Positive attitudes and behaviors promoted among parents, adolescents and the community towards improvement of adolescent sexual and reproductive health;
- Strengthened capacity of key stakeholders to deliver effective and efficient adolescent sexual and reproductive health programs.
- School Health Programs is one of the best settings to reach adolescents with sexual and reproductive health education and services including life skills training. The Ministry of Education and Vocational Training in collaboration with the Ministry of Health and Social Welfare and other partners have developed policy and guidelines on school HIV education, life skills training and counseling for young people. Some of the schools have also trained peer educators and formed school health clubs as a strategy for ensuring young people's access to information. Teaching and learning materials have also been developed and approved by Education Material Approval Committee (EMAC) to be used by teachers as reference and some by pupils during peer education sessions. However, these services are not available in most school due to shortage of teachers trained to provide the services.

Family Planning has always been an emphasis at policy level, though not always matched with level of financing. The government of Tanzania has all along recognized the importance of Family Planning methods which are registered and allowed by the Ministry of Health. In 1969, while presenting the second Five Year Development Plan to the Annual General Meeting of the ruling Party (TANU) the then President of Tanzania, Mwalimu Julius K. Nyerere warned the nation that:

“Giving birth is something in which mankind and animals are equal, but rearing the offspring and especially educating them for many years is a unique gift and responsibility of man to look after them properly rather than thinking about the number of children and the ability to give birth for it happens that man's ability to give birth is greater than his ability to bring up the children in a proper manner”.

In 1973 the National Executive Committee declared its support for the Family Planning Association of Tanzania (UMATI) and requested the Government (Ministry of Health) to assist UMATI in the promotion and delivery of child spacing services by using the above methods. In 1974 the Government through, the Ministry of Health directed that child spacing advice and services be provided as an integral part of Maternal

and Child Health Services – (MCH) in all health facilities in the country – resulting in the provision of integrated MCH/FP services.

Several Legislation and Regulations aimed at promoting the health and social well-being of women and young children were instituted. These measures directly or indirectly encouraged the practice of child spacing and family planning development at large. For instance, the law which governs maternity leave of 84 days for employed female workers once every three years encourages child spacing and hence Family Planning Development at large. The income tax relief of up to four (4) children or dependents for all workers and the provision of travel allowance for up to four (4) children once every (two) years when going on annual leave again discouraged parents from bearing more than four children.

Currently, there is growing number of programs and development partners supporting Family Planning regardless of the bottlenecks in access to FP services and/or commodities. All Family Planning activities provided by various agencies are coordinated by the Reproductive and Child Health Unit of the Ministry of Health. There is also Family Planning Unit (FPU) which became operational in 1986, and has been gradually strengthened to its present capacity. The FPU is responsible for initiating and developing Family Planning standards and guideline on service provision, training and other aspects of quality care. However, FP is not integrated in TB and malaria interventions, whereas in AIDS it is now reinforced as an objective towards PMTCT and currently eMTCT.

During Pregnancy

Interventions during pregnancy are mainly channeled through Ante-Natal Clinics (ANC) and therefore rarely accessed by pregnant women who do not attend the clinic, due to lack of money to pay for health services and distance to health facility. The woman is monitored for hemoglobin level to control anemia, protein in urine and blood pressure to control pregnancy- induced high blood pressure. Other tests that are made include stool to support treatment for intestinal worms and VDRL for syphilis. Malaria is integrated in ANC services where access to ITN is done and Malaria prophylaxis. For Malaria prophylaxis, women are supposed to receive two doses of Fansidar for Intermittent Preventive Treatment (IPT) during routine antenatal care visits. The subsidized Insecticide Treated Nets (ITNs) are also accessed during the ANC visit. The impact of malaria on MNCH is appreciated as causing up to 15% of

maternal anemia, causing low birth weight and still birth.

HIV and AIDS is also integrated in ANC through the Prevention of Mother To Child Transmission (PMTCT). The focus is both to ensure an HIV-free start in life of a newborn and quality of life of a mother. This is done by testing and counseling for HIV for all mothers at ANC except who opt out, provision of antiretroviral for HIV prophylaxis. It also offers treatment of eligible women, counseling and support for infant feeding, safer obstetric practices and family planning to prevent unintended pregnancies in HIV-infected women. The Ministry of Health with support from UNICEF and UNAIDS have finalized cost estimation for Elimination of Mother to Child Transmission of HIV 2012-15. The plan was released in May 2012.

Tuberculosis services are not integrated at policy and program level, but referrals are made to pregnant mothers who are HIV positive.

During Birth

The Baby

There are three major causes of neonatal deaths in Tanzania: (1) infection, (2) birth asphyxia, and (3) complications due to low birth weight and immaturity. The following interventions are provided:

- The Integrated Management of Childhood Illness (IMCI) introduced in Tanzania in an attempt to reduce child mortality, a strategy developed by WHO and UNICEF. The strategy focuses on training health workers to manage childhood illnesses at primary health care facilities, strengthening the health system to enable effective supervision and supplies, and improving community and household practices related to child health.
- Helping Babies Breathe (HBB) is another strategy which addresses Birth Asphyxia and is implemented by the MoHSW and was established in September 2009. The target is to train 11,000 nurses and midwives at national level on skills in critical steps for the survival of the baby.
- The Kangaroo Mother Care which tackles low birth weight baby and immaturity by ensuring that the baby is kept warm is initiated and supported by UNICEF. The program covers health facilities in Temeke District who teach mothers the 'Kangaroo Mother Care' technique which helps to keep a low birth weight baby warm and enables breastfeeding which provides protection from infection.

The Mother

The major intervention for mother care during delivery is Safe Motherhood Initiative (SMI) through life saving skills and Emergency Obstetric Care (EmOC) which is categorized into Basic (BEmOC) and Comprehensive (CEmOC). Health care providers are trained and facilities equipped to perform EmOC. More than 80% of maternal deaths can be prevented if pregnant women access essential maternity care and assured of skilled attendance at childbirth as well as emergency obstetric care.

The Ministry of Health and Social Welfare in collaboration with Ifakara Health Institute have established a 3-month course to train Assistant Medical Officers in carrying out emergency obstetric surgery; and nurses on how to provide safe anesthesia in rural health centres. This was the first course of its type to be introduced in sub-Saharan Africa. Graduates from this course have started to support nine rural health centres in Morogoro, Kigoma and Coast regions in providing caesarean sections which have increased deliveries to more than 50% in the upgraded health centre.

In 2007 misoprostol drug was registered in Tanzania for prevention and treatment of postpartum hemorrhage in hard to reach population. Since 2009, the government has also provided tri-cycle ambulances in rural areas as a means of improving attendance to obstetric emergency services. In year 2009/10 a total of 370 tri-cycle ambulances were purchased and distributed to health centres and dispensaries (note that there are estimated 5160 health centers and dispensaries).

The use of trained Traditional Birth Attendants (TBA) to reduce maternal mortality has limited, and often conflicting evidence. Some authors support the use of trained TBAs in areas where home births are common, maternal and neonatal mortality remains high and the shift to skilled attendance at delivery is a distant reality. The current focus for use of TBA is to motivate TBAs to refer pregnant mothers to attend ante-natal clinic and deliver at health facilities.

Post-Partum and Post-Natal and Family Planning

Most maternal deaths occur in the first 24 hours to 7 days after delivery which is the period where hemorrhage and sepsis can happen. Postnatal care is a key for continuum of care from home to health facility for both

maternal and baby health since women can access family planning counseling, management of anemia, referral for bleeding and infection complication and baby check-up as well.

As reported by MoHSW (2009), health facilities offering post natal care services are only 60% of 82% facilities which offers antenatal care. The report also indicated overall poor attendance to postnatal check-up in the country of less than 30% since majority (71%) do attend after four weeks mainly due to economic barriers and cultural taboos around leaving the home during period of seclusion.

Because of cultural or traditional practices or lack of access, mothers do not always seek post-partum care, even if they have a potentially life-threatening condition, such as postpartum bleeding. Providers at the local health facility may not be able to assess the gravity of such maternal complications and provide treatment or timely referral. There is a clear need for greater emphasis on post-partum care including counseling on applying family planning, and for greater continuity and cooperation between those who supervise the delivery and the services that follow at the facility level and in the community.

Infancy and Childhood

The Expanded Programme of Immunization (EPI) has performed well over the past decade with immunization coverage of 75% for all vaccines for children 12-23 months (TDHS, 2010). Currently the policy is to provide each child with one dose of BCG, four doses of OPV, three doses of DTP-HB and one dose of measles vaccine. Vaccine for BCG which stands for Bacille Calmette-Guerin is the intervention to protect infancy from TB, in Tanzania the vaccine is given as early as after the baby is born. This is the intervention for reducing risk infancy from acquiring TB, though science shows that this prevent severe forms of TB and not complete vaccine. HIV and TB infection are independently associated with increased risk of maternal and perinatal mortality; the impact of dual HIV and TB infection is even more severe, resulting in higher risk of preterm birth, Low Birth Weight, and intrauterine growth retardation.

Child growth is also monitored by using the Nutrition indicators for under-fives and has shown some improvement over the years but under nutrition is still widely prevalent in Tanzania. Anemia is also highly prevalent among under-fives the main causes of anemia are nutritional

deficiency, intestinal worms and malaria.

Training on Essential Nutrition Actions (Vitamin A supplementation, exclusive breastfeeding, complementary feeding, and iodine) is in the early stages of implementation. Vitamin A deficiency is the leading cause of preventable blindness in children and raises the risk of disease and death from severe infections. Vitamin A supplementation twice a year has been estimated by the World Bank (1993) to be one of the most cost-effective health interventions, Vitamin A supplementation twice a year has been estimated by the World Bank (1993) to be one of the most cost-effective health interventions. According to TDHS 2010, 61 percent of children ages 6-59 months had received vitamin A supplements in the six months before the survey.

Case management of common childhood illness is a key step to reducing child mortality. Appropriate management of malaria (when a child is seen to have symptoms for malaria is taken for a test and other procedures follows, but testing for malaria is not mandatory that every child must test when attending normal clinics), pneumonia, diarrhea and dysentery can reduce under-five mortality by 5, 6, 15 and 3% respectively. The IMCI strategy has been implemented at scale in Tanzania from 1996 with all districts implementing at different levels of coverage. Tanzania was part of an IMCI inter-country evaluation and the results were encouraging, but issues around quality of care and supervision were noted.

1.2. MNCH integration at Policy level

Integration into AIDS:

Pre-pregnancy: Family planning is integrated into HIV Counseling and testing, Care and treatment, Home Based Care. The guidelines for integration are now being developed. Example, within PMTCT, family planning access is measured by percentage of HIV positive mothers accessing family planning services and the target is 80% by 2015. This is a policy guidelines and implemented at facility level. Sexual Reproductive Health is also part of HIV education in schools as per revised curriculum of the ministry of education.

Pregnancy: HIV counseling and testing is integrated at ANC and all mothers attending ANC services are tested for HIV except those who opt out. During Delivery, HIV test is also done for those mothers who may

have missed the test during pregnancy, and ARV prophylaxis are given to mother who are found HIV positive during pregnancy and for treatment when she qualifies according to CD4 cut off levels. Children are given ART for prophylaxis. Children born from HIV positive mothers have their blood taken for Early Infant Diagnosis and by December 2011, 4603 (96%) of Reproductive and Child Health (RCH) facilities had integrated PMTCT in routine ANC. They deliver and provide Post natal care services; about 64 % of estimated HIV infected pregnant women and 56 % of babies born to them received ARVs for PMTCT and 19 % of pregnant women with advanced HIV infection were started on lifelong antiretroviral treatment (MoH 2012). The GFATM round 8 reprogrammed to reallocate \$2 million for PMTCT, an impact of which is yet to be evaluated.

Postnatal: ANC visits include HIV counseling and testing and referrals are done to care and treatment for eligibility to ART.

Integration in Malaria:

Pre-pregnancy: Universal coverage interventions for malaria prevention are done and they address MNCH such as universal coverage for use of Insecticide Treated Nets. There has also been Under-five catch up campaign which was providing ITNs to under five children. Some interventions for Malaria are not directly targeting Mother and Child alone, but benefit both child and mother. Interventions such as Indoor Residue Spraying and laticide control all reduce the risks of malaria to children and mother.

Pregnancy: At Antenatal Clinic health education on risks of pregnancy are normally given as a practice. ITN have been subsidized for all pregnant mothers through the voucher scheme⁴. At ANC pregnant mothers are also given the anti-malaria drugs (Fansidar) for prophylaxis (The intermittent Presumptive Therapy (IPT)). These interventions are aimed to improve maternal Child Health outcomes.

Postnatal: Health promotion and education are provided at ANC level and ITN are provided to mothers who may have missed them during pregnancy. The Integrated Management of Childhood Illnesses (IMCI) also includes Malaria as one of the commonest febrile illness among children.

⁴Under the Voucher scheme, a pregnant mother pays a small premium and is given a voucher which she takes to the retail shop to collect the ITN and the retailer shopkeeper is refunded the difference upon presenting the voucher to the MoH representative.

Integration in TB:

Pre- pregnancy: there are no interventions available related to women at child bearing age. However, TB screening is done to people with symptoms such a bad cough that lasts 3 weeks or longer, Pain in the chest, Coughing up blood or sputum (phlegm from deep inside the lungs), Weakness or fatigue, Weight loss, loss appetite, Chills, Fever and Sweating at night.

Pregnancy: Pregnant women are counseled for HIV testing. According to the TB strategic plan 2009-2015, women who are found HIV positive to be tested for TB and referrals done as appropriate.

Postnatal: BCG vaccination to infant for TB prevention is given after the baby is born. However, this is facilitated by immunization program and has been proving successful. And ongoing counseling is done for women who are on TB treatment when attending post natal

1.3. Conclusions

There are favorable policies both in health specific policies and strategies for MNCH and integration of MNCH into development policies is appreciated. At policy level, AIDS and Malaria seems to be more integrated, with some integration of TB for women who are HIV positive and Tb vaccination after birth.

CHAPTER 2:

MNCH BUDGET ANALYSIS

2.1. Macro-Budget Analysis

In year 2011/12, the Government of Tanzania budgeted 13,525 billion shillings which is 16.6% increase from 11,600 billion for financial year of 2010/11. Within the same budget the government expected to spend 8,600.3 billion for recurrent which is 27% more than domestic collection of 6,775.9 billion. This means that the Government of Tanzania cannot finance its own recurrent cost. Health sector financing still shares reasonable amount (nominal values) compared to other sectors, its budget only increased by 0.3% in year 2011/12 while infrastructure increased by 85%. Sixty two-percent of the 2011/12 budget was allocated for sectors⁵ equivalent to 8,357.4 billion and the rest (38%) is allocated for others issues.

2.2 Health Sector Financing

Health sector budget increased by 0.3% from financial year 2010/11 to 2011/12 i.e from 1205.9 to 1209.1 billion; during this period inflation was recorded to be 19.6% as of November 2011. This means in real value that health budget available for the financial year 2011/12 is less than that of previous year. As seen in Figure 2 below, health sector share has been

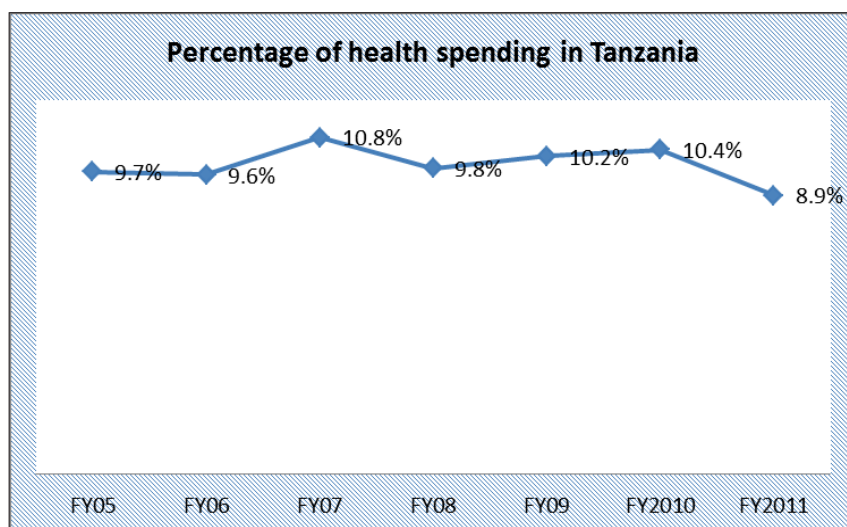


Figure 2:
Percentage of
health sector
spending in
Tanzania

⁵ Sectors mean specific functional ministries such as education, Agriculture, Health etc.

almost constant; peaked in year 2007 at 10.8%. Despite the commitment seen at policy level in chapter one, and Abuja commitment⁶ to increase health sector budget to 15%, analysis shows that the health budgets for the country have never reached 11% and in fact it decreased in the current financial year (2011/2012) from 10.4% to 9.8% of the total national budget including consolidated Fund. Drugs and medical supplies were allocated to cost (25.8 billion) in year 2011/12 which is 2% of health budget. This is a decrease from 43.6 billion in year 2010/11 which was 4% of health budget. Given the inflation between these two years, this implies that access to treatment will be harder this financial year than last year.

2.3. Financing for Maternal Newborn and Child Health

Financing for Maternal and Child Health in Tanzania has in recent years been decreasing See figure 3 below. In year 2008/9 the MCH budget

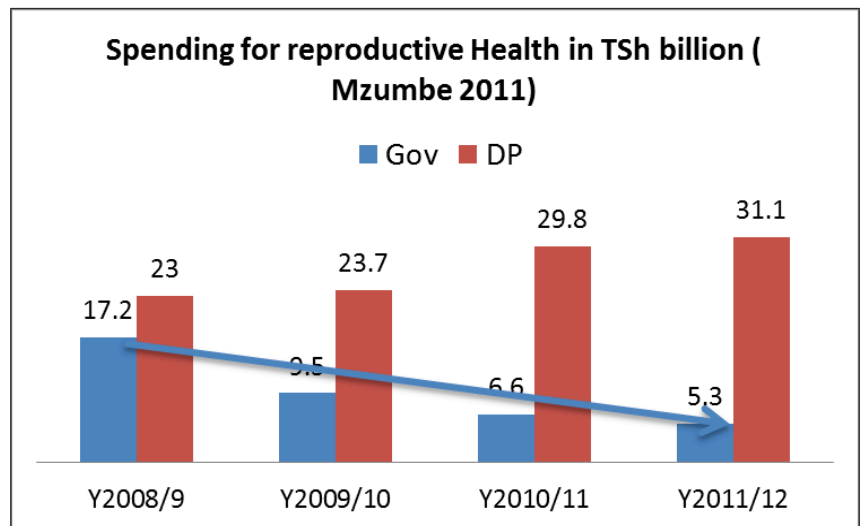


Figure 3: Spending on Reproductive Health (MNCH); On budget Tsh-Biln.

was Tsh. 40 billion in total for Government and Development Partners. It decreased to 35.6 Billion in year 2010/11, then increased to Tsh. 36 billion in year 2011/12. Albeit good Government policies and strategies on MCH, its financial contribution to MCH has been steadily decreasing.

Analysis of funding for two consecutive years including off budget was done including off-budget and it showed that a total of 98.7 billion (representing 8% of the health budget) was budgeted for year

⁶ Abuja Declaration meant to allocate 15% of national spending for Health sector

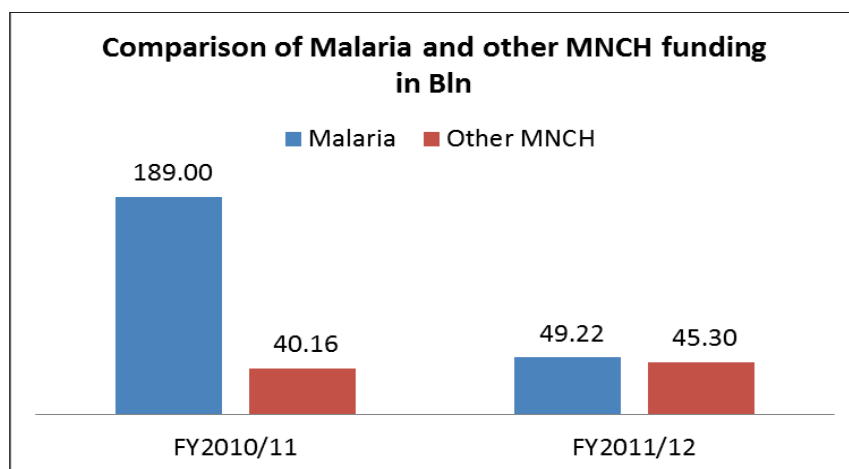


Figure 4: Malaria and MNCH budget including off-budget; Tsh Biln

2011/12 which is a decrease from 229.2 billion budgeted for 2010/11; this represent a difference of 130.5 billion equivalents to 57%. The decrease affected more Malaria spending which shared 82% from (189 billion) in year 2010/11 (see figure 4). If malaria is not considered to be part of MNCH, other MNCH interventions for year 2010/11 cost 40.2 billion. It should be noted here that not all malaria spending are directly targeting MNCH, since the universal coverage of Long Acting Nets (LAN) went beyond Maternal and Newborn. Malaria budget decreased mainly due to completion of universal ITN coverage and Under-five catch up campaign for provision of ITN to under-fives.

Apart from Malaria, other spending lines for MNCH include Family planning, vaccinations, procurement of delivery kits, reduction of malnutrition, Maternal Mortality project⁷, monitoring, evaluation and tools development, diagnosis and treatment of cancer of cervix and other reproductive cancers.

The main MNCH interventions as seen in the budget books are Family Planning, Immunization, Delivery Kits, Malnutrition and Maternal Mortality Project described in note 3 below shared about 21Bln for each year consecutively. This means that it constituted 52% of MNCH budget for year 2010/11 and 42% of MNCH in year 2011/12.

⁷ This is a project funded by ADB targeting three regions of Tabora, Mara and Mtwara due to their high MMR. The information available for this analysis indicate that money will be used in improving access through supporting 80 dispensaries, 30 health centers, 8 district hospitals and building medical assistants colleges.

The table below summarizes the different areas of MNCH, their allocation in billion for 2010/11 and 2011/12.

Table 2: Areas of MNCH per budget allocation

TZS in billion	FY2011	% share	FY2010	% share
ToT on SRH	0.04	0%	0	0%
ToT on Cancer of cervix	0.03	0%	0	0%
Procure vaccines (BCG, DPT, OPV, TT)	5.55	6%	2.4	1%
Provide immunization	0.7	1%	3.2	1%
EPI office management	0.16	0%	0.1	0%
RCH office management	0.17	0%	0.2	0%
Procure contraceptives	1.18	1%	0.5	0%
Training to RCH coordinators	0.02	0%	0	0%
Monitoring and data audit	0.06	0%	0	0%
Support maternal mortality project	21.13	21%	30.9	13%
Procure contraceptives	5.18	5%	3.5	1%
Procure and distribute delivery kits	3	3%	3	1%
Reduce child malnutrition (UNICEF+WHO)	12.27	12%	3.7	2%
Support malaria initiatives GF+ others	49.22	50%	189	80%
Total	98.7		236.5	

It should be noted that PMTCT prong 3 and 4 are regarded as MNCH intervention, but since their interventions are linked to care and treatment, they are difficult to extract the actual money used for this purpose. For example, HIV testing which is important entry to ANC, uses the same kits for all HIV testing. The ARVs used for prophylaxis are the same used for AIDS treatment, thus for the purpose of integration, they are not extracted to be costed separately as MNCH interventions, yet they are.

2.4. Functional Classification of MNCH Budget

In this section, the report looks at which function of MNCH spends how much in proportion and in absolute values. It also compares the functional budgets for two years (2010 and 2011) for which information was available for analysis. In general money available for MNCH in 2010 was more than twice that available for financial year 2011/12. Malaria in these two years shared largest portion of funding at 82% and 50% in FY 2010 and FY2011 respectively. This fact is because of GFATM, DFID and President Malaria initiative all of which funded the campaigns for use of Long Acting Nets; the campaigns were Under-Five Catch up campaign and universal ITN coverage in Tanzania. These were linked to the African Leaders Initiative on Malaria.

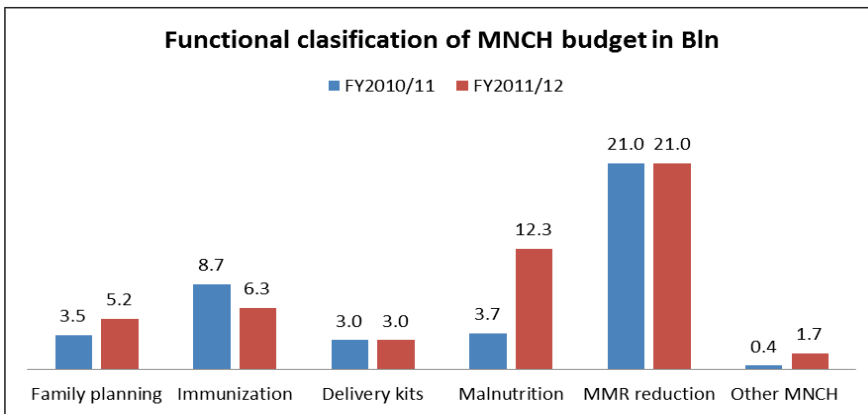


Figure 5: Functional spending on MNCH in Tsh. Bln

As shown in figure 5, family planning, Malnutrition and other MNCH⁸ services had their budgets increased.

The MMR project maintained its share at 21 Billion for year 2010/11 and 2011/12. The MMR project covers three regions of Tabora, Mara and Mtwara with construction of dispensaries, health centers and medical assistant college. This intervention is strategic, but does not necessarily lead to reduction of MMR unless some other direct interventions are done. The funding for Family Planning has increased mainly as a result of increased Government contribution to family planning which increased from Tsh. 0.5 Billion to 1.2 Billion. The DFID financial support to family planning was not included in the analysis (figure 5) and so is the USAID and Australian AID since they are off-budget. DFID alone will contribute Tsh. 4.6 billion.

⁸ Other MNCH services includes ToT for SRH, Services for Cancer of Cervix, M&E etc.

According to the RH supplies interchange (<http://rhi.rhsupplies.org>), USAID is the main financer of family planning commodities in Tanzania. In year 2011/12, it procured contraceptives worth Tsh. 10.5 billion sharing 57% of all procurement.

2.5. Conclusions

Financing for health sector has continuously remained below the Abuja target of 15%; similarly, financing for MNCH is increasingly becoming donor dependent for both off and on budget. Areas such as procurement of delivery kits, family planning, cancer of the cervix, and sexual reproductive health have remained grossly under budgeted. Since services are integrated such as HIV counseling and testing and PMTCT, the cost presented may be under-estimate

Chapter 3:

Discussion and Recommendations

3.1. Discussions

Key policies in Tanzania prioritize MNCH and targets have been set; albeit they are not consistent from one document to another. Example the Maternal Mortality target for 2015 differs among the three documents; (1) National road map set the target at 193 per 100,000 live births by 2015, (2) MKUKUTA/NSGPR shows 265 and (3) Primary Health Care Development Plan shows a target of 220 by 2015. More information can be seen at annex 1.

The policies and strategies have been developed and they cover a range of stages from pre-pregnancy, Pregnancy, during birth, after birth etc. This is very comprehensive and needs to be appreciated. Analysis however shows that interventions are provided as facility based - come and be served; which depend on community's health seeking behavior. This is the major weakness of this program since few people attend the health facility as recommended (number and frequencies). Example, where ANC services are provided at health facilities, its only 4 in ten mothers made four recommended visit. This means that 6 in each ten pregnant women will miss the services. Again while safe delivery would be perceived to occur at health facility and attended by professionals, assessment of wealth quintile-health assessment shows that only 33% of poorest deliver at health facility as compare with 89% of wealthiest who deliver at health facilities (TDHS 2010). The Ministry of Health policy is to provide these maternal and child services at no user fee, but in practice user-fee is still a limiting factor to the extent that the main reason for home delivery (as reported by TDHS 2010) was lack of money (24%) followed by limited health service infrastructure (11%).

Integration of Family planning has been done at HIV counseling and Testing Centers, PMTCT, Home Based Care and Care and Treatment to less extent. The Technical Working Group for integration are established and functional, and these can provide avenues for learning for MNCH/ATM integration. The nature of integration seems to have been pushed by the magnitude in which the MNCH relates to the three disease.

Example because the impact of Malaria and HIV is so high to women and Children, there appears to be more integration with HIV and Malaria than there are with TB. HIV and Malaria have been integrated in MNCH services and to lesser extent TB. Within the practical aspect, extent of integration differs from one level⁹ of health facility to another.

Analysis shows that financing for MNCH occupied 20% of health budget in financial year 2010/11 and this decreased to 8% in 2011/12. This is significant reduction was mainly due to reduction in financing for Malaria, where in the previous year, there was financing for universal access for ITN supported by GFATM and PMI. This means that MNCH financing is mainly covered by donors. Further analysis shows that key interventions such as Family Planning and purchase of delivery kits are still receiving meager allocation.

While the budget allocation for both MNCH and medical supplies decreased in this financial year (2011/12), analysis of maternal supplies in health facilities done by USA | DELIVER project to 36 health facilities indicated that all 36 health facilities did not have Magnesium, Iron Sulphate, Misoprostol and Oxytocin¹⁰. twenty healthy facilities did not have Fansidar for Malaria prophylaxis among pregnant mothers. Six health facilities did not have ergometrix supplies (to prevent maternal hemorrhage during delivery).

This analysis shows that there are good, but inconsistent strategies and targets to address MNCH in Tanzania. Finance allocated for MNCH including medical supplies remains inadequate to meet the targets set in the policies. Since the policies and strategies have been approved, they remain binding and the Government needs to make fair allocation to meet the targets.

3.2. Recommendations

Given that the policy environment and statements supports MNCH, there is a strong ground for advocacy for increased resources for MNCH to ensure that it is integrated in AIDS, TB and Malaria and services are provided as pre-policy requirements. The following recommendations are made:

⁹ Health system in Tanzania is pyramidal, meaning there are more facilities at the bottom and less at the top. The facilities at the bottom have weaker capacity and infrastructure as compared to those on top hence the extent of integration is different.

¹⁰ These are maternal health supplies used during pregnancy and during delivery

1. Advocate with Ministry of Health and Planning Commission to ensure that there is consistency in the targets such as Abuja 15% target that are set for the country across strategies and plans that will facilitate standardized measurement of progress against these targets
2. Engage selected members of parliament and development partners in health to pressure the Government to increase its allocation in general and specifically for MNCH programs.
3. Design and implement an Expenditure Tracking for MNCH at national level and district level and possible Social Accountability Monitoring. A systematic study to estimate MNCH budget needs is also recommended for advocacy to have evidence base.
4. Expand tracking of stock outs for maternal health commodities and engage parliamentary committee on social services through a site visit to health facilities to see levels of stock out firsthand
5. Design and implement service-user feedback system so that advocacy team can be informed when pregnant mothers are required to pay or bring with them materials to the health facilities
6. Advocate for community based interventions that build the capacity of community systems to increase demand of MNCH services through health promotion towards health seeking behavior.

ANNEX:

1. MNCH Targets From Different National Documents

Indicators MDG Target

Indicators	MDG Target (2000-15)	National Roadmap (2008-15)	NSGPR Target (2010-15)	PHSDP Target (2007-17)
Maternal Mortality Ratio	From 529 to 133 by 2015	From 578 to 193 by 2015	From 454 to 265/100,000 in 2015	From 578 to 220 by 2012
Births attended by trained personnel	From 43.9 to 90% by 2015	From 46% to 80% by 2015	From 50.6 to 80% in 2015	46% in 2004 to 80% by 2012
ANC attendance at least 4 visits		From 64% to 90% by 2015		
Neonatal mortality reduced		From 32 to 19/1,000 live births by 2015	From 26 to 19/1,000 in 2015	
Infant mortality rate	From 115 to 38/1,000 live births by 2015	From 112 to 54/1,000 live births by 2015	From 51 to 38/1,000 live births in 2015	
Under-five mortality rate	From 191 to 64/1,000 live births by 2015			
Modern contraceptive prevalence rate	Universal access to family planning by 2015	From 20% to 60% by 2015		
Total Fertility Rate			From 5.4 to 5 by 2015	

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