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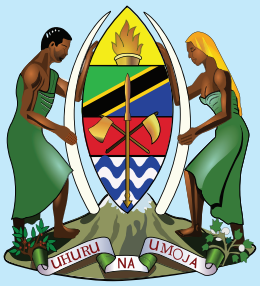


**MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN**

# NATIONAL PLAN FOR REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH & NUTRITION (2021/2022 - 2025/2026)

## One Plan III

**NOVEMBER, 2021**

**THE UNITED REPUBLIC OF TANZANIA**

**Ministry of Health, Community Development, Gender, Elderly and Children**

# National Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health & Nutrition (2021/2022 - 2025/2026)

# One Plan III

**November, 2021**

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# Foreword

The sustainable and rapid reduction of maternal, newborn and child deaths and overall improved access to quality services in sexual, reproductive, maternal, newborn, child, adolescent health and nutrition is a priority in Tanzania. Tanzania has committed to several international and regional goals to achieve the 2030 Sustainable Development Goals (SDGs) and the commitment is reflected in national development and health policies like Tanzania Vision 2025 and HSSP V 2021-2025. The Global Strategy for Women's, Children's and Adolescents' Health of 2016-2030 guide interventions in One Plan III in such a way nobody is left behind to achieve the SDGs by 2030. The three pillars of "Survive, Thrive and Transform" guide the RMNCAH and Nutrition interventions in this plan.

Most of maternal, newborn and Child deaths can be prevented by improving coverage and quality of RMNCAH health services provided along the continuum of care. newborn and Child health outcomes will succeed by improving coverage and access to immunization, quality management of small and sick newborn, childhood illnesses and proper nutrition. Strengthening the quality and coverage of adolescent and youth friendly services at facilities and community will contribute on reduction of early pregnancies and related outcomes. Triple elimination of HIV, syphilis and Hepatitis B will improve the wellbeing of mother and the baby. All these interventions ensure optimal health for all.

This Plan recognizes the importance of having adequate skilled, motivated, accountable and enabled human resources for health and other pillars of the health system for provision of quality RMNCAH and nutrition services.

The Government expects that all stakeholders will align themselves with this Plan in line with accountability framework, resulting into delivery of quality RMNCAH & Nutrition interventions. Together, we can improve the health of Tanzania's men, women, newborn, children and adolescents and build a prosperous nation.

Dr Dorothy O. Gwajima (MP)
**Minister for Health, Community Development, Gender, Elderly and Children**

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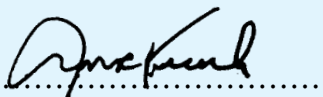

Prof. Abel N. Makubi
**Permanent Secretary**

# Abbreviations

| | |
|---|---|
| AYFSRHS | Adolescent and Youth Friendly Sexual & Reproductive 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 |
| BCIC | Behaviour Change Information and Communication |
| BEmONC | Basic Emergency Obstetric and newborn Care |
| BF | Breastfeeding |
| BMFHI | Baby & Mother Friendly Hospital Initiative |
| CEmOC | Comprehensive Emergency Obstetric Care |
| CHMT | Council Health Management Team |
| CHW | Community Health Worker |
| COLSC | Commission on Life Saving Commodities |
| CPR | Contraceptive Prevalence Rate |
| CRVS | Civil Registration and Vital Statistics |
| EBF | Exclusive Breast Feeding |
| ECD | Early Childhood Development |
| EHSP | Essential Health Service Package |
| EID | Early Infant Diagnosis of HIV |
| 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 |
| FP | Family Planning |
| GBV | Gender Based Violence |
| HFs | Health Facilities |
| HIV | Human Immunodeficiency Virus |
| HMIS | Health Management Information System |
| HRH | Human Resources for Health |
| HTC | HIV Testing and Counselling |
| IARC | International Agency for Research on Cancer |
| IEC | Information, Education and Communication |
| IMCI | Integrated Management of Childhood Illness |
| IMR | Infant Mortality Rate |

| | |
|---|---|
| ITNs | Insecticide Treated Nets |
| IYCF | Infant and Young Child Feeding |
| M & E | Monitoring and Evaluation |
| MDGs | Millennium Development Goals |
| MMR | Maternal Mortality Ratio |
| MNCAH | Maternal, newborn, Child and Adolescent Health |
| MOHCDGEC | Ministry of Health, Community Development, Gender, Elderly & Children |
| MVA | Manual Vacuum Aspiration |
| ORS | Oral Rehydration Solution |
| PO-RALG | President's Office-Regional Administration & Local Government |
| PMTCT | Prevention of Mother-to-Child Transmission (of HIV) |
| PNC | Post Natal Care |
| PPH | Post-Partum Haemorrhage |
| QI | Quality Improvement |
| RMNCAH | Reproductive, Maternal, newborn, Child and Adolescent Health |
| SARA | Service Availability and Readiness Assessment |
| SBA | Skilled Birth Attendant |
| SDG | Sustainable Development Goal |
| SRH/FP | Sexual and Reproductive Health/ Family Planning |
| STI | Sexually Transmitted Infections |
| TFR | Total Fertility Rate |
| U5MR | Under five 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 |
| YFS | Youth Friendly Services |

# CHAPTER 1 Background and Introduction

## 1.1 SDGs, Global and Regional commitments

Tanzania has committed to global and regional initiatives that ensure optimal health for all, focusing on Women and Children (Figure 1). The UN Sustainable Development Goals (SDGs 2030), direct countries to ensure Good Health and Wellbeing (Goal 3), Quality Education (Goal 4), Gender Equality (Goal 5), Clean Water and Sanitation (Goal 6) Reduce Inequalities (Goal 10) and enhancing Partnerships for achieving all Goals (Goal 17). The Global Strategy for Women, Children, and Adolescents Health envisions a world in where every woman, child, and adolescent in every setting realizes their right to physical, mental health and well-being, has socioeconomic opportunities, and can participate fully in shaping prosperous and sustainable societies. The strategy employs three pillars of survive, thrive and transform to end preventable morbidity and mortality.

Tanzania is committed to achieving Gender Equality and Equity, guided by the Global Convention on eliminating all forms of discrimination against Women (CEDAW). As of 2020, the country doubled the FP users as part of the FP2020 initiative, is also committed to achieving FP2030 commitment. Tanzania collaborates with Africa regional bodies and member states in ensuring effective implementation of the revised Maputo Plan of Action 2016-2030 on sexual and reproductive health, which is in line with Africa Agenda 2063 that calls for inclusive growth and sustainable development for prosperous Africa. These commitments guide the country to achieve its vision to improve women and children health and social wellbeing.

### Key Global, Regional and National Guiding Policies and Strategic Plan


**Figure 1: Key global, regional, and national guiding policies and strategic plans**

## 1.2 RMNCAH in the country's national development and health agenda

### i. Tanzania Development Vision 2025

Tanzania Development Vision 2025 aims to achieve a high quality of livelihood for its citizens, peace, stability and unity, good governance, a well-educated and learning society and a competitive economy capable of producing sustainable growth and shared benefits by 2025. The vision identifies RMNCAH as one of the priorities contributing to a higher-quality livelihood for all Tanzanians. This will be attained through strategies, which will ensure realization of the following health service goals:

- Access to quality primary health care for all
- Access to quality reproductive health services
- Reduction in infant and maternal mortality rates by three-quarters Universal access to clean and safe water and sanitation
- Life expectancy of a typical middle-income countries
- Food self-sufficiency and food security
- Gender equality and empowerment of women in all health parameters.

### ii. Five Years' Development Plan 2016/17 – 2020/21and 2021- 2025

The ending Five Years' Development Plan 2016/17 – 2020/21 and 2021 – 2025 target to improved quality of life and human wellbeing. Some of the key interventions according to this plan are:

- Strengthening health systems (primary and referral)
- Equipping district, regional and referral hospitals with modern equipment
- Training health staff (short and long courses).

### iii. The National Health Policy and Policy Implementation Strategy 2020 – 2030

The Government is in the process of reviewing and updating the NHP 2007. The vision of the health policy is to have a healthy and prosperous society that contributes fully to the development of individuals, their communities and the nation. Mission of the health policy is to provide sustainable health services of acceptable quality standards for all citizens without financial constraints, based on geographical and gender equity. The main Objective of the health policy is to increase the life expectancy and quality of life of citizens by reducing deaths, diseases and disabilities, especially among those most at risk, by establishing a health care system that meets the needs of all citizens.

### iv. Health Sector Strategic Plan V (2021-2025)

The vision of HSSP V is to have a healthy and prosperous society that contributes fully to the development of individuals and the nation. Its mission is to provide sustainable health services with standards that are acceptable to all citizens without financial constraints, based on geographical and gender balance.

***RMNCAH in HSSP V Strategic Direction***

The government will implement the strategy of *survive, thrive and transform call for action.* The primary health care providers and community health volunteers will continue to sensitize and educate the community on the importance of maternal and child health, and reproductive health for all groups including young people.

In collaboration with stakeholders, the Government will continue to increase access to high quality emergency obstetric and neonatal care and will increase focus on key activities during delivery and immediate post-natal phase which save lives e.g. partograph use, essential neonatal care, early breastfeeding, postpartum, cervical cancer screening and family planning. Government will continue to strengthen reproductive health services at all health care facilities and engage with women, men, youth and people with disabilities.

The Government will also improve Infrastructure, referral system, increase skilled staff, medicines and equipment to provide quality and friendly reproductive health services that appeal to women, men and young people. In the training curricula there will be more attention for implementation of RMNCAH services. In collaboration with stakeholders, the Government will expand youth friendly services, not alone by improving infrastructure, supplies, etc. but also by reorienting health staff in compassionate care, patient charter and rights of adolescents. This will be attained by supporting the implementation of priorities identified in the National Agenda to Accelerate Investment for Adolescent Health and Wellbeing - NAIA (2019 – 2022) and the National School Health Strategic Plan (2018 - 2023). The two plans mainly prioritize school age and adolescent health, education, child protection, equity, gender, and inclusiveness, WASH, nutrition, HIV and AIDS.

The health sector intends to continue to provide vaccinations services to children and adolescents to avoid vaccine-preventable diseases. Growth monitoring and nutritional advice will be available and where needed. Health of children will be promoted through health education. The government will strengthen partnerships with the private sector in improving RMNCAH. Government will enter into service agreements with private sector providers to expand access to maternal and child care, and will improve adherence to quality standard.

## 1.3 The National Road Map Strategic Plan to Improve Reproductive, Maternal, newborn, Child and Adolescent Health in Tanzania (One Plan II 2016 – 2020)

The ending RMNCAH National Roadmap was aligned and contributed to the Health Sector Strategic Plan IV and other related higher policy and strategic plans. The focus of One Plan II was on reducing preventable maternal, newborn, child, and adolescent deaths and suffering underscoring survival of women and children as outlined in the Global Strategy (UN SG II 2016-2030). The strategic plan had seven operational targets. In total, the One Plan II was subdivided into 12 programmatic intervention areas (Maternal Health, newborn Health, Child Health, Adolescent Health, Family Planning, RH Cancers, M&E, Gender, Leadership and Governance, HRH, Finance and Administration and personnel).

In terms of the cost, the five-year plan's cost was estimated at US $ 1,330,947,290 and break down of those cost in percentage as portrayed in Table 1. The last donor mapping and resource tracking indicated that there was US $ 142M support for RMNCAH interventions.

**Table 1: RMNCAH Five-year cost 2016-2020**

| Intervention area | Five years cost in US$ |
|---|---|
| Maternal Health | 276,377,870 |
| newborn and Child Health | 433,651,203 |
| Adolescent | 20,104,391 |
| Family-Planning | 429,299,254 |
| RH Cancers | 2,970,938 |
| Others | 168,543,634 |
| **TOTAL** | **1,330,947,290** |

# CHAPTER 2 Situational Analysis:

## Global and Tanzania trends in coverage of RMNCAH & Nutrition interventions

### 2.1 Newborn care

#### 2.1.1 Global situation of neonatal mortality

Globally, progress has been made in reducing neonatal deaths. Neonatal mortality has declined from 37 to 18 per 1,000 live births between 1990 – 2017 (UNICEF, 2019). Neonatal deaths are increasingly contributing to under-five deaths (from 40% in 1990 to 47% in 2017 respectively). Sub-Sahara Africa has the highest NMR at 28 per 1,000 live births compared to other settings. of the 2.5 million neonatal deaths that occur globally, 75% is contributed by Prematurity (35%), birth asphyxia (24%) and infections (15%), Figure 3. Most of these deaths are potentially preventable (WHO, 2019) through improving; availability of Skilled providers, quality of antenatal and postnatal care and care of small and sick newborn (WHO, 2014; UNICEF, 2019).

An annual reduction rate of 4.3% is recommended to attain the 2030 goal of having NMR < 12 per 1,000 live births.

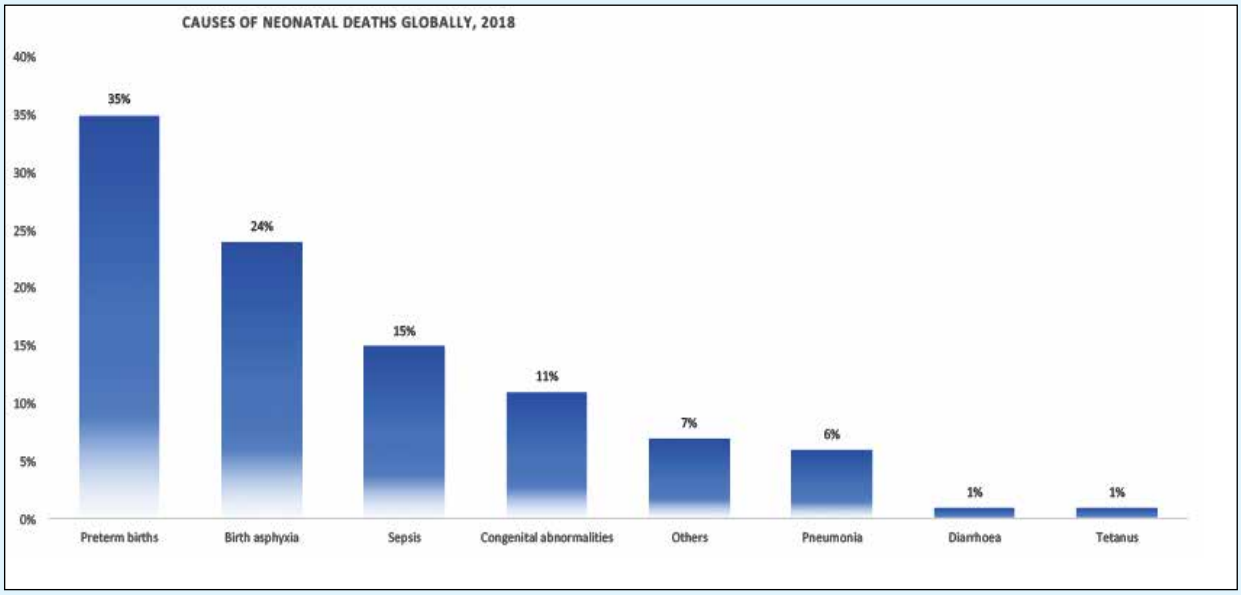


**Figure 2: Causes of neonatal mortality globally (Source: UNICEF, 2019)**

#### 2.1.2 Tanzania situation

Tanzania experienced a slow decline in NMR compared to infant and under-five deaths, Figure 4. NMR declined from 26 to 25 per 1,000 live births in 2010 and 2015/16 respectively. UNICEF reported NMR of 21 per 1,000 live births in 2018. This translates to 44,000 deaths per year (TDHS; UNICEF, 2019). The One Plan II target of NMR of 16 per 1,000 live births was not achieved.

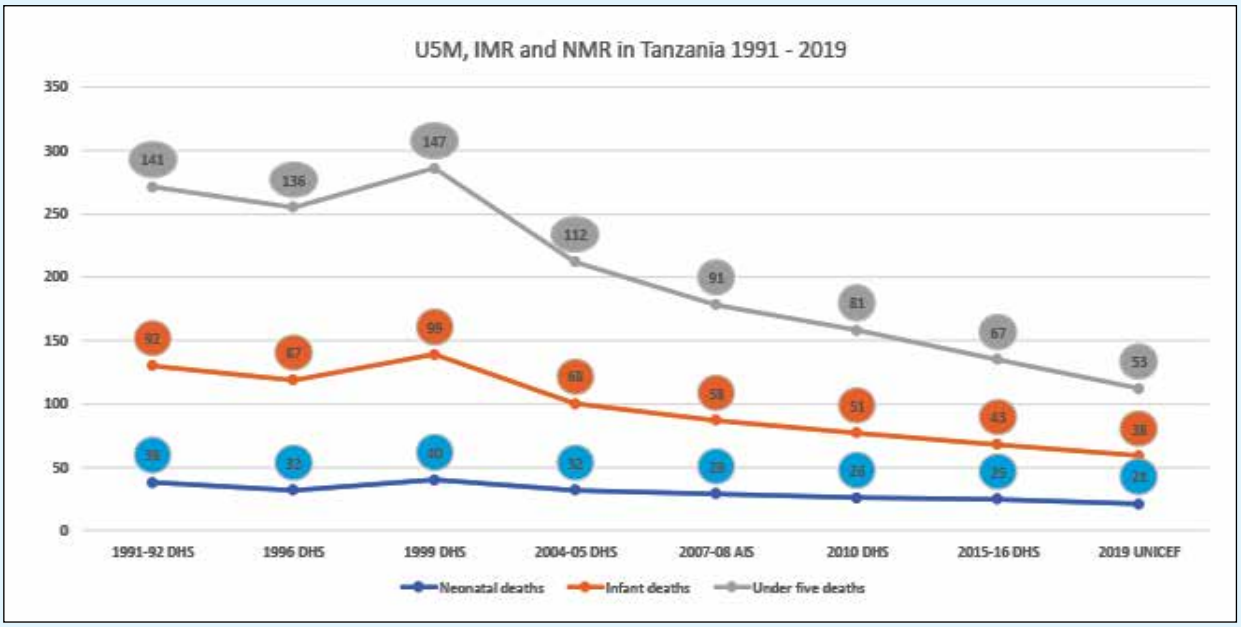


**Figure 3: Trends in U5, infants and neonatal mortality in Tanzania (Source: MTR Analytical Report, 2019; UNICEF 2019)**

In 2017, Birth asphyxia (33%) is the leading cause of neonatal deaths in Tanzania, followed by preterm births (28%), and sepsis (24%), Figure 5. Success in reducing under-five deaths in the country will closely depend on addressing neonatal deaths as they contribute to 39% of the child mortality (DHIS-2; UNICEF, 2019).

## 2.1.3 Progress in neonatal interventions during One Plan II

### 2.1.3.1 Intrapartum care

Practices during childbirth, especially quality monitoring of labour is key in preventing birth asphyxia, a leading cause of neonatal deaths in Tanzania. Availability of facilities with partograph and can manage labour using partographs is high (87% and 77%) respectively (SARA, 2020). Despite the availability, studies have shown suboptimal quality of intrapartum care in the country (Duysburgh et al, 2013; Nyamtema et al, 2018; Mdoe et al, 2018). Qualitative work during MTR of HSSP IV corroborates these findings.

DHIS2 shows that proportion of FSB has not improved, rather increased over time in Tanzania; 42.2% in 2016 and 45% in 2019 respectively (DHIS2). Interventions targeting quality of intrapartum care are urgently needed.

### 2.1.3.2 Essential newborn Care (ENC) practices

The 2020 target was to have 75% of facilities that conducts deliveries should offer ENC. SARA (2020) showed 73% of the facilities could offer-hygienic cord care, EIBF and thermal protection. Population studies show stagnation of early initiation of breastfeeding (EIBF) in Tanzania with coverage of 51% in 2015/16 and 54% by 2018 (TDHS, TNNS, 2018). Facility-data tend to overestimate prevalence of EIBF as shown in the study at Temeke whereby observation showed only 20% of newborns are put on breast within the first hour, while drying and skin-to-skin practice in 90% and 70% of births respectively (EN-Birth study).

### 2.1.3.3 newborn Resuscitation (NR)

In Tanzania equipment for NR are available in 68-90% of facilities (Arlington et al, 2017; SARA, 2020). SARA report (2020) has shown only 61% of facilities with deliveries can offer NR, and only 37% had at least one provider trained on NR. Evaluation of Helping Babies to Breathe (HBB) program in 15 regions, showed there is high drop in retention of knowledge and skills (57% of providers could perform well at 4-6 months after training compared to 87% immediate after training) (Arlington *et al,* 2017).

### 2.1.3.4 Care of small newborns (LBW/ Preterm)

The coverage of KMC in Tanzania is still low; in 2017 42% of facilities could offer KMC, which has declined further to 34% in 2020 (SARA, 2020). KMC coverage is better at hospitals (82%) than health centres (62%).

In addition, few facilities (20%) can offer corticosteroids during pregnancy to prevent preterm births (SARA, 2020).

### 2.1.3.5 Care of sick newborns (sepsis)

Injectable antibiotics for neonatal sepsis, is only available at 41% of health facilities; 95% of hospitals, 76% of health centres and 33% of dispensaries respectively (SARA, 2020).

The Program data shows by June 2021, a total of 159 (45.4%) Hospitals had Neonatal Care Units (NCU) and 39 Health Centre had a Stabilization Unit and KMC room. The period before 2018, the Country had limited service availability and functionality of NCU in Tanzania. And the One Plan II had no target on NCU.

### 2.1.3.6 Emergency transport and triage for newborns

Only 5% of the dispensaries and 53% of the health centres had emergency transport in place to transfer newborns or women with complications (SARA, 2020).

In summary, with increasing institutional deliveries (77% in 2018 and 83% in 2019 - DHIS2), more newborn deaths are occurring within hospitals. Coverage of lifesaving-emergency interventions for newborns by SARA (2020) is low (mean availability of 32%), especially at lower primary-health care facilities (26% dispensaries compared to 56% at health centres and 77% hospitals).

### 2.1.3.7 Postnatal care visits for newborns

Nearly a third of newborn complications and deaths occur within the first 24 hours after birth and 75% within the first week. There is a steady increase in postnatal care visits within 2 days for neonates. TDHS of 2015/16 showed coverage of 41%. Tracking progress through DHIS-2 the country has registered some improvement to 71% in 2019.

### 2.1.3.8 MPDSR

Perinatal death reviews are conducted regularly as reported in the MTR of the HSSP IV. Key bottle neck is that actions are not taken for the recommendations given for each review. Strengthening and empowerment of the health quality teams at facility level to work independently is needed.

### 2.1.3.9 Providers training and competence in newborn care

Skills of providers in different components of neonatal care (e.g. ENC, NR, KMC, EBF) is suboptimal as shown by several studies and in MTR of HSSP IV. Further, less than 50% of facilities with deliveries have at least one staff trained in newborn care.

### 2.1.3.10 Community promotion and preventive activities for newborns

There is a need to strengthen community interventions for newborns that will ensure that essential health promotion, health protection and prevention activities are available.

**Table 1: Progress in Newborn Health Indicators**

| S/No | Indicator | Baseline Value 2016 | Target by 2020 | Progress 2019/ 2020 |
|---|---|---|---|---|
| | Neonatal mortality rate (deaths per 1,000 live births | 25 (TDHS 2015/16) | 16 | 21 (UNICEF, 2019) |
| | Postnatal care visit within 2 days | 41% (TDHS 2015/16) | 80% | 71% (DHIS-2, 2019)<br>65% (DHS-2, 2018) |
| | Early initiation of breastfeeding (within 1 hour after birth) | 51% (TDHS, 2015/16) | 90% | 54% (TNNS, 2018)<br>75% (DHIS-2, 2018) |
| | ARV prophylaxis for HIV exposed infants | 56% (DHIS-2) | 80% | 98% (DHIS-2, 2019) |
| | Hospitals with functional KMC services | 20% (One Plan II) | 75% | 34% (SARA, 2020)<br>42% (SARA, 2017) |
| | Primary health facilities with at least one of the services providers trained on newborn Resuscitation | 35.2% | 80% | 43% (SARA, 2017) |
| | Hospitals with functional Neonatal Care Unit (NCU) | 4.0% | No Target | 45.4% (Program data, RCH) |
| | *Health facilities* conducting deliveries offering ENC | 13% | 75% | Hygienic cord care: 73%<br>Immediate & EBF: 73%<br>Thermal protection: 73%<br>(SARA, 2020) |

## 2.2 Child Health and Nutrition

### Global situation

Underfive mortality have declined by 59%, from 12.6 million deaths in 1990 to 5.3 million deaths in 2018 (UNICEF, 2019).

SSA is the region with highest U5 deaths in 2018, at 78 per 1,000 live births compared to global level of 39 per 1,000 live births. A total of 121 countries have attained the SDG target of 2030 of reducing under-five mortality to less than 25/1,000 live births, while 50 countries, most in SSA need to accelerate efforts to meet the U5M target of 2030.

Pneumonia (15%), diarrhoea (8%) and malaria (5%) are still the leading causes of deaths for children after neonatal period. Malnourished children, especially with acute malnutrition have higher risk of death due to the three diseases. Nutrition-related factors contributes to 45% of deaths among under-five children (UNICEF, 2019).

**Tanzania situation**

Children under 5 years constitute 16% of Tanzania's population (Census, 2012).

### 2.2.1 Child mortality

U5M has declined from 141 per 1,000 live births in 1990, to 53 per 1,000 live births in 2019 (MTR Analytical Report, 2019; UNICEF, 2019). The infant mortality rate (IMR) declined from 101 to 38 per 1,000 live births. To achieve the SDG target of 25 per 1000 live births in 2030, the ARR of 6.5% per year is required (MTR Analytical Report, 2019). Figure 6 shows the causes of U5 deaths in Tanzania.

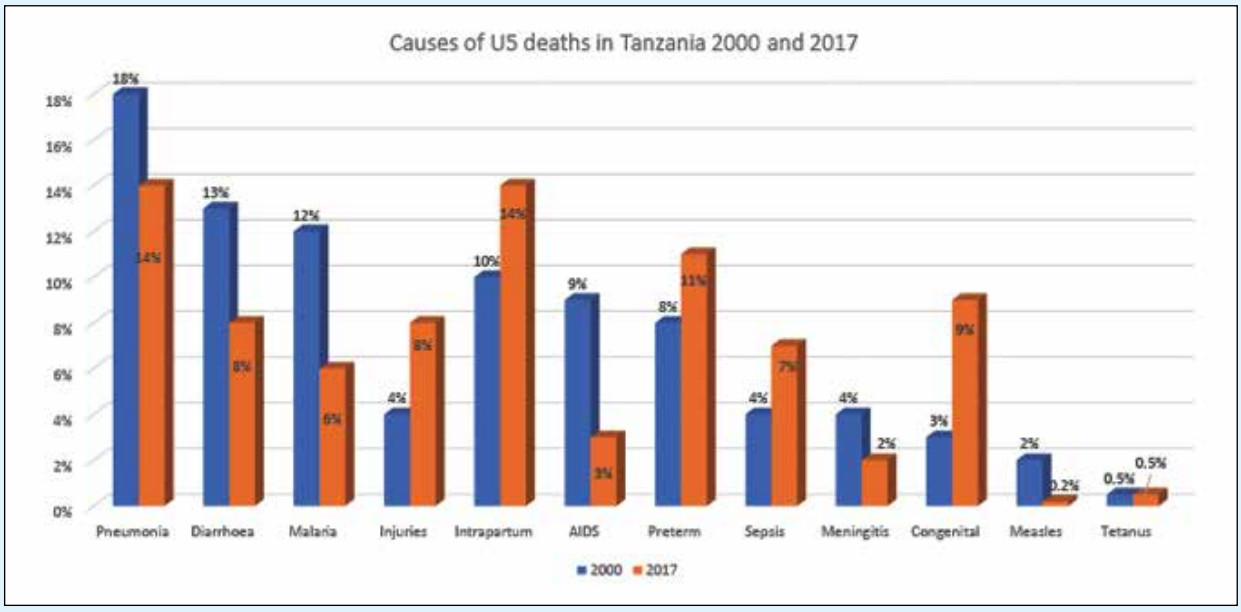


**Figure 4: Causes of U5 deaths in Tanzania (Source: UNICEF, 2018)**

### 2.2.2 Nutrition indicators among under-five children

***Breastfeeding and complementary feeding practices***

Early initiation of breastfeeding (EIBF) and exclusive breastfeeding (EBF) are among high impact interventions for child survival and optimal breastfeeding coverage of 90% has a potential to avert 11% of U5 deaths (Black et al, 2013).

Nearly 93% of children are breastfed within the 1st 24 hours of birth in Tanzania, but EIBF is sub-optimal. MTR of HSSP IV also showed an increasing trend in EIBF using DHIS2 data, from 61% in 2015 to 76% in 2018 (MTR Analytical Report, 2019). Continued breastfeeding up to two years is not a problem in Tanzania, median duration of breastfeeding is 20.8 months.

TDHS shows the proportion of children given minimum acceptable diverse foods have declined from 56% in 2010 to 26% in 2015/16. Proportion of children given minimum acceptable meal frequency was 34% in 2010 and 39% in 2015/16 respectively. As a result, only 9% of Tanzanian children in 2015/16 and 2018 had appropriate IYCF practices, compared to 21% in 2010 (TDHS 2010 & 2015/16; UNICEF, 2019). Scale-up of interventions addressing optimal breastfeeding and appropriate IYCF practices both in the community and at facilities cannot be over-emphasized in the country

### *Anaemia in children*

Anaemia among children is another nutrition indicator that shows poor progress in Tanzania. One plan II aimed at reducing prevalence of anaemia in U5 to less than 20% by year 2020. However, the prevalence of anaemia among under-fives has been stagnant; 59% in 2010 and 58% in 2015/16 respectively. Anaemia is also high among children with stunting in Tanzania (Sunguya et al, 2020). Other studies among under-fives in Tanzania shows similar findings of high prevalence of anaemia; ranging from 59 – 85% in different settings (Kejo et al, 2018; Sunguya et al, 2020).

Though anaemia is severe public health problem among children in Tanzania, only 57% of health facilities can test haemoglobin levels among children and 68% can offer iron supplementation for children (SARA, 2017; SARA, 2020).

### *Trends in nutrition status among under-fives*

Stunting has declined from 42% in 2010 to 34% in 2015/16, by 2018 the Tanzania Nutrition Survey showed a stunting level of 32%. The global 2025 nutrition goal recommended 40% reduction of stunting levels from 2015, therefore, Tanzania is required to reduce stunting levels to 20% by 2025.

MTR of HSSP IV analytical report has detailed analysis of inequities in stunting. Stunting is much higher among rural and children in the poorest households, regional variation also exists (MTR Analytical Report, 2019). Wasting remained at 5% throughout 2010-2015/16, declining to 3.4% in 2018 (TNNS, 2018).

### *Growth monitoring and Care for Child Development*

Growth Monitoring and Promotion (GMP) is routinely offered in nearly all health facilities (91%) with RCH care in Tanzania (SARA, 2020). The key bottleneck with GMP in the country is that, weight is the only measure taken while height is not measured in most cases regardless of the introduction of new growth charts for girls and boys. Current growth charts in RCH cards therefore alert providers if the child is on track for underweight, overweight or wasting. The charts also help to catch early cases of under nutrition and prevent progression to severe acute malnutrition (SAM). Length/ height despite being key in monitoring stunting is not routinely collected, though 85% of facilities have height measuring equipment (SARA, 2020). New Growth cards has area to record height and charts to show progress in height for age. Implementation of new growth charts for girls and boys will improve appropriate assessment and documentation.

In summary the country is not doing well on nutrition indicators for under-fives. Given child undernutrition contributes to 45% of under-five deaths (UNICEF, 2019), focused efforts, using evidence-based nutrition interventions are urgently needed to achieve the national and global nutrition targets by 2025.

**Table 2: Breastfeeding, Infant and Young Child Feeding practices and nutrition status among under-fives in Tanzania**

| S/No | Indicator | Baseline Value (2016) | Target by 2020 | Progress |
|---|---|---|---|---|
| 1. | U5MR (deaths per 1,000 live births) | 67 | 40 | 53 (UNICEF, 2019) |
| | **Breast feeding & CF practices** | | | |
| 2. | Early initiation of breastfeeding | 51% | 90% | 54% (TNNS, 2018)<br>76% (DHIS 2, 2018)<br>Improving but far from goal |
| 3. | Exclusive breastfeeding for 6 months | 59% | 90% | 58% (TNNS, 2018)<br>No progress |
| 5. | Appropriate complementary feeding practices at 6-23 months (food diversity) | 56%<br>(2010 TDHS) | 90%<br>Indicator in One Plan II | 21 – 35%<br>Studies, TNNS, 2019<br>No progress |
| | **Anaemia** | | | |
| 6. | Anaemia among under-fives | 58% | < 20% | 58 – 84%<br>No new survey data, but no progress |
| | **Nutrition status** | | | |
| 7. | Stunting | 34% | 22% | 32% (TNNS, 2018) Poor progress |
| 8. | Overweight/obese | 4% | | 3 % (TNNS, 2019) |
| 9. | Wasting | 5% | < 5% | 3.4% (TNNS, 2019) |

### 2.2.3 Child immunization coverage

One Plan II target for 2020 was to have Pentavalent 3 vaccine coverage of 90% in 90% of regions and councils respectively as well as Measles/Rubella vaccine coverage of 90%. Immunization rates are high in the country, with a coverage of > 90% for all antigens (MTR Analytical Report, 2019; VIMS, 2020). New vaccines have also been introduced: HPV for cohort of girls aged 14 years and Inactivated Polio Vaccine (IPV).

The coverage of 90% in 90% of the regions was achieved in 2018 according to DIHS 2 data. By the end of 2019, measles-rubella (MR 1) coverage was 100%. PCV 3 coverage increased from 88% in 2016 to 97% in 2019 and Rotavirus 2 increased from 90% - 100% in the same period.

There are councils lagging in Penta 3 and MR 1 coverage. 23 councils (12%) out of 195 are with Penta 3 coverage < 90% and 38 (19%) with MR 1 coverage of < 90% by the end of 2019 (VIMS, 2020). MR2 coverage is struggling with 99 (51%) of councils having coverage < 90% at the end of 2019 (VIMS, 2020).

#### *Vitamin A*

The coverage of Vitamin A supplementation has dropped from 61% to 41% between TDHS of 2010 and 2015/16 respectively. Tanzania Nutrition survey also noted same declining trend of Vitamin A coverage from 72% in 2014 to 64% in 2018 (TNNS, 2018). The decline of Vitamin A supplementation occurred more among the poorest children.

However, SARA (2020) reported that 85% of facilities surveyed could offer Vitamin A supplementation and 86% had vitamin A capsules in stock.

### 2.2.4 Childhood illnesses: care seeking and treatment for pneumonia, diarrhoea and malaria

Deaths due to pneumonia, diarrhoea and malaria among children have declined from 1990 to 2019, see Figure 4 and 6, but they are still the leading cause of under-five deaths in Tanzania. Partly this has been contributed by improvement in vaccination and breastfeeding practices especially EBF.

Vaccination coverage (Penta 3, PCV 3 and Rota 2) is high in Tanzania without rural-urban differences. Suboptimal-breastfeeding and IYCF practices may partly explain the number of diarrhoea cases observed in the country, even after the introduction of rota virus vaccine in 2013. Lack of new survey data after TDHS of 2015/16 makes it difficult to assess progress for care-seeking for pneumonia, diarrhoea and fever during One Plan II period.

While prevalence of malaria has declined from 9% in 2011/12 to 7.3% in 2017 among U5s, the use of insecticide-treated nets (ITNs) has declined over time. Ownership of ITNs has declined from 92% in 2012, to 61% in TMIS of 2017. Further, proportion of children who slept under ITNs has dropped from 72% in 2012 to 55% in 2017 and for pregnant women from 75% to 51% respectively.

SARA (2020) reported that 85%, 81% and 75% of facilities can offer curative services for malaria, pneumonia and diarrhoea among children respectively. Availability of drugs for management is good; ORS packets and Zinc are available at (88% and 70% of facilities) and 77% of health facilities had amoxicillin syrup for management of pneumonia (SARA, 2020).

Key challenge with IMCI lies in providers and adherence to guidelines. SARA (2020), reported that only 42% of the facilities had providers trained in IMCI. IMCI guidelines are available in 71% of facilities, but studies have shown lack of adherence to guidelines and low quality of services offered by providers.

**Table 3: Status of immunization coverage, care seeking and treatment for pneumonia, diarrhoea & malaria among under-five children in Tanzania**

| S/No | Indicator | Baseline Value (2016) | Target by 2020 | Progress |
|---|---|---|---|---|
| | **Immunization** | | | |
| **1.** | DPT-HepB-Hib 3 Regions coverage | 84% in 90% of the regions | 90% in 90% of the regions | 91% (DHIS 2, 2018)<br>100 % (VIMS, 2020) |
| **2.** | DPT-HepB-Hib 3 Councils coverage | 83% in 90% of councils | 90% in 90% of the councils | 88% in 195 councils (VIMS, 2020) |
| **3.** | Measles Rubella coverage | 80% in 90% of the councils | 90% in 90% of the councils | MR1 81 % in 195 councils<br>MR2 49% in 195 councils<br>by end 2019 (VIMS, 2020) |
| **4.** | Vitamin A | 41% (TDHS 2015/16)<br>61% (TDHS 2010) | 90% | 64% (TNNS, 2018)<br>72% (TNNS, 2014) |

| S/No | Indicator | Baseline Value (2016) | Target by 2020 | Progress |
|---|---|---|---|---|
| | **Pneumonia, Malaria & Diarrhoea** | | | |
| **5.** | Care seeking for pneumonia | 71% (TDHS 2010) | 90% | 55% (DHS 2015/16)<br>No data after 2015/16 |
| **6.** | Care seeking for diarrhoea | 53% (TDHS 2010) | 90% | 43% (DHS 2015/16)<br>No data after 2015/16 |
| **7.** | Care seeking for malaria/ fever | 77% (TDHS 2010) | 90% | 40 – 57% (DHS 2015/16 and studies) |
| **8.** | ITN use among U5 | 72 % (TMIS 2012) | 80% | 55% (TMIS 2017)<br>54% (TDHS 2015/16) |
| **9.** | Pregnant women who slept under an insecticide-treated net (LLIN) | 75 % (TMIS 2012) | 80% | 51% (TMIS 2017)<br>54% (TDHS 2015/16) |
| **10.** | Staff trained in IMCI | | | 42% (SARA, 2020) |
| | **Birth registration** | | | |
| **11.** | Birth registration | 16% (TDHS 2010) | 60% | 26% (TDHS 2015/16) |

### 2.2.5 Hospital causes of U5 deaths

Under five deaths are significantly contributed by neonatal deaths that accounts for 39% of all under five deaths (DHIS2 2015-2019)., With such a high contribution, the need to target neonatal causes of deaths (ref. Figure 5) to attain the 2030 goal of < 25 per 1,000 live births among children cannot be over emphasized.

Causes of deaths after neonatal period in the hospital, tally with the review above on child health interventions. DHIS2 shows that pneumonia (12.3%) and malaria (10.8%) are among the leading causes of hospital deaths among children. Poor progress in nutrition indicators (EBF, IYCF, anaemia & stunting) is reflected in hospital statistics as deaths secondary to malnutrition (4.4%) are the 3rd causes of U5 deaths in Tanzania during post-neonatal period.

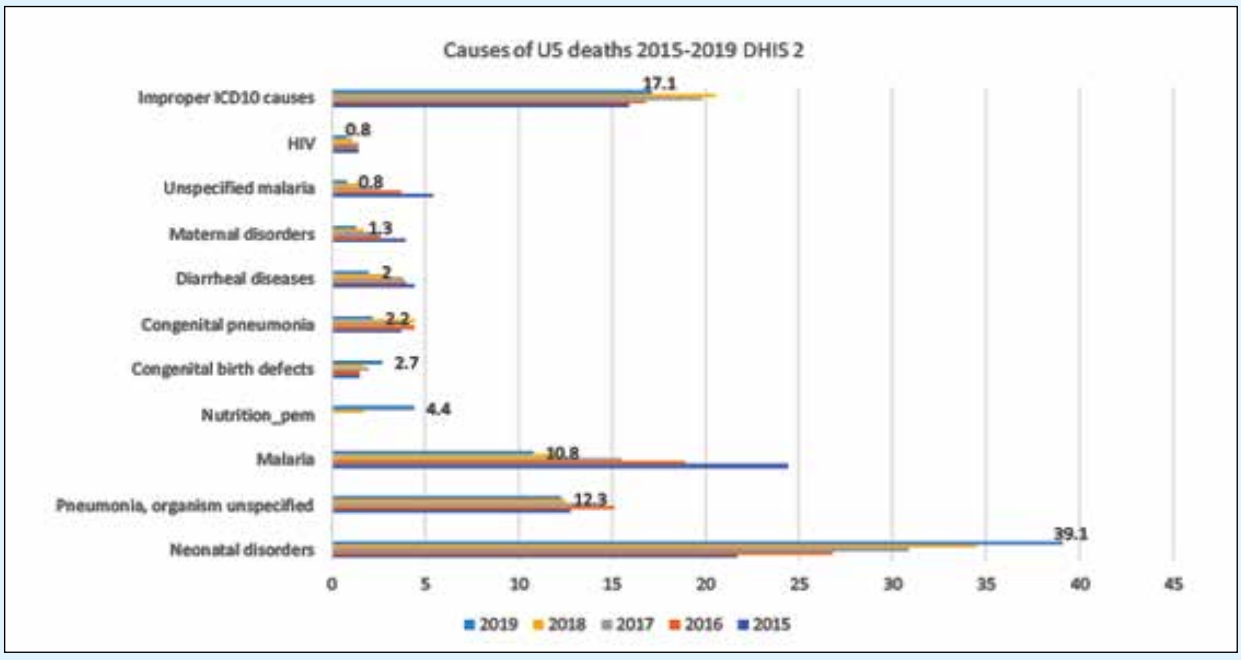


**Figure 5: Hospital causes of U5 deaths in Tanzania 2015-2019 (Source: DHIS 2)**

### 2.2.6 Birth registration of under-five children

Providing legal identity for all including birth registration is SDG no 16.9. Birth registration is free of charge for under-fives children in Tanzania. Further, the process has been decentralized with ward executive officers and facilities given mandate to officially register U5s.

Despite the efforts, TDHS of 2015/16 showed that the coverage of birth registration was 26% in Tanzania, far from 2020 goal. Using DHIS-2 data and total deliveries as denominator, birth registration was 9.9%, 10.0% and 9.0% in 2016, 2017 and 2018 respectively. Low registration contrasts with high immunization coverage in the country. There is an opportunity to use immunization programs to increase birth registration rates.

### 2.2.7 Early childhood development (ECD)

ECD program is important for thrive and transforming of children to attain their full potential. Tanzania is at infancy in terms of training and having programs for Early Childhood Development (ECD). Integration of stimulation interventions, nutrition and health has been shown to improve children's development and promote positive outcomes from the early years through to adulthood. ECD component which was not in One Plan II interventions, needs to be addressed in the next five years (2021-2025). The country is in the process of developing the first National multi-sectorial ECD programme for the period 2021/2022 to 2025/26.

### 2.2.8 Children aged 5-9 years

Approximately 500,000 older children (5 to 9 years) died in 2019, a decline of 61% from 1990 (WHO, 2020). Injuries (including road traffic injuries and drowning) are the leading causes of death among older children (5-9 years). There is absolutely no data in Tanzania regarding epidemiology of diseases and causes of mortality in children aged 5-9 years, a situation that needs to be rectified in 2021-2025.

### 2.2.9 Community and outreach activities for children

Community preventive, promote and follow-up activities for under-fives are lacking in many settings, and if present, they are fragmented and poorly conducted and coordinated. Further there is lack of package of community-based care that describes which activities community health workers (CHWs) can perform for children. Integrated community package for RMNCAH including children is lacking, as a result contribution of community interventions in child health and survival is difficult to measure.

## 2.3 HIV/ PMTCT

### Global PMTCT and HIV situation in children

Globally, estimates show that 150,000 children were newly infected with HIV in 2019, a 52% reduction since 2010, but still four times the 2018 target. The 2018 target was to reduce new HIV infections in children (0-14 years) to less than 40,000 and reduce to 20,000 by 2020. Rate of MTCT can be less than 1% if known interventions are implemented. Some countries have eliminated MTCT of HIV. But most of SSA countries have rates ranging from 4-12% (UNAIDS, 2020).

Prevention of MTCT of HIV can be ensured when pregnant women LWHIV are diagnosed, started on antiretroviral therapy (ART), and retained on ARTs during pregnancy, delivery and breastfeeding period. Globally, 85% of pregnant women LWHIV in 2019 received ART for prevention of MTCT of HIV (UNAIDS, 2020).

### Tanzania situation

The PMTCT programme started in 2000 and by the end of 2019, there were a total of 6,829 health facilities that provide PMTCT services in RCH settings. This is an increase from 5,927 in 2015 (PMTCT Annual Report, 2019). Testing of pregnant women and ART coverage among HIV pregnant women is high: at 99% and 98% respectively. ARV prophylaxis among HIV-exposed children is also high, improved from 91.5% in 2017 to 98% in 2019, Table 6.

The coverage of Early Infant Diagnosis (EID) for HIV-exposed children has been persistently low. HIV testing among exposed infants significantly dropped over the past five years from 79.0% in 2015 to 58.1% in 2019. Mother-to-child transmission of HIV is calculated using SPECTRUM modelling method. The Spectrum based estimate showed decline of MTCT rate from12.6% in 2018 to 7.8% in 2020. The target was to have MTCT of < 5% by 2020.

**Table 4: Selected PMTCT Indicators from 2015 – 2019 (DHIS-2)**

| Indicator | 2015 | 2016 | 2017 | 2018 | 2020 target | Progress |
|---|---|---|---|---|---|---|
| RCH facilities with PMTCT services | 5927 | 6145 | 6344 | 6596 | - | 6,829 (2019) |
| % pregnant women screened for HIV | 93.1% | 94.9% | 98.4% | 99.2% | 100% | 99.0% (2019) |
| ART coverage among HIV+ pregnant women | 97% | 100% | 100% | 99% | 100% | 98.0% (2019) |
| | | | | | | |
| HIV exposed children received ARV prophylaxis | 88% | 91% | 91.5% | 98.9% | > 90% | 97.9% (2019) |
| HIV exposed children receive cotrimoxazole | 81% | 81% | 83% | 89% | 60% | 86% (2019) |
| | | | | | | |
| EID Testing rate at 6 weeks | 69.8 | 67.7 | 55.6 | 54.5 | 90% | 55.0% (2019) |
| Mother to Child HIV Transmission *(using Spectrum)* | No data | No data | No data | 12.6% | < 5% | 9.4% (2019) |
| | | | | | | |
| ARV coverage among children (0-14 years) | No data | No data | No data | 47% | 60% | 82% (2020) |
| *Syphilis* | | | | | | |
| % pregnant women screened for Syphilis | 32% | 36% | 40% | 67% | 80% | 73% (2019) |
| Syphilis positive women treated | 52% | 57% | 63% | 68% | No target | - |

By June 2020, there has been a substantial increase in the number of children (0-14 years) enrolled in care and treatment; from 51,513 in 2015 to 76,878 in 2020. There are 62,813 children who are currently on ART treatment, giving ART coverage of 82%.

### Dual elimination of MTCT of HIV and syphilis

WHO recommends that countries should improve interventions to accelerate the global agenda of dual elimination of MTCT of HIV and syphilis by 2030 (WHO, 2015). The aim is to have ≤ 50 congenital syphilis cases per 100,000 live births and having MTCT of HIV of < 5% and <1% by 2020 and 2030 respectively. This will be achieved by having coverage of 95% for antenatal care, 95% for syphilis and HIV testing, and 95% treatment coverage (WHO, 2007).

Tanzania is on the right track for HIV-testing and treatment coverage for pregnant women, but far from the syphilis elimination goal. The coverage of syphilis testing was 67% and 73% in 2018 and 2019 respectively according to DHIS-2. Treatment for syphilis-positive cases was at 68% in 2018, while the recommended coverage for testing and treatment is 95%.

Currently HIV Syphilis is duo testing is being scaled up to all health facilities providing PMTCT services. Health workers at RCHS are trained on HIV Syphilis duo testing.

## 2.4 Adolescents Health

### Global situation

A considerable proportion of the world's human capital for the future is concentrated in the global young population. Globally around 1.2 billion people are adolescents aged 10-19 years. In 2016, approximately 1.2 million adolescents died, most due to preventable causes (WHO, 2016). The burden in adolescent mortality is higher in low and middle-income countries.

Causes of deaths in adolescents differ by sex. In younger adolescent girls (10-14 years) HIV/AIDS, road traffic accidents (RTA) and lower respiratory infections such as pneumonia due to indoor air pollution are the leading causes. For older adolescent aged 15-19 years, maternal conditions resulting from complications of pregnancy and unsafe abortions are the leading causes of deaths. For males aged 10-19 years, RTA, interpersonal violence, drowning and HIV/AIDS are leading causes of deaths (WHO 2016).

The global community is committed to address the burden of adolescent pregnancies and child marriage, as reflected in the SDG target 3.7 on universal access to Sexual and Reproductive Health (SRH) services and target SDG 5.3 on ending all forms of harmful practices including child, early and forced marriages. Adolescent marriage is widespread despite the global commitments. United nation (UN) estimates that 15 million girls experience child marriage each year (Brides, 2015). Globally, one in every five girls is married, or in union before reaching age 18 years. In the developing countries, about 40% of girls are married before age 18 years, and 12% of girls are married before age 15 years (UNFPA, 2020).

Globally, adolescent pregnancies has declined, its estimated 13 million children are still born to women under 20 years of age, with 90% of these births taking place in developing countries (WHO, 2017). Adolescent birth rate is still high: at 44 births per 1,000 girls aged 15-19 years (WHO, 2016; WHO, 2019). The Global strategy for women's, children's and adolescents' health recommends adolescent birth rate should be a key indicator to be monitored (3.7.2) in the 2030 SDG goals (WHO, 2016). Access to comprehensive information and services on contraceptives as well as laws prohibiting early marriage (< 18 years) are key in preventing unwanted pregnancies among adolescents.

***HIV burden*:** In 2019, about 1.7 million adolescents aged between 10 and 19 were living with HIV globally, 88% of those are in sub-Saharan Africa (UNICEF, 2020). Adolescents contributes to about 5% of all PLWHIV and 10% of new adult HIV infections. In 2019, adolescent girls accounted for 75% of all new HIV infections among adolescents globally. The proportion was higher in SSA

(83%) than 53% in Asia Latin America & Caribbean (UNAIDS, 2020). In SSA, 4 times as many adolescent girls were newly infected with HIV than adolescent boys. SSA shoulder 80% of new infections among adolescents globally, there is a need to have setting specific interventions.

***Gender based violence*:** Target 5.2 in the SDGs requires participating countries to eliminate all forms of violence against women and girls by 2030. Target 16.1 aims to reduce all forms of violence and death rates everywhere and 16.2 aims to end abuse, exploitation, and all forms of violence against children by 2030. Globally, 1 in 10 girls under the age of 20 years report experiencing sexual violence (WHO, 2016).

**Tanzania situation – Adolescent Health**

The Government of Tanzania is committed to improve adolescents health through attaining SDG target 3.7 on universal access to Sexual and Reproductive Health (SRH) services and meet indicator 3.7.2 as well as attaining SDG 5.2 and 5.3 on eliminating all forms of violence among girls and eliminate all harmful practices (MoHCDGEC, 2016b, 2017b).

### 2.4.1 Sexual and reproductive health

**Trends in sexual debut and adolescent marriages**

The median age of sexual debut among adolescent girls (15-19) remains 15 years, since TDHS of 2004/05. Nearly one in four adolescents (23.1% & 24.5%) started sex at an age < 15 years in 2004 and 2015/16 respectively (TDHS 2004/04, 2015/16; Ngoda, 2020). Tanzanian adolescents get married at an early age; with a median age 16 years (MoHCDGEC *et al.*, 2016; Ngoda, 2020) (Table 1). The proportion of adolescents who are married/cohabiting has not changed significantly in fifteen years (26.3% in of 2004/05 and 23% in 2015/16).

***Trends in adolescent fertility rate (AFR) and teenage pregnancies***

Tanzania AFR remains persistently high. AFR among 15-19 years old is at 132 births per 1000 adolescent girls in 2015/16 (TDHS, 2005; 2010; 2016). Teenage pregnancies defined adolescents aged 15-19 who had a live-birth or are pregnant at the time of survey remained significantly high. About one in four adolescents had begun childbearing by the age of 19, with higher rates of 30% or above in the lake zone, Western and South East Zone (Figure II).

Risk of adolescent pregnancies is 20% higher among adolescents with sexual debut < 15 years and 2-times higher among adolescents who are married, cohabiting, divorced or widowed. Adolescents with secondary education have 40% less risk of pregnancies than those with no education (Ngoda, 2020). Despite the government efforts, repeated pregnancy is still high in Tanzania. TDHS surveys indicate an increased proportion of the second pregnancy from 15.8% to 18.6% from 2004/05 to 2010, and then slightly increased again to 18.8% in 2015/16. This means 1 in 5 having a second pregnancy while still adolescents (Ngoda, 2020)

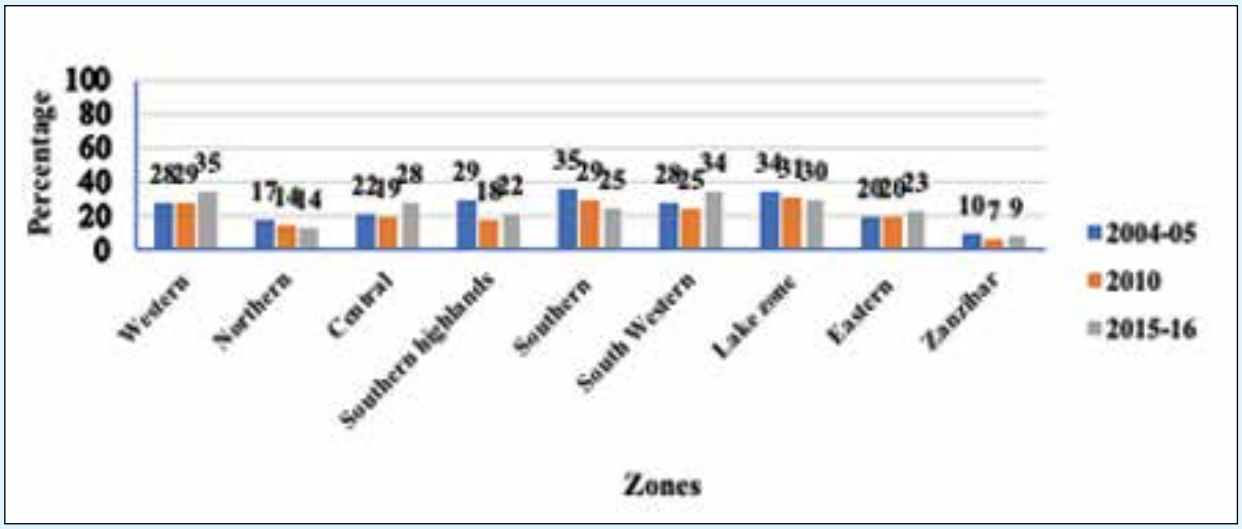


**Figure 6: Prevalence of adolescent pregnancies by zones, in Tanzania from TDHS 2004/05 to 2015/2016 *(Source: Ngoda, 2020)***

***Adolescent modern contraceptive use, unmet need and demand satisfied by a modern method.***

Despite high level of awareness of modern contraceptive methods among adolescents, adolescents m-CPR remains persistently low (18.9% ) compared to the national average 32% (TDHS, 2004/05; 2010; 2015/16). Adolescents method of choice is predominantly short-acting (76%) (Dennis *et al.*, 2017; Nsanya *et al.*, 2019; Tull, 2019). There has been a fluctuating trend of condom use during the last sexual intercourse among sexually active unmarried adolescent girls aged 15-19 years which declined from 50% to 37%. A similar trend was observed for adolescent boys; a decline from 46% in 2010 to 34.6% in 2015/16 (TDHS, 2004/05; 2010; 2015/16). Unmet need for Family Planning remains high among adolescents (26.5%). Only 63% of health facilities have the availability of adolescent services, Furthermore, information on demand met for modern FP among adolescents and unsafe abortion are lacking.

***Availability and use of Adolescent and Youth Friendly Reproductive Health Services***

One Plan II goal was to increase the coverage of AFSRHS from 30% to 80% by 2020 (MoHCDGEC, 2016). Trained staff in offering FP to adolescents and AFSRH service is a key bottle neck and only 39% of staff providing FP services have been trained on Adolescent friendly services (SARA 2017). Availability of guidelines in facilities with AFSRH care is also limited (38%). Further, language used by providers, negative attitudes of providers, lack of privacy, and confidentiality are other barriers for availability and access to AFSRH services by adolescents (Mbeba et al, 2012; Mchome et al, 2015).

### 2.4.2 Use of health facilities during pregnancy, childbirth, and postnatal period by adolescents

Analytical report, MTR of HSSP IV showed that use of health services by adolescents for ANC, childbirth and postnatal care services does not differ with older women. Attendance for ANC

is high (98.5%), same as starting ANC care at the first trimester (70%). The coverage of births at health facilities was 80% among births to adolescent girls in 2018. Postnatal care within 24 hours was also very similar among adolescent girls compared to all women with deliveries in 2018 (67%).

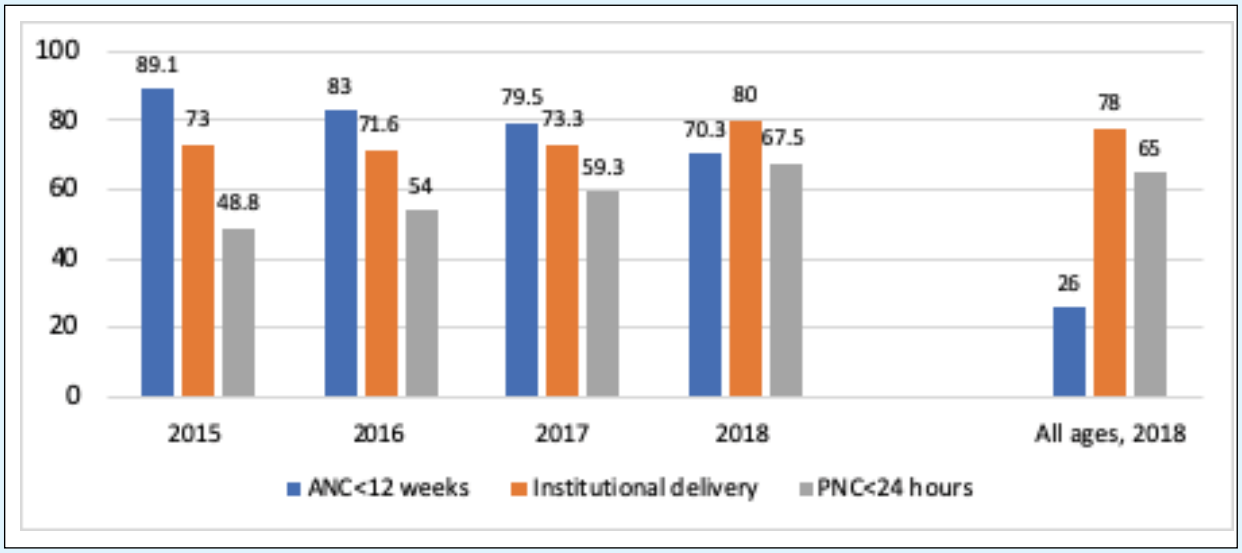


**Figure 7: Health service coverage among adolescent girls 15-19 years for early ANC visit (<12 weeks), institutional delivery and postnatal care (within 24 hours), compared with women 15-49 years, DHIS2 2015-2018, mainland Tanzania. (Source: Analytical Report MTR of HSSP IV, 2019)**

### 2.4.3 Trends in GBV among adolescents in Tanzania

The proportion of adolescent girls (15-19 years) that have ever experienced gender-based violence have not declined much from 2010 to 2015/16 (30.3% to 27.3%). The recent TDHS shows that the proportion of adolescent girls experiencing physical violence (from 17.1% to 16.1%) and sexual violence (from 6.4% to 5.4%) (TDHS, 2010; TDHS, 2015/16).

The prevalence of sexual and/or physical violence does not vary substantially according to urban or rural residence among females. There are notable regional variations in the prevalence of both physical and sexual violence by regions. In four regions, experiences of physical violence among females ages 15-19 exceeds 35%: Dodoma (49%), Morogoro (47%), Mara (41%) and Kagera (37%). By contrast, Kaskazini Pemba has the lowest prevalence of physical violence among females aged 15-19 (2%) (Population Council, 2012).

### 2.4.4 Adolescent HIV situation

Indicators for HIV among young people usually report data for people aged 15-24 years.
The picture emerging in Tanzania is that while knowledge on where to test and HIV testing is improving, evidence shows that there is a decline in proportion of young people with comprehensive knowledge on HIV and proportion of those who used condom at last sex (Table 8). Proportion of young people ever tested (49%) is far from the 2020 goal of 90% testing for HIV.

**Table 5: HIV care indicators among young people aged 15-24 years**

| Indicator | 2007/08 HIV Indicator survey | 2011/12 HIV Indicator survey | 2017 HIV Indicator survey | Comment |
|---|---|---|---|---|
| Per cent of young people (aged 15-24) with comprehensive, correct knowledge of HIV | **Total - no data**<br>Women- 39.2<br>Men- 41.5 | **Total - 43.4**<br>Women- 40.0<br>Men- 47.0 | **Total - 36.9**<br>Women- 36.7<br>Men- 37.0 | ↓ |
| Per cent of young people (aged 15-24) who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse | Women- 31.5<br>Men- 36.9 | Women- 33.9<br>Men- 40.6 | Not captured | ↑ |
| Per cent of young people (aged 15-24) who report using a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months. | **Total - no data**<br>Women-46.3<br>Men-49.0 | Not captured | **Total - 32.0**<br>Women- 29.9<br>Men- 33.5 | ↓ |
| Per cent of young people (aged 15-24) who know a place to get tested for HIV | Women -76.1<br>Men - 79.8 | Women - 85.9<br>Men - 84.2 | Not captured | ↑ |
| Per cent of young people (aged 15-24) who have ever been tested for HIV and received the result of the last test | **Total - no data**<br>Women- 33.3<br>Men- 19.1 | **Total – no data**<br>Women- 49.2<br>Men- 32.2 | **Total - 49.0**<br>Women- 60.0<br>Men- 37.9 | ↑ |
| Per cent of young people (aged 15-24) who have been tested for HIV in the last 12 months and received the result of the last test | Total-no data<br>Women- 18.4<br>Men- 15.2 | Total-no data<br>Women- 28.6<br>Men- 20.5 | **Total - 27.8**<br>Women- 34.4<br>Men- 21.1 | ↑ |

### *HIV prevalence among adolescents*

HIV prevalence among young people aged 15-24 years have declined from 3.2% in 2011/12 to 2.2% in 2017 respectively (THIS 2011/12; TAIS, 2017). In 2017 survey, women aged 15-24 years had 3-fold higher prevalence of HIV (2.4%) than men (0.6%) of the same age. Preventive interventions should consider gender differences in HIV new infections.

### *ART coverage among adolescents and young people living with HIV*

In Tanzania, the utilization of comprehensive services for HIV/AIDS is inadequate. Only 56% of ALHIV aged 10-19 years are on ART when compared to the 2020 target of 90% (UNICEF, 2019). This may be contributed with low enrolment into Care and Treatment as well as poor retention. Furthermore, there is limited information on viral load suppression among adolescents who are on ART.

## 2.4.5 Adolescent Nutrition

There is limited information on indicators for adolescent nutrition in Tanzania. TDHS shows the prevalence of anaemia among 15-19 adolescent girls was 43.7% in 2015/16, increasing from 38% in 2010. Anaemia is therefore a public health problem among adolescent girls in Tanzania, calling a need to closely monitor this indicator.

Studies in Tanzania among adolescents aged 10-19 years have shown that the prevalence of stunting ranged from 14 – 18% while 5-12% were overweight/obese (Ismail et al, 2019; Lillie et al, 2019; Darling et al, 2020). Physical inactivity is a challenge, with only 8% of adolescents reported physical activity of more than 1 hour daily (Darling et al, 2020).

## 2.5 Family Planning (FP) and fertility

### Global situation

Family planning is among the high impact interventions in the Global strategy for women, children and adolescent health 2016-2030 (WHO, 2016). The Sustainable Development Goal, target 3.7 calls on countries "by 2030, to ensure universal access to sexual and reproductive health-care services, including family planning information and education, and the integration of reproductive health into national strategies and programmes".

Globally, 44% of the 1.1 billion WRA age (15-49 years) are using modern contraceptive methods. When compared to other regions of the world, SSA region has the lowest modern contraceptives (m-CPR) use, highest unmet need (17.1%), and higher rates of unintended pregnancies (Bearak et al, 2018). Nearly 56% of united pregnancies end with unsafe abortion in SSA, putting women at risk of maternal deaths (WHO, 2012; Bearak et al, 2018).

Demand for FP satisfied with modern methods is target 3.7.1 in the SDGs. In SSA, only 55% of the need for FP is being met with modern methods when compared to the proposed level of 75% (Osotimehin, 2015).

### Tanzania situation

Family planning services have been integrated in Maternal and Child Health care since 1974. Tanzania recognize FP as one of the key interventions in accelerating the reduction of maternal, newborn, child and adolescent deaths, and in improving maternal, child and adolescent health (MOHCDGEC, 2016; UNICEF, 2020). Tanzania has also committed to accelerate ICPD promise towards achieving the goal of zero unmet needs for family planning services. FP services are free, and contraceptive methods are routinely offered, preferably at all levels of health facilities with exception of surgical methods.

### 2.5.1 TFR

The total fertility rate (TFR) has declined from 5.2 in TDHS 2015/16 to 4.9 in TMIS 2017. TFR varies between rural (5.7) and urban (3.5) settings, and vary widely between regions: from below 3.5 in Dar Es Salaam, Arusha, Mtwara and Kilimanjaro, to above 6.5 in Katavi, Tabora, Geita, Singida and Simiyu (Analytical Report, MTR of HSSP IV).

### 2.5.2 Modern contraceptive use: trend, methods, and factors

The prevalence of modern contraceptive use (m-CPR) among married women has increased steadily in Tanzania, from 20% in 2004/05 to 32% in 2015/16. Same trend has been noted among WRA; with m-CPR use increase from 23.0% in 2004/2005, to 34.3% in 2015/2016 (Yussuf et al, 2020). There are regional variations in m-CPR, with seven regions having m-CPR of 45%

or higher. The increase in m-CPR use is higher for rural than urban setting. Couple Years of Protection (CYPs) has increased approximately from 4.3 million in 2016 to 7.9 million in 2019 (MOHCDGEC, 2019). Therefore, One Plan II target of 6.4 million CYP was achieved in 2018. The increase may have been contributed by several efforts including the updating of NFPCIP, and FP2020 commitment fostering routine FP services delivery in facilities and scale up of outreach services to increase access in hard-to-reach areas.

Regarding FP methods mix, injectable (12.5%), implants (7.5%) and pills (5.2%) are the common modern contraceptive methods used by WRA in Tanzania. IUCD coverage and male sterilization have consistently remained very low, at with less than 1% percent (MOHCDGEC, 2016; Yussuf et al, 2020). Implants have shown the largest increase from 0.5% in 2004/05 to 6.5 in 2015/16. Dynamics that influences the uptake of different contraceptive methods over time need to be understood and considered in the next 5 years to improve method mix, especially for long-term reversible methods (LARCs).

Focusing on LARC is important, considering the high discontinuation rate of short-term methods within 12 months after starting a method (26% - 34%) than long term methods (< 10%) (TDHS, 2015/16; Benova et al, 2017; Safari et al, 2019; Sato et al, 2020).

Health system factors are key in influencing use of modern contraceptives including LARCs in Tanzania. Despite the availability of services and methods (84% of health facilities have FP services) and high level of women's knowledge and awareness on contraceptives (> 90%) (SARA, 2020) (Benova et al, 2017), the uptake of LARC has remained low. Studies have shown that provider factor is the major bottleneck in the provision of LARC in Tanzania (MOHCDGEC, 2019). Only 45% of facilities have at least one staff trained in FP (SARA, 2020). Inadequate health infrastructure that offers privacy and sporadic stock-outs of methods may be other factors compromising provision of long-term FP methods.

Data on integration of FP with existing programs within the facilities is limited. For example information on integration of FP counselling and services in high volume services like vaccination/ child growth, CTC, PMTCT, CPAC and others is not available. Immediate postpartum FP care is another existing platform that has an ability to increase use of modern methods.

### 2.5.3 Unmet need and demand for FP satisfied with a modern method

Unmet need for FP is high in Tanzania. While overall demand for FP methods has increased from 51% in 2004/05 to 61% in 2015/16, unmet need for FP has remained stagnant (22% in 2004/05, 25% in 2010 and 22% in 2015/16 TDHS respectively). Unmet need differ markedly by regions, ranging from 10% in Lindi and Mtwara to 35% in Geita (MOHCDGEC, 2016).

Demand for FP satisfied by modern methods is a key indicator (3.7.1) in SDGs. Demand satisfied by modern methods has increased in Tanzania, from 39.5% in 2004/05, 48.3% in 2010 to 53% in 2015/16 respectively. The global goal is to have 75% or more of demand for FP satisfied by modern method (UN, 2019b). Regions in the Southern zone i.e. Mtwara (81%) and Lindi (79%) and Ruvuma (71%) are the only ones that has met the goal, with regions in the Lake and Western zone performed the least (at 41%).

The combination of slow increase in m-CPR and high unmet need, lead to unwanted pregnancies. Nearly 60% of unwanted pregnancies end with abortion, and most of the abortions will be unsafe, putting women at increased risk of morbidity and deaths.

### 2.5.4 Community FP services

Community counselling and distribution of modern methods is another model of improving availability, access and method-mix of modern contraceptives. Use of community cadres in provision of FP methods is low. Only 2% of non-users of FP reported to be visited by a field worker who discussed on FP method in the 2015/16 TDHS. Women visited by a field worker were twice more likely to use a modern method in the 2015-16 survey than those who were not visited (Yussuf et al, 2020). Strengthen Community FP distribution and education through CHWs and other providers should be considered in 2021-2025 as well as outreach services. The RMNHCAH community package has integrated FP services with other activities.

Private sector is under utilized in provision of modern contraceptive methods. While 61% of all women using a modern method obtains the method from a government sector, only 2% obtain the method from private health facilities, 11% from religious, 11% from pharmacy and 10% from accredited drug dispensing outlet (ADDO). Ways or models to strengthen PPP and involve non government health sector to increase access and availability of methods is needed (MOHCDGEC, 2016).

### 2.5.5 Progress in indicators for family planning

Progress on FP indicators during One Plan II is shown on Table.

**Figure 8: FP Indicators progress during One Plan II period**

| S/N | Indicator | Baseline value (2016) | Target by 2020 | Progress by 2020 |
|---|---|---|---|---|
| 1. | Contraceptive prevalence rate with modern methods (among married women 15–49) | 27 % | 45%<br>One Plan II | 32%<br>(TDHS, 2015/16) |
| 1b | m-CPR among women of reproductive age (WRA) | 34%<br>(Yousuf et al 2020<br>2015/16 TDHS data) | 60%<br>HSSP IV | 44% (DHIS2 (2019)<br>38% (DHIS2 2018)<br>35% (DHIS2 2017) |
| 2. | Number of clients receiving modern FP methods | 2.6 million | 4.2 million | 5.6 million |
| 3. | Proportion of modern FP methods clients reached through outreach services | 15.2% | 30% | 27.2% |
| 4 | Couple Years of Protection for all modern methods | 4.3 million | 6.4 million | 7.9 million<br>(DHIS 2, 2019) |
| | **Other FP indicators need to be monitored** | | | |
| 5 | Total Fertility Rate (TFR) | 5.2 | | 4.9 (TMIS, 2017) |
| 6 | Unmet need for FP | 25%<br>TDHS, 2010 | | 22%<br>TDHS, 2015/16 |
| 7 | Demand for FP satisfied with modern method (SDG 3.7.1) | 48%<br>(TDHS 2015/16) | | 53%<br>(TDHS 2015/16) |

## 2.6 Maternal Health

**Global situation:** Evidence showed a decline in maternal mortality whereby 532,000 maternal deaths were registered in 2000 and 289,000 maternal deaths in 2017 which is equivalent to 44% decline (WHO, 2019). Sub-Saharan Africa (SSA) accounts for 66% of maternal deaths globally. It has an annual decline rate of maternal deaths of 2.9% from 1990 – 2017, while an annual decline of 5.5% was needed to achieve the 2015 goal.

Tanzania was among the countries that did not attain the MDG 5 (WHO, 2015; WHO, 2019). High impact, innovative, integrated and quality interventions are needed to achieve the SDG goal of reducing preventable maternal deaths to achieve the MMR of less than 70 per 100,000 live births by 2030.

### Tanzania situation on maternal health

Achieving the zero preventable maternal deaths is one of the goals Tanzania recommitted for ICPD at the end of 2019. Tanzania has not made significant progress in reducing maternal deaths between 2004/05 to 2015/16. The MMR in the 2015/16 survey was 556 deaths per 100,000 live births same as 5-10 years before the survey (TDHS 2004/05 and 2015/16). The need to have current data for planning has pushed the country to plan on performing the first Reproductive Age Mortality Study (RAMOS) (September – December 2021).

Analysis on causes of maternal deaths that have been reported to RCHS is shown in Figures 16 and 17 respectively. Postpartum Haemorrhage (29%), Pre-eclampsia (19%) and anaemia (9%) were the leading causes of deaths in 2018. There were no significant changes in 2019, still postpartum haemorrhage (31.4%), pre-eclampsia (14%) and anaemia (5%) were among the leading causes of death among women. Deaths secondary to anaesthesia complications increased from 3% in 2018 to 5% in 2019.

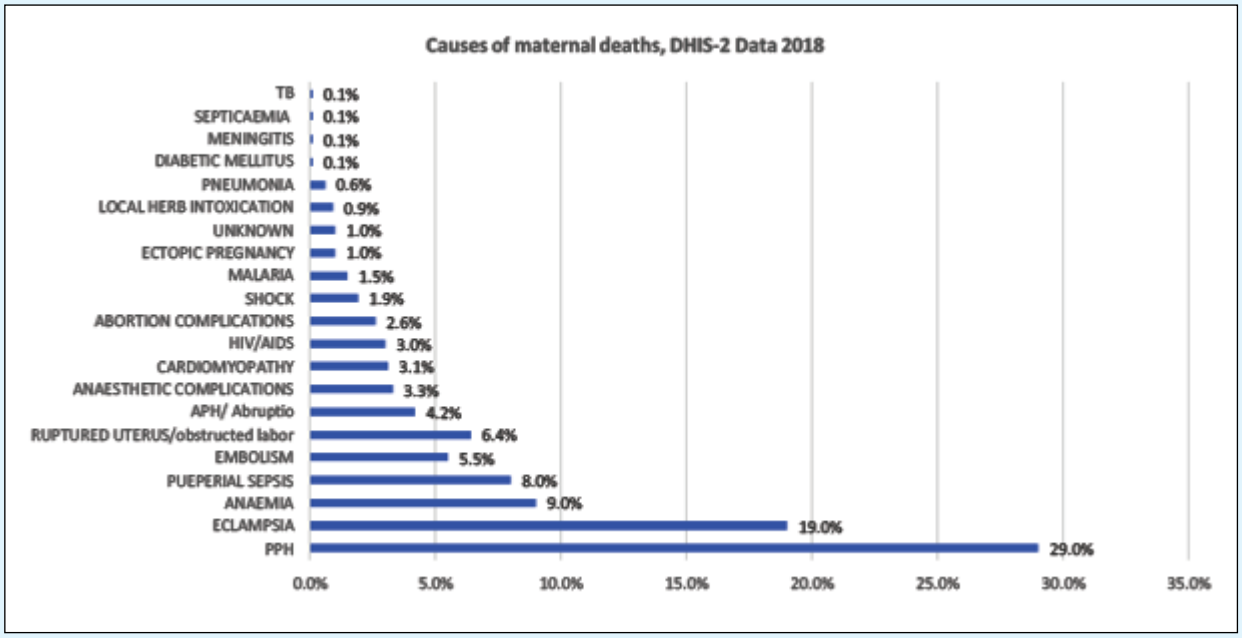


**Figure 9: Causes of maternal deaths in Tanzania 2018 (Program, 2018)**

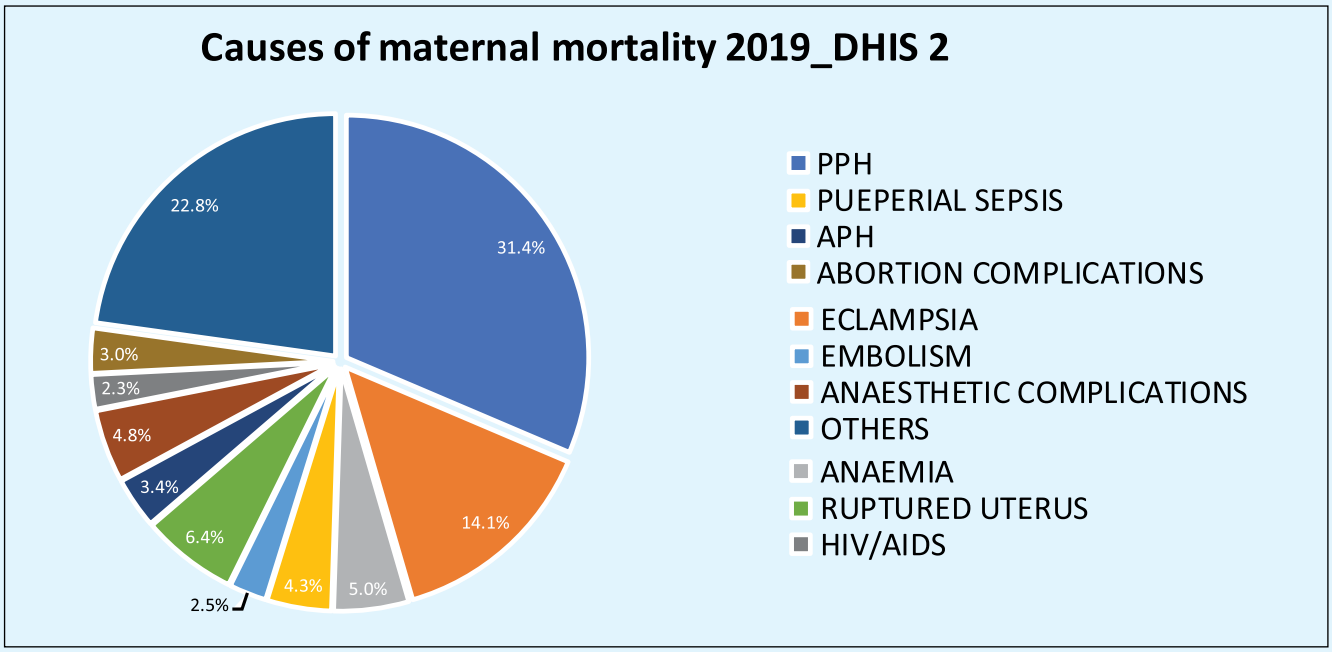


**Figure 10: Causes of maternal deaths in Tanzania (Program, 2019)**

Currently, most women deliver at health facilities in Tanzania (83%), therefore it is not surprising 93% of all reported maternal deaths in 2019 occurred within health facilities. MPDSR review shows that delay in obtaining care and after arriving at facilities, delay in referral between facilities and substandard care are the main cause of deaths (Maro et al, 2016). Further MPDSR reviews have demonstrated limited knowledge and skills of primary level health care providers, general practitioners and midwives, that contributes significantly to maternal and newborn morbidity and death hence calling for change of policy to availability of specialists closer to community at district hospitals. Lack of blood and blood products and delay in care seeking by the women (1st delay), were also identified as contributing factors to some deaths. This shows there is an urgent need to look into the quality-of-care women receive at the health facilities. Nearly 30% of the deaths occur among women aged 15-24 years old -Table 10. Further analysis of the data was not possible due to the way deaths are reported.

**Table 6: SDC characteristics of the 1,657 maternal deaths reported to RCHS in 2019**

| Variable | n (%) |
|---|---|
| Age group (years) | |
| 14-19 | 180 (10.9) |
| 20-24 | 314 (19.0) |
| 25-29 | 322 (19.5) |
| 30-34 | 402 (24.2) |
| 35-39 | 307 (18.5) |
| 40+ | 132 (7.9) |
| Level of facility | |
| Hospital | 1,089 (65.8) |
| Health Centre | 284 (17.1) |
| Dispensary | 163 (9.8) |
| Community | 121 (7.3) |

Quality of ANC and Delivery care interventions is suboptimal in Tanzania (MTR HSSP IV, 2019). SARA (2020) showed that while 9 in 10 facilities had BP machines and could offer TT, IPT, iron and folic supplementation, only 56% of the assessed facilities could screen for anaemia and 63% had dipstick to measure protein in urine. Pre-eclampsia (measured by high BP and protein in urine), is the 2nd leading cause of MDs, and can be detected and controlled during pregnancy, but many facilities, especially dispensaries cannot screen/detect it. Likewise, nearly half of facilities cannot measure anaemia while it is the 3rd cause of MDs. MTR of HSSP IV showed that for most of the women, there is a missed opportunity to avert mortality because many pregnant women with detected problems during pregnancy, are either poorly managed or they do not receive timely response to avert progression to severe morbidity and mortality.

Magnesium sulphate, key in management of severe pre-eclampsia and eclampsia, is available in 90% of the facilities with deliveries in Tanzania (SARA, 2020). Nearly 8 in 10 women attend 4 or more ANC visits, yet severe preeclampsia and eclampsia continue to be the main killers. DHIS-2 data shows that the percent of women who had pre-eclampsia (pre, during or post-partum) or eclampsia (pre, during or postpartum) among all institutional deliveries was about 10 per 1,000 deliveries for the mainland and did not change much from 2016-2020. However, the same data shows that only 60% of (pre) eclamptic women received magnesium sulphate from 2016-2019, and this proportion increased to 66% in the most recent years, Figure 18. Sub optimal skills of providers and competency in responding and managing obstetric complications is the key issue that needs to be addressed (Maro et al, 2016; MTR HSSP IV).

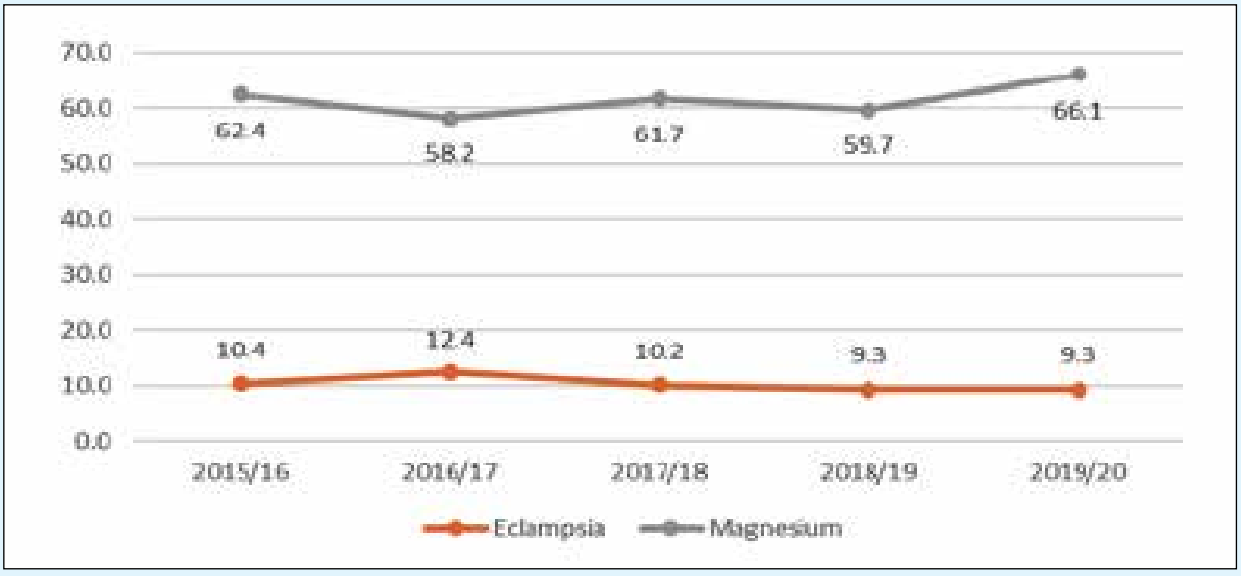


**Figure 11: (Pre) Eclampsia per 1000 deliveries and MgSO4 per 100 (pre)eclampsia diagnoses (DHIS-2 2016-2019)**

Partograph use and oxytocin are some of the essential care practices during childbirth. According to DHIS-2 data, use of oxytocin after delivery is high (96%) in all the regions, and has remained at this level from 2017-2020 (Figure 2.6.4). The lowest coverage region is Njombe and the highest is Rukwa. Regardless of high oxytocin coverage, PPH is still a leading cause of MDs. This maybe associated with providers not being skilled enough to respond in appropriate manner to women who develop complications like bleeding. For this reason, EmOC training remains important in Tanzania.

Monitoring of labour using pantographs (key in detecting complications) is sub-optimal. Partographs are available (93%), however, inadequate knowledge, skills and accountability on monitoring labour using partographs remains a challenge (MTR HSSP IV, 2019).

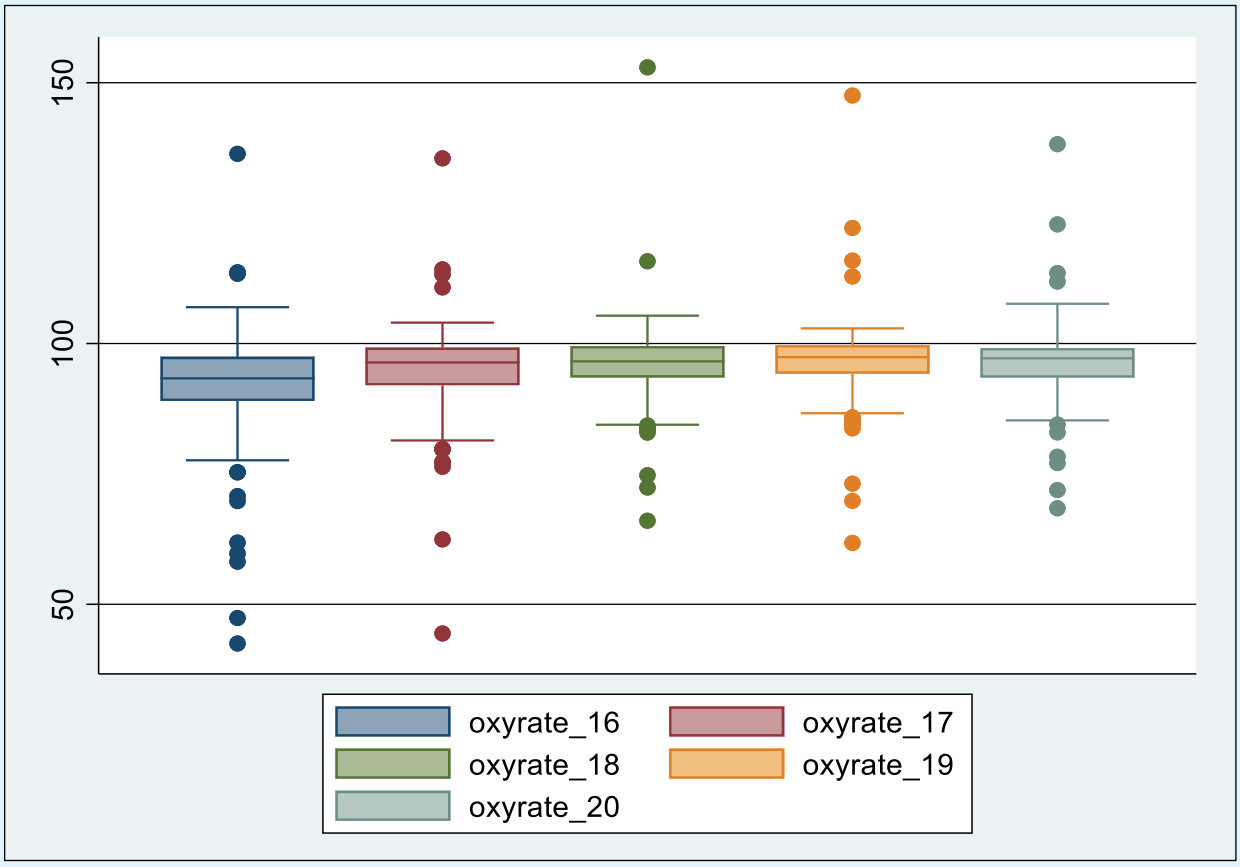


**Figure 12: Coverage of oxytocin among women who have delivered in institutions, by council (DHIS-2)**

Availability of basic emergency obstetric and newborn care (BEmONC) for women with complications during labour and delivery is limited. Only 56% of the assessed facilities with delivery can offer BEmONC. The coverage is lower at dispensary and at rural facilities (SARA, 2020). Dispensaries are supposed to be the first point of care for most women, especially in rural areas when faced with obstetric complications, but most of facilities cannot offer signal functions that require skills like MVA, vacuum or newborn resuscitation (NR). The first level facilities are thus failing and missing an opportunity to stabilize the patients before referrals.

Availability of comprehensive EmONC is higher at hospitals (87%) than the health centres (24%). Lack of competent and skilled staff, problems with anaesthesia equipment, problems with blood and its products and limited experience of clinicians are some of the limitations reported by health providers in provision of CEmONC (MTR of HSSP IV, 2019).

Maternal and Perinatal Death Reviews are conducted nearly to all maternal deaths compared to perinatal deaths where the evidence shows that the reviews have not reached 50% as recommended by WHO. Despite the reviews, the key issue here then, is the response or lack thereof, to the advice given after reviews.

Mentoring and supportive supervision from the national level to facilities is sub-optimal and done in an ad hoc manner mainly due to staff shortage, commitment and financial reasons. Mentoring and supervision from the regions and district level is also low.

It can be summarized that the key issues that needs to be prioritized in the next 5 years to avert preventable maternal deaths include the following; quality ANC and childbirth services, skills and competence of providers in offering rapid response and quality emergency obstetric and newborn care services, fully functional EmONC facilities (at dispensaries and health centres), poor management of women with problems/ complications during the antenatal period or delivery, and poor/ weak referral system between the facilities.

**Table 7: Progress in maternal health indicators during One Plan II (Source: MTR HSSP IV, 2019)**

| Indicator | Baseline (Year) | Target 2020 | Progress | Comments |
|---|---|---|---|---|
| Maternal mortality per 100,000 live births | 556 (TDHS 2015-16) [1] | 192 | | No progress in the past decade; no new population-based data |
| ANC: first visit before 12 weeks of pregnancy | 24% (TDHS 2015/16)<br>13% (DHIS 2015) | 60% | 34% (DHIS, 2019)<br>26% (DHIS 2018) | Modest increase but still well-off target |
| ANC at least 4 visits among pregnant women | 51% (TDHS 2015/16)<br>37% (DHIS 2015) | 80% | 81% (DHIS 2019)<br>64% (DHIS 2018)<br>62% (TMIS 2017) | Steady increase |
| IPT 2 | 35% (TDHS 2015/16) | 90% | 87% (DHIS 2018) | Major increase, target likely to be met |
| Anaemia in pregnancy | 53%<br>(TDHS 2010) | <20% | 57%<br>(TDHS 2015/16) | |
| Anaemia testing coverage among pregnant women | 43% (DHIS 2) | | 62% (DHIS 2, 2018) | |
| Institutional delivery rate | 63% (TDHS 2015/16) | 80% | 83% (DHIS 2019)<br>78 % (DHIS 2018) | Target of 2020 met |
| Skilled Birth Attendants use during childbirth | 64% (TDHS 2015-16)<br>60% (DHIS, 2015) | 80% | 79% (DHIS 2019)<br>76 % (DHIS 2018) | A rapid increase between 2017 and 2018; 2020 goal near |
| Postnatal care within 48 hours (women) | 34% (TDHS 2015-16) | 80% | 73% (DHIS, 2019)<br>65% (DHIS, 2018) | Rapid increase in PNC use; 2020 target within reach |
| C- Section Rate | 6 % (TDHS 2015/16);<br>6.3% (DHIS, 2015) | 5-15 % | 10% (DHIS, 2019)<br>8% (DHIS, 2018) | 2020 goal has been met, but wide regional variation |
| Basic EmONC Services: facilities that can provide BEMONC (%) | 13% Dispensaries<br>28% Health Centres<br>(2015) | 70%<br>100% | 51% Dispensaries<br>76% Health Centres<br>(2020 SARA) | Health centres on right track not dispensaries |
| Comprehensive EmONC Services: facilities that can provide CEMOC (%) | 12% Health Centres<br>59% (2015) | 80%<br>100% | 24% Health Centres<br>87% Hospitals<br>(2020 SARA) | Hospitals on the right track but not health centres |

## 2.7 Reproductive health cancers

### 2.7.1 Cervical cancer

#### Global situation

Cervical cancer is a public health problem especially in low resourced countries. GLOBOCAN estimated there were 570,000 cases of cervical cancer and 311,000 deaths globally in 2018 (Bray et al, 2018; Arybn et al, 2020). Nearly 84% of cervical cancer and 88% of all deaths occurred in low-resourced countries (Arbyn et al, 2020).

The highest burden in incidence and mortality of cervical cancer is at Eastern and Southern Africa. Age -standardized incidence rate (ASR) per 100,000 women is 43.1 in Southern Africa and 40.1 in Eastern Africa compared to the global ASR of 13.1 per 100,000 women (Aryban et al, 2020).

Persistent infection with High-Risk Human Papilloma Virus (HR-HPV) especially subtype 16 and 18 is the main trigger and cause of cervical cancer (Bray et al, 2018). Currently HPV vaccines (bivalent and quadrivalent) containing HPV16 and HPV18 antigens given to young adolescent girls who are not yet sexually active is the main primary prevention measure for cervical cancer (Arbyn et al, 2018). Early detection through screening and treatment is the main secondary prevention measure. Pap smear had been used for screening in high-resourced settings, but randomised trials have shown that screening with HPV DNA tests protects better against future cervical precancerous lesions and invasive cancers than screening by cytology (Ronco et al, 2014; Smith et al, 2019). Screening using HPV DNA methods are increasingly recommended in both resource-poor and rich settings (Smith et al, 2019; WHO, 2019).

The 2016-2030, Global Strategy for Women's, Children's and Adolescent's Health also highlighted the importance of prevention and control of cervical cancer (WHO, 2016). The WHO elimination strategy for cervical cancer is to reduce ASR to less than 4 per 100 000 women globally by 2030. The goal will be achieved by; vaccinating 90% of all girls by age 15 years; screening 70% of women in the age range of 30–60 years using high-precision tests and treating at least 90% of all cancerous lesions (WHO, 2019).

#### Tanzania situation

Cervical cancer is a major public health problem in Tanzania. Of the 25,028 new cancer cases among women in 2018, cervical cancer (39%) and breast cancer (12%) were leading. The ASR of cervical cancer is higher in Tanzania is 59.1 per 100,000 women. Cervical cancer is also the leading cause of cancer related mortality in Tanzania at 43 per 100,000 women. Most of the women present for care with advanced disease.

#### 2.7.1.1 Cervical cancer screening and management in Tanzania

Cervical cancer screening started in 2002, scaled up to the 26 mainland regions by 2011. Screening is available at all levels of facilities. Currently there are 650 health facilities that offer cancer screening. VIA is the screening method, and positive VIA are treated at the same visit, with cryotherapy or with Loop Electrosurgical Excision Procedure (LEEP) for larger lesions (MOHCDGEC, 2019). Health facility coverage (650 sites) for cervical cancer screening is low

(11%). Coverage is 82% at district hospital, 46.7% at health centre and 100% at regional and zonal hospitals. Among the 650 sites, 430 (66%) have functional cryotherapy for treating cervical precancerous lesions and 30 health facilities provide both cryotherapy and LEEP for treatment of small and large cervical pre-cancer lesions respectively. Lack of cryotherapy at some screening facilities is a key challenge for same day treatment.

In the updated cervical cancer guideline, the ministry had added HPV DNA testing and thermal ablation as additional screening and treatment method for precancerous lesions where feasible (MOHCDGEC, 2019). The target group for screening is women aged 30- 50 years and the screening interval is 5 years for VIA or HR-HPV negative women.

By the end of 2018, a total of 1.2 million women were screened for cervical cancer, out of those 533,440 were aged 30-50 years. This number of women screened is equivalent to 11% of the women aged 30-50 years by year 2018 this also I corroborated by MOHCDGEC CECAP evaluation report 2018 and other studies (Cunningham et al, 2015; Mabelele et al, 2018). The current levels of screening (11%) is far behind the target of 50% by 2018 in the National RH cancer program, and of 80% by 2020 in One Plan II.

Immediate treatment of pre-cancerous lesions detected during screening is key in preventing development of invasive cervical cancer. The proportion of women with VIA positive results who were treated with cryotherapy, thermocoagulation and/or LEEP increased from 45% in 2015 to 59% in 2016, then declined to 50% and 51.6% in 2017 and 2018 respectively (MOHCDGEC, 2019). This is below the program target of 80% and global target of 90% respectively.

Sensitization, community education and engagement is key in uptake of cervical cancer screening. In Tanzania about 69-82% of the women in the community have heard about cervical cancer (Cunningham et al, 2015; Mabelele et al, 2018; Moshi et al, 2018). However comprehensive knowledge on causes, preventive methods and treatment is generally low (18%- 20%), and comprehensive knowledge was much lower in rural than urban women (Cunningham et al, 2015; Moshi et al, 2018).

Training of health care providers to have skills and competence to screen and treat cervical cancer is important for program success. Rick et al (2017) reported 69% of interviewed health providers had never received any cervical cancer training. Similar results were reported by Bernstein et al (2018).

### 2.7.1.2 HPV Vaccine coverage and level

HPV vaccination is part of the National Immunization Program in Tanzania, introduced as a pilot in 2014 and scaled-up in 2018 to the whole country. The HPV vaccine used in Tanzania is Gardasil, two doses given 6 months apart, and it is given to girls aged 9-14 years old (MOHCDGEC, 2019). However, due to global shortage of vaccines, the country agreed to provide the HPV vaccine to the upper age cohort, 14 years old, as there are plans to extend the program to the other eligible girls (JSI, 2018).

The HPV-1 coverage increased from 60% in 2018 to 78% in 2019 respectively. HPV-2 vaccine also improved from 32% in 2018 to 49% in 2019, Figure 20.

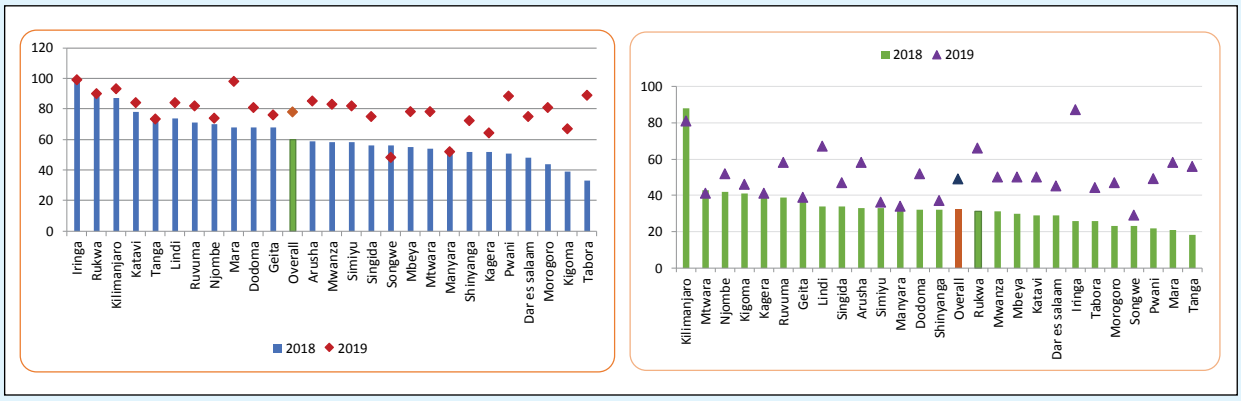


Figure 13: HPV-1 (left) and HPV-2 (right) coverage in Tanzania mainland 2018-2019

The proportion of girls fully immunized by HPV vaccine increased from 46% in 2018 to 63.5% in 2019. The 64% coverage by 2019 is below One Plan II target of 80% by 2020.

The key challenge in the HPV vaccination program is in the second dose of the (HPV-2) vaccine. In 2019, HPV-1 coverage was 78% compared to HPV-2 coverage of 49%. Twelve regions had HPV-1 vaccination coverage of < 80% and 24 regions out of 26 had HPV-2 coverage of < 80% in 2019. The community and adolescent girls understanding of the significance of HPV vaccination is another challenge (Watson-Jones et al, 2012). The health system challenges involved shortage of human resources, transport and supplies to be able to conduct the vaccination programs as planned (Gallagher et al, 2018). For 2020, the coverage may also be affected by the COVID-19 pandemic.

### 2.7.2 Breast and Prostate cancers

Prostate cancer is the second most common cancer in Tanzania, followed by breast cancer (Globocan, 2018). In males, prostate cancer is the most common cancer contributing to (26%) of the new cases in 2018, while breast cancer is the second common cancer among women (12%) of the new cases in the same years.

Despite the burden, data for these two RH cancers are not routinely collected neither in the DHIS-2 nor in surveys. At this time it will be difficult to put them as national or program indicators.

## 2.8 Violence against women (GBV) and children (VAC)

### 2.8.1 Global situation

Globally, it is estimated that up to 1 billion children (50% of all children) aged 2–17 years have experienced physical, sexual, or emotional violence or neglect in the year 2018, majority of these estimates in Asia, Africa, and Northern America. WHO estimates that almost 53,000 child deaths in 2002 were homicides, an estimated 150 million girls and 73 million boys under 18 have experienced forced sexual intercourse or other forms of sexual violence involving physical contact. In the Global School-Based Student Health Survey carried out in a wide range of developing countries, between 20% and 65% of school-aged children reported having been verbally or physically bullied in school in the previous 30 days.

It is estimated that over 200 million girls and women worldwide are living with the effects of FGM, and despite efforts to eradicate the practice about 68 million girls are at risk of being mutilated by 2030.

### 2.8.2 Gender Based Violence response and Management in Tanzania

Tanzania is committed to ICPD promise of ending sexual and GBV and VAC of all forms, including zero child early and forced marriages as well as zero female genital mutilation and elimination of all forms of discrimination all women and girls.

The burden of GBV is high in Tanzania. The 2015/16 TDHS reported 40% of women age 15-49 have ever experienced physical violence, and 17% had ever experienced sexual violence. Among ever married/ ever partnered women, the prevalence of physical, emotional and sexual violence by their close partners was 40.1%, 36.6% and 13.8% respectively. On the other hand, FGM is still a common practice in some communities and it is increasingly practising on girls under the age of one. One in ten women in Tanzania aged 15-49 has undergone FGM. Of these 35% underwent FGM under the age of one.

GBV has been associated with multiple negative effects. Increased risk of unplanned and/or unwanted pregnancies, increased risk of HIV/STI transmission, negative pregnancy outcomes (abortion, preterm labour and delivery and low birth weight), and increased maternal morbidity and mortality (TDHS 2015/16; Sigalla et al, 2017). Long term disabilities include mental health problems, chronic pain syndrome, drug and alcohol misuse and the victims become perpetrators of violence. In addition, FGM can result into both short and long term physical emotional and uro-gynaecological complications that predisposed the women to life threatening in health complications (PPH, Prolonged labour, tears, still birth and neonatal deaths) or chronic pain and disabilities (WHO, 2018).

The health sector is one of key stakeholders in GBV and VAC multi-sectorial national response. The GBV and VAC services has been integrated with other services at all levels of health facilities in Tanzania. 15 health facility based one-stop centres have been established countrywide. Review and updating of GBV and VAC management protocols, service delivery guidelines for health care workers, and health care providers training to survivors has been achieved during the implementation of one plan II. Moreover, integration of GBV, VAC and FGM competencies into the nurse training curricula and establishment of women and children protection committees at all level of government structure were achieved. Tanzania has increased the proportion of health facilities providing GBV and VAC services from 1% in 2016 to 32% in 2020. The proportion of GBV and VAC survivors who experienced any violence who reported within 72 hours after an event has also increased from 23% in 2019 to 28% in 2020 (DHIS 2).

## 2.9 Male health and involvement in SRH

Male involvement (MI) and participation was prioritized in One Plan II. During its implementation Men were engaged through SRH, PMTCT and other maternal programs primarily through their partners. Currently, there is inadequate awareness among health providers of what constitutes male involvement in SRH services.

## 2.10 Community engagement and participation in RMNCAH

Community mobilization and engagement is very important in all RMNCAH interventions i.e. for newborns, children, adolescents, women and men. Community understanding and perception of problems is key in shaping healthcare seeking and adherence to interventions. Most of health promoted and preventive activities for RMNCAH can be done at the community level. This will strengthen services provision along the continuum of care, from the community to primary care level.

Currently, there is integrated community RMNCAH package, with community communication, mobilization, and engagement strategy that takes advantage of the existing manpower, community structures and resources. However, there is a need to scale-up the integrated community RMNCAH interventions and improve partners coordination at all levels.

The communities have in existence Community Health Workers (CHWs) who are formally trained, and those who have gained experience by working with different RMNCAH programs. The HSSP IV MTR noted that all councils have implemented the government policy that requires councils to involved communities in governing of health facilities. Members of the communities constituted the health facility governing committees/ boards. Some councils reported some communities that supported the services delivery by constructing the wards and provision of residential houses for the staff to enhance retention. Moving forward there is a need to ensure these governing committees, have Standard Operating Procedures, functional and members have necessary skills and knowledge to oversee the health facilities.

## 2.11 Supply chain and logistics

Commodity security is key in RMNCAH services. Tanzania has supportive national policies and systems for logistics management systems, that results in timely and adequate supply of RMNCAH essential and lifesaving commodities. The ministry has integrated most health commodities into one supply chain logistics system (ILS), implementing the National Pharmaceutical Action Plan (NPAP), and implement the electronic systems that facilitate business processes and communications between health facilities and MSD (e-LMIS and ERP-E9). The Ministry has also increased the frequency of health commodity delivery to health facilities moving from quarterly to bimonthly deliveries and changing to monthly reporting to improve data visibility. The efforts have led to increased availability of essential and lifesaving health commodities to 90% by the end of 2019.

In the MTR of HSSP IV, substantial progress in the availability of medicines and supplies was reported in most of the regions. Health facilities in some regions experienced sporadic stock outs. The reasons for stock outs were inadequate financial capacity at the health facilities and MSD delay to acknowledge stock outs - a requirement for using prime vendors and procuring from other sources. In this there is a need to ensure sufficient allocation of RMNCAH commodities budget, communication coordination between MSD and health facilities to improve product availability at the last mile and eliminate product stock outs at all levels of the supply chain.

# CHAPTER 3 Scope of One Plan III and Emerging Priorities

## 3.1 Scope of One Plan III

One Plan III builds on the foundation of One Plan II targets and HSSPV priorities. While One Plan II anchored its strategies and interventions on survival, One Plan III strategies and interventions is extending beyond survival, broaden the scope to address issues pertaining to thrive and transform. One Plan III operationalizes the Global Commitment for Women's, Children's and Adolescent's Health (2016-2030) of Survive, Thrive and Transformation. Quality of care continues to be the central focus of One Plan III and be a base for improving survival and thrive.

Interventions in One Plan III, especially those aiming to improve access and utilization of quality RMNCAH services, has changed from programmatic thinking to targeting each individual client in a holistic manner. With the exception of the R, each letter in the RMNCAH title, targets a person i.e. M = Maternal (WRA from pre-pregnancy, pregnancy, childbirth, postnatal), N = Neonate, C = Child, and A = Adolescent. In this new strategy men are included and attempt to address their own SRH health needs has been done. Client centred approach helps to address key interventions in a more targeted, inclusive, and holistic approach.

## 3.2 Emerging Issues and Priorities

Overall RMNCAH services utilization have increased, however quality of care remains a key bottle neck in turning the advantage of utilization of services into survival. Low number of skilled providers, adequate infrastructure and equipment remains a challenge. Further, there is a need to strengthen community engagement and communication to increase utilization and/or adherence to interventions. Also, there is a need to establish the levels of Maternal and child mortality to inform future planning. One Plan III focuses on client centred approach and health system strengthening interventions, and the below figure provides a summarized implementation strategy (Figure 12).

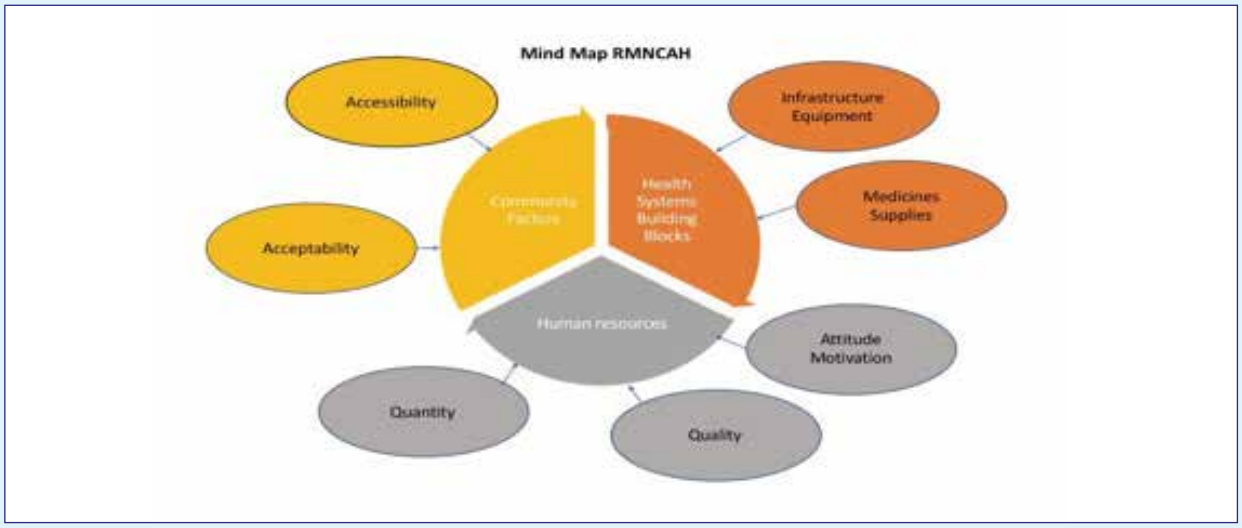


**Figure 14: Gaps in RMNCAH domains as reported in MTR of HSSP IV (Source: MTR of HSSP IV, main report)**

## 3.3 Prioritization of issues considered in 2021-2025

### 3.3.1 Newborn Health

***Need to be maintained or sustained***

- Good coverage of BCG and OPV vaccination at birth
- Improved postnatal care visits for newborns within 48 hours after birth

***Focus for One Plan III***

- Ending preventable neonatal deaths (21 per 1,000 live births) is far from the 2020 and 2030 goals. The decline is slow, accelerated efforts are needed (ARR of 5% is needed to attain the 2030 goal of < 12 per 1,000 live births),
- Improving intrapartum care practices and newborn resuscitation, key in averting a big proportion of neonatal deaths in the country,
- Improvement in availability of quality Neonatal Care Units (NCU) including KMC in the hospitals and health centres to improve survival of sick and small babies,
- Improvement of the management of sepsis (sick newborns) by increasing the availability of recommended antibiotics and introducing advanced care at higher level facilities,
- Limited skills and competence of service providers in the provision of Essential newborn Care. newborn care is addressed in pre-service curriculum and in-service integrated training (Integrated Competence based training guidelines in place, rollout is needed)
- Improvement HMIS data (DHIS-2) through adjusting or revising indicators to capture meaningful neonatal data that can be used to inform progress of the interventions,
- Strengthening the peri-/neonatal audit system.
- Neonatal Care units (NCU) in all hospitals as per minimum standards stipulated in the Tanzania Integrated National Guideline for Neonatal Care and Establishment of Neonatal Care Units (MOHCDGEC, August 2019), and
- Community health package for newborns is introduced.

### 3.3.2 Child health and nutrition

***Need to be maintained***

- High immunization coverage for all antigens, with more focus in 23 councils that are not doing well
- High coverage of routine weight/age monitoring

***Focus for One Plan III***

1. Ending preventable under-five deaths in line with 2030 goal.
2. Improve child survival and environment for thriving to reach their full potential.

***2.1: Nutrition***

- Improve nutrition among pregnant women to address anaemia and low birth weight,
- Improve EBF, complementary feeding practices and general nutrition among under-fives,

- Addressing high anaemia micronutrient deficiencies among under-fives,
- Accelerated efforts to address stunting - multi-sectorial and multi-levels approaches are required to address nutrition issues.

### *2.2: Prevention and management of childhood illness*

- Improve preventive practices for 3 key causes of under-five deaths after neonatal period,
- Improve community health seeking behaviour for pneumonia, diarrhoea and malaria, and
- Ensure universal availability of services and drugs for management at health facilities.

3. Improved quality of services
4. Increase competent providers with knowledge and skills in IMCI,
5. Roll-out Paediatric Standard Treatment Guidelines, and Essential Medicines List for Children to improve Management of Severe Acute Malnutrition and In-Patient,
6. Improve coverage of birth registration, using other performing platforms
7. Scale-up Early Childhood Development interventions
8. Establish baseline information on disease pattern and causes of deaths for 5-9 years old children,
9. Introduce death surveillance and review for children under-fives
10. Research on models to improve quality and quantity of food and micronutrients at family level

## 3.3.3 eMTCT of HIV syphilis and Hepatitis B

### *Need to be maintained/ sustained*

- High HIV testing coverage among pregnant women
- High ART treatment coverage for HIV-positive women
- High ARV and cotrimoxazole prophylaxis for HIV-exposed infants

### *Focus for One Plan III*

- Intensified efforts in reducing MTCT of HIV from 7.9% in 2020 to reach the MTCT of HIV of 2% by 2030 (an ARR of 7.5% is needed).
- Improvement of HIV-exposed children (EID) for timely identification and linkage of infected children to ART care.
- Increase efforts in the reduction of loss to follow up of HIV exposed infants.
- Roll out Point of Care DNA-PCR testing in the effort to increase early access and reduce Turn-Around-Time for DBS samples in selected health facilities.
- Strengthened implementation of maternal retesting of HIV-negative women at 3rd trimester, during labour or postpartum period to identify possible incident infections during pregnancy and breastfeeding.The PMTCT program targets to achieve a 90% target of HIV-retesting by 2030 from the current coverage of 28% (DHIS2, 2020). Retesting aims at reducing MTCT of HIV during pregnancy and breastfeeding period.
- Improvement in the retention of mothers in PMTCT care.

- Availability of skilled health care providers in the provision of PMTCT services in all health facilities for the improvement of PMTCT services.
- Triple elimination of HIV, Syphilis and Hepatitis B through intensified testing during pregnancy and treatment of positive cases.

### 3.3.4 Adolescent health

***Need to be maintained/ sustained***

- High attendance for antenatal care (ANC 1; first visit at 1st trimester and ANC 4+ times) and Postnatal care within 2 days after delivery.
- High use of health facilities and skilled birth attendance (SBA) during childbirth

***Need to be improved***

- Strengthen multi-sectorial collaboration between departments/ ministries as guided by NAIA.
- Strengthen SRH interventions for in school adolescents within the school health program.
- Improve use of modern contraceptive methods among adolescents to prevent teenage pregnancies prioritizing regions with high prevalence
- Promote nutritional education and strengthening school gardening programmes for micronutrients rich food
- Increase number of health facilities rendering Adolescent and youth Friendly Sexual Health services

### 3.3.5 Family planning

***Need to be maintained or sustained***

- High level of services provision to achieve high level of Couple Years of Protection (CYP)
- High m-CPR and demand for FP met by modern methods in seven regions while maintaining efforts in other regions

***Focus for One Plan III***

- Scale-up update of FP and PPFP services
- Ensure continuous and uninterrupted availability of FP commodities to address client's choice
- Scale up comprehensive FP services delivery in under served areas
- Scale up the provision of the Long-Acting Reversible Contraceptives methods across all facilities
- Overcome barriers on adopting Long-Acting Reversible Contraceptives
- Improve FP services integration across all health facilities.
- Strengthening partnership with Private and NGO owned health facilities to offer Comprehensive FP services
- Capacitate more CHW to conduct counselling and distribute allowed FP methods at the community level

### 3.3.6 Maternal Health

***Need to be maintained/ sustained***

- High attendance for ANC1 (however ANC1 should be below 12 weeks), ANC 4 or more times, institutional deliveries, SBA use and postnatal care use within 2 days of birth
- High coverage of TT, IPT and mebendazole coverage
- In EmONC: maintain high availability of injectable uterotonics, magnesium sulphate and injectable antibiotics

***Need to be improved in the next five years***

- Invest on the Quality of ANC (Kanzi data, ANC1 below 12 weeks, attend minimum of 8 contacts, testing, management of identified problems, insist on facility delivery and FP) and follow up of identified problems (e.g. measure of BP, protein in urine, haemoglobin, syphilis) (ANC below 12 weeks needs to be improved)
- Invest in testing and manage anaemia during pregnancy. Anaemia is flagged because it was the 3rd leading cause of maternal deaths in 2018 and 2019. Only 56% facilities have machine to test for Hb during pregnancy and 6 in 10 women get tested.
- Quality of intrapartum care: (Kanzi data, use of monitoring tools i.e. Pantograph, use of experts through WhatsApp groups, management of identified problems, AMSTEL, availability of medicines and medical supplies, availability of blood and blood products, Anaesthesia services especially to CEmONC sites.
- Quality of Post-partum care. More than 50% of under-five deaths are neonatal deaths majority being early neonatal deaths, some maternal deaths especially due to embolism, anaemia and sepsis are happening in the post-natal period.
- Anaesthesia services especially in CEmONC sites. OJ Training, mentorship, attachments and supervision are needed.
- Providers' skills in detecting and management of obstetric and newborn emergencies and complications during ANC, labour and delivery and post-partum period.
- Maternal and Perinatal Deaths Surveillance and Response (MPDSR) where the main aim is to provide information, recommendations and actions to be taken so as to eliminate preventable maternal and perinatal deaths. This allows a full understanding of the chain of events related to maternal and perinatal death, identify the main problem in the management of the patient from before admission to the time of death and come up with the best solution to correct the identified gap.
- Quality Improvement initiatives - This allows the facility to identify common issues pertaining to repeated problems and come up with best facility solutions to address these issues.
- Community participation and involvement in RMNCAH continuum of care especially during ANC, L&D and Post-partum care.
- Referral system, especially accessibility of emergency transport from one facility to higher level. Only 9% of the facilities with delivery have access to emergency transport, thus this is a bottle neck in saving lives of women and newborn once there is a complication.
- Competence based training in the pre-service training curricula.

### 3.3.7 RH Cancer

Ending preventable deaths and morbidity due to cervical cancer is important. In order to achieve that the following needs to be addressed in health system.

***Need to be maintained or sustained***

- Strengthen the integration of cervical cancer screening into other RMNCAH platforms e.g. Family Planning, STI clinics, HIV-care and treatment clinics and other RCH clinics child growth monitoring clinics at RCH, STI clinics.

***Need to be improved***

- Increasing service delivery points offering cervical cancer screening and other RH cancers.
- Equip more facilities (220 out of 650) that offer screening with cryotherapy or thermal coagulation.
- Improve availability of gas used for cryotherapy and maintenance of cryotherapy machines.
- Strengthen the identification of reaching 14-year-old adolescent girls who are not in school and follow up for dosage completion.
- Continue to implement awareness raising activities on RH cancers in the community.

***Need to be introduced***

- Further, introduction of other point of care, high precision screening test like HR-HPV may be a way forward using existing platforms like Gene-x pert, COBUS, etc.
- Develop a community package that will help to increase comprehensive knowledge on cervical cancer, importance of screening and prevention.
- Introduce RH cancers training curricula for both in-service and pre-service providers.

### 3.3.8 GBV and VAC

***Needs to be improved***

- Increased number of health facilities reporting GBV and VAC in the country.
- Integration of FGM in GBV and VAC management protocols.
- Improve providers' skills in providing care, and in linkage with other departments dealing with survivors of GBV/ VAC.
- Improve community awareness on importance of timely reporting for GBV and VAC care at health facilities level.

## 3.4 Implementation Guiding Principles

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

- **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.
- **Complementaries:** 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-sectorial 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 The National Road Map Strategic Plan to Improve Reproductive, Maternal, newborn, Child & Adolescent Health and Nutrition in Tanzania (2021 - 2025)
- **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 under served areas.
- **Phased planning, and implementation:** Promoting implementation in clear phases with time lines 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. Main-streaming 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.

# CHAPTER 4 Country's Strategic Direction on RMNCAH

## 4.1 Vision

A state where, universal access of sustainable and quality, Reproductive, Maternal, newborn, Child and Adolescent Health (RMNCAH) Services is provided along the life course.

## 4.2 Mission

Provision of comprehensive, integrated, high impact, client - centred and cost-effective interventions on quality Reproductive, Maternal, newborn, Child and Adolescent Health services

## 4.3 Goal

To improve quality RMNCAH services in line with HSSP V.

## 4.4 Impact Indicators

1. Maternal Mortality Ratio reduced from 250 per 100,000 live births to 100 per 100,000 live births by 2025.
2. Neonatal Mortality Rate reduced from 20 per 1,000 live births to 15 per 1,000 live births by 2025.
3. Still birth rate reduced from 16 per 1,000 total births to 12 per 1,000 births by 2025.
4. Under-Five Mortality Rate reduced from 50 per 1,000 live births to 38 per 1,000 live births by 2025.
5. Teenage pregnancies (among girls aged 15-19) reduced from 27% to 20% by 2025.
6. Mother-to-child transmission of HIV reduced from 8% to 2% by 2025.

## 4.5 Objectives

1. To create an enabling environment for provision and utilization of quality, equitable and accessible RMNCAH and nutrition services.
2. To strengthen the capacity of health systems for planning, management and service delivery of RMNCAH services.
3. To increase access and utilisation of quality RMNCAH services.
4. To improve quality of care for RMNCAH services

## 4.6 Logical Framework

| Results (Impact) | Objectives | Strategies |
|---|---|---|
| Reduced maternal mortality ratio<br>Reduced neonatal mortality rate<br>Reduced underfive mortality rate<br>Reduced teenage pregnancy (15 – 19 years)<br>Reduce MTCT of HIV and syphilis | 1. To create an enabling environment for provision and utilization of quality, equitable and accessible RMNCAH and nutrition services | 1.1: Policy leverage |
| | | 1.2: Leadership, governance and accountability |
| | | 1.3: Financing for RMNCAH and nutrition |
| | 2. To strengthen the capacity of health systems for planning, management and service delivery of RMNCAH services | 2.1: Improve Services delivery |
| | | 2.2: Improve Human resources for health |
| | | 2.3: Improve RMNCAH&N commodity security |
| | | 2.4: Improve Health management information system |
| | | 2.5: Improve Community systems for RMNCAH |
| | | 2.6 Improve Research for RMNCAH Services |
| | 3. To increase access and utilisation of quality RMNCAH services. | 3.1: Prioritized packages of RMNCAH - interventions |
| | 4. To improve Quality of Care (QoC) for RMNCAH services | 4.1: Improved package of QoC |

# CHAPTER 5 Strategies and Interventions

## Strategies and interventions that will help to achieve the objectives in One Plan III are shown in Tables 5.1 to 5.4 below

**Table 5.1: Strategies and interventions to create enabling environment for provision and utilization of quality, equitable and accessible RMNCAH and Nutrition services**

| **Strategic Objective 1: To create an enabling environment for provision and utilization of quality, equitable and accessible RMNCAH and Nutrition services** | |
|---|---|
| **Strategies** | **Interventions** |
| 1.1: Policy leverage | Develop, Review, or update and disseminate integrated RMNCAH and Nutrition guidelines, protocols, and SOPs |
| | Integrate RMNCAH and Nutrition skill-based interventions in professional training curriculum |
| | Strengthen scope of functions for skilled birth attendants to conduct life-saving procedures |
| 1.2: Leadership, governance and accountability | Strengthen coordination, governance and integrated planning for RMNCAH and Nutrition services at all levels |
| | Improve accountability for maternal, newborn and child mortality at all levels |
| | Strengthen inter-sectoral coordination and collaboration for RMNCAH and Nutrition interventions |
| | Establish an evidence-based system to inform RMNCAH and Nutrition financing |

**Table 5.2: Strategies and Interventions to strengthen the capacity of health systems for planning, management and service delivery of RMNCAH services.**

| **Objective 2: To strengthen the capacity of health systems for planning, management and service delivery of RMNCAH services** | |
|---|---|
| **Strategies** | **Interventions** |
| 2.1: Improve services delivery | Strengthen systems of clinical audit and continuous quality improvement of RMNCAH services |
| | Strengthen delivery of essential and emergency RMNCAH interventions |
| | Strengthen integrated in-service training, supportive supervision, mentoring and CPD for RMNCAH programs |
| | Enhance/ improve basic infrastructures for RMNCAH Services |
| | Adopt and scale up use of proven innovations in RMNCAH to improve service delivery |
| | |
| 2.2: Improve Human resources for health (HRH) | Support health training institutions to have enabling curriculum to produce graduates with basic core competencies in RMNCAH services |
| | Improve the number and core competences of health workers in provision of services including RMNCAH services |
| | Advocate for regular employment and equitable deployment of skilled personnel for health including RMNCAH Services |
| | Strengthen capacity of mentors to provide RMNCAH packages at national, regional and district levels |
| | Advocate for a continuous system that provides motivation and retention for HRH at levels |
| | |
| 2.3: Improve RMNCAH commodity security | Strengthen pipeline for RMNCAH commodities and equipment |
| | Increase tracking of RMNCAH lifesaving commodities |
| | Improve coordination, collaboration and accountability of supply chain activities |
| | Strengthen capacity of health system at all levels to forecast and procure RMNCAH lifesaving commodities and equipment |
| | Strengthen mobilization of resources for RMNCAH commodities |
| | Advocate for Planned Preventive Maintenance of RMNCAH Equipment |
| | |
| 2.4: Improve Health management information system (HMIS) | Improve capacity for RMNCAH data use for planning, service provision and decision making at all levels |
| | Support generation of electronic RMNCAH data from all service delivery points |
| | Enhance monitoring, evaluation and operational research to strengthen knowledge management and evidence |
| | |
| 2.5: Improve Community systems for RMNCAH | Strengthen community systems and structures to deliver the integrated service package for RMNCAH |
| | Improve capacity of CHW to support RMNCAH service delivery |
| | |
| 2.6 Improve Research for RMNCAH Services | Support comprehensive RMNCAH operation research to provide data for decision-making |

**Table 5.3: Interventions to increase access and utilization of quality RMNCAH and Nutrition services**

| **Strategic Objective 3. To increase the access and utilisation of quality RMNCAH services** | |
|---|---|
| **Strategies** | **Interventions** |
| 3.1: Men's Health | Develop and introduce package of male sexual and reproductive health services |
| | Strengthen male involvement in RMNCAH services |
| 3.2: Maternal Health | Improve access and utilization of long-acting and other modern contraceptive methods including integration with other RMNCAH services |
| | Sustain and improve quality of a full range of ANC services |
| | Strengthen intrapartum care including increasing access and availability of basic emergency obstetric and newborn care (BEmONC) services including skills to respond to emergencies |
| | Improve access and availability of comprehensive EmONC including safe surgery, anaesthesia, safe blood and blood products |
| | Strengthen capacity at all levels of care to improve comprehensive post-abortion care by using full range of available technology |
| | Improve coverage and utilization of quality postnatal care services and integration of other RMNCAH services |
| | Sustain HIV testing, ART coverage and improve maternal viral load suppression and syphilis screening for dual elimination |
| | Improve cervical and breast cancer screening and care |
| | Improve GBV and VAC services |
| | Strengthen menopause and post menopause services for women |
| | Strengthen referral systems for improved RMNCAH services |
| 3.3: The Neonate (0 – 28 days) | Strengthen availability and coverage of quality neonatal care services |
| | Strengthen availability of emergency newborn care at all levels with delivery services |
| | Strengthen basic essential newborn care at all levels (early initiation of breastfeeding, thermal care, cord cutting) |
| | Strengthen provision of care for preterm, sick and small babies |
| | Provide appropriate care for the HIV and congenital syphilis for exposed neonates |
| | Strengthen neonate death surveillance, review and response systems |
| 3.4: Child (1 – 59 months) | Improve growth monitoring and promote optimal infant and young child feeding practices |
| | Sustain high coverage of routine immunization and improve other child-interventions with impact (zinc sulphate, ORS and Vitamin A supplementation) |
| | Manage sick children on basis of IMNCI and ETAT protocols |
| | Introduce and strengthen under five death surveillance, auditing and response systems |
| | Promote use of LLIN in the endemic regions and provide appropriate management for malaria cases |
| | Improve early infant diagnosis of HIV and ART treatment including follow-up of HIV-infected children at facility and community |
| | Strengthen Early Child Development Care |
| | Promote pre-school health interventions |
| 3.5: The Older Child (5 – 9 Years) | Promote and strengthen school health interventions like screening, de worming, vaccination, and nutrition |
| 3.6: The Young Adolescent (10 – 14 years) | Promote age and gender specific comprehensive sexuality education for in and out of school adolescents |
| 3.7: The Older Adolescent (15 – 19 years) | Increase coverage of comprehensive adolescent and youth friendly services at all facilities and communities |
| | Increase adolescents engagement, participation, involvement and uptake of HIV, SRH, GBV and adolescent pregnancies preventive services |
| | Improve parent to child communication on SRH issues |

**Table 5.4 Interventions to improve Quality of care for RMNCAH services ***

| **Strategic Objective 4: To improve provision and experience of care in RMNCAH and Nutrition Services** | |
|---|---|
| **Strategies** | **Interventions** |
| 1.1: Policy | Operationalize QoC framework |
| | Adopt/ develop QoC indicators for routine monitoring and actions for RMNCAH at all levels |
| 1.2: Leadership, governance and accountability | Engage and build capacity of health managers at all levels for accountability and support in QoC for RMNCAH services |
| | Implement QoC assessment during supportive supervision at all levels |
| | Ensure quality improvement teams and functional at all levels |
| 1.3: Financing for RMNCAH and Nutrition | Ensure budget allocation for quality improvement activities |
| | |
| 2.1: Improve services delivery | Strengthen systems of clinical audit and continuous quality improvement (ready in 2.1 above) |
| | Strengthen integrated in-service training, supportive supervision, mentoring and CPD of RMNCAH programs (repeat) |
| | Implement of client charter at facility level |
| | Ensure adherence to protocols and SOPs in providing RMNCAH services |
| 2.2: Improve Human resources for health (HRH) | Ensure on-going capacity building of health care workers on RMNCAH technical update |
| | Capacity building for health care workers and managers in provision of respectful care |
| 2.3: Improve RMNCAH commodity security | Improve capacity of districts in monitoring essential commodities and develop early warning system for depleted commodities |
| 2.4: Improve Health management information system (HMIS) | Improve capacity of health managers and health care workers in using routine RMNCAH data to improve planning, service provision and decision making at all levels |
| 2.5: Improve Community systems for RMNCAH | Disseminate client charter at community level |
| | Improve community knowledge of RMNCAH services and rights |
| 2.6: Generation and use of evidence to improve RMNCAH Services | Conduct context specific operational studies in RMNCAH to provide real time data for decision-making |
| | Build capacity of health managers and health care workers to gather, synthesize and apply evidence for quality improvement |
| | Ensure collection and use of routine data on quality of care (both provision and experience of care) |
| | |

* Activities for quality of care in chapter 6 will be included within interventions 5.1 – 5.3

# CHAPTER 6 Implementation Framework (Activities)

Strategic Objective 1: To create an enabling environment for provision and utilization of quality, equitable and accessible RMNCAH and Nutrition services

## 6.1 Policy Leverage

1.1.1 Develop, Review, or update and disseminate integrated RMNCAH and Nutrition guidelines, protocol, and SOPs

1.1.2 Integrate RMNCAH and Nutrition skill-based interventions in professional training curriculum

1.1.3 Strengthen scope of functions for skilled birth attendants to conduct lifesaving procedures

## 6.2 Leadership, governance and accountability

1.2.1 Strengthen coordination, governance and integrated planning for RMNCAH and Nutrition services at all levels

1.2.2 Improve accountability for maternal, newborn and child mortality at all levels

1.2.3 Strengthen inter-sectoral coordination and collaboration for RMNCAH and Nutrition interventions

## 6.3 Financing for RMNCAH and Nutrition interventions

1.3.1 Strengthen prioritization of funding for RMNCAH and Nutrition programs/ interventions

1.3.2 Establish an evidence-based system to inform RMNCAH and nutrition financing

| Objective 1: To create an enabling environment for provision and utilization of quality, equitable and accessible RMNCAH and Nutrition services | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Interventions** | **Activities** | **21** | **22** | **23** | **24** | **25** | **Responsible Body** | **Collaborators** | **Means of Verification** |
| **Strategy 1.1: Policy Leverage** | | | | | | | | | |
| 1.1.1 Develop, Review, or update and disseminate integrated RMNCAH and Nutrition guidelines, protocol, and SOPs | Develop guidelines for integrating CSE content in the existing secondary school curriculum, Teachers' Certificate and Diploma curricula, and teaching methods | | | | | | | | |
| | Develop, Review and update ANC guidelines, job aids, SOP and checklists to provide all services as per visit including malaria, which also are evidence based | | | | | | | | |
| | Print Nutrition guidelines, protocols, SOPs, IEC/BCC and Job aids (Hospitals 280, HCs 822 and Dispensaries 6,833) | | | | | | | | |
| | Develop, Review and update ANC guidelines, job aids, SOP and checklists to provide all services as per visit including malaria, which also are evidence based | | | | | | | | |
| | Review, Printing and Dissemination of integrated National Guideline for Neonatal Care and Establishment of Neonatal Care Units | | | | | | | | |
| | To review, update and print SOPs (including job aids and response protocol) to support immunization services | | | | | | | | |
| | Review Education Policy Guideline (2004) for implementing life skills and HIV programs in primary schools, secondary schools, and Teacher Colleges to incorporate the delivery of CSE as an integrated subject | | | | | | | | |
| | Review, printing and dissemination of Growth Monitoring and Child Development training packages to incorporate updates and ECD materials | | | | | | | | |
| | Review, printing and dissemination of the IMCI training packages to incorporate updates and Modules for Early Childhood Development (ECD/CCD) | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **Strategy 1.1: Policy Leverage** | | | | | | | | | |
| 1.1.2 Integrate RMNCAH and Nutrition skill-based interventions in professional training curriculum | Participate in updating pre-service (Nursing/midwifery, Clinical Medicine) curriculum with RMNCAH and nutrition technical information | | | | | | | | |
| | Support health training institutions in strengthening skills laboratories by setting clinical skills stations and guiding in essential RMNCAH equipment and supplies for skill labs | | | | | | | | |
| | Build capacity of health training institution tutors and clinical instructors on integrated Sexual & RMNCAH and Nutrition package | | | | | | | | |
| 1.1.3 Strengthen scope of functions for skilled birth attendants to conduct lifesaving procedures | Advocate expansion and/or understanding of scope of function for nurses - midwives to conduct life-saving procedures | | | | | | | | |
| | Review task shift and sharing policy/guideline | | | | | | | | |
| | Disseminate and orient on task shifting and sharing policy guidelines | | | | | | | | |
| **Strategy 1.2: Leadership, governance and accountability** | | | | | | | | | |
| 1.2.1 Strengthen coordination, governance and integrated planning for RMNCAH and Nutrition services at all levels | Conduct regular advocacy engagement with decision making bodies e.g. parliamentarians, regional consultative committee, district consultative committee, etc. | | | | | | | | |
| | Conduct annual mapping for all RMNCAH implementing partners | | | | | | | | |
| | Conduct ARH and Gender TWGs quarterly meetings | | | | | | | | |
| | Conduct RMNCAH TWG quarterly meetings | | | | | | | | |
| | Conduct IVD TWG quarterly meetings | | | | | | | | |
| | Conduct newborn and Child Health TWG quarterly meetings | | | | | | | | |
| | Capacity building for managers at national, regional and district levels to provide stewardship, planning and oversight of One Plan III | | | | | | | | |
| | To conduct Mid-level Managers (MLM) training to immunization managers at national, regional and district levels | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **Strategy 1.2: Leadership, governance and accountability** | | | | | | | | | |
| | To Support IVD staff to attend short courses on leadership and management, supply chain and service delivery | | | | | | | | |
| | Conduct RMNCAH and Nutrition annual meeting | | | | | | | | |
| 1.2.2 Improve accountability for maternal, newborn and child mortality at all levels | Establish system for notification, review and response for under-five deaths | | | | | | | | |
| | Establish accountability system for stillbirth notification (Fresh SB or Macerated SB) | | | | | | | | |
| | Monitor progress of implementation of RMNCAH and Nutrition at National, regional and district levels | | | | | | | | |
| | Build capacity of various health facilities committee bodies especially QI committees | | | | | | | | |
| | Develop SoP for accountability of providers who repeats mistakes that predispose to MNC deaths | | | | | | | | |
| 1.2.3 Strengthen inter-sectoral coordination and collaboration for RMNCAH and Nutrition interventions | Advocate to Ministry of Education to ensure that every school and college have matron or patron responsible for Health issues including SRH and nutrition | | | | | | | | |
| | To advocate implementation for NAIA_AHW across sectors | | | | | | | | |
| | Conduct review of newborn and Child Health TWG membership and functions | | | | | | | | |
| | Conduct update of RMNCAH TWG membership and functions | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **Strategy 1.3: Financing for RMNCAH and nutrition** | | | | | | | | | |
| 1.3.1: Strengthen prioritization of funding for RMNCAH and Nutrition interventions | Conduct advocacy meetings with members of Parliament and engage them to support securing financial resources for strengthening immunization services | | | | | | | | |
| | Advocate for improved funding for RMNCAH and Nutrition services at the all levels | | | | | | | | |
| | Resource mobilization for RMNCAH and Nutrition | | | | | | | | |
| | Sensitization of private sectors (PPP) on engagement and support of immunization services | | | | | | | | |
| | Advocate for availability 'ring-fence budget for RMNCAH and Nutrition services | | | | | | | | |
| 1.3.2 Establish an evidence-based system to inform RMNCAH and nutrition financing | Conduct resource tracking for RMNCAH and Nutrition against results and outcome to inform policy and future resource mobilization | | | | | | | | |
| | Orient assistant accountants of HCs and in-charge of health facility governing committee on financial management system | | | | | | | | |
| | Capacitate regions, district and HF managers to conduct planning and effective management of using available resources | | | | | | | | |

## Strategic Objective 2: To strengthen capacity of health systems for planning, management and service delivery of RMNCAH services

### 2.1 Improve service delivery

2.1.1 Strengthen systems of clinical audit and continuous quality improvement
2.1.2 Strengthen delivery of essential and emergency RMNCAH interventions
2.1.3 Strengthen integrated in-service training, supportive supervision, mentoring, and CPD of RMNCAH programs
2.1.4 Enhance basic infrastructures for RMNCAH Services
2.1.5 Adopt and scale up use of proven innovations in RMNCAH to improve service delivery

### 2.2 Improve Human resources for health (HRH)

2.2.1 Support health training institutions to have enabling curriculum to produce graduates with basic core competencies in RMNCAH services
2.2.2 Improve the number and core competencies of health workers in provision of services including RMNCAH Services
2.2.3 Advocate for regular employment and equitable deployment of skilled personnel including specialists for health including RMNCAH services
2.2.4 Strengthen capacity of mentors to provide RMNCAH packages at national, regional and district levels

### 2.3 Improve RMNCAH commodity security and equipment

2.3.1 Strengthen pipeline for RMNCAH commodities and equipment
2.3.2 Improve tracking of RMNCAH lifesaving commodities
2.3.3 Improve coordination, collaboration and accountability of supply chain activities
2.3.4 Strengthen capacity of health system at levels to forecast and procure RMNCAH life-saving commodities and equipment
2.3.5 Strengthen mobilization of resources for RMNCAH commodities and equipment
2.3.6 Advocate for planned preventive maintenance of RMNCAH equipment

### 2.4 Improve Health Management Information System (HMIS)

2.4.1 Improve capacity for RMNCAH data use for planning, service provision and decision making at all levels
2.4.2 Support generation electronic RMNCAH data from all service delivery points
2.4.3 Enhance monitoring, evaluation and research to strengthen knowledge management and evidence

### 2.5 Improve Community systems for RMNCAH

2.5.1 Strengthen community systems and structures to deliver the integrated service package for RMNCAH
2.5.2 Improve capacity of community health workers (CHWs) to support RMNCAH service delivery

### 2.6 Improve research for RMNCAH services

2.6.1 Support comprehensive RMNCAH operational research to provide data for decision making

| Objective 2: To strengthen the capacity of health systems for planning, management and service delivery of RMNCAH services | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Interventions** | **Activities** | **21** | **22** | **23** | **24** | **25** | **Responsible Body** | **Collaborators** | **Means of Verification** |
| **Strategy 2.1: Improve Service delivery** | | | | | | | | | |
| 2.1.1 Strengthen systems of clinical auditing and continuous quality improvement of RMNCAH services | Support Capacity building to Health Facility Quality Improvement Team (QIT) including comprehensive supportive supervision, trainings, coaching and mentorship | | | | | | | | |
| | Support dissemination of best practices emanating from HFQIT performance for peer reviews | | | | | | | | |
| | Develop and disseminate quality improvement package for RMNCAH services | | | | | | | | |
| | Disseminate quality improvement package for RMNCAH services | | | | | | | | |
| | Support capacity building to MPDSR Committees at all levels | | | | | | | | |
| | Provide means to perform quality maternal and perinatal death reviews and response at all levels | | | | | | | | |
| | Strengthen system of surveillance, review and response of maternal and perinatal deaths as per MPDSR Guideline | | | | | | | | |
| 2.1.2 Strengthen delivery of essential and emergency RMNCAH interventions | Conduct National EmONC Assessment | | | | | | | | |
| | Capacity building on ANC packages though on-job training (OJT) and other models | | | | | | | | |
| | Sustain capacity for testing of HIV, and improve capacity for syphilis, haemoglobin, urine for protein to pregnant women | | | | | | | | |
| | Support all facilities to implement BEmONC signal functions for 24/7 | | | | | | | | |
| | Incorporate knowledge and skills for EmONC in Continuous Professional Development Programs | | | | | | | | |
| | Capacity building of health centres, district and referral hospitals on safe anaesthesia and safe surgeries | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **Strategy 2.1: Improve Service delivery** | | | | | | | | | |
| 2.1.2 Strengthen delivery of essential and emergency RMNCAH interventions | Provide permissive environment in maternity and labour wards including training of service providers for provision of respectful and compassionate maternity services | | | | | | | | |
| | Provide competence-based capacity building (drill) on EmONC services including attachment, coaching and mentorship to enhance safe surgery | | | | | | | | |
| | Capacity building of facilities to provide a range of family planning methods including postpartum family planning (PPFP) | | | | | | | | |
| | Provide checklists and protocols that will guide health workers and motivate not to skip a critical step in screening RMNCAH problems, (e.g. GBV, infertility, diabetes, high BP, etc.) | | | | | | | | |
| | Increase coverage of Kangaroo mother care services | | | | | | | | |
| | Advocate for provision of integrated RMNCAH services under one roof | | | | | | | | |
| 2.1.3 Strengthen integrated in-service training, supportive supervision, mentoring and CPD for RMNCAH programs | Review integrated mentorship training package for RMNCAH | | | | | | | | |
| | Conduct integrated RMNCAH training services for related interventions | | | | | | | | |
| | Review RMNCAH integrated supportive supervision tools for related interventions | | | | | | | | |
| | Support health workers with knowledge and skills to provide multiple RMNCAH services, under one roof | | | | | | | | |
| | Conduct integrated supportive supervision and mentorship for RMNCAH services | | | | | | | | |
| | Evaluate progress of implementation of supportive and mentorship program | | | | | | | | |
| | Monitor and evaluate all pre and in-service RMNCAH trainings | | | | | | | | |
| | Update e-learning training modules on immunization and upload in the e-learning platform | | | | | | | | |
| | Conduct refresher trainings for health care providers to update knowledge and skills in provision of RMNCAH Services | | | | | | | | |
| | Incorporate RMNCAH content in CPD | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **Strategy 2.1: Improve Service delivery** | | | | | | | | | |
| 2.1.4 Enhance basic infrastructures for RMNCAH Services | Conduct facility readiness capacity assessment and establishing Neonatal Care Units | | | | | | | | |
| | Conduct advocacy for establish functional Neonatal Care Units (NCUs) in all hospitals | | | | | | | | |
| | Advocate for separate functional ICU for maternity care in all hospitals | | | | | | | | |
| | Modify or renovate existing labour wards at all levels to be able to provide respectful maternity care | | | | | | | | |
| 2.1.5 Adopt and scale up use of proven innovations in RMNCAH to improve service delivery | Develop electronic IEC materials to educate clients and communities in use of RMNCAH services | | | | | | | | |
| | Enhance use of mobile technology to improve information and communication on RMNCAH services | | | | | | | | |
| | Incorporate, update and disseminate comprehensive immunization messages in m-health application | | | | | | | | |
| | Develop, disseminate and use RMNCAH electronic IEC/BCC materials (twitter, Facebook, WhatsApp, radio, TV, SMS) to reach target populations | | | | | | | | |
| | Adopt and scale-up innovative approaches in provision of RMNCAH services | | | | | | | | |
| **2.2 Improve Human Resources for Health (HRH)** | | | | | | | | | |
| 2.2.1 Support health training institutions to have enabling curriculum to produce graduates with basic core competencies in RMNCAH services | Advocate for resource mobilization for pre services training need for RMNCAH | | | | | | | | |
| | Facilitate curriculum review at training institutions to incorporate RMNCAH related content including customer care package | | | 3.7.1 | | | | | |
| | Support training institution with necessary infrastructure (skills labs), equipment and training materials for RMNCAH | | | | | | | | |
| | Orient tutors at training institutions on issues related to RMNCAH services | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **2.2 Improve Human Resources for Health (HRH)** | | | | | | | | | |
| 2.2.2 Improve the numbers and core competences of health workers in provision of services including RMNCAH Services | Advocate for a standardized induction course package including RMNCAH modules | | | | | | | | |
| | Advocate for strengthening key RMNCAH Courses such as Midwifery, Theatre Management, Anaesthesia, Neonatal Care Nurse | | | | | | | | |
| | Increase competences for emerging RMNCAH technologies and services including cervical and breast cancer prevention, new vaccines, etc. | | | | | | | | |
| 2.2.3 Advocate for regular employment and equitable deployment to provide RMNCAH packages at national, regional and district levels | Advocate for regular employment and equitable deployment of skilled personnel for Health including RMNCAH Services | | | | | | | | |
| | Advocate for policy change on availability of specialists at district hospitals to save life women, newborn and children | | | | | | | | |
| | Advocate for retention mechanisms of skilled services providers | | | | | | | | |
| 2.2.4 Strengthen capacity of mentors to provide RMNCAH packages at national, regional and district levels | Facilitate comprehensive supportive supervision, coaching and mentorship at levels of care. | | | | | | | | |
| | Print and disseminate Mentoring packages | | | | | | | | |
| | Coordinate professional associations and bodies to incorporate mentorship and supportive supervision program into CPD plan | | | | | | | | |
| | Review and update tools for mentorship and supportive supervision | | | | | | | | |
| | Orient national, regional and district TOTs to use mentoring and supportive supervision packages | | | | | | | | |
| | Provide targeted induction training for RMNCAH interventions | | | | | | | | |
| | Conduct Mentorship for respective programs | | | | | | | | |
| | Monitor the implementation of mentoring program | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **2.3 Improve RMNCAH commodity security and equipment** | | | | | | | | | |
| 2.3.1 Strengthen pipeline of RMNCAH commodities and equipment | Conduct annual quantification of RMNCAH commodities | | | | | | | | |
| | Procure RMNCAH Commodities as per projected National demand | | | | | | | | |
| | Strengthen the use of technology for supply chain management system (SCMS) to ensure availability and access of RMNCAH commodities | | | | | | | | |
| | Adopt and implement a Total Market Approach (TMA) to support CS/ SCM in the country | | | | | | | | |
| | Ensure availability of supply chain management related material and documents such as ledger book, prescription forms, Report and Requisition form, etc. | | | | | | | | |
| | Produce monthly, quarterly and semi-annual reports of various commodities | | | | | | | | |
| | Support and monitor availability of safe blood and blood products | | | | | | | | |
| | Provide necessary tools to collect specimens and improve referral in the clinic | | | | | | | | |
| | Procure remote temperature system up to facility level for implementation of temperature monitoring devices replacement plans (for vaccines). Procure temperature monitoring devices (fridge tags and freeze tags) up to facility level | | | | | | | | |
| | Facilitate Procurement and distribution of essential equipment, medicines and supplies for neonatal care, including for newborn resuscitation (in LBW, HDU/NICU, KMC, etc.....) | | | | | | | | |
| | Procure Cold chain equipment (CCE) for use at district and health facilities | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **2.3 Improve RMNCAH commodity security and equipment** | | | | | | | | | |
| 2.3.2 Improve tracking of RMNCAH lifesaving commodities | Develop e-supply chain management information system | | | | | | | | |
| | Track and conduct audits on availability and use of RMNCAH commodities | | | | | | | | |
| | Link e-supply chain information system in the DHIS2 | | | | | | | | |
| 2.3.3 Improve coordination, collaboration and accountability of supply chain activities | Conduct semi-annual zonal supply chain stakeholders meeting | | | | | | | | |
| | Conduct national quarterly RMNCAH Commodity security meeting | | | | | | | | |
| | Strengthen linkage and collaboration with Development Partners to support availability of RMNCAH commodities | | | | | | | | |
| | Conduct supportive supervision, on Job Training and Mentoring on e-LMIS and RMNCAH commodity monitoring. | | | | | | | | |
| 2.3.4 Strengthen capacity of health system at all levels to forecast and procure RMNCAH life-saving commodities and equipment | Conduct forecasting of RMNCAH commodities at all levels of service delivery points | | | | | | | | |
| | Procure RMNCAH commodities and equipment | | | | | | | | |
| | Capacitate national, regional, districts and health facilities on e-LMIS system redesign to track RMNCAH commodities | | | | | | | | |
| 2.3.5 Strengthen mobilization of resources for RMNCAH commodities | Advocate for more resources from Government budget to improve availability of RMNCAH commodities | | | | | | | | |
| | Solicit resources from Development Partners and non-health actors to support availability of RMNCAH commodities | | | | | | | | |
| 2.3.6 Improve for Planned Preventive Maintenance of RMNCAH equipment | Advocate for resource allocation in the budget for maintenance of equipment at all levels | | | | | | | | |
| | Implement preventive maintenance plan for RMNCAH equipment | | | | | | | | |
| | Advocate for biomedical engineers to be involved in equipment maintenance | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **2.4 Improve Health management information system (HMIS)** | | | | | | | | | |
| 2.4.1 Improve Health management information system for RMNCAH Services/ Improve capacity for RMNCAH data use | Capacity building on RMNCAH data use to RHMTs and CHMTs for planning, service provision and decision making | | | | | | | | |
| | Capacity building on RMNCAH data use to health workers for planning, service provision and decision making at all levels | | | | | | | | |
| | Develop/align data capturing system and data collection tools to reflect adolescent age disaggregation and capturing of reliable and consistent data for monitoring and reporting AYSRH services | | | | | | | | |
| | Support the piloting and roll-out of the developed data systems and tools for AYSRH services | | | | | | | | |
| | Analyse RMNCAH data and disseminate results using simple tools like score cards and develop action plan | | | | | | | | |
| | Review paper based HMIS tools for new interventions to be entered/ adopted into DHIS2 | | | | | | | | |
| | Print HMIS tools for RMNCAH interventions at all health facilities | | | | | | | | |
| 2.4.2 Support generation of electronic RMNCAH data from all service delivery points | Advocate for establishment of electronic data collection at service delivery points | | | | | | | | |
| | Capacitate health providers on electronic data collection at all service delivery points | | | | | | | | |
| | Establish RMNCAH computer data registry through linkage with other programs such as IVD, NTLP and NACP | | | | | | | | |
| 2.4.3 Enhance monitoring, evaluation, and research to strengthen knowledge management and evidence | Analyse and extract quarterly RMNCAH Score cards | | | | | | | | |
| | Harmonize/ develop and disseminate integrated RMNCAH monitoring tools including M&E Framework | | | | | | | | |
| | Develop M&E plan (including M&E framework, baseline, midline, and end-line studies) to facilitate monitoring and reporting of AYSRH services | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **2.4 Improve Health management information system (HMIS)** | | | | | | | | | |
| 2.4.3 Enhance monitoring, evaluation, and research to strengthen knowledge management and evidence | Support documentation and dissemination of M&E products and materials, including lessons and best practices in the implementation of RMNCAH interventions | | | | | | | | |
| | Conduct data quality assessment (DQA) for RMNCAH services | | | | | | | | |
| **2.5 Improve Community systems for RMNCAH** | | | | | | | | | |
| 2.5.1 Strengthen community systems and structures to deliver the integrated service package for RMNCAH | Review community RMNCAH essential interventions packages (include incorporation of updates and components of ECD/CCD) | | | | | | | | |
| | Printing and disseminate the developed community RMNCAH essential intervention package | | | | | | | | |
| | Recruit and harmonize CHW cadres for conducting community RMNCAH activities, including for immunization | | | | | | | | |
| | Advocacy to community (leader, influential people and community members) to support RMNCAH interventions and response | | | | | | | | |
| 2.5.2 Improve capacity of CHWs to support RMNCAH service delivery | Capacity building to community Health Workers through integrated RMNCAH Community package, including on newborn care and Community IMCI | | | | | | | | |
| | Provide IEC/BCC materials to support CHWs to promote RMNCAH interventions | | | | | | | | |
| | Provide necessary equipment and tools to CHWs | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **2.6 Improve Research for RMNCAH Services** | | | | | | | | | |
| 2.6.1 Support comprehensive RMNCAH operational research to provide real time and data for decision-making | Develop and disseminate RMNCAH research agenda | | | | | | | | |
| | Conduct monitoring of sentinel sites surveillance system | | | | | | | | |
| | Conduct bi-annual sentinel site review meeting for immunization services | | | | | | | | |
| | Support sentinel site data and performance review meeting | | | | | | | | |
| | Facilitate comprehensive RMNCAH Studies to provide real time and operational data for decision-making including: Maternal and newborn mortality study (RAMOS) after every three years; and Annual quality of care assessment in RMNCAH | | | | | | | | |

## Strategic Objective 3: To increase access and utilization of quality RMNCAH and nutrition services

### 3.1 Men's Health

3.1.1 Develop and introduce package of male sexual and reproductive health services

3.1.2 Strengthen provision of HIV/ STI/TB prevention, education, care, treatment and support

### 3.2 Maternal Health

3.2.1 Improve access and utilization of long acting and other modern contraceptive methods including integration with other RMNCAH services

3.2.2 Sustain and improve quality of full range of ANC services

3.2.3 Strengthen intrapartum care including increasing access and availability of basic EmONC including skills to respond to emergencies

3.2.4 Improve access and availability of Comprehensive EmONC including safe surgery, anaesthesia, safe blood and blood products

3.2.5 Increase capacity at all levels of care to improve comprehensive post-abortion care by using full range of available technology

3.2.6 Improve coverage and utilization of postnatal care services and integration of other RMNCAH services

3.2.7 Sustain HIV testing, ART coverage, and improve maternal viral load suppression & syphilis screening for dual elimination

3.2.8 Improve cervical cancers screening and care

3.2.9 Improve gender-based violence (GBV) and violence against children (VAC) services

3.2.10 Strengthen menopause and post menopause services for women

3.2.11 Strengthen referral systems for improved RMNCAH services

### 3.3 Neonate/ newborn (0 – 28 days)

3.3.1 Strengthen quality of neonatal services at all levels

3.3.2 Improve quality of care for sick and small babies (premature and low birth weight babies)

### 3.4 Child Health (1-59 months)

3.4.1 Improve growth monitoring and promote optimal infant and young child feeding practices

3.4.2 Sustain high coverage of routine immunization and improve other child-interventions with impact (zinc sulphate, ORS and Vitamin A Supplementation)

3.4.3 Manage sick children on basis of IMNCI and ETAT protocols

3.4.4 Introduce and strengthen under five death surveillance, auditing and response systems

3.4.5 Promote use of LLIN in the endemic regions and provide appropriate management for malaria cases

3.4.6 Improve early infant diagnosis of HIV and ART treatment including follow-up of HIV-infected children at facility and community

3.4.7 Strengthen Early Child Development Care

3.4.8 Promote pre-school health interventions

## 3.5 Older Child Health (5-9 years)

3.5.1 Promote and strengthen school health interventions like screening, deworming, vaccination, and nutrition

## 3.6 The Young Adolescent (10-14 years)

3.6.1 Promote age and gender specific comprehensive sexuality education for "in and out" of schools adolescents

## 3.7 The Older Adolescent (15-19 years)

3.7.1 Increase coverage of comprehensive adolescent and youth friendly services at all facilities and communities

3.7.2 Increase adolescent engagement, participation, involvement and uptake of HIV, SRH, GBV and adolescent pregnancies preventive services

3.7.3 Improve parent to child communication on SRH issues

3.7.4 Increase inter sectoral collaboration in implementation of adolescent and youth related interventions

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **3. Increased Access and Utilisation of Quality RMNCAH and Nutrition Services** | | | | | | | | | |
| **3.1 Men's Health** | | | | | | | | | |
| 3.1.1 Develop and introduce package of male sexual and reproductive health services | Conduct situational analysis to determine the male needs in sexual and reproductive health services | | | | | | | | |
| | Disseminate results of the situational analysis on male needs in sexual and reproductive health services | | | | | | | | |
| | Develop and disseminate guidelines on male friendly sexual and reproductive health services | | | | | | | | |
| | Develop training package and monitoring tools for Male Friendly sexual and reproductive health services | | | | | | | | |
| | Build capacity of R/CHMT and healthcare workers through training, editorship and coaching on Male Friendly sexual and reproductive health services | | | | | | | | |
| | Develop standardized minimum package for male friendly services including management of erectile dysfunction | | | | | | | | |
| | Conduct prostate cancer screening for males | | | | | | | | |
| 3.1.2 Strengthen male involvement in RMNCAH services | Conduct couple counselling and testing for HIV | | | | | | | | |
| | Provide information and education on Sis, FP, RH cancers, nutrition, danger signs and birth preparedness, child growth to men during RCH visits | | | | | | | | |
| | Provide referral and linkage to care for Sis, HIV and prostate cancer | | | | | | | | |
| | Develop system for tracking male involvement in RMCAH Services | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **3.2 Maternal Health** | | | | | | | | | |
| 3.2.1 Improve access and utilization of long acting and other modern contraceptive methods including integration with other RMNCAH services | Provide family planning services at all service delivery points offering RCH services | | | | | | | | |
| | Capacitate health care workers on comprehensive FP service provision | | | | | | | | |
| | Integrate FP services with other RMCAH Services including cervical cancer screening, immunization and HIV/PMTCT | | | | | | | | |
| | Provide FP methods to postpartum and post-abortion clients | | | | | | | | |
| | Conduct Capacity building to health workers on Postpartum FP | | | | | | | | |
| | Conduct Capacity building to health workers on permanent methods of FP services | | | | | | | | |
| | Conduct Capacity building to health providers in offering a range of FP methods | | | | | | | | |
| | Conduct trainees follow up to trained Haws to ensure quality provision of family planning services | | | | | | | | |
| 3.2.2 Sustain and improve quality of full range of ANC services | Provide routine quality monitoring of pregnancy e.g. BP, protein in urine, haemoglobin | | | | | | | | |
| | Screen and manage pregnant women for HIV, syphilis and anaemia | | | | | | | | |
| | Track and manage identified pregnant mothers with danger signs | | | | | | | | |
| | Capacity building of Health Care Workers (HCWs) on provision of integrated ANC package | | | | | | | | |
| | Conduct external and internal supportive supervision and editorship on ANC services | | | | | | | | |
| | Capacity of building of HCWs and community health workers (CHWs) on follow up of identified pregnant mother with danger signs | | | | | | | | |
| | Capacitate health care workers on antenatal corticosteroid use | | | | | | | | |
| | Support procurement of ANC commodities | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **3.2 Maternal Health** | | | | | | | | | |
| 3.2.3 Strengthen intrapartum care including increasing access and availability of basic EmONC services including skills to respond to emergencies | Capacitate health care providers to provide Basic Emergency Obstetric and newborn care services (BEmONC) | | | | | | | | |
| | Building capacity of health care providers on use of partographs to monitor progress of labour | | | | | | | | |
| | Build capacity of health care providers and reinforce use of AMSTL to prevent PPH | | | | | | | | |
| | Scale up use of innovative consultation system to seek expertise in managing challenging patients e.g. use of WhatsApp | | | | | | | | |
| | Conduct editorship on universal precautions to prevent and control infections (IPC) for facilities conducting deliveries through facility quality improvement team | | | | | | | | |
| | Facilitate for conducive environment at BEmONC facilities to offer timely referrals for complications | | | | | | | | |
| 3.2.4 Improve access and availability of Comprehensive EmONC including safe surgery, anaesthesia, safe blood and blood products | Institute "periodic" fire work drills to manage unconscious patient, PPH, severe pre-eclampsia/ eclampsia, at CEmONC sites | | | | | | | | |
| | Establish intensive care unit (ICU) for maternity care | | | | | | | | |
| | Capacitate hospitals to have capacity for production and storage of blood and blood products | | | | | | | | |
| | Capacitate providers on the CEmONC service provision | | | | | | | | |
| 3.2.5 Increase capacity at all levels of care to improve post-abortion care | Conduct CPAC training to providers from all health facilities at all levels | | | | | | | | |
| | Capacitate the health care providers to provide Post Abortion family planning services | | | | | | | | |
| | Provide comprehensive information on RMNCAH services within post abortion care | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **3.2 Maternal Health** | | | | | | | | | |
| 3.2.6 Improve coverage and utilization of postnatal care services and integration of other RMNCAH services | Build capacity of health care providers for provision of quality postpartum /natal care | | | | | | | | |
| | Develop a tracking mechanism that ensure all delivered mothers are discharged after 24-hours post delivery | | | | | | | | |
| | Orient HCP to Identify, manage and track women and newborn with danger signs in postpartum/ natal period | | | | | | | | |
| | Conducting education to women on EIBF, EBF, warmth, hygienic cord care, and on danger signs | | | | | | | | |
| | Integrate postpartum care with other RMNCAH services e.g. PPFP, HIV care, Immunization | | | | | | | | |
| 3.2.7 Sustain HIV testing, ART coverage and improve maternal viral load suppression and syphilis screening for dual elimination | Orient HCWs on PMTCT change package | | | | | | | | |
| | Conduct coaching to support PMTCT change package implementation | | | | | | | | |
| | Capacitate health care providers for dual HIV & Syphilis screening | | | | | | | | |
| | Support provision of psychosocial support to the infected and affected with HIV/AIDS to increase compliance of care and to reduce stigma | | | | | | | | |
| | Support retention of HIV-positive mothers and their exposed infants in care/treatment | | | | | | | | |
| | Provide counselling on the importance of dual protection (use of hormonal contraceptives and condom) against unintended pregnancy, Sis and HIV | | | | | | | | |
| | Support follow-up of HIV infected mothers at facility and in community | | | | | | | | |
| | Design HIV RMNCAH integrated outreach services | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **3.2 Maternal Health** | | | | | | | | | |
| 3.2.8 Improve cervical and breast cancer screening and care | Conduct facilities readiness assessment for establishment of reproductive health cancers screening and treatment services | | | | | | | | |
| | Build capacity of Health Care Providers on cervical and breast cancer screening and treatment | | | | | | | | |
| | Integrate cervical cancer screening with other RMNCAH services e.g. FP, HIV | | | | | | | | |
| | Equip health facilities with essential equipment and supplies for cervical and breast cancer screening and care | | | | | | | | |
| | Conduct community awareness to create demand for cervical cancer screening | | | | | | | | |
| | Support procurement of Cryotherapy machines and Scale-up treatment of cervical cancer using thermal coagulation and ablation treatment machines | | | | | | | | |
| | Conduct QI assessments to improve quality of cervical cancer prevention program | | | | | | | | |
| | Build capacity of technicians on repair and maintenance of treatment machines | | | | | | | | |
| 3.2.9 Improve GBV and VAC services | Capacitate and orient R/CHMTs on GBV and VAC programs | | | | | | | | |
| | Capacitate health care workers on GBV and VAC package | | | | | | | | |
| | Scale up one stop centres for GBV and VAC services | | | | | | | | |
| | Integrate GBV screening in other RMNCAH services | | | | | | | | |
| | Strengthen linkage of GBV/VAC services with other expertise (psychosocial support and supportive groups) to reduce PTSD and stigma to affected victims. | | | | | | | | |
| | Increase community awareness on GBV/VAC | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **3.2 Maternal Health** | | | | | | | | | |
| 3.2.10 Strengthen menopause and post menopause services for women | Conduct situational analysis to determine the menopausal needs | | | | | | | | |
| | Disseminate results of the situational analysis on menopausal needs | | | | | | | | |
| | Develop training package for menopausal services | | | | | | | | |
| | Build capacity of Health Care Workers on provision of menopausal services | | | | | | | | |
| | Establish services for women in menopause to be linked with other RMNCAH services | | | | | | | | |
| 3.2.11 Strengthen Referral systems for improved RMNCAH services | Procure Ambulances to BEmONC facilities to offer timely referrals for complications | | | | | | | | |
| | Support facilities on effective communication for referral services | | | | | | | | |
| **3.3 The Neonate/ newborn (0-28 days)** | | | | | | | | | |
| 3.3.1 Strengthen quality of neonatal care services at all levels | Increase neonatal equipment and expertise for neonatal care in health all facilities as per level of care | | | | | | | | |
| | Orient R/CHMTs on essential and comprehensive newborn care (early initiation of breastfeeding, immunization, thermal care, resuscitation, KMC) | | | | | | | | |
| | Roll out intensive neonatal services to all district and referral hospitals | | | | | | | | |
| 3.3.2 Improve quality care of Essential newborn care, care of the sick and small babies (premature and low birth weight babies) | Conduct facility capacity assessment and establishment Neonatal Care Units (NCU) in all Hospitals and CEmONC Health Centres-Including establishment of KMC rooms | | | | | | | | |
| | Conduct TOT on Integrated National Competence Based Trainings Guideline for Neonatal Care and Establishment of Neonatal Care Units | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **3.3 The Neonate/ newborn (0-28 days)** | | | | | | | | | |
| | Conduct Competence based Trainings (On-The Job Training, Clinical editorship) for newborn care (Essential newborn Care Including newborn Resuscitation, Care of the Pre-term and LBW, Care of Sick babies, etc.) using integrated National Guideline for Neonatal Care and Establishment of Neonatal Care Units, to service providers from Hospital, Health Centre and dispensary Level. | | | | | | | | |
| | Orientation of MPDSR Committees at all levels to improve perinatal death notification, review and response | | | | | | | | |
| | Orientation of QI Committees and WITs to improve problem Identification, Analysis, Action plan development and monitoring of implementation. | | | | | | | | |
| | Capacity building to community Health Workers on newborn care through the RMNCAH Community package | | | | | | | | |
| | Facilitate Procurement and distribution of essential Equipment's, Medicines and Supplies for neonatal care at NCU | | | | | | | | |
| | Capacity building to community Health Workers on newborn care through the RMNCAH Community package | | | | | | | | |
| **3.4 Child (1 – 59 months)** | | | | | | | | | |
| 3.4.1 Improve growth monitoring and promote optimal Infant and Young Child feeding practices, including EBF and age-appropriate complementary feeding practices | Conduct competence-based OJT training to service providers from RCH Clinics, Labour ward, Postnatal ward on Growth Monitoring and Child Development training packages | | | | | | | | |
| | Advocate and facilitate for availability of child health booklets, length boards, weighing scale, playing materials for child nutritional assessment, stimulation and developmental mile stone assessment. | | | | | | | | |
| | Identify and capacitate qualified personnel (nurses) for effective management of services for growth monitoring at facility levels. | | | | | | | | |
| | Sensitize early initiation of breastfeeding and exclusive breastfeeding for six months of life | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **3.4 Child (1 – 59 months)** | | | | | | | | | |
| .4.1 Improve growth monitoring and promote optimal Infant and Young Child feeding practices, including EBF and age-appropriate complementary feeding practices | Build capacity of health workers on growth monitoring at facility level. | | | | | | | | |
| | Ensure availability and utilization of guidelines and checklists at workplace to ensure effective child growth monitoring (including child booklet) | | | | | | | | |
| | Ensure availability and use of anthropometric tools at all levels | | | | | | | | |
| | Promote implementation of the Baby-Mother Friendly Hospital Initiative (BMFHI) | | | | | | | | |
| | Promote optimal infant and young children feeding practices | | | | | | | | |
| | Improve coverage for supplementary feeding | | | | | | | | |
| | Promote Nutrition counselling & Education to caregivers attending RCHS clinic | | | | | | | | |
| | Strengthen identification, referral processes and monitoring for underweight and obese children | | | | | | | | |
| 3.4.2 Maintain high coverage of immunization and interventions with high impact (zinc sulphate, ORS and Vitamin A supplementation) | Provide routine immunisation as per the schedule by promoting the "reaching every child" strategy | | | | | | | | |
| | Conduct child health days, African vaccination week (Vitamin A supplementation, deworming, zinc sulphate and ORS) | | | | | | | | |
| | Conduct dissemination of immunization information through community local radio/TV spots, and conduct national and zonal media seminars for promoting immunization services | | | | | | | | |
| | Engage CSOs, religious leaders and other NGO'S to support demand creation of immunization services | | | | | | | | |
| | Monitor and evaluate Reaching Every Child (REC) Strategy implementation | | | | | | | | |
| | Integrate early child development and care in immunization program | | | | | | | | |
| | Build capacity of health care workers to offer quality immunization services, zinc sulphate, ORS and Vitamin A supplementation | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **3.4 Child (1 – 59 months)** | | | | | | | | | |
| | Capacitate R/CHMT to monitor and supervise immunization services | | | | | | | | |
| | Conduct regular campaigns to improve coverage in low performing Regions for routine immunization, zinc sulphate, and Vitamin A supplementation | | | | | | | | |
| | Conduct active search for vaccine preventable diseases | | | | | | | | |
| 3.4.3 Manage sick children on basis of IMNCI and ETAT protocols | Capacity building of health care workers on Integrated Management of Childhood Illnesses (IMNCI) and Emergency Triage Assessment and Treatment (ETAT) | | | | | | | | |
| | Ensure all hospital and clinics use "knowledge and skills" to perform ETAT to save life of children and other groups | | | | | | | | |
| | Strengthen IMNCI at facilities and at community level | | | | | | | | |
| 3.4.4 Strengthen management of malnutrition (severe/acute malnutrition) | Orientation training to service providers on Paediatric Standard treatment Guidelines and Essential Medicines List for Children to build capacity of providers for Management of Severe Acute Malnutrition (In patient care) | | | | | | | | |
| | Build the capacity of health care workers on IMCI to detect malnutrition and respond appropriately by giving early referral for specialist care (Outpatient care) | | | | | | | | |
| | Provide appropriate information to parent/guardian about prevention and treatment of malnutrition | | | | | | | | |
| | Develop comprehensive package to strengthen facility and community linkage to support care of children with malnutrition | | | | | | | | |
| 3.4.5 Strengthen under five death surveillance, auditing and response systems | Develop/review and disseminate under five mortality surveillance, auditing and response guidelines | | | | | | | | |
| | Monitor and evaluate implementation of under-five mortality surveillance, auditing and response guidelines | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **3.4 Child (1 – 59 months)** | | | | | | | | | |
| 3.4.5 Promote use of LLINs in the endemic regions and provide appropriate management for malaria cases | Conduct community sensitization using media, IEC/BCC material and other platforms on the importance of using long life insecticide impregnated nets (LLIN) | | | | | | | | |
| | Distribute LLIN via ANC, under five growth monitoring clinics and other RMNCAH services that are deemed practical and support them with the best way to use LLIN | | | | | | | | |
| | Conduct monitoring and evaluation for the use of LLIN | | | | | | | | |
| 3.4.6 Improve early infant diagnosis of HIV and ART treatment including follow up of HIV infected children at facility and community | Ensure early identification of HIV-infected children through early infant diagnosis | | | | | | | | |
| | Improve turnaround time for DNA PCR results so as initiate early treatment for HIV-infected infants | | | | | | | | |
| | Introduce electronic system for releasing results directly to the health facility where the sample was collected | | | | | | | | |
| | Link the HIV-infected child into care and treatment clinic as well as with a community health worker in the catchment area to support follow up | | | | | | | | |
| | Prevent opportunistic infections such as PCP, TB and cryptococal meningitis in children who are HIV positive | | | | | | | | |
| | Provide nutrition counselling including advantages of optimal breastfeeding for HIV-exposed children as per WHO recommendations on feeding of HIV positive children | | | | | | | | |
| | Integrate measles and rubella vaccination at 18 months with HIV testing to exposed | | | | | | | | |
| | Link the child to the community to provide sustained psychological support | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **3.4 Child (1 – 59 months)** | | | | | | | | | |
| 3.4.7 Strengthen Early Child Development Care | Assess facilities for availability of space and equip for Early Child Development | | | | | | | | |
| | Capacity building of health care providers on Early Child Development (ECD) at all levels | | | | | | | | |
| | Train health care workers to routinely assess children according to developmental milestones | | | | | | | | |
| | Train health workers to implement early child development activities | | | | | | | | |
| | Educate and train care givers (parents and guardians) on early childhood development | | | | | | | | |
| | Organize and allocate child friendly rooms e.g. play and stimulation activities at health facilities | | | | | | | | |
| | Provide commodities and supplies for play and stimulation activities | | | | | | | | |
| 3.4.8 Promote pre-school health interventions | Promote healthy nutritional practices for pre-school children | | | | | | | | |
| | Provide outreach high impact interventions monitoring services at pre-school level | | | | | | | | |
| **3.5 The Older Child (5 – 9 Years)** | | | | | | | | | |
| 3.5.1 Promote school health interventions like screening, deworming, vaccination and nutrition | Conduct school health programs (immunization, screening and referral to relevant health facilities) | | | | | | | | |
| | Conduct nutrition assessments for young children at schools | | | | | | | | |
| | Promote healthy nutritional practices for school children | | | | | | | | |
| | Provide outreach high impact interventions monitoring services to school children | | | | | | | | |
| | Develop IEC materials for young children and parents on RMNCAH and nutrition | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **3.5 The Older Child (5 – 9 Years)** | | | | | | | | | |
| | Link school health program with care of HIV infected children | | | | | | | | |
| | Provide HPV vaccine at 9 years | | | | | | | | |
| | Improve delivery of age appropriate sexual and reproductive health information and care including management of violence, alcohol and drug related issues | | | | | | | | |
| | Review and adopt the peer group training manual on adolescents' violence prevention and response | | | | | | | | |
| **3.6 The Young Adolescent (10 – 14 years)** | | | | | | | | | |
| 3.6.1 Promote age and gender-specific comprehensive sexuality education for "in and out" of school including GBV | Educate, manage and protect young adolescents from alcohol and drug related issues | | | | | | | | |
| | Capacitate health care providers on protect young adolescents from alcohol and drug related issues | | | | | | | | |
| | Conduct analytical review in terms of CSE integration with the existing secondary school curriculum, Teachers' Certificate, and Diploma curriculum and teaching methods | | | | | | | | |
| | Conduct health education on nutrition and physical activities (healthy diet and lifestyle) | | | | | | | | |
| | Build skills among adolescents to identify, counteract and report GBV and VAC | | | | | | | | |
| | Collaborate with stakeholders to facilitate comprehensive sexuality education curriculum | | | | | | | | |
| | Assist parents to communicate with young adolescents on SRH including GBV issues | | | | | | | | |
| | Capacitate schools and clinics to administer HPV 1 & 2 vaccines to adolescent girls aged (10-14) years | | | | | | | | |
| | Strengthen provision of adolescent pregnancies preventive education and care | | | | | | | | |
| | Strengthen provision of HIV/ Sis prevention, education, care, treatment and support | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **3.7 The Older Adolescent (15 – 19 years)** | | | | | | | | | |
| 3.7.1 Increase coverage of comprehensive Adolescent and Youth Friendly Services at all facilities and communities | Capacitate the health facilities to offer comprehensive Adolescent and Youth Friendly services | | | | | | | | |
| | Build adolescents knowledge and skills on SRH by using age-appropriate educative materials | | | | | | | | |
| | Strengthen provision of HIV/ STI prevention, education, care, treatment and support for adolescents | | | | | | | | |
| | Update and review Adolescent and Youth SRH IEC materials | | | | | | | | |
| | Print and distribute IEC materials for AYSRH services | | | | | | | | |
| | Educate adolescents using multiple approaches to promote prevention of teenage pregnancies and promote use of long-acting reversible contraceptives | | | | | | | | |
| | Conduct outreach services to provide youth friendly services in integrated manner with other RMNCAH services | | | | | | | | |
| | Increase coverage of comprehensive adolescent and youth friendly services at all facilities and communities | | | | | | | | |
| | Increase adolescent engagement, participation, involvement and uptake of HIV, SRH, GBV and adolescent pregnancies preventive services | | | | | | | | |
| | Improve parent to child communication on SRH issues | | | | | | | | |
| | Increase inter sectoral collaboration in implementation of adolescent and youth related interventions | | | | | | | | |
| | Conduct quarterly supportive supervision visits for sites providing adolescent friendly services (health facilities and schools) | | | | | | | | |
| | Coordinate joint multi-sectorial monitoring visits and reviews for AYSRH services to the LGAs annually | | | | | | | | |
| | Provide life skills and nurture good behaviour to protect and manage against GBV, alcohol and drug related issues | | | | | | | | |
| | Harmonize CSE for out-of-school adolescents | | | | | | | | |
| | Conduct SS/CM to improve quality of AYFHS | | | | | | | | |

| Interventions | Activities | 21 | 22 | 23 | 24 | 25 | Responsible Body | Collaborators | Means of Verification |
|---|---|---|---|---|---|---|---|---|---|
| **3.7 The Older Adolescent (15 – 19 years)** | | | | | | | | | |
| 3.7.2 Increase youth engagement, participation, involvement and uptake of HIV, SRH, GBV and adolescent pregnancies preventive services | Capacitate introduction of community adolescent and youth friendly SRH services | | | | | | | | |
| | Introduce edutainment (such as auntie Stella) to care for adolescent needs for understanding sexuality and coping with body changes | | | | | | | | |
| | Strengthen development and distribution of electronic, print, social media and peer educators' educative information/materials to prevent risky behaviours among adolescents | | | | | | | | |
| | Support and capacitate introduction of youth-led IEC services for SRH, HIV/Sis and nutrition | | | | | | | | |
| | Give information on risk factors for HPV and importance of screening in adulthood | | | | | | | | |
| | Link SRH and HIV/Sis prevention with sports to support uptake of IEC and youth friendly services | | | | | | | | |
| 3.7.3 Improve parent to child communication on SRH issues | Conduct integrated parent engagement on SRH | | | | | | | | |
| | Capacitate programs for parents skills training in prevention of adolescent pregnancies, and in HIV/ STI prevention, education, care, treatment and support | | | | | | | | |
| | Strengthen communication with children to discuss issues related to GBV, alcohol and substance misuse | | | | | | | | |

# CHAPTER 7 Monitoring and Evaluation

## 7.1 Introduction

The RMNCAH monitoring and evaluation plan aims to inform progress and performance of the plan for the period from 2021- 2025. Tracking of progress will annually at programmatic level using routine data, and periodically using information from national surveys. The results of annual and periodic surveys should help the government and other stakeholders to assess the progress towards the 2025 goals and review interventions and annual activity plans accordingly. The M&E indicators in One Plan III includes impact, coverage, risk factors and health system indicators that are in HSSP V as well as other program indicators.

## 7.2 Data sources

The MOHCDGEC has developed a monitoring and evaluation strategic framework (MESF 2019-2024) that specifies the roles of the different data sources.[1] This includes the key data sources: routine health management information system (clinical and administrative), surveillance of diseases and risk factors, surveillance of vital events (SAVVY) and CRVS, and population-based surveys. Multiple data sources will be used to obtain indicators proposed in the One Plan III. These will include;

- Periodic national community-based surveys like Tanzania Demographic and Health Survey (TDHS), Tanzania HIV Indicator Survey, Tanzania Malaria Indicator Survey (TMIS), and Tanzania National Nutrition survey (TNNS).
- Census
- Routine Health Management Information System, (DHIS 2) data base
- Periodic studies conducted by the program e.g. EmONC assessment study
- Program data e.g. PMTCT, Family planning and other programs
- Service Availability and Readiness Assessment (SARA) survey

## 7.3 Performance review process

There will be a midterm review of the One Plan III in 2023. The MTR of the sector including RMNCAH will be chaired by the government and the results will help to guide adjustment of annual operation plans for the remaining two years to achieve the 2025 and ultimately the 2030 SDG goals.

End term- evaluation will be performed in 2025. The final review involves a comprehensive analysis of progress and performance for the whole period of the One Plan III. The final review will build on the annual and mid-term reviews, program review, as well as research that has been conducted during the five years of the plan.

[1] Ministry of Health, Community Development, Gender, Equity and Children. Monitoring and evaluation strategic framework (MESF 2019-2024). Dodoma. May 2019.

## 7.4 Monitoring Framework

Indicators for M & E are presented by thematic areas within RMNCAH as shown in Table 6.2. Indicators that are in HSSP V are shown in Table 6.1.

Table 7.1: RMNCAH Impact indicators that are in HSSP V

| | | HSSP IV | | HSSP V | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Indicator** | **Target/2020 (HSSP IV/ One Plan II)** | **Achievement up to 2020** | **Baseline 2020** | **Target 2025** | **Data Sources** | | |
| | **Impact** | | | | | | | |
| 1 | **Maternal mortality per 100,000 live births** | 192/100,000 | 250/100,000 | 250 per 100,000 (MOH Projection) | 100 per 100,000 live births | RAMOS | | |
| | **Institutional maternal mortality ratio per 100,000** | No specific target HSSP IV/ One Plan II | No data | 160-200 (MOH review 2009-2012) | < 100 per 100,000 live births | DHIS 2; MDSR | | |
| 2 | **Neonatal mortality per 1,000 live births** | 19 per 1,000 | 25 per 1,000 (TDHS 2016); 20 per 1,000 (UN IGME) | 20 per 1,000 (UN IGME, 2019) | 15 per 1,000 live births | Survey | | |
| 3 | **Under-5 mortality per 1,000 live births** | 54 per 1,000 | 50 (UNIGME projection 2019) | 50 per 1,000 (UN IGME, 2019) | 38 per 1,000 live births | Survey | | |
| 4 | **Teenage girls (15-19) who are pregnant or have born a child** | 20% | 27% pregnant or had birth (TDHS 2015/16) | 27% pregnant or had birth (TDHS 2015/16) | 20% | Survey | | |
| 5 | **PMTCT: newborn with HIV infection** | 2% at end of exposure period | 8% (UNAIDS, 2020) | 8% (UNAIDS, 2020) | 2% | UN estimates and program data | | |
| 6 | **Total fertility rate** | 5.0 | 4.9 (TMIS 2017) | 4.9 (TMIS 2018) | 4.2 | TDHS Surveys 2021 & 2026 | | |
| | | | | | | | | |

Table 7.2: RMNCAH program indicators by thematic area (* indicator in HSSP V)

| | | One Plan II | | One Plan III | | | |
|---|---|---|---|---|---|---|---|
| | **Indicator** | **Target 2020 (One Plan II/ HSSP IV)** | **Achievement/ level up to 2020** | **Baseline 2020** | **Target 2025** | **Data Sources** | **Type of indicator** |
| | **newborn Health** | | | | | | |
| 1* | Neonatal mortality per 1,000 live births | 19 per 1,000 | 25 per 1,000 (TDHS 2016); 20 per 1,000 (UN IGME) | 20 per 1,000 (UN IGME, 2019) | 15 per 1,000 live births | TDHS Surveys 2021 & 2026 | Impact |
| 2 | Still birth rate (deaths per 1,000 births) | 19 per 1,000 births | 16 per 1,000 births (TDHS 2015-16) | 16 per 1,000 births | 12 per 1,000 births | TDHS Surveys 2021 & 2026 | Quality |
| 3 | Fresh stillbirths | No specific target | 43% (DHIS-2) | 43% | 31% | DHIS-2 | Quality |
| 4 | Postnatal care visit within 2 days | 80% | 65% (DHIS-2, 2018) | 65% (DHIS-2, 2018) | 80% | TDHS 2021 & 2026 DHIS-2 | Coverage |
| 5* | Early initiation of breastfeeding among all newborn children | 90% | 54% (TNNS, 2018) | 54% (TNNS, 2018) | 65% | TDHS 2021 & 2026; TNNS | Risk factor |
| 6 | ARV prophylaxis for HIV exposed infants | 90% | 98% (DHIS-2, 2019) | 98% (DHIS-2, 2019) | 100% | DHIS-2 | Coverage |
| 7 | Hospitals with functional KMC services | 75% | 34% (SARA 2020) | 34% (SARA 2020) | 50% | SARA | Coverage |
| 8 | Proportion of health facilities with deliveries that can offer newborn resuscitation (NR) | No specific target | 61% (SARA, 2020) | 61% (SARA, 2020) | 75% (ENAP) | SARA | Coverage, quality |

| | | One Plan II | | One Plan III | | | |
|---|---|---|---|---|---|---|---|
| | **Indicator** | **Target 2020 (One Plan II/ HSSP IV)** | **Achievement/ level up to 2020** | **Baseline 2020** | **Target 2025** | **Data Sources** | **Type of indicator** |
| 9 | Low birth weight (LBW) | 2% | 6.3% (TNNS, 2018) | 6.3% (TNNS, 2018) | 4% | TDHS, TNNS | Coverage |
| | **Child Health** | | | | | | |
| 1* | Under-5 mortality per 1,000 live births | 54 per 1,000 | 50 (UNIGME, 2019) | 50 per 1,000 (UN IGME, 2019) | 38 per 1,000 live births | TDHS Surveys 2021 & 2026; Census 2022 | Impact |
| | | Breastfeeding & complimentary feeding practices | | | | | |
| 2 | Exclusive breastfeeding for 6 months | 90% | 59% | 58% (TNNS, 2018) | 68 % (2% annual increase) | TDHS 2021 & 2026; TNNS | Coverage/ risk factor |
| 3 | Appropriate complementary feeding practices at 6-23 months (IYCF) | No specific target | 30% (TNNS, 2018) | 30% (TNNS, 2018) | 40% | TDHS 2021 & 2026; TNNS | Coverage/ risk factor |
| | **Anaemia among under fives** | | | | | | |
| 4* | Anaemia (6-59 months) | < 20% | 58% (TDHS 2015/16) | 58% (TDHS 2015/16) | 44% (25% decline) | TDHS 2021 & 2026; TNNS | Coverage/ risk factor |
| | **Nutrition status among under fives** | | | | | | |
| 5* | Children under 5 years who are stunted | 22% | 32% (TNNS, 2018) | 32% (TNNS,2018) | 20% | TDHS 2021 & 2026; TNNS | Coverage/ risk factor |
| 6 | Wasting | < 5% | 3.4% (TNNS, 2018) | 3.4% (TNNS, 2018) | < 2% | TDHS 2021 & 2026; TNNS | Coverage/ risk factor |

| | | One Plan II | | One Plan III | | | |
|---|---|---|---|---|---|---|---|
| | **Indicator** | **Target 2020 (One Plan II/ HSSP IV)** | **Achievement/ level up to 2020** | **Baseline 2020** | **Target 2025** | **Data Sources** | **Type of indicator** |
| 7 | Overweight/obese | No specific target | 3% (TNNS, 2018) | 3 % (TNNS, 2018) | No increase | TDHS;TNNS | Coverage |
| **Immunization** | | | | | | | |
| 8* | Full immunization coverage among infants | > 90% | 91% (DHIS-2 2018) | 91 % (TDHS | >90% At least 80% of councils with penta3 coverage > 90% | TDHS 2021 & 2026 | Coverage |
| 9 | Measles Rubella coverage | 90% in 90% of the councils | MR 80 % in 195 councils by end 2019 (VIMS, 2020) | MR 80 % in 195 councils by end 2019 (VIMS, 2020) | > 95% in 95% of councils | TDHS; DHIS-2 | Coverage |
| 10 | Vitamin A | 90% | 64% (TNNS, 2018) | 64% (TNNS, 2018) | 90% | TDHS 2021 & 2026;TNNS | Coverage |
| **Pneumonia, Malaria & Diarrhoea** | | | | | | | |
| 11 | Care seeking for pneumonia | 90% | 55% (TDHS 2015/16) No data after 2015/16 | 55% (TDHS 2015/16) | 90% | TDHS 2021 & 2026 | Coverage |
| 12 | Care seeking for diarrhoea | 90% | 43% (TDHS 2015/16) No data after 2015/16 | 43% (TDHS 2015/16) | 80% | TDHS 2021 & 2026 | Coverage |
| 13 | Care seeking for malaria/ fever | 90% | 40% (TDHS, 2015/16) No data after 2015/16 | 40% (TDHS, 2015/16) | 80% | TDHS 2021 & 2026 | Coverage |
| 14* | ITN use among U5 | 80% | 56% (TMIS, 2017) | 56% (TMIS, 2017) | 80% | TDHS 2021 & 2026 TMIS | Coverage |
| **Birth registration** | | | | | | | |
| 15* | Birth registration | No specific target | 26% (TDHS, 2015/16) | 26% (TDHS, 2015/16) | 90% | TDHS 2021 & 2026 Birth registration system-RITA | Health systems inputs |

| | | One Plan II | | One Plan III | | | |
|---|---|---|---|---|---|---|---|
| | **Indicator** | **Target 2020 (One Plan II/ HSSP IV)** | **Achievement/ level up to 2020** | **Baseline 2020** | **Target 2025** | **Data Sources** | **Type of indicator** |
| **PMTCT Indicators** | | | | | | | |
| 16* | Mother to Child HIV Transmission (at the end of exposure period) | < 5% | 7.9% (UNAIDS, 2020)<br>9.4% (DHIS, 2019) | 7.9%<br>(UNAIDS, 2020) | 3% | UN estimates; Program data | Impact |
| 17 | HIV exposed children received ARV prophylaxis | > 90% | 98%<br>(DHIS-2, 2019) | 98%<br>(DHIS-2, 2019) | 100% | DHIS-2 | Coverage |
| 18 | Early Infant Diagnosis (EID) Testing rate at 6 weeks | 90% | 55.0%<br>(DHIS-2, 2019) | 55.0%<br>(DHIS-2, 2019) | 90% | DHIS-2 | Coverage |
| 19 | ART coverage among HIV-positive children | 60% | 82% (DHIS-2 2020)<br>47% (DHIS-2 2018) | 82%<br>(DHIS-2 2020)<br>47%<br>(DHIS-2 2018) | 90% | DHIS-2 | Coverage |
| **Adolescent Health** | | | | | | | |
| **Fertility and contraceptive use** | | | | | | | |
| 1* | Teenage girls (15-19) who are pregnant or have born a child | 20% | 27% pregnant or had birth<br>(TDHS 2015/16) | 27% pregnant or had birth<br>(TDHS 2015/16) | <20% | TDHS Surveys 2021 & 2026 | Impact |
| 2 | Adolescent marriages (adolescents aged 15-19 who are married/ cohabiting) | No specific target | 23% (TDHS, 2015-16) | 23%<br>(TDHS, 2015-16) | 17% | TDHS Surveys 2021 & 2026 | Risk factor/ coverage |
| 3 | Modern contraceptive use (adolescents aged 15-19) | No specific target | 19% (TDHS, 2015-16) | 19%<br>(TDHS, 2015-16) | 25% | TDHS 2021 & 2026;TNNS | Coverage |
| 4 | Demand for FP met by modern methods (15-19 years) | 60% | 48%<br>(TDHS, 2015-16) | 48%<br>(TDHS, 2015-16) | 62% | TDHS 2021 & 2026 | Coverage |

| | | One Plan II | | One Plan III | | | |
|---|---|---|---|---|---|---|---|
| | **Indicator** | **Target 2020 (One Plan II/ HSSP IV)** | **Achievement/ level up to 2020** | **Baseline 2020** | **Target 2025** | **Data Sources** | **Type of indicator** |
| **HIV care** | | | | | | | |
| 5 | HIV Testing<br>among girls (15 to 19 years)<br>among boys (15 to 19 years) | <br>80%<br>80% | <br>60% (TDHS, 2015-16)<br>38% (TDHS, 2015-16) | <br>60% (TDHS, 2015-16)<br>38% (TDHS, 2015-16) | 80% | HIV Indicator survey | Coverage |
| **Adolescent & youth friendly services and use of maternal services** | | | | | | | |
| 6 | Proportion of facilities providing Adolescent & Youth Friendly SRH services (AYFSRH) | 80% | 69% (SARA, 2020) | 69% (SARA, 2020) | 80% | SARA | Coverage |
| 7 | Early antenatal care coverage among pregnant women< 12 weeks | 60% | 70% (DHIS-2, 2018) | 70% (DHIS-2, 2018) | 80% | DHIS-2<br>TDHS 2021 & 2026 | Coverage |
| 8 | Institutional deliveries (complemented by SBA rate) | 80% | 80% (DHIS-2, 2018) | 80% (DHIS 2018) | 90% | DHIS-2<br>TDHS 2021 & 2026 | Coverage |
| **Gender-based violence among adolescents** | | | | | | | |
| 9 | GBV (< 20 years) _ever | No specific target | 27% (TDHS 2015/16) | 27% (TDHS 2015/16) | 20% | TDHS 2021 & 2026 | Coverage |
| **Adolescent nutrition** | | | | | | | |
| 10* | Anaemia among adolescents (15-19) years | No specific target | 47% (TDHS 2015-16) | 47% (TDHS, 2015-16) | 35%<br>(25% decline) | TDHS 2021 & 2026;TNNS | Risk factors/ coverage |
| **Family planning indicators** | | | | | | | |
| 1* | Total fertility rate | 5.0 | 4.9 (TMIS, 2017) | 4.9 (TMIS, 2017) | 4.2 (based on AARR 2.3% / year) | Surveys 2021 & 2026 | Impact |
| 2 | Prevalence of modern-Contraceptive use (m-CPR) among married women 15–49 | 45% | 32%<br>(TDHS 2015/2016) | 32%<br>(TDHS 2015/2016) | 49% | Surveys 2021 & 2026<br>DHIS-2 | Coverage |

| | | One Plan II | | One Plan III | | | |
|---|---|---|---|---|---|---|---|
| | **Indicator** | **Target 2020 (One Plan II/ HSSP IV)** | **Achievement/ level up to 2020** | **Baseline 2020** | **Target 2025** | **Data Sources** | **Type of indicator** |
| 2b | Prevalence of modern-Contraceptive use among women of reproductive age (WRA) | 45% | 38% (DHIS-2, 2018)<br>34% (TDHS, 2015-16) | 38%<br>(DHIS-2, 2018)<br>34%<br>(TDHS, 2015-16) | 42% | TDHS 2021 & 2026<br>DHIS-2 | Coverage |
| 3 | Unmet need for FP | - | 22% (TDHS, 2015-16) | 22% (TDHS, 2015-16) | 17% (AAR 1%) | TDHS 2021 & 2026 | Coverage |
| 4* | Demand satisfied with modern methods among currently married women 15-49 | 45% | 53% (TDHS 2015/16) | 53%<br>(TDHS 2015/16) | 62% (based on AARC 2010-2016 1.5%) | TDHS 2021 & 2026 | Coverage |
| 5 | Couple years of protection for all modern methods (CYP) | 6.4 million | 6.6 million<br>(DHIS-2, 2018) | 6.6 million<br>(DHIS-2, 2018) | 11 million<br>(1% annual increase) | DHIS-2 | Coverage |
| | **Maternal health indicators** | | | | | | |
| 1 | Maternal mortality per 100,000 live births | 192/100,000 | No data available for population level | 524 per 100,000<br>(UN MMEIG, 2017) | 232 per 100,000 live births | TDHS Surveys 2021 & 2026; MDSR | Impact |
| | Institutional maternal mortality ratio per 100,000 | No specific target HSSP IV/ One Plan II | No data | 160-200<br>(MOH review 2009-2012) | < 100 per 100,000 live births | DHIS 2; MDSR | |
| | **Pregnancy** | | | | | | |
| 2* | Early antenatal care coverage among pregnant women < 12 weeks | 60% | 27% (DHIS-2, 2018) | 27%<br>(DHIS-2, 2018) | 60%<br>Councils (at least 50% of councils > 80%) | TDHS 2021 & 2026 DHIS-2 | Coverage |
| 3 | Antenatal care visits 4 or more times | 80% | 61% (DHIS-2, 2018) | 61%<br>(DHIS-2, 2018) | 80% | TDHS 2021 & 2026 DHIS-2 | Coverage |
| 4* | Anaemia prevalence in women 15-49 years | <20% | 45% (TDHS 2015-16) | 45%<br>(TDHS 2015-16) | 34%<br>(25% reduction) | TDHS 2021 & 2026 TNNS | Risk factor |
| 5 | Syphilis screening during pregnancy | 80% | 67% (DHIS-2, 2018) | 67%<br>(DHIS-2, 2018) | 95% (WHO elimination goal) | DHIS-2 | Coverage |

| | | One Plan II | | One Plan III | | | |
|---|---|---|---|---|---|---|---|
| | **Indicator** | **Target 2020 (One Plan II/ HSSP IV)** | **Achievement/ level up to 2020** | **Baseline 2020** | **Target 2025** | **Data Sources** | **Type of indicator** |
| 6 | HIV testing among pregnant women | 95% | 99% (DHIS-2, 2019) | 99% (DHIS-2, 2019) | 100% | DHIS-2 | Coverage |
| 7 | Proportion of pregnant women who BP was measured during ANC visits | No specific target on One Plan II | 71% (TDHS, 2015-16) | 71% (TDHS, 2015-16) | 90% | TDHS 2021 & 2026 | Quality |
| 8* | IPTp2 doses among pregnant women | 80% | 56% (TMIS 2017)<br>79% (DHIS2 2018) | 56% (TMIS 2017)<br>79% (DHIS2, 2015) | 85% | TDHS 2021 & 2026; DHIS-2; TMIS | Coverage |
| 9* | Use of ITN among pregnant women | 80% | 51% (TMIS, 2017) | 51% (TMIS, 2017) | 80% | TDHS 2021 & 2026<br>TMIS | Coverage |
| **Childbirth indicators** | | | | | | | |
| 10* | Institutional deliveries (complemented by SBA rate) | 80% | 76% (DHIS-2, 2018) | 76% (DHIS-2, 2018) | 85%<br>At least 75% of councils with > 75% coverage | TDHS 2021 & 2026 DHIS-2 | Coverage |
| 11* | Skilled Birth Attendance use during childbirth | 80% | 77% (DHIS-2, 2018) | 77% (DHIS-2, 2018) | 85% | TDHS 2021 & 2026 DHIS-2 | Coverage |
| 12* | Caesarean section rate | 5-15% | 8% (DHIS-2, 2018) | 8% (DHIS-2, 2018) | 10%<br>Equity: all regions have at least 8% C-section rates | TDHS 2021 & 2026 DHIS-2 | Access, quality |
| 13 | Basic EmONC coverage | Dispensaries: 70%<br>Health Centres: 100% | Dispensaries: 51%<br>Health Centres: 76%<br>(SARA, 2020) | Dispensaries: 51%<br>Health Centres: 76%<br>(SARA, 2020) | Dispensaries: 70%<br>Health Centres: 100% | SARA<br>Periodic national surveys | Coverage, quality |
| 14 | Comprehensive EmONC coverage | Health Centres: 80%<br>Hospitals: 100% | Health Centres: 24%<br>Hospitals: 87%<br>(SARA, 2020) | Health Centres: 24%<br>Hospitals: 87%<br>(SARA, 2020) | Health Centres: 80%<br>Hospitals: 100% | SARA<br>Periodic national surveys | Coverage, quality |

| | | One Plan II | | One Plan III | | | |
|---|---|---|---|---|---|---|---|
| | **Indicator** | **Target 2020 (One Plan II/ HSSP IV)** | **Achievement/ level up to 2020** | **Baseline 2020** | **Target 2025** | **Data Sources** | **Type of indicator** |
| **Postnatal care** | | | | | | | |
| 15 | Postnatal care within 48 hours (women) | 80% | 65% (DHIS-2, 2018) | 65% (DHIS-2, 2018) | 65% (DHIS-2, 2018) | TDHS 2021 & 2026 DHIS-2 | Coverage |
| **Reproductive health cancers** | | | | | | | |
| 1* | Cervical cancer screening coverage among women 30-50 years in last 3 years | 60% | 11% (DHIS-2, 2018) | 11% (DHIS-2, 2018) | 30% | TDHS 2021 & 2026 DHIS-2 | Coverage |
| 2 | HPV vaccine coverage rate (Percentage of girls fully immunized by HPV vaccine by 15 years of age) | No specific target in One Plan II 80% PROGRAM | 64% (VIMS, 2019) | 64% (VIMS, 2019) | 80% | Vaccine Information Management System (VIMS) | Coverage |

# CHAPTER 8 Costing of RMNCAH Strategic Plan

## 8.1 Methodology

Costing of the One Plan III was completed using the One Health Tool, consistent with the HSSP V process. Service delivery interventions costs used a population-based approach, where a target population for a service is multiplied by the proportion of the population needing the service, and the coverage to estimate an annual number of services. The number of services is multiplied by the cost per service (estimated using an ingredients-based costing approach) to calculate the total cost per intervention. Target populations were estimated using the Spectrum demographic projections (calibrated to NBS population projections) and epidemiological models which incorporate the effects of preventive and curative care to provide a holistic picture of the population needing services.

Above service delivery costs such as supervision, training, policy, and guideline development were calculated using activity-based costing where the cost per item is multiplied by the number of activities or items to estimate the costs of each training or supervisory trip.

## 8.2 Resource needs for the One Plan III

The cost of the One Plan III is estimated to rise from 750 billion Tanzanian shillings in 2021 to 800 billion shillings by 2025. The total cost to implement One Plan III over the five years (2021-2025) is around four trillion shillings (Table 15). The costs are primarily found in Objective 3, which is where the bulk of the service delivery components sit.

The costing team has detailed analysis of cost for each key strategic objective. Below is the summary of total cost for One Plan III. Objective 3 would rise from nearly 700 billion shillings to 800 billion shillings, while Objectives 1 and 2 would fall from the early years of the plan (from 12 to 9 billion shillings and 37 to 15 billion shillings respectively), as those objectives represent early investments in order to facilitate program scale up and quality improvements that support Objective 3.

**Table 8: Total cost of One Plan III by Objective (TZS, billions)**

| | 2021 | 2022 | 2023 | 2024 | 2025 | Total |
|---|---|---|---|---|---|---|
| Objective 1 | 12 | 14 | 14 | 9 | 9 | 58 |
| Objective 2 | 37 | 38 | 36 | 21 | 15 | 146 |
| Objective 3 | 697 | 740 | 777 | 784 | 798 | 3,796 |
| **Total** | **746** | **791** | **827** | **814** | **822** | **4,000** |

Costs by health area are also estimated in the table below. Maternal and neonatal health is the largest component, rising from 230 billion shillings to 260 billion shillings from 2021-2025, followed by child health (188 billion shillings rising to 200), immunization, and nutrition. Cross cutting strategies include items such as sector meetings or policy and guideline development which cut across health areas.

**Table 9: Total cost of One Plan III by health area (TZS, billions)**

| | 2021 | 2022 | 2023 | 2024 | 2025 | Total |
|---|---|---|---|---|---|---|
| Adolescent Health | 15 | 13 | 15 | 13 | 13 | 68 |
| Child Health | 188 | 208 | 214 | 204 | 200 | 1,015 |
| FP | 74 | 84 | 103 | 101 | 104 | 466 |
| Nutrition | 117 | 121 | 126 | 130 | 133 | 626 |
| Immunization | 120 | 122 | 122 | 114 | 112 | 590 |
| MNH | 230 | 240 | 247 | 252 | 260 | 1,229 |
| Cross cutting | 1 | 1 | 1 | 1 | 1 | 5 |
| Grand Total | 746 | 791 | 827 | 814 | 822 | 4,000 |

Appendix A includes a detailed cost by strategy for each component of the plan.

## 8.3 Impact of the One Plan III

The impact of the One Plan III was estimated using the Lives Saved Tool. Compared to a flat lined coverage, or status quo scenario, the One Plan III would be estimated to avert more than 100,000 child deaths, nearly 20,000 maternal deaths, and more than 40,000 stillbirths. The most impact interventions for babies and children include ORS, pneumonia treatment, and case management of premature babies. The most impact interventions at averting maternal deaths include care during childbirth such as blood transfusion and parenteral administration of antibiotics, and ANC care including management of hypertension during pregnancy.

## Appendix A: Detailed cost by strategy for each key strategic intervention

| Strategic intervention | 2021 | 2022 | 2023 | 2024 | 2025 | Total |
|---|---|---|---|---|---|---|
| 1.1.1 Develop, Review, or update and disseminate integrated RMNCAH and Nutrition guidelines, protocol, and SOPs | 9,705,209,915 | 11,940,058,834 | 12,212,059,073 | 7,833,918,139 | 7,875,043,894 | 49,566,289,855 |
| 1.1.2 Integrate RMNCAH and Nutrition skill-based interventions in professional training curriculum | 59,251,368 | 61,028,909 | 62,859,776 | 64,745,570 | 66,687,937 | 314,573,560 |
| 1.1.3 Strengthen scope of functions for skilled birth attendants to conduct lifesaving procedures | 10,950,254 | 11,278,761 | 11,617,124 | 11,965,638 | 12,324,607 | 58,136,384 |
| 1.2.1 Strengthen coordination, governance and integrated planning for RMNCAH and Nutrition services at all levels | 1,096,505,246 | 1,129,400,403 | 876,588,440 | 754,453,992 | 777,087,612 | 4,634,035,693 |
| 1.2.2 Improve accountability for maternal, newborn and child mortality at all levels | 12,360,201 | 44,565,433 | 13,112,937 | 13,506,325 | 13,911,515 | 97,456,411 |
| 1.2.3 Strengthen inter-sectoral coordination and collaboration for RMNCAH and Nutrition interventions | 10,300,000 | 21,218,000 | - | - | - | 31,518,000 |
| 1.3.1: Strengthen prioritization of funding for RMNCAH and Nutrition interventions | 476,542,931 | 466,438,519 | 480,431,675 | 494,844,625 | 509,689,964 | 2,427,947,714 |
| 1.3.2 Establish an evidence-based system to inform RMNCAH and nutrition financing | 246,437,615 | 253,830,743 | 261,445,665 | 122,044,390 | 125,705,722 | 1,009,464,135 |
| 2.1.1 Strengthen systems of clinical auditing and continuous quality improvement of RMNCAH services | 1,379,307,361 | 2,639,082,618 | 2,090,781,138 | 2,153,504,572 | 2,218,109,709 | 10,480,785,399 |
| 2.1.2 Strengthen delivery of essential and emergency RMNCAH interventions | 5,756,767,957 | 7,471,706,588 | 8,383,785,904 | 5,854,952,367 | 5,061,926,545 | 32,529,139,361 |
| 2.1.3 Strengthen integrated in-service training, supportive supervision, mentoring and CPD for RMNCAH programs | 2,717,193,081 | 2,763,108,369 | 2,087,713,165 | 1,925,164,350 | 1,982,919,280 | 11,476,098,244 |
| 2.1.4 Enhance basic infrastructures for RMNCAH Services | 307,540,778 | 316,767,002 | 239,367,881 | 157,039,723 | 92,194,470 | 1,112,909,855 |
| 2.1.5 Adopt and scale up use of proven innovations in RMNCAH to improve service delivery | 246,219,770 | 253,606,363 | - | - | - | 499,826,132 |
| 2.2.1 Support health training institutions to have enabling curriculum to produce graduates with basic core competencies in RMNCAH services | 416,120,000 | 487,660,508 | 441,461,708 | 285,879,238 | 294,455,615 | 1,925,577,069 |
| 2.2.2 Improve the numbers and core competences of health workers in provision of services including RMNCAH Services | 123,600,000 | 312,555,197 | 185,763,590 | 78,785,617 | 81,149,185 | 781,853,589 |

| Strategic intervention | 2021 | 2022 | 2023 | 2024 | 2025 | Total |
|---|---|---|---|---|---|---|
| 2.2.3 Advocate for regular employment and equitable deployment to provide RMNCAH packages at national, regional and district levels | 257,500,000 | 265,225,000 | 273,181,750 | 281,377,203 | 289,818,519 | 1,367,102,471 |
| 2.2.4 Strengthen capacity of mentors to provide RMNCAH packages at national, regional and district levels | 1,733,705,147 | 2,159,649,390 | 2,183,550,937 | 1,587,501,859 | 1,043,618,911 | 8,708,026,243 |
| 2.3.1 Strengthen pipeline of RMNCAH commodities and equipment | 10,023,272,171 | 10,420,774,321 | 10,733,397,551 | 1,324,031,524 | 1,293,232,251 | 33,794,707,818 |
| 2.3.2 Improve tracking of RMNCAH lifesaving commodities | 41,200,000 | 42,436,000 | 43,709,080 | 45,020,352 | 46,370,963 | 218,736,395 |
| 2.3.3 Improve coordination, collaboration and accountability of supply chain activities | 531,903,948 | 547,861,066 | 564,296,898 | 581,225,805 | 598,662,580 | 2,823,950,298 |
| 2.3.4 Strengthen capacity of health system at all levels to forecast and procure RMNCAH life-saving commodities and equipment | 183,039,240 | 188,530,417 | 194,186,330 | 200,011,920 | 206,012,277 | 971,780,184 |
| 2.3.5 Strengthen mobilization of resources for RMNCAH commodities | 51,500,000 | 53,045,000 | 54,636,350 | 56,275,441 | 57,963,704 | 273,420,494 |
| 2.3.6 Improve for Planned Preventive Maintenance of RMNCAH equipment | 82,400,000 | 84,872,000 | 87,418,160 | 90,040,705 | 92,741,926 | 437,472,791 |
| 2.4.1 Improve Health management information system for RMNCAH Services// Improve capacity for RMNCAH data use | 2,088,087,111 | 1,358,508,421 | 1,399,263,673 | 1,441,241,584 | 1,073,313,809 | 7,360,414,598 |
| 2.4.2 Support generation of electronic RMNCAH data from all service delivery points | 413,122,782 | 425,516,466 | 438,281,960 | - | - | 1,276,921,208 |
| 2.4.3 Enhance monitoring, evaluation, and research to strengthen knowledge management and evidence | 698,440,396 | 581,494,458 | 693,217,364 | 723,872,408 | 745,588,580 | 3,442,613,207 |
| 2.5.1 Strengthen community systems and structures to deliver the integrated service package for RMNCAH | 2,065,871,041 | 2,171,485,554 | 2,169,208,821 | 2,187,989,127 | - | 8,594,554,543 |
| 2.5.2 Improve capacity of CHWs to support RMNCAH service delivery | 7,149,503,568 | 5,522,991,506 | 3,792,454,168 | 1,953,113,896 | - | 18,418,063,138 |
| 2.6.1 Support comprehensive RMNCAH operational research to provide real time and data for decision-making | 339,823,368 | 144,638,183 | 453,952,539 | 32,189,912 | 323,548,201 | 1,294,152,203 |
| 3.1.1 Develop and introduce package of male sexual and reproductive health services | 958,530,607 | 1,146,540,601 | 906,761,911 | 707,587,400 | 728,815,022 | 4,448,235,541 |
| 3.1.2 Strengthen male involvement in RMNCAH services | | | | | | - |

| Strategic intervention | 2021 | 2022 | 2023 | 2024 | 2025 | Total |
|---|---|---|---|---|---|---|
| 3.2.1 Improve access and utilization of long acting and other modern contraceptive methods including integration with other RMNCAH services | 64,196,572,032 | 71,059,971,958 | 82,476,040,848 | 87,007,243,373 | 92,591,426,204 | 397,331,254,415 |
| 3.2.10 Strengthen menopause and post menopause services for women | 6,358,394,698 | 8,733,360,320 | 13,494,895,512 | 9,267,806,062 | 7,160,423,428 | 45,014,880,020 |
| 3.2.11 Strengthen Referral systems for improved RMNCAH services | | | | | | - |
| 3.2.2 Sustain and improve quality of full range of ANC services | 211,201,595,980 | 219,023,889,032 | 226,747,957,817 | 234,674,931,981 | 243,384,779,937 | 1,135,033,154,747 |
| 3.2.3 Strengthen intrapartum care including increasing access and availability of basic EmONC services including skills to respond to emergencies | 683,214,162 | 703,710,586 | 724,821,904 | 746,566,561 | 768,963,558 | 3,627,276,771 |
| 3.2.4 Improve access and availability of Comprehensive EmONC including safe surgery, anaesthesia, safe blood and blood products | 878,094,527 | 901,675,437 | 925,963,774 | 950,980,761 | 907,191,814 | 4,563,906,313 |
| 3.2.5 Increase capacity at all levels of care to improve post-abortion care | 674,088,691 | 925,748,469 | 1,430,281,385 | 982,126,551 | 758,692,761 | 4,770,937,857 |
| 3.2.6 Improve coverage and utilization of postnatal care services and integration of other RMNCAH services | 1,037,487,822 | 1,068,612,457 | 1,100,670,830 | 683,487,431 | 703,992,054 | 4,594,250,594 |
| 3.2.7 Sustain HIV testing, ART coverage and improve maternal viral load suppression and syphilis screening for dual elimination | 1,428,578,111 | 1,471,435,455 | 1,515,578,518 | 1,561,045,874 | 1,607,877,250 | 7,584,515,208 |
| 3.2.8 Improve cervical and breast cancer screening and care | | | | | | - |
| 3.2.9 Improve GBV and VAC services | 493,768,528 | 710,201,173 | 414,516,284 | 426,951,773 | 439,760,326 | 2,485,198,083 |
| 3.3.1 Strengthen quality of neonatal care services at all levels | 2,005,789,328 | 2,065,963,008 | 2,869,737,262 | 1,427,730,931 | 2,257,533,560 | 10,626,754,090 |
| 3.3.2 Improve quality of care for sick and small babies (premature and low birth weight babies) | 7,720,499,765 | 16,208,900,688 | 16,608,265,578 | 11,886,471,305 | 7,989,606,511 | 60,413,743,847 |
| 3.4.1 Improve growth monitoring and promote optimal Infant and Young Child feeding practices, including EBF and age-appropriate complementary feeding practices | 3,859,230,224 | 3,362,867,831 | 3,135,935,765 | 3,230,013,838 | 3,326,914,254 | 16,914,961,912 |
| 3.4.2 Maintain high coverage of immunization and interventions with high impact (zinc sulphate, ORS and Vitamin A supplementation) | 266,290,585,566 | 276,965,745,820 | 284,741,294,851 | 290,072,566,875 | 292,942,419,676 | 1,411,012,612,789 |

| Strategic intervention | 2021 | 2022 | 2023 | 2024 | 2025 | Total |
|---|---|---|---|---|---|---|
| 3.4.3 Manage sick children on basis of IMNCI and ETAT protocols | 3,206,074,738 | 3,774,007,977 | 2,915,421,162 | 3,002,883,797 | 1,546,485,155 | 14,444,872,829 |
| 3.4.4 Strengthen management of malnutrition (severe/acute malnutrition) | 107,443,920,318 | 112,417,153,470 | 116,620,798,755 | 120,277,889,298 | 123,321,995,243 | 580,081,757,084 |
| 3.4.5 Promote use of LLINs in the endemic regions and provide appropriate management for malaria cases | | | | | | - |
| 3.4.5 Strengthen under five death surveillance, auditing and response systems | - | 308,595,780 | 317,853,654 | 163,694,632 | - | 790,144,065 |
| 3.4.6 Improve early infant diagnosis of HIV and ART treatment including follow up of HIV infected children at facility and community | 970,437,160 | 1,425,062,412 | 1,314,832,505 | 451,425,827 | 464,968,601 | 4,626,726,505 |
| 3.4.7 Strengthen Early Child Development Care | 1,980,980,810 | 2,185,046,235 | 2,250,597,622 | 2,266,967,440 | 2,334,976,463 | 11,018,568,571 |
| 3.4.8 Promote pre-school health interventions | | | | | | - |
| 3.5.1 Promote school health interventions like screening, deworming, vaccination and nutrition | 2,263,328,015 | 2,246,355,856 | 2,241,626,549 | 2,308,875,346 | 2,378,141,606 | 11,438,327,372 |
| 3.6.1 Promote age and gender-specific comprehensive sexuality education for "in and out" of school including GBV | 1,803,346,660 | 1,856,575,000 | 1,966,908,600 | 1,857,089,537 | 1,565,020,000 | 9,048,939,797 |
| 3.7.1 Increase coverage of comprehensive Adolescent and Youth Friendly Services at all facilities and communities | 8,048,023,232 | 8,137,610,156 | 8,390,696,413 | 7,525,768,964 | 7,751,836,167 | 39,853,934,932 |
| 3.7.2 Increase youth engagement, participation, involvement and uptake of HIV, SRH, GBV and adolescent pregnancies preventive services | 3,558,060,950 | 2,588,797,571 | 3,429,193,153 | 2,273,527,796 | 2,341,733,630 | 14,191,313,101 |
| 3.7.3 Improve parent to child communication on SRH issues | 391,400,000 | 403,142,000 | 415,236,260 | 427,693,348 | 440,524,148 | 2,077,995,756 |