

PROGNOSIS FOR MATERNAL, NEWBORN, AND CHILD HEALTH IN TANZANIA

PLANS FOR INTERVENTIONS IN THE SHORT, MEDIUM, AND LONG TERM

Brief

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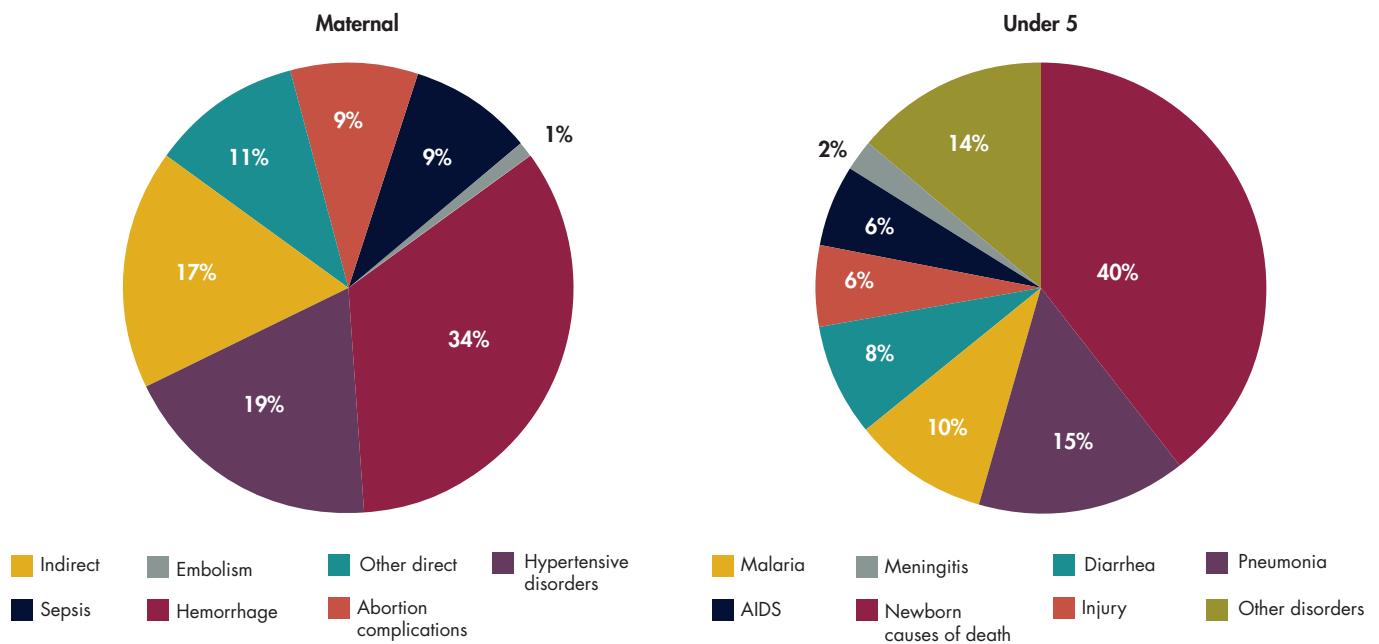
Maternal, Newborn, and Child Health Status

Tanzania’s government recognizes that the country’s sustainable development and transition to middle-income status depends on the health of the Tanzanian people. To that end, the country has worked hard to achieve Millennium Development Goal (MDG) 4 to reduce child mortality and MDG 5 to improve maternal health. The results are mixed. As of 2013, Tanzania is on track for its Goal 4 target, bringing the under-age-five mortality rate down to fewer than 54 deaths per 1,000 live births.¹ However, 40 percent of these deaths occur in the first 28 days of life, and the decline in newborn mortality has been much slower than for under-five deaths overall. Moreover, decline in the maternal death rate has been slight—from 578 deaths per 100,000 live births in 2004–2005 to an estimated 410 per 100,000 in 2013. It is estimated that 7,900 mothers die each year due to complications during labor and delivery. Therefore, Tanzania is not on track to achieve goals for neonatal and maternal mortality.

Most of the maternal and under-five deaths have preventable causes, as Figure 1 shows.²

Neonatal mortality in Tanzania results primarily from preterm birth complications, asphyxia at birth, and sepsis—conditions that can be avoided with better quality care at birth, resuscitation, and management of infection. About half of the deaths among all other children younger than five are caused by pneumonia, diarrhea, or malaria. Many deaths would not occur with expanded coverage of preventive and curative interventions. Moreover, 41 percent of children under five are stunted by malnutrition (a figure that has changed little since 1991), which in turn increases the risk of death from infection. Finally, more than half of all maternal deaths result from direct obstetric complications, such as obstetric hemorrhage and hypertension. High-quality intrapartum and postnatal care, comprehensive emergency obstetric and newborn care (CEmONC), and skilled birth attendance can reduce

Figure 1. Causes of maternal mortality and the mortality of children under 5



Source: *Women and Children First: Countdown to Ending Preventable Maternal, Newborn and Child Deaths in Tanzania*

this number, but only if three major types of delay are also addressed: delay in recognizing and seeking care, delay in transport to facilities to receive basic emergency obstetric and newborn care (BEmONC) and CEmONC, and delay in receiving care at facilities.³

The country’s maternal, neonatal, and child mortality rates all would improve with greater access to voluntary family planning, which reduces the number of unintended pregnancies and enables healthy timing and spacing of births. Globally, access to contraception has been shown to be one of the most cost-effective ways to save the lives of women and children⁴ while at the same time addressing unmet need for family planning, which was 25 percent in Tanzania in 2010.⁵

The Current Policy Framework

In 2013, Tanzania’s Ministry of Health and Social Welfare (MOHSW) reviewed its national, medium-term maternal, neonatal, and child health strategic plan—the One Plan—and revised it to accelerate the country’s progress toward MDGs 4 and 5 in the 500 days remaining. The result was the Sharpened One Plan (launched in April 2014), which focuses on interventions in two of the country’s poorest, most rural zones—Lake

and Western. In these zones, maternal, newborn, and child mortality is high and disparities between urban and rural uptake of services are great. In recognition, the Sharpened One Plan aims to scale up interventions with the highest potential impact, such as family planning, care at birth, postpartum care, and postnatal care; mechanisms to avert stockouts of commodities essential to reproductive maternal, neonatal, child, and adolescent health (RMNCAH); and increased accountability and transparency at every level of the health system responsible for RMNCAH.

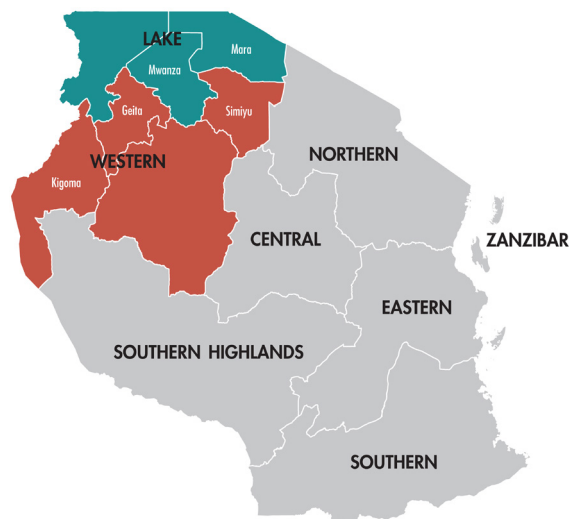
If the Sharpened One Plan were fully funded at US\$206 million (US\$1 equals TZS 1,624), an analysis using the Lives Saved Tool (LiST) shows it could have the following impacts by December 2015:

- 30 percent reduction in maternal deaths
- 31 percent reduction in neonatal deaths
- 25 percent reduction in under-five deaths⁶

However, this scenario requires more funding than the country is likely to be able to raise by the end of this year.

Also in 2014, with support from the World Bank Group and other development partners, Tanzania engaged in

Zones and Regions Identified for Scale-up



Tanzania’s Sharpened OnePlan calls for a US\$206 million investment in maternal, neonatal, and child health (MNCH) interventions in the Lake and Western zones by the end of 2015. Big Results Now narrows the focus to five regions within these zones and calls for an investment of US\$66 million in MNCH by mid-2018.

Source: Health Policy Project

Big Results Now (BRN)—an initiative across multiple development sectors. The government reported the results of its work on the healthcare sector in January 2015.⁷ Over its three phases, the BRN for health has four areas of focus: human resources for health distribution, health commodities, performance management, and RMNCH. For RMNCH, the stakeholders propose to reduce maternal and neonatal mortality in five regions within the Lake and Western zones by 20 percent by June 2018. The LiST analysis conducted for the Sharpened One Plan suggests the goal is feasible. To accomplish it, BRN will scale up high-impact interventions to complement those under the Sharpened One Plan. It will raise community awareness (and hence demand) for BEmONC and CEmONC, upgrade facilities to offer these services, use mobile phone messaging to support use of the services at the upgraded facilities, and increase voluntary blood donations to keep pace with the demand associated with expansion of emergency care. (See Box 1 for details.)

BOX 1. The Special Focus of “Big Results Now” on Reproductive, Maternal, Neonatal, and Child Health

The most specific interventions to improve reproductive, maternal, neonatal, and child health (RMNCH) are those proposed as part of the Big Results Now (BRN) healthcare initiative. RMNCH is one of the initiative’s four focal areas. Here is a summary of BRN’s plan for RMNCH:

- **5 regions:** Geita, Kigoma, Mara, Mwanza, Simiyu
- **Investment:** US\$66 million (TZS 107 billion)
- **Goals:**
 - Reduce maternal mortality from 453 deaths per 100,000 live births as of 2012 to 291 per 100,000
 - Reduce neonatal mortality from 20 deaths per 1,000 live births as of 2012 to 10 per 1,000
- **Deadline:** Three phases conducted by June 2018
- **Scope:**
 - 104 health facilities meeting standards for CEmONC by 2018
 - 453 facilities meeting standards for BEmONC
 - 16,969 community health workers on task by 2018
 - mHealth (SMS) system through a public-private partnership (PPP): 39 million messages per year by 2018
 - 120,000 units per year of donated blood
 - Mass media campaign through PPP
- **Distribution of BRN budget:**

CEmOC expansion: 34%	BEmOC expansion: 42%	Community health workers: 13%
mHealth: 7%	Blood banks: 2%	Mass media: 2%

If Tanzania can reach these goals by June 2018, it would surpass BRN’s 20 percent reduction target. That said, BRN requires an investment of US\$66 million (TZS 107 billion) for the five regions. So far, development partners have committed funds to cover 19 percent of only one of the RMNCH interventions: CEmONC expansion.⁸ The total financial need for BRN together with the Sharpened One Plan is high, and securing full funding for both will be a hard task.

The Next Medium-Term Plan

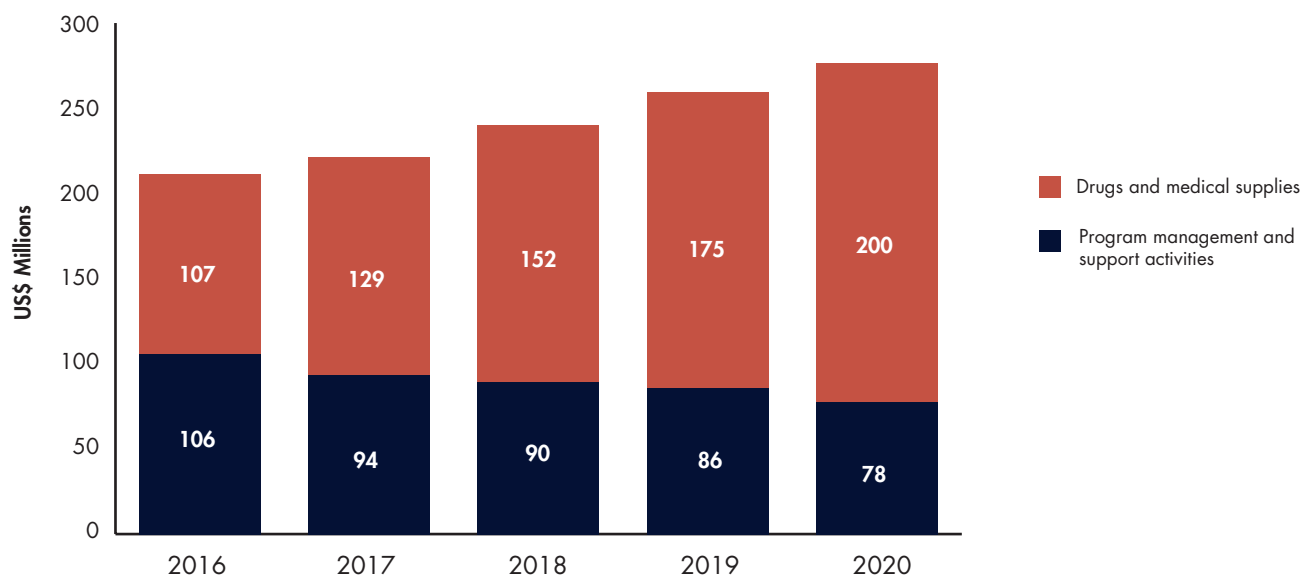
The work in 2014 to create the Sharpened One Plan and BRN will inform Tanzania’s next five-year plan to reduce maternal, newborn, and child deaths. The One Plan II 2016–2020 (currently being drafted) will help to provide guiding principles on investment priorities for RMNCAH, given budgetary pressures.

Informal reports indicate that the strategy will retain the Sharpened One Plan’s geographic focus on the underserved Lake and Western zones, while also calling for scale-up among rural populations across all regions. The new plan will also maintain the Sharpened One Plan’s focus on high-impact maternal and neonatal interventions during labor and immediately postpartum. Although the ministry’s goal through 2015 is to maintain achievement of RMNCAH services in the zones beyond

Lake and Western, simply holding ground will not suffice in the medium term. The new plan will differ from its predecessors (the Sharpened One Plan and BRN) by also targeting moderate scale-up of RMNCAH services in nonpriority geographic areas. Because the 2015 Tanzania Demographic and Health Survey is not yet complete, the calculation of baseline coverage of RMNCAH services for One Plan II will be similar to that done for the Sharpened One Plan.

Ensuring the availability of emergency obstetric and newborn care in health facilities will also play a central role in One Plan II. The Sharpened One Plan failed to carry forward the first One Plan’s commitments to scale up CEmONC facilities. The White Ribbon Alliance Tanzania and the Parliamentary Group for Safe Motherhood led an advocacy campaign immediately following the Sharpened One Plan’s launch, which led to a petition the following month by 81 Members of Parliament, calling on the government to ensure that health centers in the country provide CEmONC services.^{9,10} The BRN strategy is further indication that RMNCAH stakeholders at large are prioritizing health system strengthening, such as facility upgrades, and demand creation as a means to improve maternal and child health, and these priorities will be reflected in the One Plan II.

Figure 2. Estimated cost of RMNCAH 2016–2020, by scenario



Advocacy, resource mobilization, and accountability have also become explicit goals of the government. Over the next six years, the Reproductive and Child Health Section (RCHS) of the MOHSW plans to conduct advocacy at all levels of government while fostering new partnerships with private-sector businesses, to ensure that adequate resources are leveraged for a coordinated response to preventable maternal and child deaths.

The Potential Long-term Cost of Expanding RMNCAH Services

In a cost analysis of the One Plan II, the ministry, in collaboration with the USAID-funded Health Policy Project, considered the incremental cost of RMNCAH interventions to the health sector.¹¹ From 2016 to 2020, the RMNCAH implementation would increase from US\$213 million (TZS 373 billion) to US\$278 million (TZS 487 billion) (Table 1). This would represent an 86 percent increase in cost to meet the demand for drugs and commodities and a 26 percent reduction in the cost of program management, health system strengthening, and other support activities. This estimate captures much but not all of the investments considered under the BRN cost estimate.

For fiscal year 2013–2014, the Ministry of Finance reported that US\$13.2 million would be spent to improve maternal, neonatal, and child health (MNCH), marking a 31 percent decrease from the prior fiscal

year.^{12,13} If government funding levels are at least maintained through 2016, the government contribution would represent 6 percent of the total investment needed for the One Plan II. Indirect government investments in RMNCAH may be concealed by other investment categories, but even so, Tanzania's previous budget suggests that the government can afford to do more. At the same time, Tanzania will be looking to development partners and the multi-partner-supported Global Financing Facility to buy into its prioritized national plans to improve RMNCAH for those most in need.

The Health Impact of Long-Term Investment in MNCH Coverage

Medium-term impact projections are pending analysis of the One Plan II's service delivery targets. In the long term, however, the ministry's LiST analysis projected the impact of scaling up coverage of the MNCH disease burden and family planning demands to 95 percent by 2030. The benefits of such progress for MNCH (shown in Table 1) are significant:

- 83 percent reduction in maternal deaths
- 84 percent reduction in under-five deaths
- 89 percent reduction in neonatal deaths

Tanzania has a long way to go to achieve these benefits. The impact of a fully funded Sharpened One Plan (also shown in Table 1) indicates how far One Plan II can take the country in that direction.

Table 1. Estimated lives saved by the end of 2015 with Sharpened One and by 2030 with universal MNCH coverage

	SHARPENED ONE PLAN			UNIVERSAL MNCH COVERAGE	
	Reduction %	Mortality Rate	Lives Saved	Reduction (%)	Lives Saved
Under 5 deaths	25	46	14,500	84	45,000
Neonatal deaths	31	16	9,400	89	22,000
Deaths 1–59 months	21	30	5,100	80	23,000
Maternal deaths	30	382	1,400	83	3,600
Stillbirths	22	20	2,500	76	11,400
Total			18,400	81	60,000

Source: *Women and Children First: Countdown to Ending Preventable Maternal, Newborn and Child Deaths in Tanzania*

Notes

1. Ministry of Health and Social Welfare. 2014. *The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008–2015: Sharpened One Plan*. Available at: <http://www.mamaye.org/sites/default/files/evidence/RMNCH%20Plan%202014%20to%202015.pdf>.
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11. The cost of procurement of commodities is included in the cost of interventions and in alignment with national clinical guidelines and service delivery targets. Pediatric malaria and HIV services are excluded from analysis, based on RCHS functionality. RMNCAH support activities provided by the ministry or its implementing partners are also included, such as advocacy, coordination, training, outreach, and monitoring and evaluation, among other program activities. The analysis excludes the cost of health labor and infrastructure, which are managed by parallel programs at the MOHSW.
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13. Ministry of Finance and Policy Forum. n.d. Government Budget for Financial Year 2012/13: Citizens' Budget Edition. Available at: http://www.opengov.go.tz/files/publications/attachments/CITIZENS_BUDGET_2012-2013_-_English_en_sw.pdf

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