UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER,
ELDERLY AND CHILDREN

THE NATIONAL ROAD MAP STRATEGIC PLAN TO IMPROVE REPRODUCTIVE, MATERNAL, NEWBORN, CHILD & ADOLESCENT HEALTH IN TANZANIA (2016 - 2020)

ONE PLAN II

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Table of Contents

Abbreviations

AFHS	Adolescent Friendly Health Services
AMTSL	Active Management of Third Stage of Labour
ANC	Antenatal care
ARI	Acute Respiratory Infection
ARR	Annual Rate of Reduction
ART	Antiretroviral therapy
ASR	Age Standardized Rate
BCC	Behaviour Change Communication
BEmOC	Basic Emergency Obstetric Care
BF	Breastfeeding
CCHP	Comprehensive Council Health Plan
CEmOC	Comprehensive Emergency Obstetric Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHF	Community Health Fund
CHMT	Council Health Management Team
CHW	Community Health Worker
COIA	Commission on Information and Accountability for Women's and Children's Health
COLSC	Commission on Life Saving Commodities
CPR	Contraceptive Prevalence Rate
CRVS	Civil Registration and Vital Statistics
EBF	Exclusive Breast Feeding
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Newborn Care
eMTCT	Elimination of Mother To Child Transmission of HIV
ENAP	Every Newborn Action Plan
EPI	Expanded Programme on Immunization
EPMM	Ending Preventable Maternal Mortality
FANC	Focused AnteNatal Care
FP	Family Planning
GBV	Gender Based Violence
HBF	Health Basket Fund
HF	Health Facility
HIV	Human Immunodeficiency Virus

HMIS	Health Management Information System
HRH	Human Resources for Health
HSSP III	Health Sector Strategic Plan III (2009 – 2015)
IARC	International Agency for Research on Cancer
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
IMPAC	Integrated Management of Pregnancy and Childbirth
IMR	Infant Mortality Rate
IPT	Intermittent Preventive Treatment
ITNs	Insecticide Treated Nets
LGAs	Local Government Authorities
LiST	Life Saved Tool
LMIS	Logistic Management Information System
M & E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MMAM	Mpango wa Maendeleo ya Afya ya Msingi
MMR	Maternal Mortality Ratio
MNCAH	Maternal, Newborn, Child and Adolescent Health
MOHCDGEC	Ministry of health, Community Development, Gender, Elderly and Children
MSD	Medical Stores Department
MVA	Manual Vacuum Aspiration
NIDA	National Identification Authority
P4P	Pay for Performance
PHC	Primary Health Care
PO-RALG	President's Office – Regional Administration & Local Government
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PPH	Post Partum Haemorrhage
RCH	Reproductive and Child Health
RCHS	Reproductive and Child Health Section
RH	Reproductive Health
RHMT	Regional Health Management Team
RITA	Registration, Insolvency and Trusteeship Agency
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SARA	Service Availability and Readiness Assessment

SBA	Skilled Birth Attendant
SUN	Scaling Up Nutrition
TDHS	Tanzania Demographic and Health Survey
TFNC	Tanzania Food and Nutrition Centre
TFR	Total Fertility Rate
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
TIKA	Tiba Kwa Kadi (CHF in urban areas)
U5	Under 5
U5MR	Underfive Mortality Rate
UNAIDS	United Nations Program on HIV/AIDS
UNCoLSC	United Nations Commission on Life Saving Commodities
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VAC	Violence Against Children
WHO	World Health Organization

Foreword

In Tanzania, the reduction of maternal, newborn and child deaths is a high ranking priority. This commitment can be demonstrated in various national documents, which include Tanzania Vision 2025, the National Strategy for Growth and Reduction of Poverty (NSGRP), National Health Policy, and the Health Sector Strategic Plan IV, to mention a few.

Maternal deaths are caused by factors attributable to pregnancy, childbirth and poor quality of health services. Newborn deaths are related to the same issues and occur mostly during the first week of life. Child health depends heavily on availability of and access to immunizations, quality management of childhood illnesses and proper nutrition. Improving access to quality health services for the mother, newborn and child requires evidence-based and goal-oriented health and social policies and interventions that are informed by best practices.

The 2015 Global Strategy for Women's, Children's and Adolescents' Health is essential as a front-runner platform for delivery of the Sustainable Development Goals (SDGs). The strategy takes stock of the lessons learnt from the MDGs and new evidence on effective investments and action. The SDGs are founded on human rights and equity and are based on the recognition that we have the opportunity and the responsibility to further transform the way we work in the period from 2016 to 2030 to be efficient and effective.

This strategy takes cognisant of the SDGs and other international strategies that skilled, motivated and enabled human resource for health and other pillars of health system are key for provision of quality reproductive health services. In the same vein, the strategy translates the national policy and strategies into an enabling environment to enhance better pregnancy outcome. This will be achieved through better service provision from pre-pregnancy to postpartum stages using Family planning, Antenatal and Emergency Obstetrics and Newborn Care interventions; and improved newborn and child health services. Furthermore, an avenue has been opened in this strategy to increase coverage and/or establishment of sustainable services on cervical, breast and prostate cancer management; care for the elderly; prevention of gender - based violence and violence against children.

Basing on the experiences we had on One Plan I implementation and on the new evidence on effective investments and action, the Government expects that all stakeholders will align to this strategic plan in accordance to the Paris Declaration on cooperation, and the UN Commission on Accountability of Women and Childrens' Health to support the implementation of prioritized RMNCAH interventions. Together, we can improve the health of Tanzanian mothers, babies and children, and build a stronger and more prosperous Nation.

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Permanent Secretary
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Executive Summary

The first National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008-2015 (One Plan) was developed in 2008 with the aim to provide guidance on the implementation of Maternal, Newborn and Child Health (MNCH) programs across different levels of service delivery and to ensure coordination of interventions and quality service delivery across the continuum of care. The One Plan had three key target indicators and fourteen operation targets, which had to be achieved by 2015. The key indicators included reducing the maternal mortality ratio to 193 per 100,000 live births by 2015, reducing neonatal mortality to 19 per 1000 live births and reducing under-five mortality rates to 54 per 1000 live births from levels in 2008 or before. Progress has been measured in Mid Term Review (MTR) reports; i.e. MTR Analytical Review of the HSSP III 2008-2015 and the One Plan (MOHSW, 2013 & 2014;). In May 2014 the Ministry of Health and Social Welfare developed the Sharpened One Plan 2014-2015 to prioritize and scale interventions for the period of 2014-2015, to improve reproductive, maternal, newborn, child and adolescent health in Tanzania.

Despite achieving the MDG4 of reducing the under-five (U5) mortality rate from 166/ 1,000 live births in 1990 to 54 per 1,000 live births (UN Inter Agency Group on Child Mortality Estimate, September 2013), Tanzania still have a very high number of newborns and under-fives dying at 39,500 and 98,000 per year respectively. The country has also observed a Maternal Mortality Rate (MMR) declined from 870 per 100,000 live births in 1990 (UN reports) to 432 per 100,000 (2012 National Population and Housing Census). However, this reduction was insufficient to attain the committed MDG 5 target of 193 per 100,000 live births. Scale up of effective, evidence based, equitable and high impact interventions will be critical for the transformative impacts within Reproductive, Maternal, Newborn, Child and Adolescent Health.

This strategic plan provides guidance for implementation of RMNCAH interventions in the country, building on the progress made under One Plan (2008-2015). The strategy focuses on reducing maternal, newborn, child and adolescent morbidity and mortality by offering quality services, of equity, offered by skilled attendants, in enabling environment and in an integrated manner along the continuum of care by taking into consideration both community and facility factors. The One Plan II has five strategic objectives and several operational targets covering areas of Maternal Health; Newborn and Child Health; Adolescent Health; Family Planning; Prevention of Mother to Child Transmission; Immunization and Vaccine Development; Reproductive Health (RH) Cancer, Reproductive Health Gender and cross-cutting programmes. The overall goal is to accelerate reduction of preventable maternal, newborn, child and adolescent morbidity and mortality in line with the National Developmental Vision

2025. The plan aims at reducing maternal mortality from 432 to 292 per 100,000 live births, neonatal mortality rate from 21 t0 16 per 1,000 live births and under-five mortality from 54 to 40 per 1,000 live births by 2020.

Chapter 1: Introduction

1.1 Historical perspective of RMNCAH services in Tanzania

In 2016, Tanzania has an estimated population of **50,733,262**; and is expected to clock **56,519,276** by year 2020. Tanzania population is mostly young; with 43.9% of the population aged below 15 years, and 3.9% aged 65 years and above as presented in Figure 1 by the Population Pyramid of Tanzania Mainland by 5-year age groups and sex based on the 2012 Census. This pyramid is broad-based, tapering off with increasing age (65 and above). This is typical of Sub-Saharan African populations with high and, sometimes, rising fertility regimes in the past. The data depicts a young population age structure, with 43.9% of the population aged below 15 years, and 3.9% aged 65 years and above. The pattern exhibited by the population pyramid is consistent with a young population age structure.

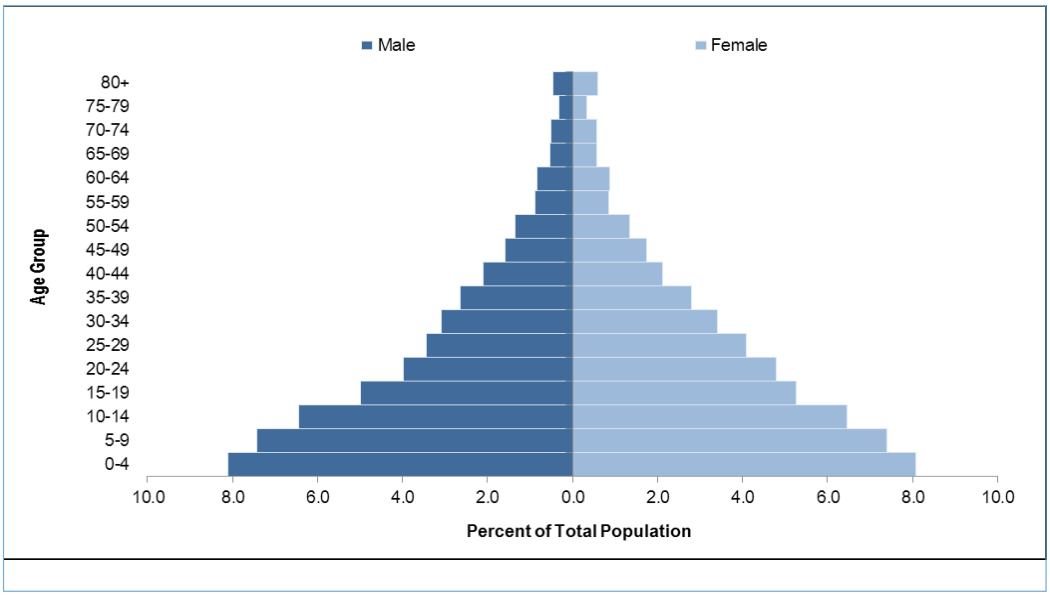

Figure 1: Population Pyramid (Five-Year Age Groups) – Tanzania Mainland, 2012 Census

The proportion of young population (0-14 years) of the total population is an indicator of the "youngness" of the population. Figure 3.5 shows that the Tanzania's population is characterized by a young age structure, with 43.9% of the total population below age 15 years. The distribution of the young persons (0-14 years) differs by region. Evidence from 2010 Tanzania Demographic and Health Survey (TDHS) shows that the regions with high proportion of young population also exhibit high fertility rates that are well above the national average of 5.4

children per woman. The population pattern depicted in Figure 1 has been almost consistent across all five previous censuses (1967, 1978, 1988, 2002 and 2012).

Tanzania Mainland with a population of **49,261,286** in 2016; and 12 million women of reproductive age and 2 million expected pregnancies is highlighted by a population growth of 3.1%. Women aged 15-49 form a special group of the population due to its role in reproduction. According to Figure 2 this group accounts for 47.2% of total female population in Tanzania Mainland. In Figure 2, with data distributed by region, the highest proportions were recorded in Dar es Salaam (61.9%), followed by Arusha (51.0%), and the lowest was in Simiyu (42.3%).

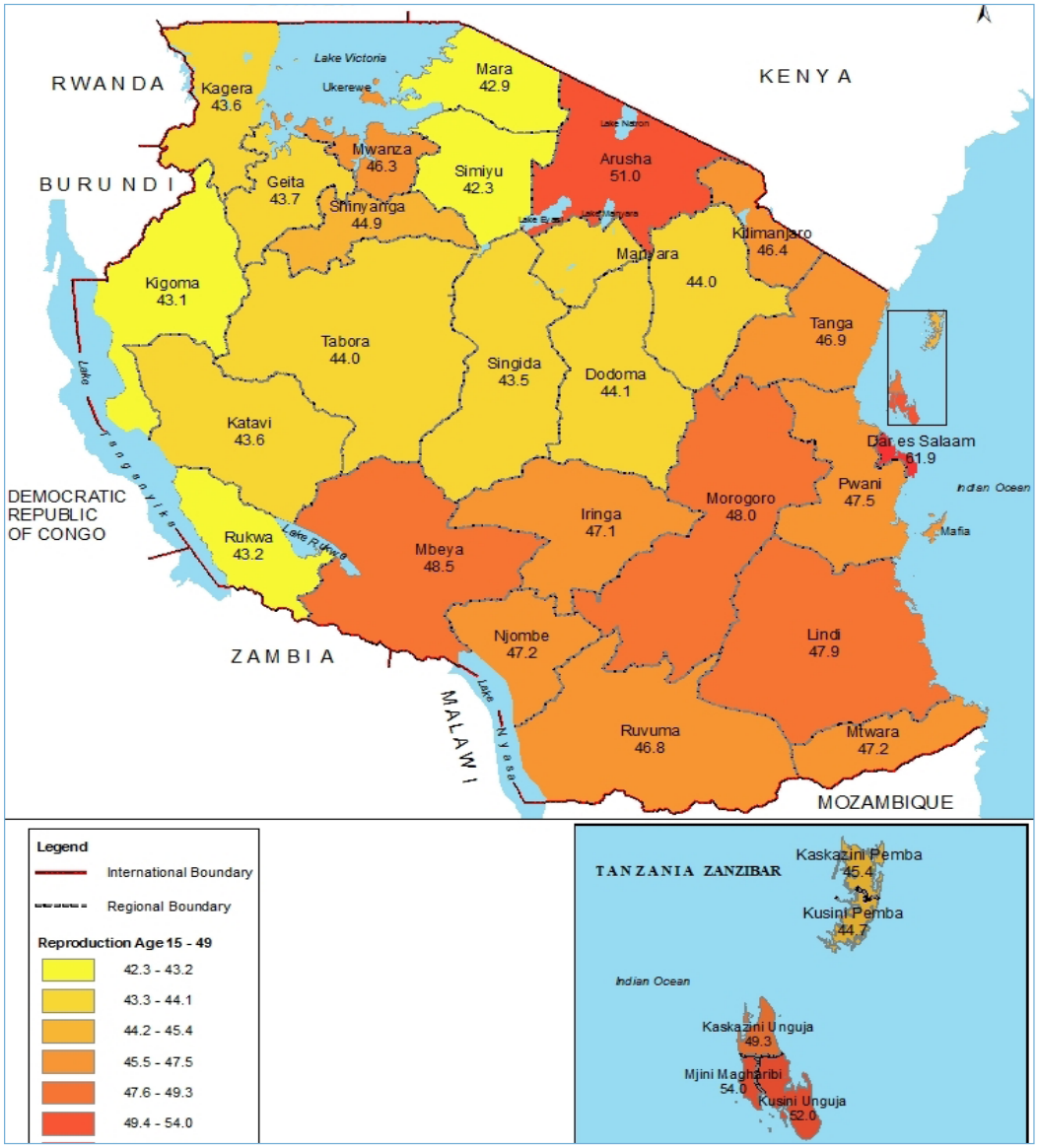

Figure 2:Women of Reproductive Age (15-49 Years) as Percentage of all Females by Region;Tanzania 2012 Census

1.2 Evolution of RMNCAH Services in Tanzania

In 1974, the Government of Tanzania began investing in maternal and child health services (MCH) to address both the population increase; the morbidity and mortality of mothers, newborns and under five children. The services provided included care during Pregnancy, delivery and family planning. In 1975 the Expanded Programme of Immunization (EPI) was initiated and in 1989 the country adopted the Safe Motherhood Initiative (SMI) and National Family Planning Services. The Baby Friendly Hospital Initiative (BFHI) was adopted in 1992 and in 1996 the country adopted the Integrated Management of Childhood Illness (IMCI) for care of common childhood illnesses. The National Program on Prevention of Mother-to-Child HIV Transmission started in 2003; The National Strategy on Infant and Young Child Feeding and Nutrition (IYCF) was developed in 2005. The National ARH services were mainstreamed in the health sector after ICPD 1994 after understanding the country situation and putting in place strategic documents to guide implementers (Adolescent Health and Development Strategy 2004-2008, ARH strategy 2011-2015). In 2008 the country introduced National Reproductive Health cancers - Cervical Cancer Prevention and Control and Health Sector Prevention and Response to gender-based violence. These key programs have shown a positive evolution over time to save the lives of women and children in the country. Tanzania has also made a commitment to provide MNCH services free of charge in 1994 in order to improve access, availability and equity of life saving interventions.

1.3 Alignment of RMNCAH with National policies and strategies

In the National Health Policy of 1990 and 2007, it clearly stated the country's commitment in addressing maternal, newborn and child health. Also being the signatory of the Millennium Development Goals (MDGs), Tanzania strengthened its commitment on reducing maternal, newborn and child deaths and improving the quality of MCH care services in order to meet MDGs 4 and 5 targets by 2015. This priority is reflected in several policy documents produced by the Government of Tanzania.

In the Tanzania Vision 2025, "access to quality reproductive health services for all individuals and reduction in infant and maternal mortality" are among the most important health service goals cited. The National Strategy for Growth and Poverty Reduction (NSGRP/MKUKUTA) also seeks to improve maternal, newborn and child health (MNCH) as one of its major objectives. The Primary Health Service Development Programme (PHSDP/MMAM 2007-2017) addresses the crucial issue of equity by calling for an increase in the coverage and quality of primary health care services for communities living in rural and remote areas. The National RCH Policy guideline 2015, The National Guideline on Essential Reproductive and Child Health Interventions in Tanzania 2003, Reproductive and Child Health Strategy (2005-2010), National Population Policy 1992, 2007 and The Health Sector Strategic Plan III 2016-2020 (HSSP IV) also address importance of reducing maternal and child morbidity and mortality.

1.4 The Government's Commitment to RMNCAH

Tanzania has signed different global and regional initiatives (see Annex 1) to confirm its continued commitment to improving RMNCAH care in the country. In 2008 the Ministry of Health and Social Welfare developed the National Roadmap Strategic Plan to Accelerate Reduction in Maternal, Newborn and Child Deaths (2008 – 2015). In May 2014 the Ministry developed the Sharpened One Plan (2008-2015) to prioritize and scale interventions that improve maternal, newborn, child and adolescent health.

1.5 Coordination of RMNCAH activities

The role of the PO-RALG and MOHCDGEC: Tanzania has a Pyramid structure of health system from the community at the lowest level to the National level. The coordination and management functions of the health system are shared between the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) and the President's Office Regional Administration and Local Government (PO-RALG). The main responsibilities of MOHCDGEC is formulation of policies and technical guidelines, overseeing service delivery, managing and supervising National and Consultant Hospitals; whereas PORALG oversees Regional and District Hospitals, Health centres Dispensaries and provision of various services at the community level through outreach clinics as well as community health workers (CHWs). Zonal RCH offices are functional arms of the Ministry of Health Community Development, Gender, Elderly and Children for provision of RMNCAH services.

Roles of the RCHS within MOHCDGEC: With respect to the main responsibilities of MOHCDGEC the RCHS Section plays four key roles; namely: To prepare and review policy guidelines, manuals for maternal, child, adolescent and community health services; and to co-ordinate, monitor and evaluate maternal, child, adolescent and community based health care including Immunization and Vaccination Development program, community based health care and family planning. Others are to liaise with other Ministries and relevant organizations dealing with Reproductive Health and Nutrition; and to review the list of standard, essential equipment and supplies for provision of quality Reproductive Health care.

Roles of the Communities: Communities are involved in RCH interventions through Councils in the process of planning, monitoring and evaluation and other health services. Their participation includes coordination of the activities of Community Health Workers, inclusion and participation in the health boards and health facility governing committees and promoting RCH outreach activities.

Roles of Private Sector: Through the Public-Private Partnership (PPP) framework, the government ensures availability and compliance to service agreements with non-governmental organizations and private for profit and not for profit institutions. Service data show that public health facilities are the preferred places for most women to get high quality ARH, FP, ANC, labour and delivery, post natal and newborn and child health services; it is essential to engage the private sector to improve MNH at public health facilities. Strengthening the PPP is thus another step towards improving the availability and utilization of affordable RMNCAH

services.

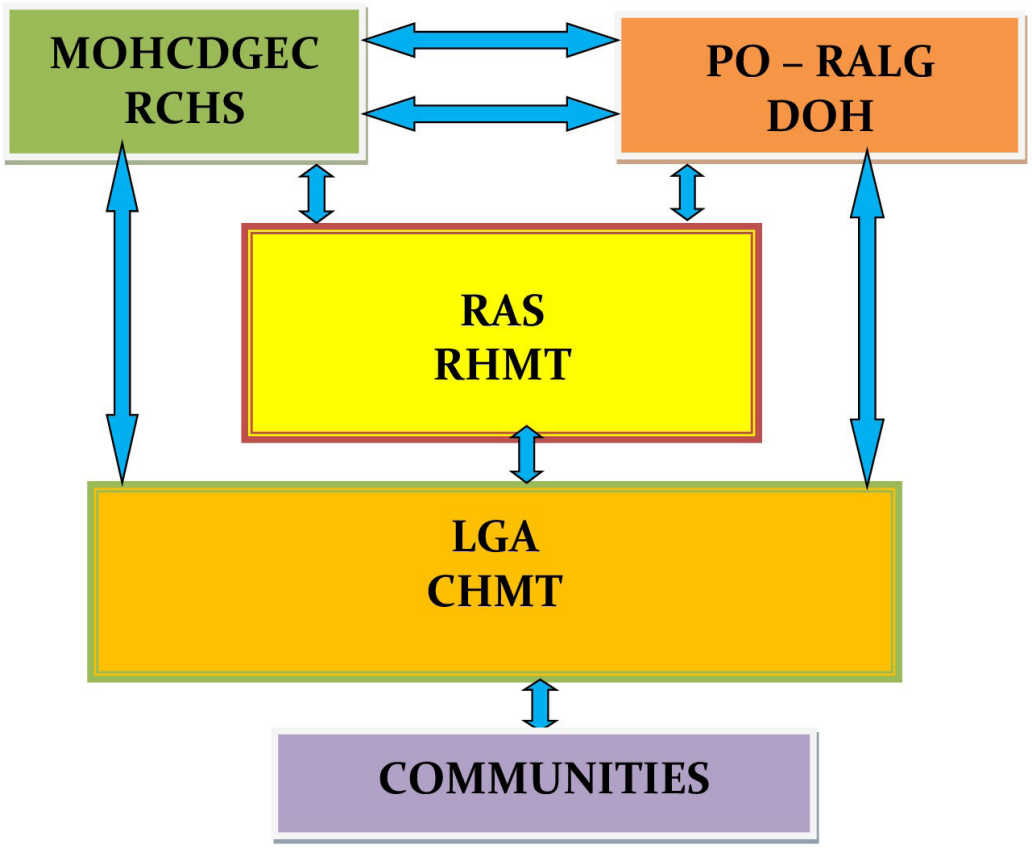

Figure 3: Roles and responsibilities of different actors in delivery of RMNCAH services

Chapter 2: Current situation of RMNCAH in Tanzania

2.1 Tanzania Progress in achieving the MDG 4

Tanzania is among the countries that achieved the MDG 4 target, reducing the U5 mortality rate (U5MR) from 166 per 1,000 live births in 1990 to 112 deaths per 1000 live births in TDHS 2004/2005. Then in 2010 further decline was reported to be 81 per 1,000 in 2010 (TDHS, 2010) and finally in 2012 a set target of 54 per 1,000 live births by 2015 was surpassed (UN Inter Agency Report 2013). The main causes of U5 mortality are as shown in Figure 4.

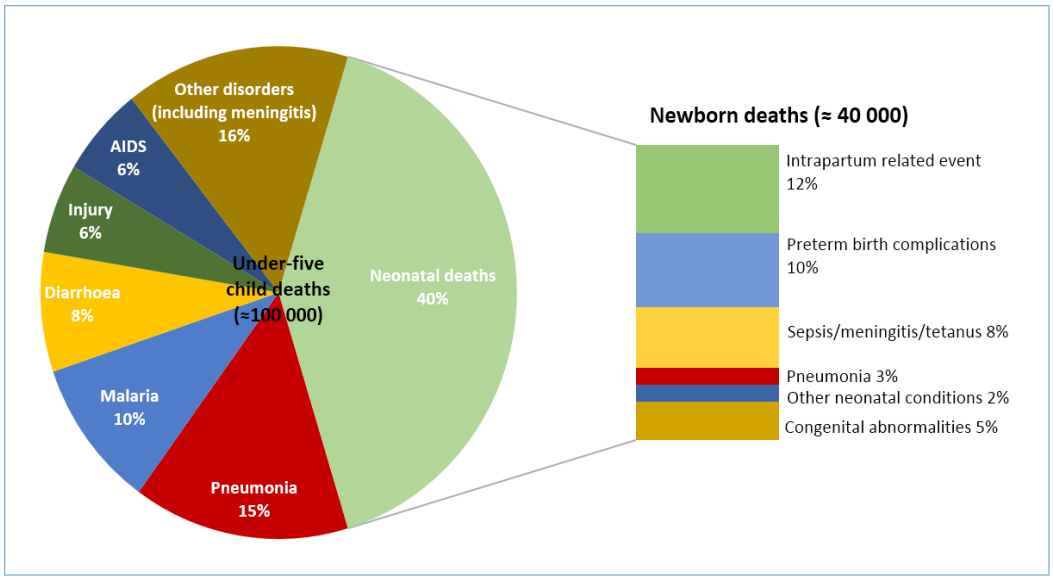

Figure 4: Causes of U5MR in Tanzania; 2012. Source: Countdown Report, 2014

Infant Mortality Rate (IMR) has declined from 68 per 1000 live births in 2004 to 51 per 1000 live births in 2010 (TDHS, 2010); and 45 per 1000 live births in 2013 according to UN Report. Progress in reducing preventable newborn deaths has been slow compared to U5MR and IMR as shown in figure 5. In the One Plan, the target was to reduce neonatal mortality rate (NMR) to 19 per 1000 live births by 2015 (MOHSW, 2008). This target has not been attained as NMR declined from 32 per 1000 live births in 2004/05 to 26 per 1000 live births in 2010 and 21 neonatal deaths per 1,000 live births in 2013 according to UN Report. Neonatal deaths contribute to 40% of U5 deaths, meaning that averting neonatal deaths is critical in overall reduction of U5MR.

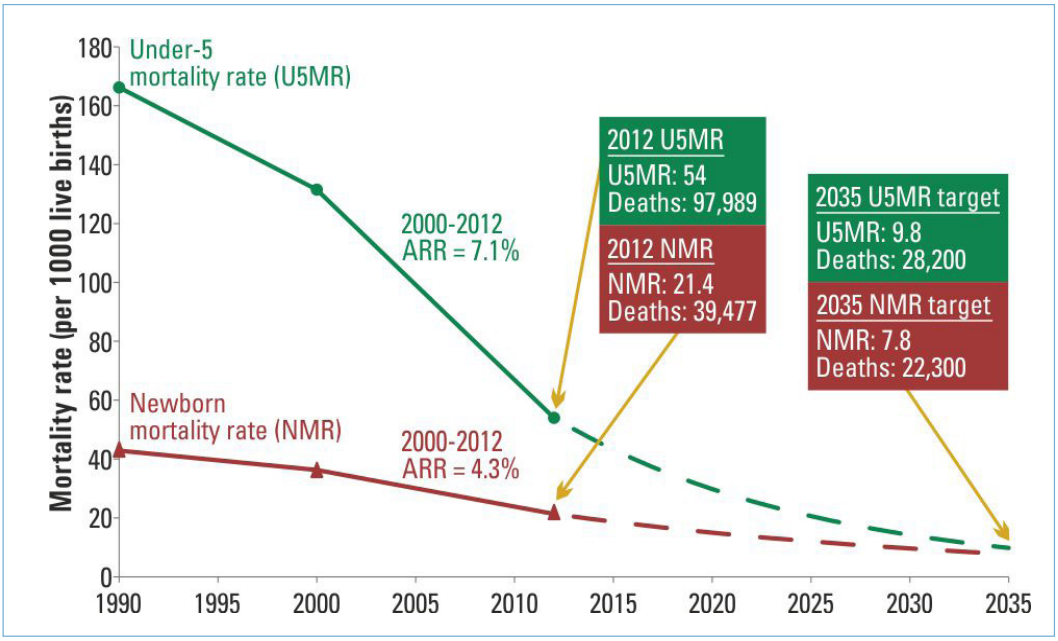

Figure 5:Annual Rate of Reduction of Under-five and Newborn mortality

2.2 Tanzania Progress in achieving the MDG 5

Tanzania has not attained her target of reducing maternal mortality ratio (MMR) to 193 per 100,000 live births by December 31st, 2015. The MMR has declined from 870 per 100,000 live births in 1990 (UN reports) to 454 per 100,000 live births in 2010 (TDHS 2010). The National Census Report (2012) recorded more progress, with further decline of MMR to **432** per 100,000 live births and in 2013 the UN-Report showed reduction of MMR to 410 per 100,000 live births (Figure 3).

Despite a 47% reduction of MMR from 1990-2014, Tanzania made insufficient progress to attain the MDG 5. An average ARR of 5.5% was required for countries to achieve the MDG goal, but from 1990-2013 Tanzania had an ARR in maternal mortality of 3.5% (Countdown to 2015 Report, 2014). The country had an accelerated ARR of 4.8% from 2000 – 2013, which is still below the recommended annual reduction rate of 5.5%.

2.3 Tanzania Progress in achieving the MDG 6

Tanzania has experienced decline of HIV incidence among people aged 15-49 from 0.36% in 2001 to 0.21% in 2012. In 2013, UNAIDS estimates showed that new HIV infections have declined by 49% (UNAIDS, 2013).

The HIV prevalence among adults in the Tanzania Mainland declined from 7.0% in 2003-2004 to 5.3% in 2011-12. The decline was significant among men from 6.3% in 2003-2004 to 3.9% compared to women where the decrease was from 7.7% to 6.3% respectively (THIS 2003-04; THMIS 2011-12).

The country has met the goal of halting and starting to reverse the spread of HIV by 2015.

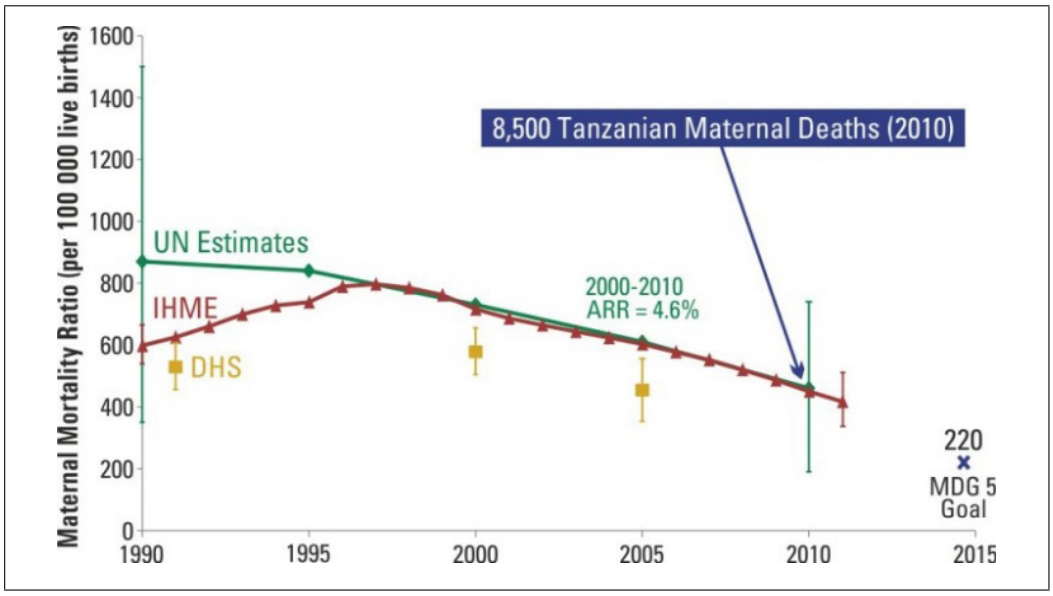

Figure 3: Progress of reducing MMR by 3/4 (1990-2010)

Mother-to-Child transmission of HIV has also declined from 25-30% in early 1990's to 8.6% in 2014 (UNAIDS, 2014; PMTCT, 2014). Several preventive interventions were put in place to combat the HIV epidemic since early 1990's including; behavioural, structural and medical interventions. Limiting number of sexual partners, condom promotion, STIs prevention and treatment, HIV voluntary counselling and testing, Antiretroviral Treatment program, PMTCT/eMTCT program, safe blood and male circumcision program are among the prevention programs that are implemented in the country.

The country is also on target to achieve malaria goal of halting by 2015 and begun to reverse the incidence of malaria. Malaria prevalence among under-fives had declined from 18% to 9% in 2011-12 (THMIS, 2011-12).

2.4 Reproductive Cancers and Health Services to the Elderly

a) Reproductive Cancers

The burden of RH cancers in Tanzania is showing an upward trend as reported by International Agency for Research on Cancer (IARC) that cervical cancer with incidence rate (ASR) is 54.o cases per 100,000 women. Mortality rate due to cervical cancer is 32.4 per 100,000, breast cancer is 9.7 per 100,000 for women and prostate cancer, 27.9 per 100,000 (Globocan, 2012).

A 2014/2015 report from Ocean Road Cancer Institute showed that among new patients; 32.8% (n=5681) had cervical cancer and 12.9% (n=5681) had breast cancer.

In Tanzania, the magnitude of mortality among the elderly people of 60 years and above was 57.4 deaths per 1,000 persons and that of 65 years and above was 74.8 deaths per 1,000 persons. Mortality was higher among males than among females for both age groups (TDHS).

Table 1: Tanzania Estimation of Reproductive Cancer (Globocan 2012)

	Incidence			Mortality		
Cancer	**Number**	**(%)**	**ASR**	**Number**	**(%)**	**ASR**
Breast	2732	8.1	19.4	1355	5.7	9.7
Cervix uteri	7304	21.6	54.0	4216	17.8	32.4
Prostate	3434	10.1	34.6	2752	11.6	27.9

b) RH services for the Elderly

The National Ageing Policy (2003) defines old age and aging as a concept a human growth from childhood, youth to old age. For the purpose of this Strategic Plan, 50 years to 60 years will be considered as a transition age to elderly and elderly will be defined as 60 years and above. These age groups will be dealt in this strategy as after the age of 50 many male and female experience long term health risks, including hormonal changes that contribute to increase risk to chronic diseases and osteoporosis.

The 2012 National Housing and Population Census results show that 5.6 % of the population are aged 60 years old and above and through population projections it is estimated that the individuals in age group will be 2,731,601 in 2016.

Reproductive health for elderly population has been placed on the agenda of the international community and the special need of ageing populations is a global agenda. In Tanzania little has been made to address this issue. Currently, there is no specific health service package aiming elderly as integral to RH programs.

To address the challenges affecting the RH to elderly, the Ministry through RCHS plans to conduct a survey to assess RH needs among elderly in Tanzania. The assessment is expected create awareness and enable programming including developing RH guidelines for elderly.

2.5 Gender in Reproductive Health and Male Involvement

a) Gender in reproductive Health

Gender issues and reproductive health are closely interrelated and jointly affect the reproductive health of both women and men in Tanzania. There are strong links between the gender norms that affect men and boys, and the harmful control and influence of men over women's sexual and reproductive health.

Gender norms contribute to acts of GBV, unsafe sex, teenage pregnancy and unsafe abortions and contribute to maternal mortality especially among adolescents and young women. Harmful practices such as early or child marriages and female genital cutting that affect the health of girls and women are as a result of gender dynamics.

b) Gender Based Violence (GBV) and Violence against Children (VAC)

GBV and VAC are common public health issues in Tanzania. In Tanzania the

prevalence of physical and/or sexual intimate partner violence ranges between 41 – 56% (Garcia-Moreno et al, 2006). TDHS 2010 shows that the prevalence of physical violence among unmarried aged 15-49, and notwithstanding sexual and emotional violence, was 39%. Furthermore, it was reported that the prevalence of GBV during pregnancy was 7-10%, adolescent girls was 24% and that women who experience GBV are likely to be missing ANC and other RH services (TDHS 2010, Hindin et al, 2008; Stockl et al, 2012); these scores are summarised in the table 5 below.

Table 2: Prevalence of GBV and VAC

	Item reported	Proportion
1.	Physical violence among unmarried aged 15-49	39%
2.	Experience of sexual violence unmarried aged 15-49	17%
3.	Experience emotional violence unmarried aged 15-49	36%
4.	GBV among adolescent girls aged 15-19	24%
5.	GBV among adolescent boys aged 15-19	13%

c) Male Involvement

Male involvement in RMNCAH programs is low e.g., in PMTCT program the data shows only 30% do come for couple counselling with their partners.

2.6 Coverage and Attainment of Reproductive, Maternal, Newborn, Child and Adolescent health targets in Tanzania

a) Continuum of care

The continuum of care of RMNCAH, include integrated service delivery to mothers, children and Adolescent from pre- pregnancy, pregnancy delivery, immediate postpartum period and child hood, such care is provided by families and communities through outpatient services, clinics and other health facilities. Safe child birth is critical to health of both the woman and the newborn, and is an essential step towards a sound child hood and productive life.

Continuum of care helps providers to identify ways of coordinating and linking resources to avoid duplication and facilitate seamless movement among care settings. Mothers, Newborn, Children, and Adolescent are inseparably linked in life and health care needs. In the past maternal, adolescent and child health policy and programmes tendered to address mothers, adolescent and child separately, resulting in gaps in health care. Today policy and programmes is shifting towards a maternal, newborn, child health and adolescent continuum of care.

Accelerated progress to scale up key packages in the continuum of care is necessary in Tanzania to achieve Sustainable Development Goals. Essential services must reach more families especially the poor, we should now focus at moving from vertical programmes towards an integrated continuum of care to address needs

of women, newborn, children and adolescent interventions, both curative and preventive.

2.6.1 Maternal Health

Maternal health includes the period from pre-pregnancy, pregnancy, labour and delivery and post natal period.

a) Adolescent Health

Adolescent Fertility Rate (AFR) among 15-19 years has declined from 132 per 1,000 population in 2004 to 116 per 1,000 population in 2010 (TDHS, 2004-05, 2010). The decrease in AFR was noted in every region, social class and zone except for the Western zone (UNICEF, 2011). By the age of 19 years, almost half (44%) of the women are either mothers or are pregnant with their first child (TDHS, 2004-05, 2010). The target was reducing AFR to < 100 per 1,000 births by 2015. One in five adolescents aged 15 -19 is married/cohabiting or divorced (18% and 1% respectively).

Awareness on one or more modern contraceptive methods is high among adolescents (96%), but only 12% of 15-19 years married adolescents use modern contraceptives, an increase from 7% in 2004/05 (TDHS, 2004-05; 2010). Use of condoms at last sex by sexually active unmarried adolescents aged 15-19 years has increased from 38% in 2004/05 to 50% in 2010 for women and from 39% to 46% for men (TDHS, 2010).

Thirty percent (30%) of incomplete abortions turning at hospitals are among 15-19 years (UNICEF, 2011). HIV: Nearly 7 out of 10 youths (15-24 years) are aware of two of the common HIV preventive methods. But only 39% and 25% of young women or men who are sexually active tested for HIV in previous year (UNICEF, 2011). Comprehensive knowledge of HIV is still low among youths; (48% and 43% of young women and men respectively); (THMIS, 2011/12). Youth aged 15 – 24 years account for 60 percent of the new HIV infections in the country. While young men and women are equally infected in the age group of 15-19 (1.3%), women aged 20-24 (1.4%) are more infected than men of the same age group.

Nutrition status: Prevalence of stunting among adolescents is high, reaching 70% at 13 years. Prevalence of anaemia among 15-19 years old was 42% in 2010, a decline from 49% in 2004/05. Some studies have shown 75% of adolescents had anaemia during their first pregnancy (UNICEF, 2011).

Adolescent Friendly SRH (AFSRH) services: Access to AFSRH and FP services is

still a challenge in the country. Studies show that only 30% of service delivery points in the country meet the national standards for AFRHS (UNICEF, 2011). The target was to have 80% of health facilities providing AFRHS/FP by 2015. Parents and community support for adolescents to access available services is low (<20) as well as limited community linkage and community outreach for provision of "youth/ adolescent friendly" SRH services.

Table 3: Adolescent Health interventions current status and target by 2020

S/No	Indicator	Baseline Value	Target by 2020
1	Awareness on one or more modern contraceptive methods	96%	>96 %
2	Use of condoms during last sex among girls (15-19 years)	50 %	80 %
3	Use of condoms during last sex among boys (15-19 years)	46 %	80 %
4	Testing for HIV among girls (15 to 19 years)	39 %	80 %
5	Testing for HIV among boys (15 to 19 years)	25 %	80 %
6	RCH facilities providing Youth Friendly services	30 %	80 %

b) Family Planning

The Contraceptive Prevalence Rate (CPR) has gradually been increasing over time from 6.6% in 1992 to 13.3% in 1999. In recent years, the modern method CPR increased to 20% of married women in 2005 and to 27% in 2010 (TDHS 2010). The increase of new clients receiving modern FP methods among all acceptors was 2.6 million in 2015 (DHIS 2015), of which 15.2 % in 2015 was through outreach approach. This translates into 4.3 million Couple Year Protection (CYP) units in 2015, for all modern family planning methods (DHIS 2015).

This increase in modern-method CPR can be attributed to capacity building of service providers, implementing the regional family planning campaign (regional Green Star re-launch Campaign), improvements in FP supply chain management as well as implementation of a country-wide FP campaign and engagement of the mass media at national and sub-national level in the family planning special event days. However, the Midterm Review of the One Plan in 2013 showed that the use of modern contraceptives methods differed significantly by residency, by zone, region, education and wealth. Women from rural areas, non-educated, poor and living in Western or Lake Zones, in particular have comparatively lower CPR (TDHS, 2010). Given the socio-economic and geographic discrepancies in CPR and the documented limited availability of long term contraceptive, there is need for concerted efforts to

generate demand for and improve access to a full range of FP services.

Among the 6,734 health facilities with RCH services in 2011, 5,366 (80%) were offering family planning services. This proportion increased to 85% in 2012 (HMIS, 2011 & 2012), and to 93.9 % out of the 5,820 facilities providing RCH services in 2014. However, despite high facility coverage of FP services, there is limited availability of long term contraceptive methods such as implants, Inter-Uterine Contraceptive Devices (IUCD), and emergency contraceptives (SARA, 2012; MOHSW & USAID, 2012). This has severely hampered women's wider choice/method mix of contraceptive methods, a reality reflected in community surveys which show that only 0.6% of women use IUCD and 2% use implants (TDHS, 2010).

Community provision of FP services: the community-based program for the provision of family planning services needs to be scaled up to cover the whole country, with special focus on rural and marginalized communities.

Other contributing factors to modern contraceptive increase are strengthening of public-private partnerships for sustained support for contraceptive procurement; capacity building for FP service provision, strengthening of family planning outreach services and training of service providers in integrated logistics System (ILS).

Table 4: Family Planning indicators current status and target by 2020

S/No	Indicator	Baseline Value	Target by 2020
1	Modern methods CPR	27 %	45 %
2	Number of clients receiving modern FP methods	2.6 million	4,2 million
3	Proportion of modern FP methods clients reached through outreach service	15.2 %	30 %
4	Couple Year Protection for all modern methods	4.3 million	6.4 million
5	Increase male involvement on HIV testing during PITC interventions	8 %	30 %

c) Antenatal Care

The TDHS 2010 report showed that attendance for antenatal care at least once is universal (96%). However, women start Antenatal care (ANC) late i.e. only 15% of pregnant women attended for first antenatal care with less than 16 weeks of gestation (TDHS 2004/05 & 2010). The ANC visits 4 or more as recommended in the Focused ANC (FANC) has decreased over time from 71% in 1999, 62% in 2004/05 and 43% in 2010 compared to the national target of 90% (TDHS 2004/05; 2010). A country specific approach to refocus ANC is critical. EmONC Assessment study conducted in September 2015, observed that urine check,

syphilis screening and haemoglobin estimation were essentially performed in less than 50% of health facilities providing FANC services. Other services such as provision of Tetanus Toxoid (TT) vaccine, MRDT, IPTp, HIV screening and testing and ARV use was over 75%.

d) Labour and Delivery

Tanzania DHS survey indicates that the proportion of women giving birth under the supervision of skilled birth attendants (SBA) has slowly increased from 43% in 2004 to 51% in 2010 (TDHS, 2004/05 & 2010). In the same period the proportion of women giving birth in the health facilities also increased from 47% to 50%. There is marked disparity in SBA coverage between urban (83% in 1999 & 83 in 2010) and rural areas (44% in 1999 & 51% in 2010), showing that urban settings had attained the 2015 goal of having 80% of births attended by SBA in 90's compared to rural areas which need accelerated efforts (TDHS 1999, 2004/05; 2010). Zonal and regional disparity on SBA coverage has been observed in Western and Lake Zones compared to Eastern and Northern zones (MTR, MOHSW, 2014).

Table 5: ANC Intervention, current status and target by 2020

Indicator	Baseline Values	Target by 2020
Antenatal		
ANC*1 coverage	96% (TDHS 2010)	>96%
ANC 4 visits	43%	70%
ANC before 12 weeks	15%	40%
TT lifetime protection	88%	90%
Anaemia in pregnancy	53%	< 20%
IPT2 doses	32%	80%
ITN coverage	71%	80%
Syphilis screening during pregnancy	38%	80%
PMTCT		
% Facilities screening pregnant women for HIV	94%	100%
% of Pregnant women tested for HIV	90%	100%
% of HIV-positive receiving ART (Option B+)	75%	90%
% of facilities with PMTCT implement option B+	95%	100%

Source:TDHS 2010,THMIS 2011/12 and SARA 2012, EmONC Assessment 2015, HMIS 2015

Labour and delivery care: Improving universal coverage of routine functions like monitoring and management of labour using partograph and active management of the 3rd stage of labour (AMTSL) for every woman would improve survival (WHO, 2012). Inconsistent use of the partograph is common at all levels of care in the country. The National EmONC Assessment observed that less than 65% of health facilities conducting deliveries were using a partograph. This is happening despite the fact the partograph is a component of the ANC card.

Availability of BEmONC: According to Tanzania (EmONC Assessment, 2015), 13% of dispensaries, 28% of all health centres and 62% of hospitals were capable of performing all 7 signal functions. The challenge to meet the target of 70% for both health centres and dispensaries is observed in the performance of mainly two signal functions namely; assisted vacuum delivery and manual removal of placenta to most of facilities surveyed. The coverage of assisted vacuum delivery was observed to be 17.1%, 33.1% and 67% for dispensaries, health centres and hospitals respectively. Coverage of post-abortion care was 34.5%, 59% and 79% for dispensaries, health centres and hospitals respectively. The overall reported national facility delivery rate is 79%.

Availability of CEmONC: The assessment done revealed 59% of hospitals and 12% of health centres provides Comprehensive EmONC services. This means that these facilities are capable of provision of blood transfusion and Caesarean section in addition to the 7 Basic EmONC functions. The survey further observed that most health facilities conducting deliveries had inadequate reference protocols to guide management of AMTSL, PPH, and Antepartum Haemorrhage, pre-eclampsia /eclampsia, obstructed labour, sepsis and babies born with difficulty in breathing. On the other hand the assessment revealed that less than 20% of facilities conducting labour and delivery had partograph for monitoring labour.

Table 6: Labour and Delivery Intervention, current status and target by 2020

Indicator	Baseline Values	Target by 2020
Care during childbirth		
SBA coverage	51%	80%
Health facility deliveries	79%	90%
BEmONC coverage	13% of dispensary	70% of dispensary
BEmONC coverage	28 % of health centres	100% of health centres
CEmONC coverage	12% of health centres	50% of health centres
CEmONC coverage	59% of hospitals	100% of hospitals
Caesarean Section rate	6%	5-15%

Source:TDHS 2010,THMIS 2011/12 and SARA 2012, EmONC Assessment 2015, HMIS 2015

e) Post-Partum Care

Postpartum period should respond to special needs of the mother and the baby, it should include the prevention, early detection and treatment of complications and provision of advice on and services for breast feeding, child spacing, immunization and maternal nutrition. Psychological problems during this period in time is not uncommon should equally be addressed. About 60% of maternal deaths and about 75% of neonatal deaths occur during the first week postpartum (TDHS 2010) Postpartum care (PNC) visit within the first 2 days is low in Tanzania, with only 31% of the women attending a post-natal care visit (TDHS, 2010) and only 4% complete the required postpartum visits (TDHS 2010)

Table 7: Postpartum Care Intervention, current status and target by 2020

Indicator	Baseline Values	Target by 2020
Postpartum care		
Mother PNC attendance within 2 days	31%	60%
Mothers who completed all required PPC visits	4%	20%

Source:TDHS 2010, HMIS 2015

2.6.2 Newborn and Child Health

a) Newborn care

Essential Newborn Care (ENC): ENC is routine care that all newborns should receive immediately after delivery. The target was to have 75% of the facilities conducting deliveries offering ENC (MOHSW, 2014; WHO, 2014), however, this has not been realized.

Early initiation of breastfeeding: The prevalence of breastfeeding within 1 hour of birth declined from 59% in 2004/05 to 49% in 2010. In Tanzania, a higher prevalence of breast feeding (BF) within 1 hour was noted in urban areas, among educated and wealthier women, women delivering at health facilities and women assisted by a skilled birth attendant (SBA). However, 31% of infants are given pre-lacteal feeds before starting to breastfeed (TDHS, 2010).

Care of Low birth weight infants: The coverage of Kangaroo Mother Care services is limited to less than 20% of health facilities conducting delivery (EmONC Assessment, Sept 2015).

Newborn infections: Thirty seven percent (37%) of dispensaries and 22% of health centres in Tanzania do not have injectable antibiotics. Good infection prevention practices are essential in preventing sepsis at health facilities. In this report, 60-80% of dispensaries or health centres lack sterilization equipment, while 50% of primary health facilities lack basic hand washing facilities like soap & running

water, alcohol based hand rub, and 20% lack disinfectant (SARA, 2013).

ARV Prophylaxis among HIV-Exposed Infants: While maternal coverage of option B+ is high (75 %), coverage of PMTCT intervention during the neonatal period or infancy is low. The proportion of HIV- exposed infants receiving ARV prophylaxis for the first six weeks after birth was 56% in 2011 and the HMIS in 2014 showed a coverage of 52%, way below the target of 80% by 2015. This target was set at 90% in the elimination of MTCT of HIV goals (PMTCT Unit, 2014).

Postnatal care visit for newborns: Nearly 50% of newborn complications and deaths occur within the first 24 hours after birth and postnatal care visit is low with only 41% of newborns were brought for post-natal care visit within 48 hours post-delivery (HMIS 2015).

Table 8: Newborn Health Interventions and 2020 targets

S/No	**Indicator**	**Baseline Value**	**Target by 2020**
1	Neonatal mortality rate (deaths per 1,000 live births	21	16
2	Postnatal care visit within 2 days	41%	80%
3	Early initiation of breastfeeding (within 1 hour after birth)	49%	90%
4	ARV prophylaxis for HIV exposed infants	56%	80%; elimination at 90%
5	Hospitals with functional KMC services	20%	75%

Source:TDHS 2010,THMIS 2011/12 and SARA 2012, HMIS 2015

b) Under Five care

Child Immunization: Tanzania Demographic and Health Survey (2010) results indicate that routine immunization coverage by antigen at the time of the survey (according to vaccination card and history) was; 95.4% for BCG, 87.8% for DTP-HepB-Hib3 and 84.5% for Measles Containing Vaccine 1 (MCV1). Rota, Pneumococcal (PCV 13), Measles second dose and Rubella as MR, and Human Papilloma Virus (HPV) vaccines have been introduced in the country.

Vitamin A: The coverage of Vitamin A supplementation is at 61%, while Vitamin A deficiency among children 6-59 months in Tanzania was measured at 33% (TDHS 2010).

Exclusive Breastfeeding (EBF) for 6 months: Though 97% of Tanzanian children are ever breastfed, the prevalence of EBF has increased from 41% in 2004/05 to 50% in 2010 (TDHS, 2004/05 & 2010). By -3 months of age 33% of infants are given semisolids or solids and it increases to 64% by 4-5 months (TDHS, 2010).

Appropriate Complementary Feeding 6 months to 2 years: Ninety percent of

children age 6-23 months consume breast-milk or other milk products, but only 56% of children are given the appropriate number of food groups and 34% are fed the appropriate number of times per day (National Bureau of Statistics (NBS) [Tanzania] and ICF Macro, 2011).

Stunting: Chronic under-nutrition is a problem as 35% of the U5 children are stunted (height for age). Only 21% of children aged 6-23 months are fed in accordance with the recommended IYCF practices (TDHS, 2010).

Anaemia: Anaemia among U5 children has decreased from 70% to 59% (TDHS 2004-05; 2010).

ARV prophylaxis and testing coverage: Coverage of PMTCT interventions during neonatal period or infancy are sub-optimal. The proportion of HIV- exposed infants accessing ARV prophylaxis was 52% in 2014, far below the elimination goal of 90% by 2015 (WHO, 2012; NACP, 2014). Performance of Cotrimoxazole prophylaxis (34%) and testing of HIV-exposed infants at 6-8 weeks after birth is also low at 30% (NACP, 2014). Low performance of PMTCT intervention during infancy may partly reflect weak postnatal care follow up services and lack of integration of services with programs like immunization which has > 95% coverage (NACP, 2011; MOHSW & USAID, 2012).

Mother-to-Child Transmission (MTCT) rates: Estimates show that MTCT of HIV was 8.6% in Tanzania (NACP, 2014; UNAIDS, 2014).

HIV Treatment among infected children: In 2013 there were about 136,000 children living with HIV in Tanzania (MTR HSSP III, 2013). The coverage of ART among children was 26% using the cut-off point of 350 CD4 count. (MTR -HSSP III, 2013).

Health care seeking and treatment for malaria: Health care seeking for children with symptoms of malaria has improved over time (TDHS, 2010; THMIS, 2011/12). ITN use by children under age 5 has also increased from 36% in 2008 to 73% in 2012 (THMIS, 2011-12) leading to a decline of malaria prevalence among U5 from 18% in 2007/08 to 9% in 2011/12 (THMIS 2007.08 & 2011/12). Among the children who had fever in the two weeks preceding the survey, 59% were treated with any antimalarial, 34% received the recommended drug i.e. ACT in 2011/12 an improvement from 25% in 2007/08 (THMIS 2007/08; 2011/12).

Health care seeking and treatment for Pneumonia: Among the children who had symptoms of pneumonia, 71% sought care in health facilities (TDHS 2010), however, information on the proportion of children treated with antibiotics for pneumonia is limited as it is not collected in the TDHS.

Health care seeking and treatment for Diarrhoea: Among the children who had diarrhoea 53% sought care in health facilities (TDHS 2010). Treatment for diarrhoea is sub-optimal. Out of Diarrhoea cases seen at facilities,-**50%** received the recommended ORS and only **4.7%** receive zinc treatment (TDHS, 2010).

Child deaths review: There is no system in place for reviewing child deaths (under-

five death review) in Tanzania despite having 98,000 deaths annually.

c) Under Underfive (U5) Birth Registration

The WHO notes that birth **registration** helps with the identification of population health needs and advises that birth registration should take place "immediately" after birth, the standard measure being within 30 days of birth as part of the global efforts aimed at improving early childhood development. In line with this, the Commission on Information and Accountability for Women's and Children's Health (CoIA) in March 2011 adopted a comprehensive resolution on children's right to health on the application of a human rights-based approach to reduce preventable U5 mortality and morbidity; including the adoption of the second resolution on birth registration. The move to high coverage health services for mothers and children makes universal birth registration at or shortly after birth a realistic goal.

In 2014, an Inter-Ministerial Memorandum of Understanding was signed for the Implementation of the National U5 Birth Registration Strategy between Ministry of Constitutional and Legal Affairs, and the then PMO-RALG and MOHSW. Health facilities increasingly play a key role in the system of Birth Registration because the majority of children are born in health facilities and nearly all children are vaccinated. Tanzania follows the internationally agreed "Reaching Every Child" (REC) approach. As a result of this agreement, the Registration, Insolvency and Trusteeship Agency (RITA) in collaboration with MOHCDGEC launched a campaign for U5 registration after a successful piloting in Temeke Municipal Council in Dar es Salaam. The new birth registration system enables all U5s to be registered and issued with birth certificates at their localities. The "U5 Birth Registration Initiative" has been rolled 2-other regions, namely Mbeya and Mwanza regions. As by mid-2016, the initiative has registered 416,844 U5s. During the period 2016 to 2020, health facilities in Tanzania Mainland, increasingly will play a role during the provision of RCH services in the system of Birth Registration because the majority of children are born in health facilities and nearly all children are vaccinated.

d) Care of children aged 5 to 9 years:

This age group remains relevant in the strategy and their health needs are partly a continuation of the under-five challenges. To address their health challenges, there is a need to take into account issues around child protection and early child development based on human rights approach. Beyond the health burden, this group is vulnerable to other environmental determinants of health injuries especially road traffic and home accidents which increase morbidity burden in this group. Effective interventions delivered through school health programs and at the community level will act as a bridge to improve adolescent health.

Table 9: Child health interventions current status and target by 2020

S/No	Indicator	Baseline Value	Target by 2020
6	U5MR (deaths per 1,000 live births)	54	40
	Immunization		
1.	DPT-HepB-Hib 3 Regions coverage	84% in 90% of the regions	90% in 90% of the regions
8	DPT-HepB-Hib 3 Councils coverage	83% in 90% of councils	90% in 90% of the councils
9	Measles Rubella coverage	80% in 90% of the councils	90% in 90% of the councils
10	Vitamin A coverage	61%	90%
	Nutrition		
11	Exclusive breastfeeding for 6 months	50%	90%
12	Appropriate complementary feeding at 6-23 months	56%	90%
13	Stunting	35%*	22%
14	Underweight	16%	14%
15	Anaemia in U5	59%	< 20%
	HIV prophylaxis and treatment		
16	ARV coverage among HIV exposed children	56%	80%; elimination 90%
17	Cotrimoxazole coverage among HIV exposed children	34%	80%
18	Testing coverage among HIV exposed children at 6 weeks or 12-18 months	30%	90%
19	Mother-to-child HIV transmission	8.6%	Elimination < 5%
20	% Children in need ART on treatment	26%	60%
	Pneumonia, Malaria & Diarrhoea		
21	Care seeking for pneumonia	71%	90%
22	Care seeking for diarrhoea	53%	90%
23	Care seeking for malaria/fever	77%	90%
24	ITN use among U5	73%	80%

*Source:TDHS 2010,THMIS 2011/12 and SARA 2012, HMIS 2015, *SMART Survey 2014*

2.6.3 RH Cancers and RH Services for the Elderly

Tanzania introduced cervical cancer screening using Visual Inspection with Acetic Acid (VIA) and treatment with cryotherapy or Loop Electro-surgical Excision Procedure (LEEP) as a strategy for cervical cancer prevention (MOHSW, 2011a). The screening has been introduced in 300 sites mainly in national, zonal and regional referral, regional hospitals as well as district hospitals (RCHS, 2014). In additional, further screening is established in some health centres but few dispensaries. Furthermore, progress has been made in primary prevention of cervical cancer by piloting HPV vaccine in Kilimanjaro region. Likewise, breast and prostate cancers its magnitude is unknown and coverage is still low though there been some initiatives to mass mobilization has been conducted in the community.

The needs for improving RH services access to the elderly population are becoming increasingly important. The elderly are highly vulnerable to poverty, and frequently have limited access to RH services, sometimes victims of sexual and gender-based violence and discrimination, particularly to women.

Table 10: Reproductive Health Cancers Services interventions current status and target by 2020

S/No	Indicator	Baseline Value	Target by 2020
Reproductive Health Cancers			
1	Proportion of Health centres providing breast cancers screening services	10%	80%
2	Proportion of female clients screened for VIA	12%	80%
3	Proportion of services delivery points providing prostate cancer screenings	5%	60%

Table 11: Health Services for the Elderly interventions current status and target by 2020

S/No	Indicator	Baseline Value in 2015	Target by 2020
RH Services for the Elderly			
1	Proportion of community based outlets to create awareness on common reproductive health problem among elderly	0 %	50 %
2	Proportion of elderly population aged 60 years and above receiving reproductive health services	0%	50 %

2.6.4 Gender in Reproductive Health

a) Gender services in Tanzania

The provision of GBV and VAC in Tanzania has been undertaken through the integration of health services which has a strong network. To achieve this, more than 1,500 HCWs have been trained to care and treatment of survivors by the end of 2015.

Throughout the country seven (7) one-stop centres have been established at district hospitals integrating different stakeholders for advanced psychological care, support and medical treatment as well as collecting forensic evidence for legal action(s). Fifteen (15) regions have been trained and currently reporting routine GBV/VAC data from their respective councils.

b) Community-based GBV and VAC prevention

To ensure sustainability of GBV and VAC detection and reporting in the communities, the MOHCDGEC has incorporated gender and reproductive issues into the curriculum of community health workers, in **early 2015**.

c) GBV communication initiative

To strengthen GBV/VAC prevention strategies, the Ministry is in process to develop a communication initiative among stakeholders from community, health facility, council/district, region and national level. Through this initiative numbers of stakeholders will be registered in the phone directory for easy referring during emergencies/events. So far, the initiative has been mapped in 10 regions. At the council level, stakeholders include police force, hospital, and social worker.

Table 12: GBV and VAC and Male Involvement interventions current status and target by 2020

S/No	Indicator	Baseline Value	Target by 2020
Gender Based Violence (GBV) and Violence against Children (VAC)			
1	Proportion of service delivery points providing post GBV services	30 %	80 %
2	Proportion of service delivery points providing post VAC services	30 %	80 %
3	Proportion of GBV and VAC survivors who experienced any violence who reported within 72 hours after an event.	30 %	60 %
4	Proportion of councils with active community based GBV and VAC prevention programs	0 %	30 %
Male Involvement			

5	Increase the proportion of CHWs oriented on Male involvement by 2020	0 %	50 %
6	Increase the proportion of health care providers trained on male involvement by 2020	0 %	60 %
7	Increase the proportion of household members that have awareness on male involvement by 2020	0 %	50%

2.7 Rationale for the One Plan II

This strategic plan provides guidance for implementation of RMNCAH interventions in the country building on the progress made under the One Plan (2008-2015). The plan takes into account sustainable development goals that aim to end preventable maternal, newborn, child and adolescent deaths by 2035. It will build those interventions that were missed in One Plan like Reproductive health as well as those that influence access and quality of RMNCAH care services like gender-based violence, violence against children, human rights, integration of services and community engagement.

The description of situation analysis in this Plan, marginal RMNCAH quality of service provision has been identified as a biggest bottleneck in reduction maternal and newborn deaths and further decline of U5 mortality. For this reason, this plan needs to address this gap critically so as to make a huge gain in SDGs by 2020 and thereafter.

Therefore, the focus of this Strategic Plan (2016-2020) is on reducing maternal, newborn, child and adolescent morbidity and mortality by putting more emphasis in the provision of quality RMNCAH services, equitable, offered by skilled attendants, in enabling environment and in an integrated manner along the continuum of care taking into consideration of community and facility factors. Objectives, goals, strategies and activities aimed in this strategic plan are expected to fill the gap observed in the RMNCAH provision during the era of MDGs.

2.8 Sustainable Development Goals

Sustainable development goals (SDGs) adopted by world leaders in September 2015, they build on the success of the MDGs and aim to go further to end all forms of poverty. The new goals are unique that they all call for action by all countries. While the SDGs are not legally binding, governments are expected to take ownership and establish frame works for achievement of 17 goals. In the development of this document the SDGs were highly considered particularly the health related goal number 3, goal number 5, on gender equality and women empowerment and goal number 17, on partnership.

Chapter 3: Vision, Goals and Targets for RMNCAH

3.1 Vision

A healthy and well-informed Tanzanians with access to quality reproductive, maternal, newborn, child and adolescent (RMNCAH) services; which are affordable, equitable and sustainable.

3.2 Mission

To promote, facilitate and support in an integrated manner, the provision of comprehensive, high impact and cost effective RMNCAH and nutrition services, along the continuum of care to men, women, newborns, children and adolescents.

3.3 Goal

To Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania in line with the National Developmental Vision 2025.

3.4 Key RMNCAH Strategies

3.4.1 Strengthen Reproductive Maternal Newborn Child and Adolescent Health:

i. Strengthen Maternal Health and Newborn health services, including: Family Planning (FP); Focused Antenatal Care (FANC); Post Natal and Newborn care; and Emergency Obstetrics and Newborn Care (EmONC).

ii. Strengthen and improve visibility of adolescent reproductive health services including strengthening the adolescent health programme, improving its visibility; and developing and implementing a comprehensive strategy for adolescent health.

iii. Scale up and expand the coverage for Reproductive Health (RH) services, including: FP, Reproductive Cancers, Reproductive Gender (GBV and VAC), and Reproductive Health needs of the Elderly, Fistula, and male reproductive health including male involvement in reproductive health interventions.

3.4.2 Scale up the child health programme:

i. Scale up coverage of the Immunization and Vaccine Development program, care for the sick child and Emergency Triage Assessment and Treatment.

ii. Strengthen the implementation of the Integrated Management of Child Illnesses (IMCI) interventions.

iii. Scale up newborn, infant and young child feeding services, including promotion of early initiation of breast feeding, exclusive breastfeeding, and complementary feeding after 6 months.

3.4.3 Strengthen response to cross-cutting issues:

i. Strengthen RMNCAH interventions through the Operationalization of the Annual One Plan II Operational Plans, and convening of annual RCH meetings.
ii. Improve the availability of RMNCAH and nutrition commodities (RMNCH Lifesaving commodities, FP commodities, vaccines, therapeutic feeds, Vitamin A for U5 children, iron-folate supplements for pregnant women).
iii. Strengthen community involvement in RMNCAH and nutrition services.
iv. Provide comprehensive health promotion and education services in all RMNCAH programmes.
v. Strengthen the RMNCAH Management Information System and Operational Research activities.

3.5 RMNCAH Impact Indicators

1. Reduce maternal mortality from 432 to 292 per 100,000 live births by 2020.
2. Reduce neonatal mortality rate from 21 t0 16 per 1,000 live births by 2020.
3. Reduce infant mortality rate from 45 to 25 per 1,000 live births in 2020
4. Reduce under-five mortality from 54 to 40 per 1,000 live births by 2020.

3.6 Operational targets to be achieved by 2020

The following operational targets will be reached by 2020. These are:

a) Adolescents Health Services

1. Reduce Adolescent fertility rate from 116 per 1,000 to 90 per 1,000.
2. Increase number of service delivery points providing Friendly Reproductive Health Services for adolescents and youth from 30% to 80%.
3. Increase community base outlets offering comprehensive SRH, life skills, Information, Education and Counselling Services from 46% to 80%.

b) Family Planning services

1. Increase modern contraceptive prevalence rate from 27% to 45% in 2020
2. Increase the proportion of new clients receiving modern FP methods among all acceptors from 2.6 million in 2015 to 4.2 million in 2020.
3. Increase the proportion of modern FP methods clients reached through outreach service approach from 15.2 % in 2015 to 30 % in 2020.
4. Increased Couple Years of Protection by all modern methods from 4.3 million in 2015 to 6.4 million in 2020.
5. Increase male involvement on HIV testing during PITC interventions from 8% to 30 % in 2020

c) Maternal Health

1. Increase four or more antenatal care visits from 43% to 70%.
2. Increase coverage of health facility delivery from 50% to 80%.
3. Increase coverage of deliveries attended by Skilled Health providers from

51% to 80%.
4. Increase coverage of BEmONC at dispensary from 13% to 50% %.
5. Increase coverage of BEmONC at health centres from 28% to 100%.
6. Increase coverage of CEmONC for hospitals from 59% to 100%.
7. Increase coverage of CEmONC from 12% to 50% for health centres.
8. Increase ART coverage and retention among HIV-positive pregnant women from 75% to 100%
9. Increase postnatal care within first 48 hours from 31% to 80%.
10. Increase male involvement on HIV testing during ANC interventions from 44 % to 60 % in 2020.

d) Newborns and Child Health

1. To reduce stillbirth rate from 16 to 8 per 1000 live births.
2. Maintain immunization coverage by antigen of Pentavalent 3 (DPT-Hepatitis B-Hib), vaccines to above 90% in 90% of the councils.
3. HPV and inactivated polio vaccines scaled up to 90% of the councils.
4. Increase initiation of breastfeeding within 1 hour after delivery from 49% to 80%.
5. Increase proportion of health facilities with health care providers conducting deliveries which provide Essential Newborn Care (ENC) to 75%.
6. Increase proportion of primary health facilities with at least 2 service providers trained in IMCI distance learning from 23 % to 50% by 2020.
7. Increase proportion of councils with at least 60% of primary health service providers trained in IMCI through distance learning approach from 10% to 50% by 2020.
8. Increase ARV-prophylaxis coverage for HIV-exposed children from 56% to 90%.
9. Increase coverage of Early Infant Diagnosis (EID) from 37% to 95% of all exposed Infants.
10. Increase ART coverage for HIV infected children from 26% to 80%.
11. Reduce Mother-to-Child Transmission rate from 8.6% to < 5%.
12. Reduce stunting among under five children from 35% to 22%.

e) Reproductive Cancers and RH Services to the Elderly

1. To increase the proportion of service delivery points providing breast cancers screening services from 5 % to 60% by 2020.
2. To increase Proportion of female clients 30-50 years screened for Cervical Cancer using VIA from 28.9% to 60% by 2020.
3. Increase the proportional of services delivery points provided prostate cancer screenings from 1% to 30% by 2020.
4. Increase community base outlets to create awareness on common reproductive health problem among elderly including sexual dysfunction, menopause and andropause from 0 to 50% by 2020.
5. To increase proportion of elderly population aged 60 years and above receiving reproductive health services to 50% by 2020.

f) Reproductive Gender and Male Involvement Health Services

1. To increase the proportion of service delivery points providing post GBV services from 18.7 % to 80%.
2. To increase the proportion of service delivery points providing post VAC services from 18.7 % to 80%.
3. To increase the proportion of GBV and VAC survivors who experienced any violence who reported within 72 hours after an event increased from 30 % to 60 % by 2020.
4. To increase the proportion of councils with active community based GBV and VAC prevention programs increased from 0 % to 30 %.
5. Increase the proportion of household members aged 15 to 49 reached by GBV and VAC SBCC messages and materials from 0 to 50 % by 2020.

g) Cross cutting

1. To sustain accountability by promoting development of national, regional and district implementation plan in line with One Plan II.
2. To increase the proportion of villages with 2 community health workers offering RMNCAH and nutrition services at community level to 75%.
3. Increase the level of data timeliness reporting from 83 % in 2015 to 95 % by 2020.
4. Increase the level of data completeness reporting from 94 % in 2015 to 98 % by 2020.

3.7 Implementation Approaches Strategies

The following approaches will be used during the operationalization of the stipulated strategies during the implementation of the One Plan II:

1. Networking, effective collaboration, joint planning and resource mobilization for RMNCAH goals and agenda in order to promote, implement, and scale up evidence-based and cost-effective interventions, and allocate sufficient resources to achieve and sustain national and international goals and targets.
2. Improve quality of care at all levels of service delivery and health administration through health system strengthening and capacity development to achieve high population coverage of high impact RMNCAH interventions including nutrition in an integrated manner.
3. Community mobilization and participation to improve key maternal, newborn and child care practices generate demand for services and increase access to services within the community.
4. Fostering partnership to conceptualise, plan and implement promising interventions among Government (as lead), donors, NGOs, the private sector and other stakeholders engaged in joint programming and co-funding of activities and technical reviews.
5. Collaborate and coordinate supportive policies and legal environment that impact on social determinants of health; girls and boys education, women's

empowerment; respectful care, opportunities for economic growth using IEC/BCC materials and put emphasize on nutrition, education, water and sanitation.

6. Strengthen RMNCAH scorecard result dissemination at all levels of the health system and among partners, for better transparency and mutual accountability.
7. Increase the efficiency and effectiveness of the organization by increasing the mandate of the organization through evidence based performance review.

3.8 Impleentation guiding principles

The following principles will guide the implementation of the One Plan II:

- **Continuum of Care:** Ensuring provision of the continuum of care from pre-pregnancy, pregnancy, labour and delivery, neonatal, childhood and adolescence across all levels of services delivery (household, community, primary facility to referral level).
- **Integration:** Ensure RMNCAH services are delivered in an integrated manner at the primary point of care to improve access and minimize missed opportunities.
- **Evidence-based approach:** Ensuring that the interventions promoted through the plan are based on priority needs, up-to-date evidence, and are cost-effective.
- **Complementarities:** Building on existing programmes by taking into account the comparative advantages of different stakeholders in the planning, implementation and evaluation of MNCH programmes.
- **Partnership:** Promoting partnership, coordination and joint programming among stakeholders including the regional secretariat, district councils, private sector, faith-based sector, academia, professional organizations, civil society organizations, as well as communities, in order to improve collaboration and maximize on the available limited resources by avoiding duplication of effort
- **Addressing underlying causes of high mortality:** Taking a multi-sectoral and partnership approach to address the underlying causes of maternal, newborn and child death such as, transport, nutrition, food security, water and sanitation, education, gender equality and women empowerment to ensure sustainability.
- **Shared responsibility:** The family/household is the primary institution for supporting holistic growth, development and protection of children. The community has the obligation and the duty to ensure the survival and health of mothers and children and ensuring that every child grows to its full potential. The state, on the other hand, has the responsibility for developing a conducive legislation and public service provision for survival, growth and development.
- **Division of labour for increased synergy:** Defining roles and responsibilities of all players and partners in the implementation, monitoring and evaluation of the activities for increased synergy and

impact.

- **Appropriateness and relevance:** Interventions must rely on a clear understanding of the status and local perceptions of MNCH in the country.
- **Transparency and accountability:** Promoting a sense of stewardship, accountability and transparency on the part of the Government as well as stakeholders for enhanced sustainability.
- **Equity and accessibility:** Supporting scaling-up of cost-effective interventions that promote equitable access to quality health services with greater attention to the youth, poor and most vulnerable children and other groups in need, especially in rural and underserved areas.
- **Phased planning, and implementation:** Promoting implementation in clear phases with timelines and benchmarks that enable re-planning for better results. Building and strengthening existing health infrastructures will be a priority.
- **Human rights and gender in health:** The right to life and health are basic human rights. Mainstreaming gender throughout the programme and adopting a human rights approach as the basis of planning and implementation is important. It is also critical to understand that children rights are important human rights and therefore need to be respected at all time.

3.9 Service delivery

Service delivery for maternal and newborn health will strategically be improved especially in low performing regions through establishment of health facilities that provides comprehensive emergency obstetric and newborn care. These health facilities to be operational, the gaps shall be identified through the results of EmONC assessment.

Clinical mentorship system for RMNCAH human resource for health will be established. This system shall link with the available supportive supervision system to close the quality gap that will be detected among health care providers. Quality improvement activities will also be linked with available HSSP initiatives.

3.10 Dissemination of RMNCAH documents

In line with the Paris declaration and for the purpose of having uniformity, equity and good coverage of all intervention across the country there shall be a dissemination of policies, strategies and guidelines on RMNCAH during the fiscal period of this strategy. The dissemination of this strategy, other related policy document and results shall be led by the Ministry in collaboration Local Government at national, regional, district and community or health facility. For this strategy, the Ministry, Local Government and stakeholders through RMNCAH TWG shall form a team that will be responsible to dissemination to all regions of Tanzania Mainland.

CHAPTER 4: Detailed interventions and activities

This chapter outlines strategic objective, activities and targets that will contribute in achieving goals of One Plan II

Strategic Objectives, Targets and Activities for One Plan II: 2016 – 2020

Program	Key Result Area	Activities	Target 2020
Maternal Health	KRA 1: Utilization and quality of ANC services improved by 2020	Activity 1.1: Procure and supply essential medicines, equipment and laboratory reagents. Activity 1.2: Conduct training to service providers on ANC. Activity 1.3: Conduct external and internal supportive supervision and mentorship. Activity 1.4: Print ANC (RCH card No. 4 and TT cards, IEC materials guidelines and job aids.	• Increase 4 ANC visits from 43% to 70%. • Increase % of pregnant women tested for Syphilis from 38% to 80%. • Increase % pregnant women tested for HIV from 90% to > 95%. • Increase ITN use for pregnant women from 71% to 90%. • At least 75% of hospitals with antenatal care services have antenatal corticosteroids to reduce morbidity and mortality due to preterm birth.
	KRA 2: Skilled birth attendant utilization increased by 2020	Activity 2.1: Mapping of cadres available by facility level and ensure strategic allocation of skilled HRH to enable appropriate service delivery. Activity 2.2: To conduct advocacy meeting with councils to lobby with pre-service students in training institutions.	• Increased SBA coverage from 51% to 80%

	KRA 3: Access and availability of BEmONC increased by 2020	Activity 3.1: Review BEmONC guidelines, IEC materials and job aids. Activity 3.2: Print and disseminate BEmONC guidelines, IEC materials and job aids. Activity 3.3: Conduct training to update knowledge and skills of health providers on Basic Emergency Obstetric and Newborn care.	• Increase BEmONC coverage from 13% at dispensary to 50% and 28% at health centres to 100%. • 100% of Health facilities conducting deliveries have recommended equipment for newborn resuscitation (bag, mask
	KRA 4: Access and availability of EmONC increased by 2020	Activity 4.1: Review and update EmONC guidelines including job aids. Activity 4.2: Print EmONC Training Package and IEC materials. Activity 4.3: Conduct training to update knowledge and skills of service providers in EmONC. Activity 4.4: Conduct mentorship for Health Centre providing CEmONC Activity 4.5: Conduct Anaesthesia training for HCWs in CEmONC sites Activity 4.6: Conduct refresher training to update competence of pre-service tutors in nursing, clinical and medical schools in EmONC Activity 4.7: Standardize architectural drawings for theatres for CEmONC sites Activity 4.8: Construct/Renovate theatres and maternity wings for CEmONC sites Activity 4.9: Advocate for Construction/Renovation of maternity waiting homes for CEmONC sites	• Increase CEmONC coverage for hospitals from 59% to 100% • Increase health centre CEmONC facilities from 12% to 50%. • 80% of CEmONC facilities quality improved to 3 stars • Increase maternity waiting homes. • Increase availability of BEmONC service; dispensaries from 13% to 50% and health centres from 28% to 100%.
	KRA 5: Enhanced accessibility and utilization of safe blood and blood products for CEmONC services in health facilities by 2020	Activity 5.1: advocate for resource mobilization for establishment of Regional blood banks in collaboration with Tanzania National Blood Transfusion Services. Activity 5.2: advocate for resource mobilization to procure equipment, supplies for collecting safe blood for satellite sites.	• 80% of the regions have function blood banks.

	KRA 6: MNCH referral system improved by 2020	Activity 6.1: Advocate to local government to procure ambulances for CEmONC facilities. Activity 6.2: Conduct sensitization meetings with business community to support referral system. Activity 6.3: Conduct advocacy meetings with councils through PPP to establish voucher scheme to enhance referral system Activity 6.4: Improve communication system between health facilities to improve quality of referral	• At least 80% of the councils have functional referral system from the community to first level facilities.
	KRA 7: Availability of life saving commodities, supplies and medicines for MNCH improved by 2020.	Activity 7.1: Procure and distribute life saving commodities i.e. Fefol, Oxytocins, Misoprostol, injection Magnesium sulphate, injection Hydralazine, tablet Methyldopa, Antenatal Corticosteroids, Inj Gentamicin, Inj Ampicillin, Inj Metronidazole, MVA kits, for all EmONC facilities. Activity 7.2: Conduct surveillance of availability of life saving commodities in EmONC facilities using ILS Gateway.	• Maternal life saving commodities stock maintained to at least less than 80% of the times.
	KRA 8: MPDSR framework and use is implemented by 2017.	Activity 8.1: Print Maternal Perinatal Death Surveillance and Response (MPDSR) guidelines Activity 8.2: Disseminate MPDSR Guidelines Activity 8.3: Support implementation of MPDSR to improve quality of care and accountability in the implementation of RMNCAH interventions. Activity 8.4: Link MPDSR with IDSR weekly reporting. Activity 8.4b: Conduct quarterly maternal death response guided by surveillance Activity 8.5: Conduct MPDSR technical meetings at: national, biannual; regional levels, quarterly; and district level, monthly. Activity 8.6: Publish and disseminate national MPDSR report.	• 80% of councils have institutionalized MPDSR

	KRA 9:Elimination of mother to child transmission (eMTCT) realized at below 5% transmission rate by 2020	Activity9.1:OrientRHMTs,CHMTsoneMTCTinterventionsand bottleneck analysis Activity 9.2:Conduct eMTCT sub-team meetings Activity9.3:Procureantiretroviralmedicines,HIVtestkits,DBSkits for RCH sites Activity 9.4: Conduct training to strengthen human resource capacity and systems to deliver quality and integrated comprehensive eMTCT services at all levels of service delivery. Activity9.5:ConductbiannualPMTCTdataqualityassessment Activity9.6:ConductPMTCTsupervisiontohealthcareworkersin RCHS facilities for quality improvement Activity 9.7: Printing registers, report forms, cards, laboratory forms, and training manuals	• ReduceMTCTofHIVfrom8.6%to 4%. • Increase % of pregnant women tested for HIV and receiving results from 90% to > 95%. • Increase ART coverage and retention among HIV-positive pregnant women from 79% to 90%. • Increase % of couple counselled and tested for HIV from 30% to 50%. • Increase%ofHIV-exposedinfants tested for HIV within 2 months of age from 30% to 90%. • Increase%ofHIV-exposedinfants receiving ARV prophylaxis from 56% to 90%. • Increase % HIV-exposed infants receiving Cotrimoxazole prophylaxis from 34% to 90%. • Increase%ofHIV-positivechildren on ART treatment from 26% to 60%.
	KRA 10:MNCAH community services improved by 2020	Activity 10.1:Train community health workers on integrated community maternal, newborn, child health and nutrition activities Activity10.2:Equipcommunityhealthworkerswithworkingtools Activity 10.3:Conduct advocacy meetings for every village to mobilize community resources for emergency transport Activity10.4:Conducttrainingforcommunityhealthsupervisors on integrated maternal, newborn, child and adolescent health Activity 10.5 Print CHWs materials on MNCAH	• At least 75% of districts have institutionalized CHW services.

	KRA 11:Postnatal care services increased in coverageandqualityby 2020	Activity 11.1:Review and update postnatal care guidelines Activity11.2:Conducttrainingtoupdateknowledgeandskillsof health care providers on essential postnatal care and monitoring Activity 11.3:To develop and print minimum package for integrated RMNCAH outreach services to reach women,newbornsandchildrenatthecommunity	• Increase%ofwomenreceiving PNC within 48 hours from 31% to 80%. • Increase women receiving PNCwithin7-daysfrom__%to 50% by 2020.
	KRA 12:Improve maternal and lactating mothersnutritionstatus and practices by 2020	Activity12.1:Developandprint,maternalnutritionguidelineand training package Activity 12.2: Pilot maternal and lactating mothers nutrition guideline and training package to few identified HCW. Activity 12.3 Disseminate maternal and lactating mothers nutritionguidelinesbyorientingregional,district and health facility teams	• Reduce anaemia in pregnancy from 53% to 37%

Program	Key Result Area	Activities	Target 2020
Newborn Health	KRA1:Essentialnewborn careservicesprovidedat all facilities conducting deliveries by 2020.	Activity1.1:ConductEssentialNewbornCareTraining(ENC)to build capacity of health care workers to provide quality ENC Activity1.2:Procurementofnewbornresuscitationequipment (ambu bags/mask sizes 0 & 1, suction devices, Resuscitation tables with Radiant warmer) Activity 1.3: Procure and distribute lifesaving medicines i.e. injection Gentamycin, Injection Amoxicillin DT, InjectionCloxacillin,InjectionVitaminK1,Injection Phenobarbitone	• Allhospitalsconductingdeliveries provide ENC • Atleast75%ofthehealthcentres conducting deliveries provide ENC • 95% of facilities conducting deliveries have recommended antibiotics for newborns' infections • 90% of the newborns without spontaneous breathing at birth are resuscitated • <5%ofresuscitatednewbornsat birth are resuscitated using bag

	KRA 2 Management of preterm and low birth weight babies improved by 2020.	Activity 2.1: Conduct needs assessment site visit for Kangaroo Mother Care (KMC) service establishment Activity 2.2: Conduct KMC training to build capacity of health care providers to provide quality care to preterm babies. Activity 2.3: Establish KMC sites at all District hospitals (equipped with KMC beds, beddings, weighing scales, low reading thermometers, calibrated feeding cups)	• 75% 0f district hospitals implement Kangaroo Mother Care (KMC) • 80% of Regional and Tertiary hospitals are centres of excellence for KMC implementation • 50% of preterm and LBW newborns receive KMC
	KRA 3 Management of sick newborn improved by 2020.	Activity 3.1: Integrated Management of Childhood Illnesses (IMCI) Training (Distance Learning mode) which includes management of sick newborns. Activity 3.2: Advocacy meetings for establishment of Neonatal Care Units/Room at hospitals Activity 3.3: Procurement of essential equipment for care of sick newborn i.e. Oxygen concentrators, Phototherapy machines, Suction machines, low reading thermometers, room thermometers, room heaters	• 50% of newborns with possible serious bacterial infection receives antibiotic therapy • 75% of the regional hospitals have functional neonatal care unit • At least 90% of health facilities conducting deliveries have essential equipment

Program	Key Result Area	Activities	Target 2020
Child health	KRA 1 Management of common childhood illnesses improved by 2020.	Activity 1.1: Train health care workers on Integrated Management of Childhood Illnesses (IMCI) Training (Distance Learning mode). Activity 1.2: Train health care workers on Emergency Triage Assessment and Treatment (ETAT) to manage paediatric emergencies at hospital and health centre level. Activity 1.3: Procurement of Paediatric emergency equipment for hospitals and health centres (Oxygen concentrators, Pulse Oxymeters, Nebulizers, Glucometers, Haemoques, Suction machines, Ambu bags/masks, Infusion pumps) Activity 1.4: Conduct Clinical Mentoring at hospital and health centre level Activity 1.5: Conduct Supportive Supervision for quality paediatric and nutrition care to hospitals and health centres	• 80% of all health facilities in a district have at least 60% of providers trained on IMCI • 90% of sick children seeking care at health facilities are appropriately managed for Pneumonia, Malaria and Diarrhoea according to IMCI guidelines • 80% of hospitals and Health Centres with functional Diarrhoea Treatment Corner (DTC) • 80% of hospitals with Triage system and functional emergency area

Program	Key Result Area	Activities	Target 2020
	KRA 2: Routine U5 vaccination and Vitamin A coverage sustained with equitable coverage by 2020	Activity 2.1: Implement Reach Every District/Child (RED/REC) Strategy activities in all councils Activity 2.2: Intensify surveillance of vaccine preventable diseases Activity 2.3: Develop, print, and disseminate immunization policy guidelines Activity 2.4: In-service, refresher, and mid-level management (MLM) training at all levels Activity 2.5: Distribution, cold chain supply and vaccine management Activity 2.6: Develop, print, disseminate and implement communication strategy (mass media, IEC, immunization week). Activity 2.7: Supportive supervision for immunization. Activity 2.8: Improve data management. Activity 2.9: Introduce new and under used vaccine. Activity 2.10: Coordination meetings at all levels Activity 2.11: Scale up integration of vitamin A supplementation within routine immunisation.	• Maintain coverage of all vaccines at 90% in 90% of the councils • Vitamin A coverage increased from 61% to 75%
	KRA 3: Improve breastfeeding rates and practices by 2020	Activity 3.1: Capacitate health care providers in assisting women to initiate breast feeding within 1 hour, and provide counselling for exclusive breastfeeding at all levels. Activity 3.2: Train community health care workers at all levels on importance of early breastfeeding initiation and breast feeding techniques.	• Increase exclusive breastfeeding prevalence from 50% to 80% • At least 75% of district hospitals are accredited BFHI

	KRA 4: Infant and Young Child Feeding (IYCF) practices and nutrition status improved by 2020.	Activity 4.1: Train health care workers at all levels on new growth monitoring standards and tools. Activity 4.2: Procure and distribute length/height boards and MUAC tapes to all health facilities offering under five growth monitoring services. Activity 4.3: Print under 5 growth monitoring booklets (sex specific). Activity 4.4: Training health care workers and CHWs on adequate meal frequency and food diversity for pregnant women and children.	• 90% of health facilities monitoring length/height for under-five • Reduce stunting from 35% to 22% • Reduce underweight from 16% to 11% • Reduce prevalence of anaemia among children from 59% to 41%
	KRA 5: Coverage of Management of Severe Acute Malnutrition (SAM) through the national health system increased by 2020	Activity 5.1: Train health care workers (including nutrition officers) and community health workers on management of MAM and SAM. Activity 5.2: Conduct regular screening for malnutrition among all U5 attending at health facilities. Activity 5.3: Procure essential supplies (therapeutic milk and food) to all district, regional, and referral hospitals for SAM treatment. Activity 5.4: Equip hospitals to manage nutritional rehabilitation.	• At least 50% of the hospitals implementing management of SAM
	KRA 6: Improved community and household practices for child survival by 2020	Activity 6.1: Conduct Quarterly Village Child Health Days	• Increase care seeking for U5 with diarrhoea, pneumonia and malaria from 53%, 71% and 73% to 90% • Increase ITN use by U5 from 73% to 90% • At least 50% of villages conduct quarterly village child health days.

	KRA 7: Improved accountability for U5 deaths by 2020	Activity 7.1: Conduct Under-five Death Reviews. Activity 7.2: Orientation to standard paediatric treatment guideline and facility assessment for paediatric quality of care.	• 50% of the hospitals conduct U5 death reviews • 80% of hospitals conduct annual assessment for paediatric quality improvement (QI)
	KRA 8: Community awareness and knowledge on newborn and child health care and services by 2020.	Activity 8.1: Prepare a message content strategy for newborn, child health and nutrition based on the contents of the RMNCAH Communication Strategy Activity 8.2: Develop IEC materials for community and messages for radio and TV on newborn and child health Activity 8.3: Conduct community sensitization and advocacy meetings at all levels. Activity 8.4: Develop and print monitoring tools to track communication initiatives.	• Message content strategy for newborn, child health and nutrition developed • IEC materials for community and messages for radio and TV on newborn and child health developed • Community sensitization and advocacy meetings at all levels conducted • Monitoring tools to track communication initiatives printed

Program	Key Result Area	Activities	Target 2020
Adolescent Health	KRA 1: Adolescent and Youth Friendly Sexual and Reproductive Health (AYFSRH) including HIV service coverage and FP increased by 2020	Activity 1.1: Conduct rapid assessment of health programmes with integrated adolescent and youth friendly services based on the national standards. Activity 1.2: Survey on barriers to accessing and using adolescent and youth friendly health services. Activity 1.3: Develop, adapt, and print tools for integrated supportive supervision of adolescent and youth friendly service provision at service delivery points. Activity 1.4: Develop, adapt, and operationalize a system for outreach, effective referral and networking for adolescent and youth SRH and HIV services. Activity 1.5: Procure essential equipment, materials and supplies for adolescent and youth friendly SRH and HIV services. Activity 1.6: Use Social marketing initiatives to provide SRH and HIV services and to adolescents and youth. Activity 1.7: Disseminate the National Standards for Adolescent and Youth Friendly Reproductive Health Services to policy/ decision makers, programme managers, supervisors and development partners at national, regional, district and community levels. Activity 1.8: Review, develop, adapt, and print training materials including a training plan to roll-out implementation of the national standards for adolescent friendly SRH Services. Activity 1.9: Assess the in-service training needs among various service providers on provision of adolescent and youth friendly SRH and HIV.	Increase proportion of health facilities providing AYFSRH services from 30% to 80%

		Activity 1.10: Build capacity of human resource in public and private health facilities to implement the national standards for adolescent friendly SRH services. Activity 1.11: Develop and outline a national minimum package of services for adolescents to be provided at each level of service delivery (job aid, SOP, and supervision checklist). Activity 1.12: Integrate adolescent health into the pre-service training curriculum. Activity 1.13: Develop framework for monitoring implementation of	
	KRA 2: Comprehensive knowledge, skills and positive behaviours on sexuality and reproductive health improved among adolescent by 2020	Activity 2.1: Review, develop, adapt, print, disseminate and distribute adolescent and youth SRH and HIV rights advocacy messages and materials. Activity 2.2: Review, adapt, harmonize, print, and distribute national IEC/BCC materials related to adolescent and youth SRH (peer education, life skills, parent guide, para professional counselling, sermons guide). Activity 2.3: Roll out adolescent SRH communication interventions delivered by CORPS e.g. lay counsellors, peer educators, village health workers using national guidelines and standards.	Increase community based outlets offering comprehensive sexuality education & SRHS services to 30%
	KRA 3: Linkage and capabilities among various stakeholders in the government, private sector and CSOs dealing with adolescent SRH strengthened by 2020	Activity 3.1: Conduct Stakeholders analysis and map key partners in advocating for adolescent SRH at all levels. Activity 3.2: Facilitate formation of adolescent SRH and rights coalition at all levels Activity 3.3: Build capacity of national, regional, district core teams and interested CSOs on advocacy on investing in adolescent and youth SRH and HIV. Activity 3.4: Advocate for resource mobilization and allocation for adolescent SRH interventions at all levels.	

	KRA 4: Institutionalize policies and supportive laws to improve access to information, education and services for adolescents by 2020	Activity 4.1: Review existing national policies and laws to conform to international/ regional conventions on adolescent sexual and reproductive health and rights. Activity 4.2: Advocate for formulation of relevant national laws, district and village by-laws to promote adolescent and youth SRH and HIV and rights. Activity 4.3: Conduct Performance organization review of RCHS in its mandate to facilitate RMNCAH service delivery in Tanzania	• Proportion of national policies and laws incorporating adolescent SRH and rights. • Proportion of regions/ districts with advocacy plan for adolescent SRH and rights. • Proportion of service providers oriented on adolescent SRH and rights, policies and laws. • Report on the performance of RCHS towards meeting its mandate.

	KRA 5: Knowledge, understanding and healthy practice for sexual and reproductive health and rights (SRHR) as well as socio-economic situation of adolescents and youth improved by 2020	Activity 5.1: Conduct rapid assessment and map existing community-based activities related to the National Youth Adolescent Parent Community Alliance (NYAPCA) Activity 5.2: Establish and strengthen National Youth Adolescent Parent Community Alliance (NYAPCA) in selected districts for provision of SRH information, education, and services (clinical and non-clinical SRH services, recreational activities, small library/learning services, and livelihood activities). Activity 5.3: Scale-up supervision of community based National Youth Adolescent Parent Community Alliance (NYAPCA) activities. Activity 5.4: Support implementation of innovative information, education, and services for adolescent and youth SRH and HIV, including those with disabilities Activity 5.5: Support utilization of existing community structures (religious leaders, parents, community and government leaders) to reach young people with age-appropriate sexual and reproductive health information and link them to services. Activity 5.6: Design and advocate on use of culturally appropriate mass media communication strategies for ASRH/FP. Activity 5.7: Build capacity of LGAs (CHMTs) on integration of youth issues into planning processes. Activity 5.8: Liaise with other sectors (CSOs, MDAs etc.) to support out of school youth access to income generating activities, business skills training, resource mobilization skills training and capacity building for youth led organization.	• Increased number of districts/regions with outlets offering ASRH information and services to 40%. • Proportion of council plans integrating adolescent and youth issues. • Increase economic empowerment networks supporting young people on Income Generating Activities to 10%.

Family Planning	KRA 1: Family Planning (FP) services and utilization improved by 2020	Activity 1.1: Train skilled health care providers to provide method mix with special focus on long term methods. Activity 1.2: Train on Training Skills, preceptorship, mentoring and coaching on FP. Activity 1.3: Update FP contents of in service and pre-service curricular of different cadre/ health training institutions. Activity 1.4: Conduct Contraceptive Technology Update for supervisors, service providers and pre-service tutors. Activity 1.5: Support trainings follow-up	• Increase modern CPR from 27% to 45%
	KRA 2: Integration of FP into other maternal, newborn, child, and adolescent health (MNCAH) programs improved by 2020	Activity 2.1: Train skilled health care providers to provide integrated FP/HIV, FP/Postpartum/Immunization outreach and PAC/FP services. Activity 2.2: Strengthen integrated outreach services to promote uptake of modern FP methods	
	KRA 3: Contraceptive coverage at community level improved by 2020	Activity 3.1: Train skilled health care providers to provide male friendly FP services. Activity 3.3: Investigate challenges influencing male involvement and participation in FP services. Activity 3.4: Conduct FP outreach services to reach males in workplaces such as mining, constructions and fishing camps. Activity 3.5: Ensure youth/young people have access and use of contraception services Activity 3.6: Partner with private sector to increase accessibility and utilization of FP.	
	KRA 4: Procurement and distribution of FP commodities improved by 2020	Activity 4.1: Quantify, procure and distribute FP commodities. Activity 4.21: Conduct zonal contraceptive security meetings. Activity 4.3: Supervise to facility-level stock contraceptive stocks.	

	KRA 5: Community awareness and knowledge on FP improved by 2020	Activity 4.3: Publicize and re-launch Green star. Activity 5.1: Train CHW to increase the scope of FP service provision at community level. Activity 5.2: Train community mobilizers/champions on how to advocate for FP uptake. Activity 5.3: Engage religious leaders to promote family planning.	

Program	Key Result Area	Activities	Target 2020
Reproductive Cancers	KRA 1: Increased coverage of reproductive cancers screening by 2020	Activity 1.2: Review and update cervical cancer strategic plan to incorporate prostate and breast cancer prevention. Activity 1.3: Update national cervical cancer guideline to incorporate breast cancer prevention. Activity 1.4: Develop guideline for prostate cancer screening. Activity 1.5: Review the national training package for cervical cancer screening to incorporate breast screening. Activity 1.6: Develop national training package for prostate cancer screening. Activity 1.7: Strengthen and establish health facilities capacity to screen and manage RH cancers. Activity 1.8: Develop outreach plan to increase uptake and utilization of reproductive health cancers. Activity 1.9: Conduct supportive supervision.	Increase by 50% the sites providing RH cancer screening
	KRA 2: Community awareness and knowledge on reproductive health cancers improved by 2020.	Activity 2.1: Develop communication strategy for reproductive health cancers. Activity 2.2: Develop IEC materials for community and messages for radio and TV on reproductive health cancers. Activity 2.3: Conduct community sensitization and advocacy meetings at all levels. Activity 2.4: Develop and Print M & E tools.	
	KRA 3: HPV vaccination coverage among adolescent girls increased by 2020	Activity 3.1: Develop HPV vaccine guidelines. Activity 3.2: Finalize, print and distribute HPV training and IEC materials. Activity 3.3: National launching of HPV rollout.	Increase coverage of HPV vaccine to 80% at national level

	KRA 5: Increased coverage of prostate cancers screening improved by 2020	Activity 5.1: Advocate for integration of prostate cancer screening into other health servicers Activity 5.2 create demand and utilization of prostate cancer screening.	Increase coverage of prostate cancer screening by 30% by 2020
	KRA 6: Knowledge and understanding of elderly reproductive health issues	Activity 6.1 Conduct rapid assessment on issues pertaining to reproductive health for the elderly Activity 6:2 Develop guideline on elderly Activity;6.3 SBCC intervention to create awareness on common reproductive health for elderly.	Increase access and availability of elderly reproductive health services by 50%.
	KRA 7; Integration of Elderly servicers into RMNCAH program	Activity 7.1: Establish reproductive health elderly-friendly services and counselling into other RMNCAH servicers. Activity 7.2 Promoting utilization of elderly friendly services.	50% of health facilities have elderly friendly services.
Program	Key Result Area	Activities	Target 2020
Gender and Male Involvement	KRA 1: Implementation of Gender in RH policies and guidelines and resource mobilization strengthened , by 2018	Activity 1.1: Develop, print and disseminate guidelines on integration of gender in RMNCAH by 2017. Activity 1.2: Develop, print and disseminate gender, GBV and VAC advocacy strategy. Activity 1.3: Operationalize and roll out male involvement guidelines in RMNCAH interventions. Activity 1.4: Review other RMNCAH guidelines to include Gender, GBV and VAC issues. Activity 1.5: Mobilize resources for GBV/VAC prevention and response activities. Activity 1.6: Conduct supportive supervision for quality post GBV/VAC services Activity 1.7; Conduct clinical mentorship to trained Health care providers	• Gender, GBV/VAC and male involvement guidelines and strategies available in 25% of the councils by 2018. • 25% of RMNCAH managers at all levels sensitized on Gender, GBV/VAC and Male involvement by 2020. • 60% of RMNCAH interventions have integrated Gender issues by 2020.

	KRA 2: Gender, GBV and male involvement integration into RMNCAH improved by 2020.	Activity 2.1: In-service training of gender, GBV, VAC and male involvement among health care providers Activity 2.2: Integrate GBV and VAC one stop centre model at referral hospital level. Activity 2.3: Inclusion of Gender, GBV, VAC and male involvement in Pre-service Curricula.	• 60% of health care providers trained on gender, GBV, VAC and male involvement by 2020. • One stop centres for GBV/VAC available in 25% of all referral hospitals by 2020. • Proportion of GBV and VAC survivors who experienced any violence who reported within 72 hours after an event increased from 30 % to 60 % by 2020. • GBV/VAC and male involvement included in pre-service curricula by 2020.
	KRA 3: Community and households empowered with knowledge and information in understanding of harmful gender norms, male involvement, and prevention and response to GBV and VAC by 2020.	Activity 3.1: SBCC interventions for addressing harmful GBV, VAC, gender norms and promoting male involvement and improving health seeking. behaviours Activity 3.2: Orient CHWs on Gender, GBV and VAC prevention interventions using national guidelines and standards. Activity 3.3: Design and conduct community based response and prevention interventions (e.g. outreach services, SASA etc.) to promote usage of GBV/VAC prevention and response services. Activity 3.4: Develop and roll out community based training package on prevention of harmful gender norms, GBV and VAC, and its implications on health.	• 50% of household members or communities have awareness on GBV, VAC and male involvement by 2020. • At least 50% of CHWs oriented on gender, GBV, VAC and Male involvement by 2020. • Proportion of councils with active community based GBV and VAC prevention programs increased from 0 % to 30 %.

Program	Key Result Area	Activities	Target 2020
Leadership and governance	KRA1:Nationalcoordination team responsible for collaborative planning and implementation of RMNCAHservicesbetween RCHS and PO-RALG established by 2017	Activity 1.1: Orient national, zonal, regional, and districtcoordinatorsonmanagementof integrated RMNCAH services.	Coordination team between RCHS and PORAG established by 2017
	KRA2:Improvemonitoring, documentationandsharing lessonslearntofkeyresults in RMNCAH and Nutrition by 2020	Activity 2.1: RCHS – inter department meetings to be organized twice per year to share key results across units. Activity 2.2: Each unit to present at least once per year key findings / results in the RCHS TWG Activity2.3:Producingande-distributionofanewsletter with key lessons and results by the RCHS twice per year.	BiannualdocumentedRMNCAHkeyresults by 2020
	KRA 3: Transformation of RCH from a section to a directorate completed by 2020	Activity 3.1: Conduct advocacy meetings at various levels to design steps to start a process oftransformingRCHSintoadepartment.	RCH Directorate formed by 2020
Human resource for health (HRH)	KRA 1: Improve HRH situation in collaboration with other department of planning and pre-service training institutions by 2020.	Activity1.1:Attendvariousmeetingforstrategicposting of skilled health workers in the local governmentbyrightcarderandequitable distribution.	Number of skilled health worker in BRN regions improved by 2020
	KRA 2: Health care workers performance and competence in RMNCAH improved by 2020.	Activity 2.1: Conduct induction trainings for newly employed MNCH providers in RMNCAH competencies. Activity 2.2: Conduct RMNCH refresher trainings.	

Health financing in RMNCAH	KRA 1: Budget allocation from Government to RMNCAH increased by 2020	Activity 1.1: Conduct bi-annual advocacy meeting to stakeholders at all levels for resource mobilization.	Government budget for health improved to 15% by 2020
		Activity 1.2: Develop RMNCAH Operational plan annually.	
	KRA 2: Resource tracking on RMNCAH plans and implementation on annual basis implemented from 2016-2020.	Activity 2.1: Conduct resource tracking annually.	
	KRA3: Share M&E results	Activity 3.1: Communicating M&E results. Activity 3.2 Extend access of scorecard web platform to Regions, Districts and implementing partners for improved coordination and joint planning.	
Administration and Personnel	KRA4: Reproductive & Child Health section performance strengthened	Activity 4.1: Training for 5s in a departmental level including KAIZEN Activity4.2: Training for RCHS staff on programs/project management (7 habits). Consult EGPAF Activity4.3: Ensure availability of working tools including computers, networking & communication tools, photocopy & scanning machines and office furniture Activity 4.4: Conduct RMNCAH meeting Annual	RCHS staff to be well trained and equipped with all necessary tools by 2020

RCH Regions and Zones	KRA5: Zonal RCHS Offices performance strengthened	Activity 5.1: Support Zonal Offices running cost including computers, scanners and furniture Activity 5.2: Support Zonal offices staff's on leadership and Management skills Activity 5.3: Conduct orientation training to newly appointed Regional and District coordinators on RMNCAH services. Activity 5:4: Capacity building of Zonal Offices on data management, use and dissemination Activity 5:5: Supportive supervision on RMNCAH services and Data Quality Auditing Activity 5:6: Support Zonal RCH meetings in 8 zones. Activity 5:7: Support National Annual RMNCAH meeting and share service data.	Zonal RCHS offices performance strengthened and equipped with working tools by 2020
	KRA6: Finalization and dissemination of the RMNCAH-Integrated Support Supervision Tool	Activity 6:1 Review and finalize the ISST Activity 6:2 Share the finalized ISST electronically Activity 6.3: Orient Zonal, Regional and Council staff on the use of the ISST 6.4: Conduct post orientation follow up of Zonal, Regional and Council staff to ascertain action plans and implementation	Finalization of RMNCAH-ISST by 2017
Monitoring and Evaluation:	KRA 1: Ensure paper based system for data collection is replaced by electronic system at all levels by 2020	Activity 1.1: Ensure paper based system for RMNCAH services data collection is gradually replaced by electronic data collection system at all Tertiary and Secondary level facilities.	

	KRA 2: Data management and use improved by 2020.	Activity 2.1: Ensure increased RMNCAH data completeness and timeliness through periodic field M and E supervision. Activity 2.2: Ensure increased RMNCAH data quality through periodic data audits by 2020. Activity 2.3: Ensure that MPDSR data is integrated into the HMIS/DHIS 2 electronic data base at Council level. Activity 2.4 Develop a tracker mechanism for tracking actions in response to MPDSR findings at district level.	
	KRA3: Share M&E results	Activity 3.1: Communicating M&E results. Activity 3.2 Extend access of scorecard web platform to Regions, Districts and implementing partners for improved coordination and joint planning.	

CHAPTER 5: Monitoring and Evaluation Framework

Monitoring and Evaluation of RMNCAH activities during 2016 to 2020 in Tanzania will aim to provide reliable information on progress towards the achievement of planned interventions; and to document insights into past and existing initiatives and assist in the planning for future interventions. The Monitoring and evaluation of RMNCAH of activities will be guided by the framework of key qualitative and quantitative indicators as stipulated in the Health Sector Strategic Plan IV (2015-2020) and the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2016 to 2020. Data from multiple sources will be used to provide strategic information for RMNCAH monitoring and evaluation.

5.1 Data Sources

Primary data for monitoring and evaluating RMNCH interventions in Tanzania during 2016 to 2020 will be collected from a combination of sources that include:

- Health Management Information System (HMIS)
- Electronic Logistic Management Information System (eLMIS)
- Human Resources for Health Information System (HRIS)
- Training Records Tracking System (Train Tracker and Train Smart records)
- Integrated Disease Surveillance and Response Strategy (IDSR) reports
- Health Facility Sentinel Sites Surveillance Systems.
- Supportive Supervision reports
- Routine Demographic Sentinel Surveillance (DSS) system.
- Special Quantitative and Qualitative Studies conducted by the Ministry and Implementing partners.
- National Facility Surveys: Tanzania Service Provision Assessments (TzSPA) surveys and Facility Mapping Surveys.
- National Community Surveys: Tanzania Demographic and Health Surveys (TDHS) and Tanzania HIV and Malaria Indicator Survey (THMIS)
- National Identification Authority (NIDA)
- Civil Registration and Vital Statistics System (CRVS)
- Population and Housing Census

5.2 Data Collection Tools and Data Flow

Several types of data collection tools and methods will be used to transfer the data from the Households, Communities and Health Facilities to the National level through Councils, Regions and Zones. HMIS and ISDR data will be collected daily in the communities and health facilities. Furthermore, IDSR data will be reported by the Councils weekly and compiled monthly, and reports sent to the Councils and the Ministry, and then after to the World Health Organization. Most the data from communities and health facilities will be compiled and reported

monthly, quarterly and annually. Survey data will be collected every five years, whereas Census data will be collected every ten years. All RMNCAH Implementing partners will be encouraged to invest into the data collection and cleaning process, and then getting data for their use from HMIS and IDSR by consulting relevant authorities at Council, Region, Zonal or National levels. During data collection at all levels, "data validation rules" will be developed and used to check for correctness, meaningfulness, and security of data that are input to the system. The rules will be implemented through automated during data collection using electronic devises at households, communities or facilities; or during data entry at Council level through an inclusion of explicit application program validation logic. With advances adoption of information and communication technology into capture, store, use and dissemination of RMNCAH data; use of manual data validation methods is expected to diminish with time and be replaced by electronic validation processes. This will include the use of computers (laptops, mini computers), tablets and iPad during data collection in the field and at health facilities.

The RMNCAH M & E technical working group will work towards the harmonization of data collection and flow.

5.3 Data Quality Management

The Ministry through the Directorate of Policy and Planning working with several implementing partners has developed a generic tool for Data Quality Management. All units and programs in the Ministry have been directed to use this generic tool for their data quality management activities. To accommodate the diversity of interventions within the Ministry, all units and programmes have been directed and encouraged to expand the generic tool to fit their purposes. In line with this, an expanded tool to address RMNCAH Data Quality Management issues is being developed and will then be used by all implementing partners. Data quality management will be done by the RCHS and implementing partners and important outcomes will include recommendations on how data quality will be improved, as well as recommendations on how to maximize the use of health facility data to guide RMNCAH programming. Activities to be performed on a quarterly basis will include managements of the accuracy, completeness and timeliness of data recording and results reporting, the identification of obstacles at each tier of the health facility reporting system, cross-checking diagnosed cases, and an management of the current utilization strategies at each tier of the health system in Tanzania. Data quality managements will be performed at selected health facilities quarterly. Data verification will be performed to compare the reported numbers from the health facilities to the number re-aggregated from the source. Once the data has been checked and re-aggregated from the source, it will be re- entered into the data base to replace the old values. This process will ensure that all units and program operate on clean, correct and useful data.

5.4 Data Analysis Strategy

In order to get an insight of the RMNCAH data collected from both communities and health facilities using HMIS/DHIS and eLMIS; RCHS will periodically monitor

commodities flow, coverage of key RMNCAH diagnosis, treatment practices, prevention services and control. The RCHS and implementing partners will be responsible for tracking of activities on a monthly, quarterly and annual basis based on what is stipulated in their Annual Operational Plans. This data from HMIS/DHIS and eLMIS will be analysed automatically within the systems and shared as reports by RCHS, Councils and implementing partners. Data can also be downloaded from HMIS/DHIS and eLMIS and analysed externally. Based on these data reports will be prepared, and then after the reports will be shared within interventions TWGs on a quarterly basis to assess where additional resources are needed. Supplemental data collection using small-scale M&E systems developed by partners will be used to share information on outputs with RCHS and the Ministry. To meet the RMNCAH evaluation objectives, multiple data points will be consulted to determine impact by conducting household or health facility level surveys. The TDHS, THMIS and TzSPA surveys will provide most of the information for the pre-post only evaluation design. Data collected will be used as analysed and presented in the official reports; and on some occasions through secondary analysis of the data to elucidate more information for decision making.

5.5 M & E Capacity Building Plan

At the central level, areas in need of strengthening include data analysis, interpretations and reporting. At Zonal, Regional and Council levels, the ZRCHCOs and the RRCHCOs; the DRCHCos and DHMIS focal people need to be trained in RMNCAH M&E. These trainings will include orientation of national level staff on RMNCAH data management and use including the FP dashboard, FP Train Tracker, and the Train Smart data base. The M & E technical working group will be used to bolster capacity in specific areas through technical assistance.

5.6 M & E Review Process, Dissemination of Results and Expected Products

Annual reviews of the RMNCAH Annual Operational Plan will take place to ensure key activities are rolling out as planned. Programmatic reviews will take place as part of this process. The purpose of the review process will be to inform the RMNCAH monitoring and evaluation process. At the conclusion of each annual review RCHS will compile a report of the current status of the RMNCAH interventions that need further strengthening, the status of M & E activities, and recommendations for plan or program modification. This report on RMNCAH program information and the current status of RMNCAH interventions will be presented to the National RMNCAH Advisory Committee; and then shared using various means as directed by RCHS Management. These means include the RCH monthly, quarterly and annual reports, the HMIS web portal, FP dashboard, and the RMNCAH scorecard.

RCH reports are normally produced monthly by programs; and quarterly and annually by programs and Councils. Standing administrative regulations require these reports to be shared during monthly, quarterly and annual programs meetings. They can be shared at Council, Region, Zonal and National levels to enhance enrichment and decision making. In this respect these RCH reports.

The HMIS webportal is a tool that has been developed by the Ministry to disseminate cleaned HMIS data to health sector stakeholders and interventions implementing partners. The data is disseminated via the HMIS is in the form of tables, figures, graphs and geographic information system maps. RMNCAH data can be accessed in the HMIS webportal by lodging into: www.hmisportal.moh.go.tz. This data can be accessed and downloaded without a need of a password. For RMNCAH, this data includes information on Family planning, Ante natal care, Labour and delivery, Post natal care, Inpatient clients notably management of childhood illnesses, Outpatient clients notably management of childhood illnesses, Child health including Diarrhoea treatment and Tracer Commodities. Among others, the HMIS webportal enhances dissemination of Family Planning data by sharing data through a Family Planning dashboard that triangulates HMIS service data, Training data and Tracer Commodities data.

Moreover, RMNCAH data is routinely shared using the RMNCAH scorecard. This is a tool based on national health priorities and populated with best available data will continue being used as a key data dissemination tool to RMNCAH Policy Makers and Managers. This card shows which indicator is doing well or lagging behind each quarter for each region and Council tracks progress produces reports for accountability and action; and fosters an environment of accountability at all levels. All levels are required to assess challenges and progresses, and to elicit appropriate coordinated responses to address issues where shortfalls towards the set targets are identified.

Chapter 6: Costing of Strategic Objective Activities

6.1 Costing of the One Plan II activities

For the purpose of costing all activities prioritised in the One Plan II; each program identified key interventions activities to be costed. The costing of the activities was projected to cover the period from 2016 to 2020. The costing of the One Plan II activities was conducted in two-stages. Stage one involved using the Lives Saved Tool (LiST) to estimate intervention impact. The second stage used UN One Health Costing Tool for the financial projections required to address the identified priorities and implement planned activities. It estimates the costs by health program and the implications for health system components, it also estimates health impact achieved by scale-up, using UN-approved epidemiological and impact models.

6.2 Assumptions made

During costing, the total cost of each health program is split by direct costs (preventive or curative interventions or health services, drugs and commodities); and indirect costs (program management and support activities). The budgeting assumptions included Service delivery and activity targets by zone, new government per diems beginning July 2015, no inflation, and harmonized budget template for meetings, workshops, assumed the national and zonal perspective of service delivery and/or trainings. The costing process does not include: freight and clearance (17%) for commodities, distribution cost (22%) for commodities, malaria and HIV interventions for mothers and children, human resources for health (number and pay package), and renovation of health facilities. The costing of the RMNCAH strategic objectives' activities is shown in the table below.

RESOURCES COSTING OF THE ONE PLAN II ACTIVITIES IN **US DOLLARS**

6.1 MATERNAL HEALTH

SN	KEY RESULT AREA	ACTIVITIES	TIME FRAME					TOTAL RESOURCES NEEDED IN US DOLLARS
			2016	2017	2018	2019	2020	
6.1.1	KRA 1: Utilization and quality of ANC services improved by 2020.	Activity 1: Activity 1.1: Procure and supply essential medicines, equipment and laboratory reagents	11,624,599	144,553	6,909,079	144,553	6,909,079	125,731,863
		Activity 2: Activity 1.2: Conduct training to service providers on Focused ANC	1,188,690	1,116,114	1,116,114	1,188,690	1,116,114	5,725,723
		Activity 3: Conduct external and internal supportive supervision	94,886	94,886	94,886	94,886	94,886	474,429
		Activity 4: Print ANC and TT cards, IEC materials guidelines and job aids	428,806	428,806	428,806	428,806	428,806	2,144,029
6.1.2	KRA 2: Skilled birth attendant utilization increased by 2020	Activity 1: Mapping of cadres available by facility level	0	0	0	0	0	0
		Activity 2: Conduct advocacy meetings at council level to motivate skilled health workers by providing a package of incentives in order to ensure quality services	80,400	80,400	80,400	80,400	80,400	402,000
		Activity 3: Conduct advocacy meeting with councils to lobby with pre-service students in training institutions	6,415	0	0	429	0	6,843

6.1.3	KRA 3: Access and availability of BEmONC increased by 2020	Activity 1: Review BEmONC guidelines, IEC materials and job aids	0	0	3,546	0	0	3,546
		Activity 1: Print BEmONC guidelines, IEC materials and job aids	0	20,686	0	0	20,686	41,371
		Activity 2: Conduct training to update knowledge and skills of health providers on Basic Emergency Obstetric and Newborn care (BEmONC)	722,608	722,608	632,432	546,503	517,152	3,141,303
6.1.4	KRA 4: Access and availability of CEmONC including availability of safe blood increased by 2020	Activity 1: Review and update CEmONC guidelines including job aids	3,546	0	0	0	0	3,546
		Activity 2: Print CEmONC guidelines and IEC materials	0	14,857	0	0	0	14,857
		Activity 2: Conduct training to update knowledge and skills of service providers in CEmONC	586,615	586,615	456,256	456,256	586,615	2,802,715
		Activity 5: Conduct refresher training to update competence of pre-service tutors in nursing, clinical and medical schools in EmOC and NC	197,096	197,096	197,096	28,157	0	619,445
6.1.5	KRA 5: Enhanced accessibility and utilization of safe blood and blood products in hospitals and health facilities by 2017.	Activity 1: Construct 5 Satellite and blood distribution sites	0	114,549	14,549	14,549	0	343,646

6.1.6	KRA 6: MNCH referral system improved by 2020	Activity 1: Procure ambulances for EmONC facilities.	160,000	160,000	160,000	160,000	160,000	800,000
		Activity 2: Conduct sensitization meetings with business community to support referral system.	0	46,843	0	0	0	46,843
		Activity 3: Conduct advocacy meetings with councils through PPP to establish voucher scheme to enhance referral system	0	96,557	96,557	96,557	96,557	386,229
6.1.7	Availability of essential commodities, supplies and medicines for MNCAH improved	Activity 1: Communication costs for monitoring of life saving commodities	37,029	0	0	0	0	37,029
6.1.8	MPSSR framework and use implemented by 2017	Activity 1: Finalize Maternal Perinatal Death Surveillance and Response (MPDSR) guideline	4,006	0	0	0	0	4,006
		Activity 2: Print Maternal Perinatal Death Surveillance and Response (MPDSR) guideline	0	103	0	0	0	103
		Activity 3: Training and advocacy for Maternal Perinatal Death Surveillance and Response (MPDSR) guideline	378,056	721,640	244,440	244,440	244,440	1,833,016
		Activity 4: Disseminate Maternal Perinatal Death Surveillance and Response (MPDSR) guideline	72,576	0	0	72,576	0	145,152
		Activity 5: Institutionalize Maternal Perinatal Death Surveillance and Response (MPDSR)	4,871	4,871	4,871	4,871	4,871	24,354
		Activity 6: Conduct biannual Maternal Perinatal Death Surveillance and Response (MPDSR)National technical meetings	29,949	29,949	29,949	29,949	29,949	149,743
		Activity 7: Publish and disseminate Maternal Perinatal Death Surveillance and Response (MPDSR) report	24,440	24,440	24,440	24,440	24,440	122,200

6.1.9	MNCAH community services improved by 2020	Activity 1: Train community health workers on integrated community maternal, newborn, child health	8,948,800	8,948,800	8,948,800	8,948,800	8,948,800	44,744,000
		Activity 2: Conduct training for community health supervisors on integrated maternal, newborn, child and adolescent health	1,791,314	0	0	1,791,314	0	3,582,629
6.1.10	Postnatal care coverage and quality increased by 2020	Activity 1: Review, update, print and distribute postnatal care guidelines	130,931	0	0	130,931	0	261,862
		Activity 2: Conduct training to update knowledge and skills of health care providers on essential postnatal care and monitoring	1,071,470	1,205,403	669,669	401,801	0	3,348,343
		Activity 3: To develop and print minimum package for integrated RMNCAH outreach services to reach women and newborns at the community	0	72,123	0	0	0	72,123
6.1.11	Improve maternal and lactating mothers nutrition status and practices by 2020	Activity 1: Develop, Print maternal, newborn, child and adolescent nutrition guideline	5,986	305,986	0	0	0	311,973
		Activity 2: Disseminate maternal, newborn, child and adolescent nutrition guideline by orientation	0	72,576	0	0	0	72,576
6.1.12	Elimination of mother to child transmission (eMTCT) realized at below 5% transmission rate by 2020	Activity 1: Orient RHMTs, CHMTs on eMTCT interventions and bottleneck analysis	149,233	0	149,233	0	0	298,467

		Activity 2: Conduct eMTCT sub-team meetings	7,540	7,540	7,540	7,540	7,540	37,700
		Activity 3: Procure antiretroviral medicines, HIV test kits, DBS kits for RCH sites	32,415,992	32,654,101	31,502,255	31,353,760	31,102,184	159,028,292
		Activity 4: Conduct training to strengthen human resource capacity and systems to deliver quality and integrated comprehensive eMTCT services at all levels of service delivery.	1235243	1235243	1235243	1235243	1235243	6,176,217
		Activity 5: Conduct biannual PMTCT data quality assessment	139,250	139,250	139,250	139,250	139,250	696,250
		Activity 6: Conduct PMTCT supervision to health care workers in RCHS facilities for quality improvement	2,669,227	2,669,227	2,669,227	2,669,227	2,669,227	13,346,133
		Activity 7: Printing registers, report forms, cards, laboratory forms, and training manuals	35,000	35,000	35,000	35,000	35,000	175,000

6.2 NEWBORN AND CHILD HEALTH

SN	KEY RESULT AREA	ACTIVITIES	TIME FRAME					TOTAL RESOURCES NEEDED IN US DOLLARS
			2016	2017	2018	2019	2020	
			RESOURCES NEEDED IN US DOLLARS					
6.2.1	KRA 1: Essential newborn care services provided at all facilities conducting deliveries by 2020.	Activity 1: Conduct Essential Newborn Care Training (ENC) to build capacity of health care workers to provide quality ENC	770,686	770,686	770,686	770,686	770,686	3,853,430
		Activity 2: Procurement of newborn resuscitation equipment (ambu bags/ mask sizes 0 & 1, suction devices, Resuscitation tables with Radiant warmer)	0	0	0	0	0	0
6.2.2	KRA2: Management of preterm and low birth weight babies improved by 2020.	Activity 1: Conduct needs assessment site visit for Kangaroo Mother Care (KMC) service establishment	24,000	0	0	0	0	24,000
		Activity 2: Conduct KMC training to build capacity of health care providers to provide quality care to preterm babies.	928	77,276	86,935	48,297	28,978	242,414
		Activity 2.3: Establish KMC sites at all District hospitals (equipped with KMC beds, beddings, weighing scales, low reading thermometers, calibrated feeding cups)	0	17,997	20,247	11,248	6,749	56,241

6.2.3	KRA 3: Management of sick newborn improved by 2020.	Activity 1: Integrated Management of Childhood Illnesses (IMCI) Training (Distance Learning mode) which includes management of sick newborns.		0	0	0	0	0
		Activity 2: Advocacy meetings for establishment of Neonatal Care Units / Room at district hospitals	115,551	90,790	0	0	0	206,341
		Activity 3: Procurement of essential equipment for care of sick newborn (Oxygen concentrators, Phototherapy machines, Suction machines, Low reading thermometers, room thermometers, room heaters, etc.)	215,612	173,479	0	0	0	389,091
6.2.4	KRA 1: Management of common childhood illnesses improved by 2020.	Activity 1: Train health care workers on Integrated Management of Childhood Illnesses (IMCI) Training (Distance Learning mode).	3,738,185	4,205,458	2,336,365	1,401,819	0	11,681,827
		Activity 2: Train health care workers on Emergency Triage Assessment and Treatment (ETAT) to manage paediatric emergencies at hospital and health centre level.	1,352,777	1,521,874	845,485	507,291	0	4,227,427
		Activity 3: Procurement of Paediatric emergency equipment for hospitals and health centres (Oxygen concentrators, Pulse Oxymeters, Nebulizers, Glucometers, Haemoques, Suction machines, Ambu bags / masks, Infusion pumps)	2,939,705	2,787,651	2,965,048	2,289,253	0	10,981,657
		Activity 4: Conduct Clinical Mentoring at hospital and health centre level	393,200	931,451	931,451	931,451	931,451	4,119,004
		Activity 5: Conduct Supportive Supervision for quality paediatric and nutrition care to hospitals and health centres	237,259	237,259	237,259	237,259	237,259	1,186,295

6.2.5	KRA 2: Routine Under Five vaccination sustained with equitable coverage by 2020	Activity 1: Implement Reach Ever District/Child (RED/REC) Strategy activities in all councils	713,597	368,529	796,416	464,388	920,650	3,263,580
		Activity 2: Intensify surveillance of vaccine preventable diseases	514,054	514,054	514,054	514,054	514,054	2,570,270
		Activity 3: Develop, print, and disseminate immunization policy guidelines	56,179	0	0	0	0	56,179
		Activity4:In-service,refresher,andmid-level management (MLM) training at all levels	1,929,368	660,763	1,521,073	646,372	1,715,930	6,473,506
		Activity5:Distribution,coldchainsupply and vaccine management	6,518,135	6,518,135	6,518,135	6,518,135	6,518,135	32,590,675
		Activity 6: Develop, print, disseminate andimplementcommunicationstrategy (mass media, IEC, immunization week)	158,408	174,249	191,673	210,841	231,925	967,096
		Activity 7: Supportive supervision for immunization	291,610	284,316	297,133	335,925	327,325	1,536,309
		Activity 8: Improve data management	3,033,246	1,661,047	1,902,399	1,672,287	2,752,175	11,021,154
		Activity9:Introducenewandunderused vaccine, SIAs	59,291,405	56,915,036	58,615,014	60,312,009	61,974,165	297,107,629
		Activity2.10:Coordinationmeetingsat all levels	170,758	107,605	112,944	118,548	124,431	634,286
6.2.6	KRA 3: Improve breastfeeding rates and practices by 2020	Activity 1: Capacitate health care providers in assisting women to initiate breast feeding within 1 hour, and exclusive breastfeeding at all levels	538,973	538,973	538,973	538,973	538,973	2,694,865
		Activity 2: Train community health care workers at all levels on importance of earlybreastfeedinginitiationandbreast feeding techniques	560,971	280,486	280,486	280,486	280,486	1,682,915

6.2.7	KRA 4: Infant and Young Child Feeding (IYCF) practices and nutrition status improved by 2020.	Activity 1: Train health care workers at all levels on new growth monitoring standards and tools	546,400	546,400	546,400	546,400	546,400	2,732,000
		Activity 2: Procure and distribute length/height boards and MUAC tapes to all health facilities offering under five growth monitoring services	344,501	344,501	344,501	344,501	344,501	1,722,505
		Activity 3: Print under 5 growth monitoring booklets (sex specific)	2,285,174	2,285,174	2,285,174	2,285,174	2,285,174	11,425,870
		Activity 4: Training health care workers and CHWs on adequate meal frequency and food diversity for pregnant women and children	932,285	735,628	735,628	735,628	735,628	3,874,797
6.2.8	KRA 5: Coverage of Management of Severe Acute Malnutrition (SAM) through the national health system increased by 2020	Activity 1: Train health care workers (including nutrition officers) and community health workers on management of MAM and SAM	1,378,114	1,097,629	1,097,629	1,097,629	1,097,629	5,768,630
		Activity 2: Conduct regular screening for malnutrition among all U5 attending at health facilities	344,501	344,501	344,501	344,501	344,501	1,722,505
		Activity 3: Procure essential supplies (therapeutic milk and food) to all district, regional, and referral hospitals for SAM treatment	0	0	0	0	0	0
		Activity 4: Equip hospitals to manage nutritional rehabilitation	85,640	130,343	171,998	206,293	168,951	763,225
6.2.9	KRA 6: Improved community and household practices for child survival by 2020	Activity 1: Conduct Quarterly Village Child Health Days	0	0	0	0	0	0
6.2.10	KRA 7: Improved accountability for U5 deaths by 2020	Activity 1: Conduct Under-five Death Reviews	71,813	56,346	0	0	0	128,159
		Activity 2: Orientation to standard paediatric treatment guideline and facility assessment for paediatric quality of care	2,356,663	3,534,994	1,472,915	883,749	0	8,248,321

6.3 ADOLESCENT REPRODUCTIVE HEALTH

SN	KEY RESULT AREA	ACTIVITIES	TIME FRAME					TOTAL RESOURCES NEEDED IN US DOLLARS
			2016	2017	2018	2019	2020	
			RESOURCES NEEDED IN US DOLLARS					
6.3.1	KRA 1: Adolescent and Youth Friendly Sexual and Reproductive Health (AYFSRH) including HIV service coverage and FP increased by 2020	Activity 1: Conduct rapid assessment of health programmes with integrated adolescent and youth friendly services based on the national standards.	1,274,171	0	0	0	0	1,274,171
		Activity 2 Survey on barriers to accessing and using adolescent and youth friendly health services	1,277,943	0	0	0	0	1,277,943
		Activity 3: Develop, adapt, and print tools for integrated supportive supervision of adolescent and youth friendly service provision at service delivery points.	56,738	0	0	0	0	56,738
		Activity 4: Develop, adapt, and operationalize a system for outreach, effective referral and networking for adolescent and youth SRH and HIV services.	44,782	4149	12069	12251	7314	80,565
		Activity 5: Procure essential equipment, materials and supplies for adolescent and youth friendly SRH and HIV services.	62,357	62,357	62,357	62,357	62,357	311,785
		Activity 6: Use Social marketing initiatives to provide SRH and HIV services and to adolescents and youth.	46,400	0	0	0	0	46,400

		Activity 7: Disseminate the National Standards for Adolescent and Youth Friendly Reproductive Health Services to policy/decision makers, programme managers, supervisors and development partners at national, regional, district and community levels.	163,547	0	0	0	0	163,547
		Activity 8: Review, develop, adapt, and print training materials including a training plan to roll-out implementation of the national standards for adolescent friendly SRH Services.	50,569	0	0	0	0	50,569
		Activity 9: Assess the in-service training needs among various service providers on provision of adolescent and youth friendly SRH and HIV.	142,857	0	0	0	0	142,857
		Activity 10: Build capacity of human resource in public and private health facilities to implement the national standards for adolescent friendly SRH services	644,373	232,966	537,197	77,655	0	1,492,191
		Activity 11: Develop and outline a national minimum package of services for adolescents to be provided at each level of service delivery (job aid, SOP, and supervision checklist	318,528	0	0	0	0	318,528
		Activity 12: Integrate adolescent health into the pre-service training curriculum	158,629	0	0	0	0	158,629
		Activity 13: Develop framework for monitoring implementation of adolescent and youth friendly SRH and HIV services in service delivery points	20,991	219,633	58,752	208,608	58,752	566,736
		Activity 14: Review meetings semi-annually and annually	86,377	86,377	86,377	86,377	86,377	431,885

6.3.2	KRA 2: Comprehensive knowledge, skills and positive behaviours on sexuality and reproductive health education improved among adolescent by 2020	Activity 1: Review, develop, adapt, print, disseminate and distribute adolescent and youth SRH and HIV rights advocacy messages and materials.	545,049	239,143	494,743	239,143	0	1,518,078
		Activity 2: Review, adapt, harmonize, print, and distribute national IEC/ BCC materials related to adolescent and youth SRH (peer education, life skills, parent guide, para professional counselling, sermons guide).	104,883	3,798,318.00	0	3,466,889	0	7,370,090
		Activity 3: Roll out adolescent SRH communication interventions delivered by CORPS e.g. lay counsellors, peer educators, village health workers using national guidelines and standards.	6,720,280	5,917,457	6,366,291	5,917,457	5,917,457	30,838,942
6.3.3	KRA 3: Linkage and capabilities among various stakeholders in the government, private sector and CSOs dealing with adolescent SRH strengthened by 2020	Activity 1: Conduct Stakeholders analysis and map key partners in advocating for adolescent SRH at all levels.	145,522	0	0	0	0	145,522
		Activity 2: Facilitate formation of adolescent SRH and rights coalition at all levels	0	0	0	0	0	0
		Activity 3: Build capacity of national, regional, district core teams and interested CSOs on advocacy on investing in adolescent and youth SRH and HIV	518,272	0	0	0	0	518,272
		Activity 4: Advocate for resource mobilization and allocation for adolescent SRH interventions at all levels.	0	0	0	0	0	0

6.3.4	KRA 4: Institutionalize policies and supportive laws to improve access to information, education and services for adolescents by 2020	Activity 1: Review existing national policies and laws to conform to international/regional conventions on adolescent sexual and reproductive health and rights.	0	0	0	0	0	0
		Activity 2: Advocate for formulation of relevant national laws, district and village by-laws to promote adolescent SRH and rights	0	0	0	0	0	0
6.3.5	KRA 5: Knowledge, understanding and healthy practice for sexual and reproductive health and rights (SRHR) as well as socio-economic situation of adolescents and youth improved by 2020	Activity 1: Conduct rapid assessment and map existing community-based activities related to the National Youth Adolescent Parent Community Alliance (NYAPCA)	142,857	0	0	0	0	142,857
		Activity 2: Establish and strengthen National Youth Adolescent Parent Community Alliance (NYAPCA) in selected districts for provision of SRH information, education, and services (clinical and non-clinical SRH services, recreational activities, small library/ learning services, and livelihood activities).	418,929	775,500	1,132,071	1,488,643	1,845,214	5,660,357
		Activity 3: Scale-up supervision of community based National Youth Adolescent Parent Community Alliance (NYAPCA) activities.	240,371	240,371	240,371	240,371	240,371	1,201,855
		Activity 4: Support implementation of innovative information, education, and services for adolescent and youth SRH and HIV, including those with disabilities	709,471	709,471	709,471	709,471	709,471	3,547,355

	Activity 5: Support utilization of existing community structures (religious leaders, parents, community and government leaders) to reach young people with age-appropriate sexual and reproductive health information and link them to services.	0	0	0	0	0	0
	Activity 6: Design and advocate on use of culturally appropriate mass media communication strategies for ASRH/FP.	0	0	0	0	0	0
	Activity 7: Build capacity of LGAs (CHMTs) on integration of youth issues into planning processes.	0	0	0	0	0	0
	Activity 8: Liaise with other sectors (CSOs, MDAs etc.) to support out of school youth access to income generating activities, business skills training, resource mobilization skills training and capacity building for youth led organization.	0	0	0	0	0	0

6.4 FAMILY PLANNING

SN	KEY RESULT AREA	ACTIVITIES	TIME FRAME					TOTAL RESOURCES NEEDED IN US DOLLARS
			2016	2017	2018	2019	2020	
			RESOURCES NEEDED IN US DOLLARS					
6.4.1	KRA 1:Family Planning (FP) services and utilization improved by 2020	Activity 1.1: Train skilled healthcare providers to provide method mix with special focus on long term methods	1,044.44	1,003,184	1,003,184	1,073,241	1,003,184	4,083,837.44
		Activity 1.2: Train on preceptorship, mentoring and coaching on FP	33,614	67,227	67,227	33,614	33,614	235,296.00
		Activity 1.3: Update FP contents of pre-service curriculum of different cadre/ health training institutions	0	19,295	7,103	7,103	0	33,501.00
		Activity 1.4: Conduct Contraceptive Technology Update for pre-service tutors	22,309	44,617	44,617	44,617	0	156,160.00
6.4.2	KRA 2: Integration of FP into other maternal, newborn, child, adolescent health (MNCAH) programs improved by 2020	Activity 2.1: Train skilled healthcare providers to provide integrated FP/ HIV, FP/ Postpartum/ Immunization outreach and cPAC/ FP services	33,033	33,033	33,033	33,033	33,033	165,165.00
		Activity 2.2: Establish integrated outreach RMNCAH clinics to promote uptake of FP services	5,052,069	5,052,069	5,052,069	5,052,069	5,052,069	25,260,345.00

6.4.3	KRA 3: Contraceptive coverage at community level improved by 2020	Activity 3.1: Train skilled health care providers to provide male friendly FP services.	121,746	121,746	121,746	121,746	121,746	608,730.00
		Activity 3.3: Investigate challenges influencing male involvement and participation in FP services.	0	100,000	0	0	0	100,000.00
		Activity 3.4: Conduct FP outreach services to reach males in workplaces such as mining, constructions and fishing camps	291,600	353,328	445,920	445,920	445,920	1,982,688
		Activity 3.5: Ensure youth/ young people access and use of contraception services	978,665	1,319,328	1,679,897	1,619,127	1,554,213	7,151,230
		Activity 3.6: Partner with private companies to increase accessibility and utilization of FP	601,705	768,224	893,273	818,487	753,573	3,835,262
6.4.4	KRA 4: Procurement and distribution of FP commodities improved by 2020	Activity 4.1: Procure and distribute FP commodities.	74,932,000	74,932,000	74,932,000	74,932,000	74,932,000	374,660,000
		Activity 4.2: Supervise zonal contraceptive stocks	118,400	118,400	118,400	118,400	118,400	592,000.00
		Activity 4.3: Publicize and re-launch Green star	108,640	108,640	108,640	108,640	108,640	543,200.00
6.4.5	KRA 5: Contraceptive coverage at community level improved by 2020	Activity 5.1: Train CHW to increase scope of FP service provision at community level.	17,440	2,094,121	1,545,079	2,317,618	515,026	6,489,284
		Activity 5.2: Train community mobilizers/champions on how to influence people on FP	0	853,248	639,936	959,904	213,312	2,666,400
		Activity 5.3: Engage religious leaders to promote family planning	78,546	164,679	141,045	207,285	141,045	732,600

6.4.6	KRA 6: Demand for FP improved by 2020	Activity 6.1: Hold annual FP Day across the country	23,090	23,090	23,090	23,090	23,090	115,450
		Activity 6.2: Radio and TV spots for demand creation	3,301,160	3,302,182	3,301,160	3,301,160	3,301,160	16,506,822
6.4.7	KRA 7: M&E and management of FP service provision improved by 2020	Activity 7.1: Implementation of Costed Implementation Plan	64,515	29,573	29,573	29,573	29,573	182,807

6.5 REPRODUCTIVE HEALTH CANCERS

SN	KEY RESULT AREA	ACTIVITIES	TIME FRAME					TOTAL RESOURCES NEEDED IN US DOLLARS
			2016	2017	2018	2019	2020	
			RESOURCES NEEDED IN US DOLLARS					
6.5.1	KRA 1: Increased coverageofreproductive cancers screening by 2020	Activity 1.1: Capacity building of service providers on reproductive health cancers	322,049.5	257,432.38	270,203.80	257,432.38	270,203.8	1,377,322
		Activity 1.2: Review and update cervical cancer strategic plan to incorporate prostate and breast cancer prevention	48,524	17,714	0	4,761	0	56,718
		Activity 1.4: Review the national trainingpackageforcervicalcancer screening to incorporate breast screening	13,654	95,234	0	0	95,234	201,952
		Activity 1.5: Strengthen and establish health facilities capacity to screen and manage RH cancers	0	110,194	0	95,238	0	205,432
		Activity 1.6: Conduct outreach programs to increase uptake and utilization of reproductive health cancers	13,075	95,234	0	95,234	0	203,551
		Activity 1.7: Conduct outreach programs to increase uptake and utilization of reproductive health cancers	14,714	5,714	5,714	5,714	15,238	56,190
		Activity1.8:Developoutreachplan to increase uptake and utilization of reproductive health cancers	4,062	0	0	0	0	4,062
		Activity 1.9: Conduct supportive supervision	9,371	9,371	9,371	9,371	9,371	9,371

6.5.2	KRA 2: Community awareness and knowledge on reproductive health cancers improved by 2020.	Activity 2.1: Conduct community sensitization and advocacy meetings at all levels.	0	0	10,324	1,904	1,904	31,754
		Activity 2.2: Develop and print M&E tools	5,414	11,428	16,964	5,414	10,714	38,621
		Activity 2.3: Finalize, print and distribute HPV training and IEC materials	37,668	30,277	25,515	27,420	20,568	141,449
		Activity 2.4; Develop and Print M&E tools	19,223	19,223	4,571	4,571	4,571	30,161
6.5.3	KRA 3: HPV vaccination coverage among adolescent girls increased by 2020	Activity 3.1: Develop HPV vaccine guidelines	30,385	0	0	0	0	30,385
		Activity 3.2 Finalize, print and distribute HPV training and IES materials	5,214	100,000	5,214	5,214	5,214	121,309
		Activity 3.3: National launching of HPV rollout	5,373	0	0	0	0	5,373
6.5.4	KRA 4: National level capacity for addressing RH cancers increased by 2020	Activity 4.1: Hire full-time staff to support RH cancer activities	43,500	43,500	43,500	43,500	43,500	203,500

6.6 GENDER IN REPRODUCTIVE HEALTH

SN	KEY RESULT AREA	ACTIVITIES	TIME FRAME					TOTAL RESOURCES NEEDED IN USD
			2016	2017	2018	2019	2020	
			RESOURCES NEEDED IN USD					
6.6.1	KRA 1: Implementation of Gender in RH policies and guidelines and resource mobilizationstrengthened , by 2018	Activity 1.1: Develop print and disseminateguidelinesonintegration of gender in RMNCH by 2018	25,231	22,734	0	17,143	0	65,108
		Activity 1.2: Develop print and disseminate gender, GBV and VAC advocacy strategy	25,231	22,734	0	17143	0	65,108
		Activity 1.3: Operationalize and roll out male involvement guidelines in RMNCH interventions	21,287	42,574	42,574	21,287	21,287	149,009
		Activity 1.4: Review other RMNCAH and HIV guidelines to include Gender, GBV and VAC issues	0	17,500	0	0	0	17,500
		Activity 1.5: Mobilize resources for GBV/VAC prevention and response activities	28,940	45,505	45,505	28,944	28,944	177,838
		Activity 1.6:Conduct supportive supervisionforqualitypostGBV/VAC services						
		Activity 1.7: Conduct clinical mentorship to trained Health care providers						
6.6.2	KRA 2: Gender, GBV and male involvement integration into RMNCAH and HIV improved by 2020.	Activity 2.1: In-service training of gender, GBV, VAC and male involvement among health care providers	77,002	77,002	38,501	38,501	38,501	269,507
		Activity 2.2: Integrate GBV and VAC one stop centres at referral hospital level	23,712	41,709	59,707	77,705	95,703	298,536
		Activity2.3:InclusionofGender,GBV, VAC and male involvement in Pre-service Curricula	0	28,000	0	0	0	28,000

6.6.3	KRA 3: Community and households empowered with knowledge and information in understanding of harmful gender norms, male involvement, and prevention and response to GBV and VAC by 2020.	Activity 3.1: SBCC interventions for addressing harmful GBV, VAC, gender norms and promoting male involvement and improving health seeking behaviours	30,954	987	13,913	987	987	47,828
		Activity 3.2: Orient CHWs on Gender, GBV and VAC prevention interventions using national guidelines and standards	33,966	33,966	33,966	33,966	33,966	169,830
		Activity 3: Design and conduct community based response and prevention interventions (e.g. outreach services, SASA etc.) to promote usage of GBV/VAC prevention and response services.	-	4,000	6,000	8,000	10,000	28,000
		Activity 3.4: Develop and roll community based training package on prevention of harmful gender norms, GBV and VAC, and its implications on health	127,869	87,260	70,117	87,260	70,117	442,623

6.7 ZONAL AND REGIONAL COORDINATION

SN	STRATEGIC OBJECTIVE	ACTIVITIES	TIME FRAME					TOTAL RESOURCES NEEDED IN US DOLLARS
			2016	2017	2018	2019	2020	
			RESOURCES NEEDED IN US DOLLARS					
6.7.1	KRA 1: Monitoring evaluation framework for RMNCH improved by 2020	Activity 1.1: Conduct Annual National RCHS Meeting	203,206	203,206	203,206	203,206	203,206	1,016,030
		Activity 1.2: Conduct Annual Zonal RCHS Meeting (Northern)	135,759	135,759	135,759	135,759	135,759	678,795
		Activity 1.3: Conduct Annual Zonal RCHS Meeting (Central)	135,759	135,759	135,759	135,759	135,759	678,795
		Activity 1.4: Conduct Annual Zonal RCHS Meeting (Southern Highland)	135,759	135,759	135,759	135,759	135,759	678,795
		Activity 1.5: Conduct Annual Zonal RCHS Meeting (Lake)	135,759	135,759	135,759	135,759	135,759	678,795
		Activity 1.6: Conduct Annual Zonal RCHS Meeting (Eastern)	135,759	135,759	135,759	135,759	135,759	678,795
		Activity 1.7: Conduct Annual Zonal RCHS Meeting (Southern)	135,759	135,759	135,759	135,759	135,759	678,795
		Activity 1.8: Conduct RMNCH Integrated supportive supervision at national level	38,528	38,528	38,528	38,528	38,528	192,640
		Activity 1.9: Conduct RMNCH Integrated supportive supervision at national level(Northern zone)	0	0	57,792	57,792	57,792	173,376

		Activity 1.10: Conduct RMNCH Integrated supportive supervision at national level(Central zone)	0	57,792	57792	57792	57,792	231,168
		Activity 1.11: Conduct RMNCH Integrated supportive supervision at national level(Southern Highland)	0	115,584	115,584	115,584	115,584	462,336
		Activity 1.12: Conduct RMNCH Integrated supportive supervision at national level	115,584	115,584	115,584	115,584	115,584	577,920
		Activity 1.13: Conduct RMNCH Integrated supportive supervision at national level	0	0	57,792	57,792	57,792	173,376
		Activity 1.15: Conduct RMNCH Integrated supportive supervision at national level	0	0	38,528	38,528	38,528	115,584

6.7.2	KRA2:Qualitymanagement and management (supervision)strengthened by 2020	Activity 2.1: Print orientation package for appointed regional and district RCHS coordinators on RMNCAH package(National)	45,714	0	0	0	0	45,714
		Activity 2.2: Conduct and update orientation package for appointed regionalanddistrictRCHScoordinators on RMNCAH package(Western)	25,465	25,465	25,465	25,465	25,465	127,325
		Activity 2.3: Conduct and update orientation package for appointed regionalanddistrictRCHScoordinators on RMNCAH package(Northern zone)	25,465	25,465	25,465	25,465	25,465	127,325
		Activity 2.4: Conduct and update orientation package for appointed regionalanddistrictRCHScoordinators on RMNCAH package(Central zone)	25,465	25,465	25,465	25,465	25,465	127,325
		Activity 2.5: Conduct and update orientation package for appointed regionalanddistrictRCHScoordinators on RMNCAH package(Southern Highlands zone)	25,465	25,465	25,465	25,465	25,465	127,325
		Activity 2.6: Conduct and update orientation package for appointed regionalanddistrictRCHScoordinators on RMNCAH package(Lake)	25,465	25,465	25,465	25,465	25,465	127,325
		Activity 2.7: Conduct and update orientation package for appointed regionalanddistrictRCHScoordinators on RMNCAH package(Lake zone)	25,465	25,465	25,465	25,465	25,465	127,325
		Activity 2.8: Conduct and update orientation package for appointed regionalanddistrictRCHScoordinators on RMNCAH package(Eastern zone)	25,465	25,465	25,465	25,465	25,465	127,325
		Activity 2.9: Conduct and update orientation package for appointed regionalanddistrictRCHScoordinators on RMNCAH package(Southern zone)	25,465	25,465	25,465	25,465	25,465	127,325

6.8 HUMAN RESOURCE FOR HEALTH								
SN	KEY RESULT AREA	ACTIVITIES	TIME FRAME					TOTAL RESOURCES NEEDED IN US DOLLARS
			2016	2017	2018	2019	2020	
			RESOURCES NEEDED IN US DOLLARS					
6.8.1	KRA 2: Health care workers performance and competence in RMNCAH improved by 2020	Activity 2.1: Develop integrated packages for induction and refresher trainings in RMNCAH competencies	137,275	137,275	137,275	137,275	137,275	686,377
		Activity 2.2: Conduct RMNCH refresher trainings	0	0	92,265	92,265	92,265	276,795

6.9 HEALTH FINANCING FOR RMNCAH

SN	KEY RESULT AREA	ACTIVITIES	TIME FRAME					TOTAL RESOURCES NEEDED IN US DOLLARS
			2016	2017	2018	2019	2020	
			RESOURCES NEEDED IN US DOLLARS					
6.9.1	KRA 2: Resource tracking on RMNCAH plans and implementation on annual basis implemented from 2016-2020	Activity 2.1: Conduct resource tracking annually national level	20,766	20,766	20,766	20,766	20,766	103,829
		Activity 2.1.2 : Conduct resource tracking annually western zone	1,131	1.131	1,131	1,131	1,131	5,657
		Activity 2.1.3: Conduct resource tracking annually Northern zone	1,131	1.131	1,131	1,131	1,131	5,657
		Activity 2.1.4: Conduct resource tracking annually Central zone	1,131	1.131	1,131	1,131	1,131	5,657
		Activity 2.1.5: Conduct resource tracking annually Southern highlands zone	1,131	1.131	1,131	1,131	1,131	5,657
		Activity 2.1.6: Conduct resource tracking annually Lake zone	1,131	1.131	1,131	1,131	1,131	5,657
		Activity 2.1.7: Conduct resource tracking annually Eastern zone	1,131	1.131	1,131	1,131	1,131	5,657
		Activity 2.1.8: Conduct resource tracking annually Southern zone	1,131	1.131	1,131	1,131	1,131	5,657

6.10 MONITORING AND EVALUATION FOR RMNCAH

SN	KEY RESULT AREA	ACTIVITIES	TIME FRAME					TOTAL RESOURCES NEEDED IN US DOLLARS
			2016	2017	2018	2019	2020	
			RESOURCES NEEDED IN US DOLLARS					
6.10.1	KRA 2: Improve monitoring, documentation and sharinglessonslearnt of key results in RMNCAH by 2020	Activity 2.1: Ensure paper based system for RMNCAH services data collection at National level is gradually replaced by electronic data collection system for at all Tertiary and Secondary level	699,857	0	0	0	0	699,857
		Activity 2.1.2: Ensure paper based system for RMNCAH services data collection is gradually replaced by electronic data collection system for at all Tertiary and Secondary level Western zone	15,561	0	0	0	0	15,561
		Activity 2.1.3: Ensure paper based system for RMNCAH services data collection is gradually replaced by electronic data collection system for at all Tertiary and Secondary level Northern zone	15,561	0	0	0	0	15,561
		Activity 2.1.4: Ensure paper based system for RMNCAH services data collection is gradually replaced by electronic data collection system for at all Tertiary and Secondary level Central zone	0	0	15,561	0	0	15,561

		Activity 2.1.5: Ensure paper based system for RMNCAH services data collection is gradually replaced by electronic data collection system for at all Tertiary and Secondary level Southern Highland zone	0	15,561	0	0	0	15,561
		Activity 2.1.6: Ensure paper based system for RMNCAH services data collection is gradually replaced by electronic data collection system for at all Tertiary and Secondary level Lake zone	0	15,561	0	0	0	15,561
		Activity 2.1.7: Ensure paper based system for RMNCAH services data collection is gradually replaced by electronic data collection system for at all Tertiary and Secondary level Eastern zone	0	0	0	15,561	0	15,561
		Activity 2.1.8: Ensure paper based system for RMNCAH services data collection is gradually replaced by electronic data collection system for at all Tertiary and Secondary level Southern zone	0	0	15,561	0	0	15,561
		Activity2.1.9:National supervision to ensure paper based system for RMNCAH services data collection is gradually replaced by electronic data collection system for at all Tertiary and Secondary level	11,493	11,493	11,493	11,493	11,493	57,463
		Activity 2.2.1: Ensure increased RMNCAH data completeness and timeliness through periodic field M and E supervisions	11,493	11,493	11,493	11,493	11,493	57,463

		Activity 2.2.2: Ensure increased RMNCAH data completeness and timeliness through periodic field M and E national meetings	16,027	16,027	16,027	16,027	16,027	80,137
		Activity 2.3.1: Ensure increased RMNCAH data quality through periodic data audits	11,493	11,493	11,493	11,493	11,493	57,463
		Activity 2.3.2: Ensure increased RMNCAH data quality through periodic data audits national meetings	16,027	16,027	16,027	16,027	16,027	80,137
		Activity 2.4.1: Ensure that MPDSR data is integrated into the HMIS/ DHIS 2 electronic data base at Council level	17,383	0	0	0	0	17,383
		Activity 2.4.2: Orientation of RCH stakeholders on the MPDSR database	13,593	0	0	0	0	13,593
		Activity 2.4.3: Orienting the RHMTs/CHMTs on the MPDSR database	18,853	18,853	18,853	18,853	18,853	94,263
		Activity 2.5.1 : Orient national level staff on RMNCAH data management and use including the FP dashboard, FP Train Tracker, and the Train Smart data base	13,593	13,593	13,593	13,593	13,593	67,966
		Activity 2.5.2:Capacity building to RHMTs/CHMTs on data management including report writing(national)	0	0	0	0	18,853	18,853

Activity 2.5.3:Capacity building to RHMTs/CHMTs on data management including report writing in Western zone	18,853	0	0	0	0	18,853
Activity 2.5.4:Capacity building to RHMTs/CHMTs on data management including report writing in Northern zone	18,853	0	0	0	0	18,853
Activity 2.5.5:Capacity building to RHMTs/CHMTs on data management including report writing in Central zone	0	18,853	0	0	0	18,853
Activity 2.5.6:Capacity building to RHMTs/CHMTs on data management including report writing in Southern highlands	0	18,853	0	0	0	18,853
Activity 2.5.7Capacity building to RHMTs/CHMTs on data management including report writing Lake zone	0	0	18,853	0	0	18,853

		Activity 2.5.8:Capacity building to RHMTs/CHMTs on data management including report writing in Eastern zone	0	0	0	0	18,853	18,853
		Activity 2.5.9:Capacity building to RHMTs/CHMTs on data management including report writing Southern zone	0	0	0	18,853	0	18,853
		Activity 2.6.1: Use of RMNCAH Score card improved (national)	34,294	34,294	34,294	34,294	34,294	171,471
		Activity 2.6.2: Use of RMNCAH Score card improved in Western zone	13,593	0	0	0	0	13,593
		Activity 2.6.3: Use of RMNCAH Score card improved in Northern zone	13,593	0	0	0	0	13,593
		Activity 2.6.4: Use of RMNCAH Score card improved in Central zone	0	13,593	0	0	0	13,593
		Activity 2.6.5: Use of RMNCAH Score card improved in Southern highlands zone	0	13,593	0	0	0	13,593
		Activity 2.6.6: Use of RMNCAH Score card improved in Lake zone	0	0	13,593	0	0	13,593
		Activity 2.6.7: Use of RMNCAH Score card improved in Eastern zone	0	0	0	13,593	0	13,593
		Activity 2.6.8: Use of RMNCAH Score card improved in Southern zone	0	0	0	0	13,593	13,593

6.10.2	KRA3:Transformation of RCH from a section to a directorate completed by 2020	Activity 3.1.1: Conduct high level advocacy meetings	15,866	15,866	0	0	0	31,731
		Activity 3.1.2: Conduct technical team meetings	59,023	59,023	0	0	0	118,046
		Activity 3.1.3: Conduct meeting with President's Office Public Service Management	20,874	0	0	0	0	20,874
6.10.3	KRA 4: Share M&E results	Activity4.1:CommunicatingM&E results with central staff	27,186	27,186	27,186	27,186	27,186	135,931
		Activity4.1:CommunicatingM&E results with RHMTs/CHMTs	75,410	75,410	75,410	75,410	75,410	377,051
6.10.4	KRA 5: Conduct Midterm review	Activity 5:1 Midterm review of One Plan II, dissemination of resultsanddraftingofmid-course correction	0	0	150,000	100,000	0	250,000
GRAND TOTAL FOR ALL ACTIVITIES			259,560,065.94	246,010,429.30	245,424,430.80	241,590,052.38	238,198,999.80	1,330,947,290.44

ANNEX 1: Performance Indicators Matrix

(a) Impact Indicators

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Maternal mortality ratio	The number of women who die of causes related to pregnancy (pregnancy, childbirth or within 42 days of termination of pregnancy, irrespective of the duration) in a given year or other period	All maternal deaths occurring in a period (usually a year)	Total number of live births occurring in the same period per 100,000 live births	432 (2012 Census)	292	TDHS, Census	Every 4 to 5 years Every 10 years
Neonatal mortality rate	The number of deaths during the first28completed days of life per 1000 live births in a given year or other period.	Number of children who die within the first 28 completed days of life	Number of live births ÷ 1000	21 UN Estimates, 2013	16	TDHS Census	Every 4 to 5 years

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Infant mortality rate	The number of infants who die before completing the first year of life per 1000 live births in a given year or other period.	Number of deaths within the first year of life.	Number of live births ÷ 1000	45 (Census 2012)	25	TDHS Census	Every 4 to 5 years Every 10 years
Under-five mortality rate	The number of children who die within the first five years of life per 1000 live births in a given year or other period.	Number of deaths within the first five years of life.	Number of live births ÷ 1000	54 UN Estimate	40	TDHS Census	Every 4 to 5 years Every 10 years
Age specific fertility rates	The number of live births per 1000 women in a specific age group for a specified geographic area and for a specific point in time, usually a calendar year.	Number of live births to women in specified age group.	1000			TDHS Census	Every 4 to 5 years Every 10 years

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Total fertility rate	The average number of children a hypothetical cohort of women would have at the end of their reproductive period if they were subject during their whole lives to the fertility rates of a given period and if they were not subject to mortality. It is expressed as children per woman.	Sum of age specific fertility rates for age groups comprising 15–49 age group.	1,000	5.2 (Census 2012)	5.0	TDHS census	Every 4 to 5 years Every 10 years
Adolescent fertility rate	The number of births per 1,000 women ages 15–19.	number of live births to women aged 15–19 years,	Estimate of exposure to childbearing by women aged 15–19 years	116 per 1,000 women (TDHS 2010)	80 per 1,000 women	TDHS Census	Every 4 to 5 years Every 10 years

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Adolescent birth rate	The annual number of live births to adolescent women per 1,000adolescent women.	number of live births to adolescentwomen	The total number of adolescent women and multiplied by 1,000.				Every 4 to 5 years Every 10 years

(b) Family Planning Indicators

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Contraceptive prevalence rate (modern methods)	Percentageofwomen aged15–49yearswho arecurrentlyusing,or whosesexualpartner is using, at least one modern method of contraception, regardless of the method used.	Number of women of reproductive age at risk of pregnancy who are using (or whose partner is using) a contraceptive method at a given point in time	Number of women of reproductive age at risk of pregnancyat the same point in time	27 % (Modern Methods)	45 % (Modern Methods)	TDHS	Every 4 to 5 years

Number of individuals accepting contraceptives(new acceptors)	The numbers of persons who accept for the first time in their lives any (program) contraceptive method; to be reportedforadefined referenceperiod(e.g., one year).	Counts of persons accepting any FP method for the first time in their lives during a one-year period	NA	2,100,000	5,000,000	HMIS	Quarterly
Percent of women 15-49 years old who have heard of three or more familyplanning(FP) methods, modern or traditional		Number of women aged15-49whohave heard about at least three methods of FP	Number of womenaged15-49 interviewed) x 100			TDHS	Every 4 to 5 years
Percent of the population who know of at least one source of modern contraceptive services and/or supplies		Number of people surveyed/ interviewed who know of at least one source of modern contraceptive services and/or supplies	Total number of people surveyed or interviewed) x 100				

Percentoffacilities that experienced a stock out of a given FP commodity, for any number of days during a given time period		Number of facilities that experienced a stock out of a given FP commodity	Total number of facilities that offer product per 100			eLMIS	Quarterly
Couple-years of protection (CYP)	The estimated protection provided by family planning (FP) services during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period					HMIS	Annually
Number of FP service delivery points offering full range of contraceptive supplies per 500,000 populations.		Number of FP service delivery points offering full range of contraceptive supplies	500,000 per population of Tanzanians (mainland)	58	60	HMIS	Annually

(c) Maternal Health Indicators

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Antenatal care coverage: before 12 weeks gestational age	Percentage of pregnant women start ANC before 12 weeks of gestation age	Number of pregnant women who start ANC before 12 weeks of gestation age x 100	Estimated number of pregnant women.	15% (< 4 months TDHS 2010) 12% (HMIS 2014)	60% (< 4 months)	HMIS TDHS (< 4 months)	HMIS (Monthly) TDHS interval
Pregnant women attending ANC 4+ times	Percentage of pregnant women who received antenatal care four or more times in a given time period.	Number of pregnant women who received antenatal care four or more times x 100	Estimated number of pregnant women.	43% (TDHS 2010) 28%	80%	TDHS TDHS	Every 4 to 5 years Quarterly
HIV positive women provided with ARV's during pregnancy	Proportion of HIV positive women provided with ARV's during pregnancy	Number of HIV positive women provided with ARV's during pregnancy	Total number of Number of HIV positive women			HMIS	Quarterly
Pregnant women tested and treated for syphilis	Percentage of pregnant women tested and treated for syphilis	Number of pregnant women tested and treated for syphilis	Total number of pregnant women tested for syphilis			HMIS	Quarterly

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Positive syphilis serology in pregnantwomen	Prevalence of positive syphilis serology in pregnant women	Number of positive syphilis serology in pregnant women	Total number of pregnant women tested for syphilis			HMIS	Quarterly
Pregnantwomen receiving two doses of SP	Percentage of pregnant women receiving two doses of SP	Number of pregnant womenreceivingtwo doses of SP	Expected number of pregnant women			TDHS HMIS	Every 4 to 5 years Quarterly
Proportion of mothersreceiving Postnatal Care within 48 hours	Proportion of mothersreceiving Postnatal Care within 48 hours	Number of mothers receiving Postnatal Carewithin48hours	Number of all women who delivered			TDHS HMIS	Every 4 to 5 years Quarterly
Deliveries taking place in health facilities	Proportion of deliveries taking place in health facilities	Numberofdeliveries takingplaceinhealth facilities during a given period	Expected number of live births/deliveries during a given period	50% (TDHS 2010)	80%	TDHS HMIS	Every 4 to 5 years Quarterly
Birthsassistedby skilledattendants	Proportion of births assisted by skilledattendants	Number of births attended by skilled health personnel during a specified period	Total number of live births during the specifiedperiod	51 % TDHS 2010	80 %	TDHS HMIS	Every 4 to 5 years Quarterly

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Facilitiesoffering EmONC services (by basic and comprehensive)	Proportion of facilities offering EmONC services (by basic and comprehensive)	Number of facilities offering EmONC services(bybasicand comprehensive)	Number of facilitiesoffering deliveryservices			TzSPA Special Surveys HMIS	Every 4 to 5 years Varies Quarterly
Percent of all births in EmOC facilities	The percent of all births in an area that take place in emergency obstetric and newborn care (EmONC) facilities (basic or comprehensive).	Number of women registered as having given birth in facilitiesclassifiedas EmONC facilities	Estimate of all the live births in the area, regardless of where the birth takes place x 100			TzSPA Special Surveys HMIS	Every 4 to 5 years Varies Quarterly

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Met need for obstetric complications (coverage of women with obstetric complications that have received EmONC out of all women with obstetric complications)	Coverage of met need for obstetric complications (coverage of women with obstetric complications that have received EmONC out of all women with obstetric complications)					TzSPA Special Surveys HMIS	Every 4 to 5 years Varies Quarterly
Caesarean sections rate	Percentage of Caesarean sections	Number of Caesarean sections	Number of all live births			TDHS HMIS	Every 4 to 5 years Quarterly
Case fatality rate for obstetric complications	Case fatality rate for obstetric complications					HMIS	Quarterly

(d) Neonatal Health indicators

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Prevalence of low birth weight	Percentage of newborn registering less than 2.5 kg weight	Number of newborn registering less than 2.5 kg weight	Number of all live births				
Early initiation of breast feeding (within the first hour)	Percentage of mothers initiating early breast feeding (within the first hour)	Number of children 0 < 24 months put to the breast within 1 hour of delivery	Total number of children 0 < 24 months) x 100			TDHS HMIS	Every 4 to 5 years Quarterly
Health facilities providing essential newborn care	Proportion of health facilities providing essential newborn care	Number of health facilities providing essential newborn care	All health facilities providing delivery services			TzSPA Special surveys	Every 4 to 5 years Quarterly
Newborns receiving postnatal care within 48 hours	Percentage of mothers and babies who received postpartum care within 48 hours of childbirth (regardless of place of delivery)	Number of mothers and babies who received postpartum care within 48 hours of childbirth x 100	Projected number of live births	65% TDHS 2010	80%	TDHS HMIS	HMIS (Monthly) TDHS interval

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Perinatal deaths (still births, deaths within the first seven days of life)	Number of perinatal deaths (still births, deaths within the first seven days of life)	Number of perinatal deaths (still births, deaths within the first seven days of life)	Per 1000 live births	TDHS 2010		TDHS	HMIS (Monthly) TDHS interval
District hospitals that have functional newborn resuscitation facilities in the delivery room	Proportion of district hospitals that have functional newborn resuscitation facilities in the delivery room	Number of district hospitals that have functional newborn resuscitation facilities in the delivery room	Number of all district hospitals			CHMT Supervision reports	Annual
District hospitals implementing Kangaroo Mother Care for management of Low Birth Weight	Proportion of district hospitals implementing Kangaroo Mother Care for management of Low Birth Weight	Number of district hospitals implementing Kangaroo Mother Care for management of Low Birth Weight	Number of all district hospitals			CHMT Supervision reports	Annual

(e) Child Health Indicators

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Antibiotic treatment for pneumonia and dysentery	Percentage of children treated with antibiotic for pneumonia and dysentery	Number of children treated with antibiotic for pneumonia and dysentery	Number of all children with pneumonia and dysentery			Special surveys HMIS	Varied Quarterly
ORS and zinc treatment in management of diarrhoea	Proportion of children with diarrhoea who were given ORS and zinc	Number of children with diarrhoea who were given ORS and zinc	Number of children with diarrhoea			THDS HMIS	Every 4 to 5 years Quarterly
Health facilities with 60% of health workers trained on IMCI	Proportion of health facilities with 60% of health workers trained on IMCI	Number of health facilities with 60% of health workers trained on IMCI	Number of health facilities providing RCH services			CHMT	Quarterly
Penta 3 Immunization coverage (DTP–HepB, Hib3)	Proportion of children under one received Penta3 vaccine in a given year or other period.	Total number of children under one year vaccinated 3 times against DPT – Hb x 100	Total number of children under one year targeted in the period	86% (TDHS 2010) 92% (HMIS 2014)	95%	THDS HMIS	Every 4 to 5 years Quarterly

Measles Immunization coverage	Proportion of children under one received measles vaccine in a given year or other period.	Total number of children under one year vaccinated against measles x 100	Total number of children under one year targeted in the period	75% (TDHS 2010) 101% (HMIS 2014)	90% in 90% of districts	THDS HMIS	Every 4 to 5 years Quarterly
Fully Immunized	Percentage of Infants who received one dose of BCG, three doses each of OPV, DPT, and Hepatitis B vaccines, and one dose of measles vaccine before reaching one year of age.	Number of Infants who received one dose of BCG, three doses each of OPV, DPT, and Hepatitis B vaccines, and one dose of measles vaccine before reaching one year of age.	Number of all Infants.			THDS HMIS	Every 4 to 5 years Quarterly
Vitamin A supplementation coverage	Survey: Proportion of children 6-59 months who received 1 dose of vitamin A in the past 6 months. HMIS: Ratio of Vitamin A doses given to children 12-59 months in past 12 months to number of children 12-59 months.	Survey: Total number of children aged 6-59 months who received 1 dose of vitamin A in the past 6 months x 100 HMIS: Number of Vitamin A doses given to children 12-59 months in past 12 months	Survey: Total number of children aged 6-59 months in the sample. HMIS: Number of children 12-59 months	61% (TDHS 2010) 69% (HMIS 2014)	90%	HMIS TDHS	HMIS (Monthly) TDHS interval

HIV positive children receiving ARV	Proportion of HIV positive children receiving ARV	Number of HIV positive children receiving ARV	Number of HIV positivechildren			HMIS	Quarterly
HIVexposedinfants tested for EID	Proportion of HIV exposed infants tested for EID	Number of HIV exposed infants tested for EID	Number of all HIV exposed infants			HMIS	Quarterly
HIVexposedinfants receiving ARV prophylaxis	Proportion of HIV exposed infants receiving ARV prophylaxis	Number of HIV exposed infants receiving ARV prophylaxis	Number of all HIV exposed infants			HMIS	Quarterly

(f) Nutrition Indicators

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Children under 5 who are underweight	Proportion of under-fives who are underweight (weight for age)	Number of children who are underweight (weight-for-age less than -2 standard deviations of the WHO Child Growth Standards median) among children aged 0-4 years x 100	Number of children underfiveyearsofage	16% (TDHS 2010)	11%	TDHS	TDHSinterval
Childrenunder5 who are stunted	Proportion of under-fives who arestunted(height for age)	Number of children who are stunted (height-for-age less than -2 standard deviations of the WHO Child Growth Standards median) among children aged 0-4 years x 100	Number of children underfiveyearsofage	42% (TDHS 2010) 35% (National Nutrition Survey, 2014)	22%	TDHS National Nutrition Survey	HMIS (Monthly) TDHSinterval National Nutrition Survey (in-between DHS)

Severe acute malnutrition (SAM) treatment coverage	Percentage of children 0-59 months with severe acute malnutrition receiving treatment	Number of new SAM cases among 0-59 month olds who received treatment (outpatient or in-patient care) in the month preceding	Estimated number of new cases of SAM among children 0-59 months. Calculated as (0-59m population x [incidence] / 12) * Number of months in reporting interval			HMIS (to be added)	Monthly

(f) Adolescent Health Indicators

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Health facilities providing Adolescent Friendly Reproductive Health Services	Percentage of health facilities providing Adolescent Friendly Reproductive Health Services	Number of health facilities providing Adolescent Friendly Reproductive Health Services	Total number of Health facilities providing RCH Services			Special surveys HMIS	Varies Quarterly
Young women aged 15-24 who have had sexual intercourse before the age of 15	Percentage of young women aged 15-24 who have had sexual intercourse before the age of 15	Number of young women aged 15-24 who have had sexual intercourse before the age of 15	All of young women aged 15-24 who had ever had sexual intercourse			TDHS	Every 4 to 5 years

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
New adolescent FP clients who received condoms (through health facilities,outreach, CHWs)	Percentage of new adolescent FP clients who received condoms (through health facilities, outreach, CHW)	Number of new adolescent FP clients who received condoms (through health facilities, outreach, CHW) clients	Number of all new adolescent FP			TDHS HMIS	Every 4 to 5 years Quarterly
Adolescents who received post abortion care services	Percentage of adolescents who received post abortioncareservices	Percentage of adolescents who received post abortioncareservices	Percentage of adolescents who received post abortion care services			HMIS	Quarterly
Adolescent (below 20 years) who reported for ANC services within 12 weeks gestation from among all ANC clients	Percentage of adolescent (below 20 years) who reported for ANC services within 12 weeksgestationfrom amongallANCclients	Number of adolescent (below 20 years) who reported for ANC services within 12 weeks gestation from among all ANC clients	Number of expected pregnancies			HMIS	Quarterly
Adolescent (below 20 years) who delivered in a health facility from among all women who delivered in health facilities	Percentage of adolescent (below 20 years) who delivered in a health facility from among all womenwhodelivered in health facilities	Number of adolescent (below 20 years) who delivered in a health facility from among all women who delivered in health facilities	Number of all deliveries			HMIS	Quarterly

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Adolescent (below 20 years) who reported for PNC services at health facilities within 48 hours after delivery from among all women who delivered	Percentage of adolescent (below 20 years) who reported for PNC services at health facilities within 48 hours after delivery from among all women who delivered	Number of adolescent (below 20 years) who reported for PNC services at health facilities within 48 hours after delivery	Number of all women who delivered			HMIS	Quarterly
New-borns by Adolescent mothers (below 20 years) who were brought for PNC services at health facilities within 48 hours after delivery from among all women who delivered	Percentage of New-borns by Adolescent mothers (below 20 years) who were brought for PNC services at health facilities within 48 hours after delivery from among all women who delivered	Number of New-borns by Adolescent mothers (below 20 years) who were brought for PNC services at health facilities within 48 hours after delivery from among all women who delivered	Number of all newborns			HMIS	Quarterly

(g) Gender Based Violence and Violence Against Children Health Indicators

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Health facilities that have integrated gender, Gender Based Violence (GBV) and Violence Against Children (VAC) services	Proportion of health facilities that have integrated gender, Gender Based Violence (GBV) and Violence Against Children (VAC) services	Number of health facilities that have integrated gender, Gender Based Violence (GBV) and Violence Against Children (VAC) services	Number of health facilities providing RCH services			HMIS	Quarterly
Female GBV clients from among all GBV clients	Percentage of female GBV clients from among all GBV clients	Percentage of female GBV clients from among all GBV clients	Percentage of female GBV clients from among all GBV clients			HMIS	Quarterly
Female VAC clients from among all VAC clients	Percentage of female VAC clients from among all VAC clients	Percentage of female VAC clients from among all VAC clients	Percentage of female VAC clients from among all VAC clients			HMIS	Quarterly
GBV clients who experienced sexual violence from among all GBV clients	Percent of GBV clients who experienced sexual violence from among all GBV clients	Number of GBV clients who experienced sexual violence from among all GBV clients	Number of all GBV clients			TDHS HMIS	Every 4 to 5 years Quarterly

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
VAC clients who experiencedsexual violence from among all VAC clients	PercentofVACclients who experienced sexual violence from amongallVACclients	Number of VAC clients who experienced sexual violencefromamong all VAC clients	Number of all VAC clients			HMIS	Quarterly
GBV clients who experienced physical violence from among all GBV clients	PercentofGBVclients who experienced physicalviolencefrom amongallGBVclients	Number of GBV clients who experiencedphysical violencefromamong all GBV clients	Number of all GBV clients			TDHS HMIS	Every 4 to 5 years Quarterly
VAC clients who experienced physical violence fromamongallVAC clients	PercentofVACclients who experienced physicalviolencefrom amongallVACclients	Number of VAC clients who experiencedphysical violencefromamong all VAC clients	Number of all VAC clients			HMIS	Quarterly
GBV clients who experienced emotionalviolence from among all GBV clients	PercentofGBVclients who experienced emotional violence from among all GBV clients	Number of GBV clients who experienced emotional violence from among all GBV clients	Number of all GBV clients			TDHS HMIS	Every 4 to 5 years Quarterly

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
VAC clients who experienced emotionalviolence from among all VAC clients	Percent of VAC clients who experienced emotional violence from among all VAC clients	Number of VAC clients who experienced emotional violence from among all VAC clients	Number of all VAC clients			HMIS	Quarterly
Percentage of GBV and VAC clients who were counselled from among all GBV and VAC clients	Percentage of GBV and VAC clients who were counselled from among all GBV and VAC clients	Percentage of GBV andVAC clientswho were counselled from among all GBV and VAC clients	Percentage of GBV and VAC clientswhowere counselledfrom among all GBV and VAC clients			HMIS	Quarterly
FemaleGBVclients who were tested for pregnancy within 72 hours after the event from among all GBV clients	Percentageoffemale GBV clients who were tested for pregnancywithin72 hoursafterthe event from among all GBV clients	Number of female GBV clients who were tested for pregnancy within 72 hours after the event from among all GBV clients	Number of female GBV clients who experienced sexual violence			HMIS	Quarterly
GBV and VAC clientswhoarrived at a health facility within 72 hours after the event from among all GBV and VAC clients	Percentage of GBV and VAC clients who arrived at a health facility within 72 hoursafterthe event from among all GBV and VAC clients	Number of GBV and VAC clients who arrived at a healthfacilitywithin 72 hours after the event from among all GBV and VAC clients	Number of all GBV and VAC clients at health facility			HMIS	Quarterly

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Intimate partner violence prevalence	Percentage of ever-partnered women 15-49 years who have experienced physical and/or sexual violence by an intimate partner in the last 12 months	Number of ever-partnered women 15-49 years who have experienced physical and/or sexual violence by an intimate partner in the last 12 months x 100	Number of ever-partnered women 15-49 years	20% (TDHS 2010)		TDHS	Every 4 to 5 years

(i) Reproductive Cancers Indicators

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
New FP clients screened for breast cancer	Percentage of new FP clients screened for breast cancer	Number of new FP clients screened for breast cancer	Number of all new FP clients			HMIS	Quarterly
Screened new FP clients who were found with suspect breast cancer (lumps, bleeding nipples)	Percentage of screened new FP clients who were found with suspect breast cancer (lumps, bleeding nipples)	Number of screened new FP clients who were found with suspect breast cancer (lumps, bleeding nipples)	Number of screened new FP clients			HMIS	Quarterly
New clients screened for cervical cancer with VIA	Percentage of new clients screened for cervical cancer with VIA	Number of new clients screened for cervical cancer with VIA	Number of new clients			HMIS	Quarterly

Cervical cancer screening	Proportion of women aged 30–50 who were screened for cervical cancer with Visual Inspection with Acetic Acid/vinegar (VIA).	Total number of women between 30 and 50 who were screened with Visual Inspection with Acetic Acid/vinegar (VIA) x 100	Number of women aged 30–50 years	11% (HMIS 2014)		HMIS	Quarterly
New clients with positive VIA results	Percentage of new clients with positive VIA results	Number of new clients with positive VIA results	Number of new clients screened with VIA			HMIS	Quarterly
Clients with cervical precancerous lesions treated with Cryotherapy	Percentage of clients with cervical precancerous lesions treated with Cryotherapy	Number of clients with cervical precancerous lesions treated with Cryotherapy	Percentage of clients with VIA positive results			HMIS	Quarterly
Clients with VIA positive results treated with cryotherapy	Percentage of clients with VIA positive results treated with cryotherapy	Number of clients with VIA positive results treated with cryotherapy	Clients with VIA positive results			HMIS	Quarterly
New clients with suspect cancer	Percentage of new clients with suspect cancer	Number of new clients with suspect cancer	Clients with VIA positive results			HMIS	Quarterly
Clients with VIA positive results treated with LEEP	Percentage of clients with VIA positive results treated with LEEP	Number of clients with VIA positive results treated with LEEP	Clients with VIA positive results			HMIS	Quarterly

Clients referred for large lesion	Percentage of clients referred for large lesion	Number of clients referred for large lesion	Number of clients with suspect cancer			HMIS	Quarterly
Clients referred for suspect cancer	Percentage of clients referred for suspect cancer	Number of clients referred for suspect cancer	Number of clients with suspect cancer			HMIS	Quarterly

(j) Community Indicators

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
Communities that have set up functional emergency preparedness committees and plans for MNCH including FP and nutrition	Proportion of communities that have set up functionalemergency preparedness committeesandplans for MNCH including FP and nutrition	Number of communities that have set up functional emergency preparedness committees and plans for MNCH including FP and nutrition	Number of communities			CHMT	Quarterly
Pregnant women that have birth preparednessplans	Proportion of pregnant women that have birth preparedness plans	Numberofpregnant women that have birth preparedness plans	Number of pregnantwomen			TDHS	Every 4 to 5 years

Children who needed referral who went for referral	Proportion of childrenwhoneeded referralwhowentfor referral	Numberofchildren who needed referral who went for referral	Number of children who needed referral			TDHS	Every 4 to 5 years
Women with knowledge of danger signs of obstetric,neonatal and child health complications	Proportion of women with knowledgeofdanger signs of obstetric, neonatal and child healthcomplications	Number ofwomen with knowledge of danger signs of obstetric,neonatal and child health complications	Number of all women			TDHS	Every 4 to 5 years
District management task forces with representation fromcommunities	Proportion of districtmanagement task forces with representationfrom communities	Number of district management task forces with representation fromcommunities	Number of districts			CHMT	Quarterly
District committees with representation fromcommunities	Proportionofdistrict committees with representationfrom communities	Number of district committees with representation fromcommunities	Number of districts			CHMT	Quarterly
Facilities with a designated staff responsible for communityhealth services	Proportion of facilities with a designated staff responsible for community health services	Numberoffacilities with a designated staff responsible for community health services	Number of facilities with			CHMT	Quarterly

Villages with community health workers implementing MNCH and nutrition interventions	Proportionofvillages with community health workers implementing MNCH and nutrition interventions	Number of villages with community health workers implementing MNCHandnutrition interventions	Number of villages			CHMT	Quarterly
Households' care-seeking rate for diarrhoea, malaria and pneumonia	Percentage of Households seeking care for diarrhoea, malaria and pneumonia	Householdsseeking care for diarrhoea, malaria and pneumonia	Number of all Households with for diarrhoea, malaria and pneumoniacases			TDHS	Every 4 to 5 years
Villages with community health workers offering RMNCAH and nutritionservicesat community level	Percentageofvillages with community health workers offeringRMNCAHand nutrition services at community level	Number of villages with community health workers offering RMNCAH and nutrition services at community level	Number of all villages			CHMT	Quarterly

(k) System Strengthening Indicators

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency
MOHCDGEC and district budget allocated to RMNCAH	Proportion of MOHCDGEC and district budget allocated to RMNCAH	Proportion of MOHCDGEC and district budget allocatedtoRMNCAH	TotalMOHCDGEC and district budget allocated to RMNCAH			Financial reports Work plans	Annual
Resources mobilized for the RMNCAH Strategic Plan	Total resources mobilized for the RMNCAH Strategic Plan	Numberofresources mobilized for the RMNCAH Strategic Plan	Projected total resources for the RMNCAHStrategic Plan			Financial reports Work plans	Annual
HMIS Data completeness	HMIS Data completeness rate	Number of health facilities with HMIS data submitted that is complete	Number of health facilities using HMIS			HMIS	Quarterly
HMIS Data timeliness	HMISDatatimeliness rate	Number of health facilities with HMIS data submitted on time	Number of health facilities using HMIS			HMIS	Quarterly
Councils whose data have been quality audited	Proportion of councilswhosedata have been quality audited	Number of councils whose data have been quality audited	Number of all councils			CHMT	Quarterly
Midterm review of the One Plan II	Midterm review conducted	-	Midterm review conducted			RCHSreports	One time

ANNEX 2: Ending Preventable Neonatal, Stillbirths and Child Mortality (EPCD) Targets beyond 2015

U5MR

Global target	Reduce U5 Mortality Rate to less than 20 per 1,000 live births by 2035 (A promise renewed, 2012)	
NEWBORN DEATHS (Every Newborn, 2014)		
	Country targets	**Global targets**
2020	Follow national target	NMR of 15 per 1000 live births
2025	Follow national target	NMR of 12 per 1000 live births
2030	NMR of < 12 per 1000 live births	NMR of 9 per 1000 live births
2035	NMR of < 10 per 1000 live births	NMR of 7 per 1000 live births
NEWBORN DEATHS (Every Newborn, 2014)		
	Country targets	**Global targets**
2020	Follow national target	SBR of 14 per 1000 total births
2025	Follow national target	SBR of 11 per 1000 total births
2030	SBR of < 12 per 1000 total births	SBR of 9 per 1000 total births
2035	SBR of < 10 per 1000 total births	SBR of 8 per 1000 total births

ANNEX 3: Assumptions in calculating MMR, U5MR, NMR and SBR targets for beyond 2015

Ending preventable Maternal Mortality (EPMM) targets beyond 2015 set a goal that by 2030, no country should have MMR > 140/100,000 live births and countries should have < 100 maternal deaths /100,000 live births by 2035, see Annex 1. The stakeholders meeting of TWG for MNCH and other organizations working in field was held in Dar es Salaam on 18th December 2014 decided on different ARR for MMR from 2015 – 2020, 2021 – 2025 and from 2026 – 2030 to achieve the MMR recommended for 2035. Tanzania decided that it will make efforts to increase ARR from the current rate of 4.8% to the recommended rate - ARR of 5.5% from 2016 – 2020. From 2021 – 2025 the country will accelerate the ARR to 6.5%, and from 2026 – 2030 the country would like to have ARR of > 7% in order to achieve the 2035 goal of having MMR < 100 per 100,000 live births.

Table 3.1: MMR reduction following different average annual rate of reduction (ARR) to meet the 2035 goals of EPMM (2014 – 2035)

ARR%	Period	2014	2015	2020	2025	2030	2035
5.5%	2015-2020	410	387	292			
6.5%	2021 – 2025			292	209		

7%	2026 -2030				209	145	
7.5%	2031 – 2035					145	98

Underfive Mortality Rate reduction estimates

A goal of achieving U5MR < 20/ 1,000 live births by 2035 was proposed in the ''Child Survival: A promised Renewed" publication (WHO, 2013). Tanzania will achieve that goal by having an ARR of 5% between 2014 – 2033. If the country can keep the current pace of 7% ARR of U5MR, then the country will achieve the goal of having < 20 U5 deaths/ 1,000 live births by 2028, Table 4.2.

Table 3.2: Rates to be reached by year following the 2030 and 2035 global goals

	2014	2015	2020	2025	2030	2035	ARR% required
U5MR	54	51	40	31	24	18	5%
NMR	21	20	16	13	10	8	4.3%
SBR	26	25	19	15	11	9	5%

Newborn Mortality Rate estimates

According to ''Every Newborn: An Action Plan to End Preventable Deaths" an accelerated ARR of 4.3% is reccommended to achieve the 2030 target of NMR of 12 or less and < 10 newborn deaths/1,000 live births in 2035. Tanzania should be able to achieve the target by following the recommended ARR of 4.3% , and in fact by 2026 the country would have achieved NMR of 12/ 1,000 live births.

Stillbiths Rate

According to the 2014 reports, stillbirth rate (SBR) is 26 per 1,000 total births in Tanzania (Countdown Report, 2014). In order to end preventable stillbirths by 2030, it is recommended that countries should at least have an average annual rate of reduction of 3.5% (WHO, 2014). The SBR proposed target for 2020 is 14/1,000 total births and < 12/ 1,000 total births in 2030. With the an ARR of 3.5%, the country will not reach the 2030 goal of < 12 stillbirths/ 1,000 total births. Thus an accelerated ARR of 5% is required. Further the 2020 recommended goal of SBR of 14/1,000 livebirths is difficult to achieve even with ARR of 8%. It is therefore recommended that the country should follow the trajectory of achieving the 2030 goal by having 5% ARR. Thus by 2020 the country should aim to reduce stillbirths to 19/total births.

ANNEX 4: Key Evidence Based Interventions in MNCH and level where they should be offered

4.1 Pre-pregnancy, pregnancy and child birth interventions (Lassi et al, 2014a & b)

	Intervention	Method/Evidence	Level to be offered
Pre-pregnancy	Family planning	Male and female condoms, oral contraceptives, emergency contraceptives and hormonal injections	Community (C), Primary (P), Referral (R)
		All of above plus implants, intrauterine devices	Primary (P)
		All of above plus surgical contraception	Referral (R)
	Prevent & manage STIs, HIV and syphilis	Counselling, condoms & antibiotics	C, P, R
		All of the above laboratory testing HIV/STIs, ARVs	P, R
	Folic acid fortification and/ or supplementation for preventing neural tube defects		C, P, R
Pregnancy & adolescents	ANC Essential care	• Iron and folic acid supplementation • Tetanus immunization in pregnancy • Prophylactic antimalarial for preventing malaria in pregnancy • ITN for preventing malaria • Counselling on birth and emergency preparedness • Screening for hypertensive disorders of pregnancy • Screening for anaemia • Screening for HIV/syphilis • Screening of Gestation Diabetes • Prevention and management of HIV including ART	C, P, R C, P, R C, P, R C, P, R C, P, R P, R P, R P, R P, R P, R P,R
	Prevention and Management of pre-eclampsia	• Low dose Aspirin for prevention of pre-eclampsia in high risk women • Use of antihypertensive drugs to treat severe hypertension in pregnancy	P, R P, R
	Magnesium sulphate for eclampsia	-	P, R
	Corticosteroid to prevent respiratory distress syndrome		R
	Antibiotics for preterm rupture of membranes	-	P, R

Childbirth	Skilled birth attendance	-	P, R
	Basic Emergency Obstetric and newborn care		P, R
	Comprehensive Emergency Obstetric Care		R
	Prophylactic antibiotics for caesarean section		R
	Active management of third stage of labour to prevent postpartum haemorrhage		P, R
PNC	Advice and provision of FP		C, P, R
	Prevent and treat maternal anaemia		P, R
	Detect and treat postpartum sepsis		P, R

4.2: Key interventions for newborn health

	Intervention	Evidence	Level to be offered
Routine foe all newborns	Essential Newborn Care Skin-to-skin care Drying and wrapping Sterile instrument for cord cutting Cord, eye, skin care Initiate breastfeeding early	- Provision of quality, routine care during time of birth for all women and newborns could prevent estimated 531,000 stillbirths and 1.325 million newborn deaths (Lancet, 2014) - Skin-to-skin care reduce risk of hypothermia by 91% especially in preterm/LBW newborns weighing < 2000 grams (Salam et al, 2014)	Community (C) Primary Health (P) Referral (R)
	Breastfeeding within 1 hour	Early breastfeeding initiation associated with; - 44% reduction in all-cause neonatal mortality (Debes et al, 2013; Black et al, 2013) - 42% reduction in mortality among LBW babies (Debes et al, 2013) - 45% reduction in infection-related neonatal mortality (Debes et al, 2013)	C, P, R
Complications at birth	Neonatal resuscitation with bag and mask for do not breath spontaneously at birth	- Meta-analysis showed decreased intra-partum related neonatal deaths with training by 30% (Lee et al, 2011; Salam et al, 2014) - In Tanzania training in HBB showed 47% reduction in early neonatal mortality (Msemo et al, 2011)	P, R

Small and sick babies	Kangaroo mother care for preterm and babies weighing < 2000 grams	- 51% reduction in mortality for newborns weighing < 2000 grams (Lawn et al, 2010; Salam et al, 2014) - 43% - 60% reduction in severe morbidity (Conde-Agudelo et al, 2011; Salam et al, 2014)	P, R
	Management with antibiotics of neonatal sepsis, pneumonia or meningitis	Treatment of sepsis and pneumonia in newborns lead to; (Zaidi et al, 2011; Salam et al, 2014) - 25% reduction in all-cause neonatal mortality - 42% reduction in pneumonia-specific mortality	P, R
	Focusing on care of small and sick newborn could further prevent 600,000 newborn deaths by 2025 (Lancet, 2014)		
	NCU	Case management of jaundice, safe oxygen therapy, I/V fluids, extra support VLBW and management of babies with respiratory distress at district/higher level may avert 20% neonatal mortality (Salam et al, 2014)	R
	PNC visit	Meta-analysis of home visits by CHWs during postnatal period especially in rural for home deliveries showed a reduction of 12% (95% CI 5–18) of newborn mortality (Kirkwood et al, 2013)	C

4.3: Key interventions for Child Health

	Intervention	Evidence	Level to be offered
Routine for all children	Exclusive breastfeeding for 6 months	Lack of exclusive breastfeeding initiation associated with; - Contributes to 804,000 child deaths - which represent 11.6% of the 6.9 million child deaths that occurred globally (Black et al, 2013).	Community (C) Primary Health (P) Referral (R)
	Appropriate IYCF to reduce stunting and anaemia		C, P, R
	Routine immunization		C, P, R
Severely sick 2^{0} under nutrition	Treatment of SAM		P, R

Sick children	Comprehensive care of childhood pneumonia		P, R
	Case management of diarrhoea		C, P, R
	Comprehensive care of children exposed or infected with HIV		P, R
	Management of childhood malaria		C, P, R
Community platforms	Community promotion of EBF, nutrition counselling and care seeking behaviour		C

ANNEX 5: Ending Preventable Maternal Mortality (EPMM) – Targets beyond 2015

Global Targets	
Global target	Reduce global Maternal Mortality Ratio (MMR) to less than 70 maternal deaths per 100,000 live births by 2030
Secondary global target	By 2030, no country should have MMR greater than 140, a number twice the global target
Country Targets	
For countries with MMR < 420 in 2010	Reduce the MMR by at least two-thirds from the 2010 baseline by 2030
For countries with MMR > 420 in 2010	The rate of decline should be greater and in 2030, no country should have MMR over 140. Countries will need to reduce their MMR at an annual rate of reduction (ARR) greater than 5.5%.

Source: WHO & USAID, 2014

ANNEX 6: Other Monitoring and Evaluation Indicators of RMNCAH

Indicators for Maternal Health Interventions

Table 6.1: Indicators depicting level and targets for 2020 of care provided during pregnancy in Tanzania

Indicator	Current level 2013 -2014	Target by 2015	2020 Target
ANC at least once	96%	100%	100%
ANC at least 4 times	43%	90%*	90%
ANC before 16 weeks of gestation	15%	60%	60%
IPT $_2$	32%	80%	80%
ITN Use in pregnancy	75%	80%	90%
TT $_{2+}$ Lifetime protection	88%	90%	100%

Anaemia in pregnancy	53%		37%
% of pregnant women screened for syphilis	38%	80%	80%
% pregnant women screened for HIV	90%	90%	> 95%
PMTCT			
Site coverage (RCH facilities with PMTCT services)	94%	100%	100%
% pregnant reached at ANC with PMTCT services	95%	80%*	100%
% HIV positive receive ART recommended in option B+	79%	90%	100%
% HIV exposed infants receive ARV prophylaxis	56%	80%	>90%

Table 6.2: Level and trends of indicators to monitor progress during childbirth

Indicator	Current level 2013-2014	2015 Target	2020 Target
Proportion of deliveries taking place in health facilities (TDHS, HMIS 2011)	50% - 56%	80%	80%
Proportion of births assisted by a skilled attendant (TDHS, NPS 2011)	51% - 62%	80%	80%
Proportion of facilities offer BEmOC (SARA)	20 % dispensaries 39 % Health centres	70 % dispensaries 70% Health Centre	70%
Proportion of facilities offer CEmOC	73% Hospitals	100%	100%
Proportion of facilities offer CEmOC	9 % Health centres	50%	50%
Caesarean section rate	4.5%	5-15%	5-15%
Met need for Obstetric Complications	Complications not recorded in HMIS		100%
Case Fatality Rate (CFR) for obstetric complications	Complications aren't recorded		< 1%

Indicators for Newborn Interventions

Table 6.3: Current levels and target for 2020 - newborn indicators

Indicator	Current level 2013-2014	2015 Target	2020 Target
NMR (per 1,000 live births)	21	19	16
SBR (per 1,000 total births)	26	-	19
Postnatal care visit (within 48 hours)	31 %	80 %	80 %[§]
Postnatal visit at home within 1st week	-		80%[§]

Indicator	Current level 2013-2014	2015 Target	2020 Target
Early initiation of breastfeeding (within 1 hour after birth)	49%	90%	90%§
Prevalence of low birth weight (LBW)	7%		< 2%*
Prevalence of preterm births/delivery	-		
% HIV exposed children who receive ARV prophylaxis	56%	80%	90%§
Proportion of health facilities with deliveries perform newborn resuscitation (NR)	-		50%‡
% of babies without spontaneous breathing at birth who were resuscitated with bag and mask			50%‡
% of health facilities with deliveries providing essential newborn care (ENC)	-	75%	75%
% of district hospitals and health centres with designated area for Kangaroo Mother Care (KMC)// or implementing KMC	-		100%
% of preterm and babies weighing < 2000 grams who received KMC	-		50%‡
% of district hospitals with functional neonatal care unit (NCU)	-		100%
% of health facilities with RCH services with antenatal corticosteroids to reduce morbidity and mortality due to preterm birth	-		90%
% health facilities where there are deliveries have recommended NR commodities (bag &mask, suction)	15-32% PHC 90% Hospitals		90%
% health facilities deliveries with recommended antibiotics for newborn infections (I/M ampicillin & gentamycin)	-		90%
Proportion of newborn with possible serious bacterial infection who received antibiotic therapy			50%‡
Proportional of district hospitals that are accredited baby friendly (BFHI)			100%
Birth registration	16%	60%	60%*

§ = target from previous policy documents

‡= recommended targets for 2020 in every newborn, WHO, 2014

*= suggestions and inputs are required from TWG

- = No data

PHC = Primary health care (dispensary & health centres)

Indicators for child health

Table 6.4: Current Level and Targets for 2020 in Child Health and Nutrition Indicators

Indicator	Current level 2013 - 2014	2015 Target	2020 Target
U5MR (per 1,000 live births)	54		40
Measles 1 Immunization Coverage	95%	90% in 90% of districts	90% in 90% of the districts*
DPT- HiB 3 (Penta 3) coverage	95%		
Vitamin A supplementation (U5)	60%	70% dispensaries	90%§
Exclusive Breastfeeding @ 6M	50%	80%	80%§
Timely complementary feeding rate	93%	100%	100%
Under-weight prevalence	16%	14%	11%
Stunting prevalence	42%	22%	22%§
Wasting prevalence	5%	< 5%	< 5%§
Anaemia prevalence	59%		41%
ART coverage among children with advanced HIV infection	23%		60%
% HIV exposed children who receive ARV prophylaxis	56%	80%	90%§
% HIV exposed children who receive Cotrimoxazole prophylaxis	34%	80%	90%§
% of HIV-exposed children tested at 6 weeks or 12-18 months	30%	80%	90%§
Mother-to-child HIV transmission rate	12.7%		< 5%§
ITN use in children	73%	80%	90%*
Malaria/fever care seeking	77%		90%*
% of children with malaria Rx with recommended drug (ACT)	34%		60%*
ARI/ pneumonia care seeking	71%		90%
% of children with pneumonia treated with recommended antibiotics	-		50%*
Care seeking for diarrhoea	53%		90%
ORS and zinc used for treatment of diarrhoea	59%		90%
% sick children correctly identified and treated following IMCI guideline	-		50%*
% health facilities with at least one trained staff in IMCI	44%		80%

§ = target from previous policy documents; ‡= recommended targets for 2020 in every newborn, WHO, 2014; *= suggestions and inputs are required from TWG, - = No data, PHC = Primary health care (dispensary & health centres)

Indicators for Adolescent health

Table 6.5: Current Level and Targets for 2020 in Adolescent Health Indicators

Indicator	Current level 2013 -2014	2015 Target	2020 Target
Adolescent Fertility Rate AFR (15-19) years)	128 per 1,000 women	< 100 per 1,000 women	< 100 per 1,000 women
Adolescent birth rate (have started childbearing by age 19)	44%%	39%	30%
Proportion of HF provide AFSRH services	30%	80%	80%
Proportion of service delivery points outside HF provide youth friendly services	-	-	50%
Sexually active adolescents (15-19) **CPR** **Unmet need for FP** **Demand of FP satisfied** **% use condom at last sex**	 12% 16% 48% 50%	-	 20% 10% 60% 65%
HIV testing among 15-24 years **Young women** **Young men**	 39% 25%		 60% 60%
% 15-19 who are married/ cohabiting	18%		30%

ANNEX 7: Sustainable Development Goals

Goal 1	End poverty in all its forms everywhere
Goal 2	End hunger, achieve food security and improved nutrition and promote sustainable agriculture
Goal 3**	**Ensure healthy lives and promote well-being for all at all ages**
Goal 4	Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
Goal 5 **	**Achieve gender equality and empower all women and girls**
Goal 6	Ensure availability and sustainable management of water and sanitation for all
Goal 7	Ensure access to affordable, reliable, sustainable and modern energy for all
Goal 8	Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all
Goal 9	Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation
Goal 10	Reduce inequality within and among countries
Goal 11	Make cities and human settlements inclusive, safe, resilient and sustainable
Goal 12	Ensure sustainable consumption and production patterns
Goal 13	Take urgent action to combat climate change and its impacts*
Goal 14	Conserve and sustainably use the oceans, seas and marine resources for sustainable development

Goal 15	Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss
Goal 16	Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
Goal 17 **	**Strengthen the means of implementation and revitalize the global partnership for sustainable development**

**** Health Related SDGs**

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