Tanzania Global Health Initiative Strategy 2010 -2015

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Table of Contents

Table of Figures

Acronyms

ANC	Antenatal Care
ART	Anti-Retroviral Therapy
BEmONC	Basic Emergency Obstetric and Neonatal Care
CDC	Centers for Disease Control & Prevention
DCM	Deputy Chief of Mission
EID	Early Infant Diagnosis
FACTS	Foreign Assistance Coordination and Tracking System
FANC	Focused Antenatal Care
FP	Family Planning
FY	Fiscal Year
GBV	Gender-Based Violence
HHS	Department of Health and Human Services
HMIS	Health Management Information System
HSSP III	Health Sector Strategic Plan III 2009–2015
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Preventive Treatment
IMCI	Integrated Management of Childhood Illnesses
ITN	Insecticide Treated Net
MNCH	Maternal, Newborn, and Child Health
MDG	Millennium Development Goal
MOHSW	Ministry of Health & Social Welfare
MKUKUTA	National Strategy for Growth and Poverty Reduction
NMPS	National Multi-Sectoral Prevention Strategy
OP	Operational Plan
PAO	Public Affairs Office
PEPFAR	US President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMI	President's Malaria Initiative
PMTCT	Prevention of Mother-To-Child Transmission
RCH	Reproductive and Child Health
RCHS	Reproductive and Child Health Services
RH	Reproductive Health
SBCC	Social and Behavior Change Communications
SWAp	Sector-Wide Approach
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
TDHS	Tanzania Demographic and Health Survey
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
URT	The United Republic of Tanzania, including the Mainland and Zanzibar
USAID	United States Agency for International Development
USG	United States Government
WASH	Water, Sanitation, and Hygiene for All Initiative
WDI	World Development Indicators
WHO	World Health Organization
WHS	World Health Statistics
WRAIR	Walter Reed Army Institute of Research
ZHSRSP II	Zanzibar's Health Sector Reform Strategic Plan II

1. Executive Summary

Building on over four decades of partnership and collaboration between the Governments of the United Republic of Tanzania (URT), civil society and the United States (USG), the five year Global Health Initiative (GHI) in Tanzania represents an opportunity to contribute further to Tanzania's development goals in health. The GHI vision is to improve the health of all Tanzanians, and especially the health of the most vulnerable groups of women, girls, newborns, and children under the age of five.

Under this vision, GHI will contribute to two of Tanzania's Millennium Development Goals (MDGs): the substantive reduction of deaths among children under five years of age and reduced maternal mortality by 2015. By increasing the availability and use of comprehensive preventive health services, USG-supported programs in Tanzania will work in three closely aligned and interwoven areas of focus: quality integrated services; health systems strengthening; and healthy behaviors. The strategy describes how the URT, private and civil society stakeholder and USG will collaborate on intensified interventions under each these focus areas to accelerate expected health impact. Comprehensive interventions will impact health results in focused regions while other activities will be national in scope.

How GHI Works: FP/RH Integration

Under URT guidance, partners will coordinate technical assistance across service delivery platforms and projects to strengthen health facilities' capacity to provide a full range of services at multiple contact points with clients. These include HIV care and treatment and maternal and child health clinics. Project elements include: the incorporation of FP/RH integration into existing provider training; updated quality assurance guidelines; consistent commodities and supplies; and inclusion into district-level URT planning and budgeting systems.

GHI supports the URT's intent of moving toward sustained health and healthcare services, with increased program efficiencies, effectiveness, and mutual accountability. For the USG, this includes a reorientation to a broader integrated focus across these programs to achieve a more lasting systems impact. As such, USG-supported programs in HIV/AIDS, malaria, tuberculosis, nutrition, family planning and reproductive health (FP/RH), and maternal, newborn, and child health will be carefully aligned and leveraged across service delivery platforms. Integrated programs that work well will be taken to scale in targeted regions throughout Tanzania. USG-supported programs will link into other sector initiatives and projects in a value-adding manner, such as education and democracy and governance.

Gender is a GHI priority in Tanzania. Interventions under GHI to address quality health services, health system strengthening, and healthy behaviors will benefit the lives and health of all Tanzanians, with a special focus given to the vulnerable populations of women and girls. Under GHI, the USG will address gender issues through programming focused on harmful gender norms, gender-based violence, and gender inequities. Solutions will include male involvement and equitable access to services and resources, with linkages to non-health activities such as education and economic strengthening.

GHI is an opportunity to maximize program impact through strategic coordination. By capitalizing on synergies within USG-supported programming, GHI builds on the considerable resources and achievements of one of the USG's largest health programs globally. These programs include *The President's Emergency Plan for AIDS Relief* (PEPFAR), *The President's Malaria Initiative* (PMI), and the new *Improving Nutrition in Tanzania* under Feed the Future. In addition, the Governments of Tanzania and the United States and other development partners will continue to harness collaborative efforts through established strong partnerships.

Achieving results under GHI is predicated upon a number of assumptions. These include level or increased government and donor funding, disbursed as planned, and progress in health sector reform, including an expanded heath workforce. Other issues might significantly impact the achievement of GHI and URT health goals. These include the URT's overall budgetary allocation to health as the government moves toward reaching the Abuja Declaration's target of national health financing at 15% of total government funding, and general resource prioritization. Another grave issue is Tanzania's current trajectory of population growth.

2. Tanzania's Health Priorities and GHI

2.1. Health and Healthcare of Tanzanians

As East Africa's most populous country, the United Republic of Tanzania (URT) has identified many economic and social development challenges as national priorities. Tanzania's population is estimated at nearly 44 million of which almost 75% live in rural areas. Classified as a low-income country, the economy is driven by tourism, agriculture, mining, trade, and communications, with considerable economic growth averaging 7% per annum over the last decade. Despite these gains, this growth has not translated into a substantially improved quality of life for most Tanzanians: during the past ten years, the annual population growth rate of 2.7% increased the absolute number of Tanzanians living in poverty by more than 1 million. Without significant improvements in governance, health, and healthcare systems, Tanzania faces the risk of overwhelming an already-fragile social service system and eroding future economic gains.

Consistent with the health Millennium Development Goals (MDGs), Tanzania's national development priorities address public health and healthcare challenges. Disparities are seen in maternal, newborn, and child health (MNCH), and Tanzania faces a generalized HIV/AIDS epidemic on the Mainland, a concentrated HIV/AIDS epidemic in the Zanzibar archipelago, and other widespread communicable diseases such as tuberculosis (TB), malaria, respiratory infections, and diarrheal diseases. Malaria is the leading cause of death for Tanzanian children and is a major cause of maternal mortality. The impact of the HIV/AIDS epidemic is enormous in Tanzania: an estimated 1.4 million people are already infected with HIV, and each year an estimated 100,000 are newly infected and 86,000 Tanzanians die. This results in disrupted family structures and an estimated 1.3 million children orphaned or vulnerable. Tanzania ranks 15th out of the 22 countries with the highest TB burden and it remains the leading cause of morbidity and mortality among people living with HIV (PLHIV). These issues are exacerbated by harmful social norms, including gender norms, gender-based violence (GBV), and gender inequities. Underlying food insecurity leads to nutritional deficiencies. *Annex 1: Key Health and Health System Indicators in Tanzania* presents an overview of Tanzania's public health and healthcare.

Over the last 15 years, Tanzania has made a number of important achievements in public health. These include a continuing rapid decline in childhood deaths with infant mortality cut almost in half, from 96 to 51 deaths per 1,000 births between 1996 and 2010. During the same time period, the under-five mortality rate fell from 137 to 81 deaths per 1,000 live births. *Table 1: Selected Reported Changes between the Tanzania Demographic Health Surveys 2004/05 and 2010* illustrates some key improvements in health that occurred in the period between the two Tanzania Demographic Health Surveys (TDHS). These include a drop in post-neonatal deaths from 36 to 25 deaths per 1,000 live births. Between 2001 and 2010, HIV prevalence fell from 7.1% to 5.7%. In addition, there has been a six-fold increase in the number of Tanzanian adults who know their HIV status, and more adults are protecting themselves from HIV infection through condom use. More children are fully immunized and sleep under insecticide-treated nets (ITNs). Increased numbers of pregnant women are taking intermittent preventive treatment (IPT) to reduce the consequences of malaria in both the woman and her unborn child.

Table 1: Selected Reported Changes between the Tanzania Demographic Health Surveys 2004/05 and 2010

Indicator	TDHS 2004/05	TDHS 2010
Contraceptive prevalence rate (currently married women)	26%	34%
Use of modern contraceptive methods (currently married women/all women)	20% / 18%	27% / 24%
Never-married men/women 15-49 who reported condom use at last sex	46% / 37%	54% / 49%
Men/women 15-49 counseled and tested for HIV and received test results	7% / 6%	40% / 55%
Pregnant women counseled and tested for HIV and received test results	9%	55%
Children under-five of age who slept under an insecticide-treated net (ITN)	16%	64%
Children age 12-23 months that are fully immunized	71%	75%
Pregnant women who received 2+ IPT doses during their last pregnancy in the last two years & received an antimalarial as part of an ANC visit (Mainland, Zanzibar)	22% / 14%	27% / 47%

However, many challenges still remain. For example, during the period between the two TDHS, although the total fertility rate fell from 5.7 to 5.4 births per woman, there have been no significant changes in Tanzania's unmet need for family planning. Although there is a possible decline in maternal mortality, the current rate of 454 per 100,000 live births is unacceptably high. Only 43% of pregnant women receive the recommended four antenatal care visits, and only 51% of births are attended to by skilled health personnel. Anti-retroviral therapy (ART) coverage among Tanzanians with advanced HIV infection is 55%.

In addition, it will be difficult to meet the health needs of a growing population with the current acute shortfall in the health workforce. Tanzania has some of the lowest health personnel coverage per population in the world. For example, there are 0.4 physicians and 2.8 nurses and midwives per 10,000 people. This is well below the corresponding average figures of 2.8 physicians and 6.7 nursing and midwifery personnel for all of the world's low income countries.

2.2. The United Republic of Tanzania's Response to Health

Health is not unified within the URT and therefore the Mainland and Zanzibar each have their own National Health Policy. GHI in Tanzania will align closely to each Ministry's priorities and strategies. The Mainland is currently implementing its third *Health Sector Strategic Plan* (HSSP III, 2009 – 2015), which was developed in line with the goals of the *National Strategy for Growth and Poverty Reduction* (MKUKUTA), the *National Health Policy* 2007, and the MDGs. Zanzibar's *Health Sector Reform Strategic Plan* (ZHSRSP II), based on the Zanzibar Strategy for Growth and the Reduction of Poverty, goes through 2011. Collectively, these documents are referred to as the National Health Plans. These guiding documents recognize the improvement of people's quality of life as essential to their ability to participate fully in their country's productive processes, thus placing the health sector as a government priority.

The Mainland's HSSP III includes eleven strategies that cover specific health service delivery areas as well as four cross-cutting components of quality, equity, gender, and governance. Strategic objectives include increasing access to decentralized healthcare; reducing the healthcare financing gap; improving maternal, newborn, and child health; and strengthening social welfare, communicable and non- communicable disease services, including HIV/AIDS, TB, malaria, and substance abuse services, prevention, and control. ZHSRSP II's strategic priorities include strengthening healthcare systems to provide quality care, including human resources for health, infrastructure, legislation and regulation, and data for decision making. Priority health interventions are reproductive and child health, health promotion and disease prevention, communicable and non-communicable diseases, mental health, social welfare, and substance abuse services and prevention.

The National Health Plans have identified a number of barriers to achieving health goals. These include healthcare infrastructure, healthcare worker coverage, the challenges of managing a health system that is in the process of decentralization, and procurement bottlenecks. An additional critical issue is healthcare financing: Tanzania's healthcare system functions in an environment of limited financial and human resources, and the overall budget relies heavily on foreign aid. The Mainland's 2009/10 health sector budget was approximately $684.3 million, of which 36% came from donor sources. However, these figures exclude the United States Government's (USG) off-budget support of over US $400 million; when added, donor support amounts to over 55% of the national budget for health. Some of Tanzania's health programs are highly dependent upon donor funding. For example, foreign funds account for 97% of the Mainland's HIV/AIDS response. Health budgetary allocation as a percentage of total government funding was 12.9% (short of the 15% Abuja Declaration target); moreover, funds are not always disbursed annually to planning levels. In addition, despite strong leadership at top levels, program execution can be uneven.

2.3. The United States Government's Health Program in Tanzania

The Governments of the United Republic of Tanzania and the United States have collaborated on public health and healthcare service initiatives for over 40 years, addressing critical health needs of the Tanzanian

people. GHI will be firmly anchored within and expand on the substantial partnerships, systems, and service delivery platforms created during these years of partnership. These include:

HIV/AIDS: through *The US President's Emergency Plan for AIDS Relief* (PEPFAR), the USG supports the URT's technical capacity to lead and manage its national response to HIV/AIDS. Since inception, Tanzania has received over $1.1 billion from the USG to prevent new HIV infections, provide care and treatment for those affected by the epidemic, and strengthen the capacity of Tanzania's healthcare system. The recently signed *Partnership Framework, 2009-2013*, which defines the roles and responsibilities of the URT and USG in addressing HIV/AIDS, has six strategic goals: service maintenance and scale up; prevention; leadership, management, accountability and governance; procurement and commodity distribution; human resources; and evidence-driven strategic decision making. Since the start of PEPFAR, there has been a dramatic increase in the number of adults and children accessing ART with 255,545 individuals receiving treatment in 2010. During the USG's fiscal year (FY) 2010, a total of 2.7 million individuals received HIV testing and counseling. 58,800 pregnant women received prevention of mother-to child transmission of HIV (PMTCT) services including ART, and 330,100 OVC received support through PEPFAR. PEPFAR funding has supported improvements in the national supply of safe blood at higher level facilities.

Malaria: Tanzania is one of the 15 original countries participating in *The US President's Malaria Initiative* (PMI) since 2005. Key PMI interventions are the distribution and use of ITNs, indoor residual spraying, IPT for pregnant women, and improved malaria diagnosis and treatment. PMI has contributed substantively to the improvements in malaria preventive behaviors and treatment as reported in the TDHS 2010. A recent assessment indicated that it is likely that PMI contributed significantly to the reduction of childhood mortality in Tanzania. Since program inception, PMI program implementers have distributed over 3.2 million ITNs, 3.4 million rapid diagnostic tests, and 6.6 million doses of artemisinin-based combination therapies for treating uncomplicated malaria cases. Additionally, the Zanzibar Malaria Control Programme scaled-up all four malaria interventions across Pemba and Unguja. High population coverage of prevention and case management strategies resulted in an unprecedented reduction in malaria prevalence to less than 0.5% in 2010. PMI supports a health facility-based malaria epidemic surveillance system to maintain results.

TB and TB/HIV: The USG's support to the URT's national TB program falls under the *Partnership Framework's* first goal. The four priority areas for support are TB screening and laboratory service to enhance TB diagnosis and treatment among PLHIV, strengthened TB case finding and TB infection control, expanded provision of HIV/AIDS care and treatment in TB settings, and multi-drug resistant TB surveillance and management. According to the USG 2010 annual progress report, during that year 312,335 HIV-infected individuals receiving HIV-related care services were screened for TB in HIV clinical setting. Of these PLHIV, 58% started TB treatment.

USG Budget FY 2011 for Health in Tanzania, Millions in USD

PEPFAR	$ 358.0
PMI	$ 46.9
MCH	$ 5.8
FP/RH	$ 20.0
Nutrition	$ 6.7
Feed the Future*	$ 1.5
HHS/CDC	$ 1.3
HHS/NIH	$ 4.6
DOD/WRAIR	$ 4.5
Peace Corps	$ 0.8
Total:	**$ 450.1**

* Non-Global Health Child Survival funds for nutrition

Maternal, Newborn, and Child Health: As an MNCH Initiative focus country, USG's supported interventions include pre- and in-service training for basic emergency obstetric and newborn and essential newborn care (BEmONC), the improvement of service quality through provider supervision and mentoring, equipment and supplies procurement, advocacy for national policies to support emergency obstetric care at lower-level facilities, and supporting community-level communications. To date, the USG has trained antenatal care (ANC) providers achieving a coverage of approximately 73% of facilities. Pre- and in-service curricula were updated for ANC and BEmONC. To strengthen prevention of illness and care for children under-five, USG is supporting the roll out of new vaccines (pneumococcal and rotavirus vaccines) as well as strengthening URT's integrated management of childhood illness (IMCI) program. The IMCI platform (both facility and community levels) is supported through the implementation of a diagnosis and management of severe febrile illness program in

the Lake Zone. Zinc for the treatment of childhood diarrhea was introduced into the national IMCI treatment guidelines and made available with oral rehydration salts over the counter in pharmacies. Central USG funding has been provided to support the Ministry of Health and Social Welfare (MOHSW) to plan for integrated disease control and elimination of neglected tropical diseases. Through PEPFAR, over 160 higher level facilities now have access to safe blood of which approximately 80% is used for maternal and child health.

Family Planning and Reproductive Health: USG support aims to increase the national contraceptive prevalence rate among women of reproductive age by 1.5% each year and by 3% in GHI's focus regions. The family planning and reproductive health (FP/RH) approach focuses on commodities, demand for services, and policies that provide more options for women. The USG plays a pivotal role in coordinating multi-lateral procurement and building long-term contraceptive security. During the past five years, the modern contraceptive prevalence rate grew from 20% to 27% among married women; stakeholders anticipate considerable future impact through concerted communication, the integration of family planning into a range of services, and consistent commodity supply.

Health Systems Strengthening: Health systems are complex, and performance depends on key components and their interactions. The World Health Organization (WHO) has identified these key components, called Health Systems Building Blocks, which affect sustainable health services. The USG's support in health systems strengthening cuts across all WHO Building Blocks, addressing intricate systems issues related to GHI service delivery goals and sustainability. The USG provides assistance to address the critical human resource shortfall; identify sustainable financing options; strengthen the commodities, logistics, and diagnostics systems; strengthen governance and management; and strengthen monitoring and evaluation (M&E) systems. The USG also plays an important role in the development of service delivery guidelines, standards, training curricula, and supervision systems. The USG is working in collaboration with other donors to assist the URT to develop Tanzania's first Health Financing Strategy to expand the base of sustainable financing.

Nutrition: The new five year nutrition flagship initiative under Feed the Future, *Improving Nutrition in Tanzania*, will launch in July 2011. The program aims to strengthen Tanzanian systems at all levels and across sectors to improve nutrition outcomes. Implementation approaches include improving livelihoods and economic growth, the health status of families, and primary education. Over the next five years, in target regions, the program will contribute to reducing the prevalence of low height for age among children under-five by 20% and maternal anemia by 20%.

Cross-Cutting Programs: The USG implements several programs in Tanzania that will contribute to the achievement of GHI goals. Within democracy and governance programs, the USG is building civil society capacity to monitor accountability and transparency in local government through public expenditure tracking at the community level. The education program works with the URT to strengthen the secondary education system and improve girls' opportunities for scholarships. Through the agriculture program, the USG supports the URT's overall economic growth plan, including women's participation. Under Feed the Future, the USG supports public-private partnerships to boost agricultural competitiveness and investment. The Water, Sanitation, and Hygiene for All (WASH) initiative focuses on reducing waterborne diseases with a focus on communities and families. Cross-cutting these programs is the USG's work in gender, including the expansion of its girl platform to help meet the health, education, democracy and governance, and economic needs of girls and adolescents.

3. GHI Objectives, Targets, Program Structure, and Implementation

3.1. Overarching Health Goals and Expected Impact

GHI in Tanzania will directly support the URT's national health and development goals to reduce maternal, neonatal, and childhood deaths. Under the URT's leadership, the USG will continue to harness efforts of other donors and funded USG partners to strengthen systems and scale up proven interventions. Comprehensive interventions will impact health results in focused regions while other activities will be national in scope. In line with GHI principles, the USG will continue to align and streamline USG health programs in Tanzania. The "smart" integration of health programs, across specific health issues, across regions, and throughout facilities and communities, will help increase efficiencies and effectiveness. A focus on country leadership and health systems strengthening will help ensure greater sustainability of results. Given the wide population coverage of USG-supported programs in Tanzania, GHI will allow the USG to add significantly to URT's MDGs 4 and 5. *Table 2: How GHI in Tanzania Contributes to URT's MDGs and GHI Global Targets* illustrates the relationship between Tanzania's MDGs and GHI's global health outcomes.

Tanzania and the GHI Principles

The GHI Strategy for Tanzania is firmly rooted within the GHI principles of:

- Focus on women, girls, and gender equality
- Encourage country ownership and invest in country-led plans
- Strengthen and leverage other efforts
- Increase impact through strategic coordination and integration
- Build sustainability through health systems strengthening
- Promote learning and accountability through monitoring and evaluation
- Accelerate results through research and innovation

Proposed initiatives and activities are designed to enact each of these principles. The strategy's performance monitoring matrix describes how the programs for each of the IRs relate to the GHI principles.

Table 2: How GHI in Tanzania Contributes to URT's MDGs and GHI Global Targets

Under-Five Mortality	
URT MDG 4	Reduce all-cause under-five mortality to 48/1000 live births by 2015 (milestone: TDHS 2010 estimate of 81/1,000)
GHI Global Outcome	Reduce under-five mortality rates by 35% across assisted countries by 2014
Maternal Mortality	
URT MDG 5	Reduce maternal mortality to 265/100,000 live births by 2015 (milestone: TDHS 2010 estimate of 454/100,000)
GHI Global Outcome	Reduce maternal mortality by 30% across assisted countries by 2014

3.2. Intermediate Results and Proposed Activities

Achieving the strategy's health goal assumes the combined success of three highly interdependent intermediate results (IRs): quality integrated services, health systems strengthening, and healthy behaviors. Ongoing USG support in all three areas will accelerate the achievement of the expected health impact. These achievements are predicated upon integration, coordination, country-led planning, and learning through monitoring and evaluation.

The strategy focuses on five regions for a more comprehensive and coordinated package of support, while other critical activities continue at the national scale and benefit the whole of the Mainland and Zanzibar. This approach is based on the existing scale and funding levels of USG support. Under GHI, efficiencies throughout USG programs will now be re-invested in an integrated manner that draws on linkages (such as with the Feed the Future and democracy programs) and will enable the USG to significantly contribute to the Nation's achievement of MDG 4 and 5. The coordinated package will target the 1.6 million under five- and 1.8 million are women of reproductive age found in the five regions and the USG expects to echo out with URT leadership and support to the rest of the country. Tools that are developed and lessons learned will be shared with and by the URT to make this feasible.

An example of these linkages and efficiencies that build on global development efforts is the USG's concept, as led by Secretary of State Hillary Rodham Clinton, of the "1,000 day period" or the time from pregnancy

through age two that is critical in shaping a child's lifelong health. Development nutrition interventions can dramatically improve a child's chances of surviving and living a healthy and prosperous life. This has been echoed by the Feed the Future strategy in Tanzania and will be enacted through GHI investments. Recognizing this, Secretary of State Clinton, then-Irish Minister for Foreign Affairs Micheál Martin, and a community of global leaders launched the 1,000 Days partnership as a way to help achieve measurable benchmarks in improving maternal and child nutrition in the 1,000 days between September 2010 and June 2013. A number of nutrition interventions have been prioritized in the GHI Tanzania strategy and Feed the Future as critical to making a cost-effective difference.

Final selection of the focus regions will be done in consultation with URT, and will be based on where current USG-supported health, HIV/AIDS, and Feed the Future programs exist, where greater efficiencies are most feasible, and where it will be most manageable to measure the impact of GHI interventions using existing capabilities. Regional targets will be set in consultation with District Health Management Teams and other partners, and will take into account funding levels as well as existing baseline assessments and national surveys (including the recent DHS, which has regional level data).

Gender cuts across all GHI interventions in Tanzania, and activities will reflect the GHI principle of women, girls, and gender equality. Programs will explore integrated approaches to gender norms that affect women's and men's health across the range of diseases to improve access and use of critical key health services. Other issues include addressing the gender-specific needs and sensitivities to women and girls and the amelioration of GBV in Tanzania. All USG operating plans in Tanzania will incorporate gender and GBV into annual planning, including implementation details and metrics and evaluation.

IR 1: Increased Access to Quality Integrated Services with Focus on Maternal, Newborn, and Child Health, Family Planning, and Reproductive Health

Under GHI, the USG endorses a strategy to achieve major improvements in health outcomes through the integration of existing USG programs in partnership with the MOHSW's Reproductive and Child Health Services (RCHS). Leveraging the robust service delivery platforms strengthened under PEPFAR and PMI, efforts will now turn to ensuring that a more complete range of highly effective MNCH, nutrition, sanitation and hygiene, and FP/RH interventions are available throughout Tanzania to help address the major causes of maternal and under-five mortality.

Each of the four sub-IRs in this focus area is designed to improve the coordination and integration of key interventions to expand MNCH interventions and increase efficiencies in RCHS services. These are: reduced unmet need for family planning services; increased access to quality delivery and newborn care; increased access to quality integrated services for women and newborns; and improved quality of primary prevention of childhood illnesses and case management of children under-five. These sub-IRs are described further in *Annex 3: Intermediate Results Frameworks*. Under this IR, the USG will directly implement activities in five focus areas in Tanzania: Zanzibar and four Mainland regions. The USG, in consultation with the URT, will finalize the choice of these regions, taking into consideration the scale and scope of available funding, each region's epidemiology, and coverage by existing platforms.

However, in line with the GHI principles to increase impact through strategic coordination and integration, both governments will work together to take these interventions to scale throughout the country. The initiative intends to achieve integrated MNCH, FP/RH, and nutrition interventions within PEPFAR-supported PMTCT programs through common systems and processes, such as strengthened standards of care, supervision, and mentoring. Other areas of focus are the improved provision of essential supplies, equipment, and service documentation, and a reinforced ethos of patient-centered care. A learning agenda will accompany the scale up and successful approaches will be promoted in other regions as funding and

opportunities allow. In line with the GHI principles of country ownership and sustainability, the USG will coordinate closely all related activities with the MOHSW Regional and District Health Management Teams.

This approach creates opportunities for comprehensive, robust MNCH and reproductive and child health (RCH) services, such as comprehensive focused antenatal care, including malaria prevention and control in pregnancy, HIV counseling and testing, and ARV prophylaxis and treatment for HIV-infected pregnant women. Other services include maternal nutrition, post-partum family planning, and safe delivery services, including BEmONC, and the promotion of exclusive breast feeding and appropriate complementary feeding with linkages to WASH and nutrition programs. GHI will also promote male involvement and engagement in MNCH and supporting health services

IR 1.1 Integration of Family Planning into the Full Range of Health Services

Family planning services and communications integration across the full range of USG-supported health services will support facilities' ability to establish and maintain the provision of family planning and health services. This includes short- and long-acting and permanent family planning methods and post-abortion care. Plans build on and expand the RCHS technical working group's support for work in family planning and HIV/AIDS service integration. Efforts include increasing integrated family planning service sustainability through inclusion in pre- and in-service national training curricula and strengthening health facilities' capacity to offer family planning services to men and women at all contact points. Family planning will be integrated into HIV/AIDS prevention, care, and treatment services, with comprehensive post-abortion care expanded into additional Mainland regions, chosen in consultation with the URT.

Illustrative Interventions

- Use the national HIV/AIDS platforms to accelerate critical services throughout the country
- Finalize the integration of family planning and health services training curricula for supervisory personnel who manage health facilities and specific provider cadres; develop pre- and in-service training materials and health facilities guidance
- Expand USG support to the RCHS service integration technical working group and develop an accelerated work plan, management tools, and a costed plan for integrated service delivery
- Include FP/RH integration in national pre- and in-service training, including the certification of master trainers
- Expand current FP/RH integration activities to focus regions
- Conduct research to inform policy and service delivery, including a study to investigate the cost and cost-savings of family planning and health integration, the impact of accelerated FP update, and ongoing services delivery programs midterm evaluations

IR 1.2 Increased Access to Quality Delivery and Newborn Care

This activity focuses on taking the nationally approved BEmONC package to scale to address major causes of maternal and newborn mortality within PEPFAR-supported PMTCT facilities. Initial scale up and monitoring will be in the same focus regions in which the supervision system is managed so that close attention is paid to program implementation, methodology, results and challenges. This ensures that the development and recruitment of human resources, efforts to increase essential commodities availability, and other important facility support are woven into routine district management systems. In addition, the program will strengthen referral systems so that complex deliveries are handled at higher level sites with lifesaving interventions, including Cesarean-section and blood transfusion services. Linkages will be made to Feed the Future nutrition interventions to address long-term issues of maternal and newborn health.

Illustrative Interventions

- Use the national PMTCT platform to accelerate availability of critical services throughout the country
- With technical assistance from resident BEmONC partner, roll out the national BEmONC curriculum with facility-based support through PMTCT partners:

    - Train supervisors and staff in BEmONC at established regional training sites
    - Conduct a BEmONC basic equipment and supplies needs assessment to address gaps
    - Establish an on-site, standards-based quality improvement system to promote facility practices
    - Link internal improvement systems to the integrated external facility supervision system (refer to IR 1.3)
- Strengthen district referral and transport systems to improve access to higher-level lifesaving interventions beyond BEmONC (i.e. Cesarean section and blood transfusions)
- To promote program sustainability, prioritize BEmONC in District Councils' annual budgeting and planning cycles by developing district level tools for costing and planning services
- Expand USG support to the RCHS to develop a costed operational plan to ensure universal access to basic safe delivery services in Tanzania and enable resource mobilization for the achievement of the plan
- Create links to food aid programs and early warning systems for acute malnutrition linked to USG-supported agriculture programs

IR 1.3 Improved Quality of Integrated Services for Women and Newborns

In line with the GHI principles to increase impact through strategic coordination and integration, the USG will work to incorporate key RCH, and nutrition interventions it is currently supporting into the PMTCT-supported supervision and mentoring activities. Together with regional and district health authorities, additional technical assistance and supervision will be provided at the facility level in order to improve the quality of care across RH health services (antenatal care, delivery, postnatal, and family planning). This includes strengthened standards of care, improved provision of essential supplies, equipment, and service documentation, and a reinforced ethos of patient-centered care. The efficiency of the total assistance package will increase through the application of supervision tools and processes that encompass the range of USG-supported programs.

Illustrative Interventions

- Expand the current HIV PMTCT supervision tool, developed under PEPFAR and now part of the national program, to incorporate standards of care for RH and nutrition services
- Pilot the expanded comprehensive supervision tool in focus regions (four Mainland regions and Zanzibar) and track impact in focus regions with the Regional and District Health Management Teams as part of the GHI learning agenda documenting the impact of an integrated approach
- Disseminate the comprehensive supervision tool to all HIV partners to conduct integrated supervision nationally
- Develop a facility based RH quality improvement system that is linked to the external supervision:
    - Facilities create plans to address deficiencies identified during internal supervision or reviews
    - Issues identified in external supervision visits are reviewed in subsequent visits to ensure they have been addressed internally

IR 1.4 Improved Quality of Primary Prevention of Childhood Illness and Case Management of Children Under-Five

Nationally, the USG supports preventive health programs for children under-five, including ITN distribution and promotion, the national childhood immunization and vitamin A supplementation programs, and the promotion of exclusive breastfeeding and complementary feeding. Under the integrated Feed the Future and GHI nutrition framework for Tanzania, the USG addresses the major causes of childhood and maternal under-nutrition, including stunting and maternal and child anemia. The program will also include activities to promote good nutrition practices and scale up provision of maternal iron folate supplementation and de-worming. PMI and the child health program support facility-based programs to address major causes of severe febrile illness in children under-five in the Lake Zone, where the burden of malaria and under-five mortality is the highest in Mainland Tanzania. The program supports Tanzania's IMCI pediatric platform for diagnosis and case management. In a complementary manner and strengthening the community IMCI platform in the Lake Zone, PEPFAR builds on and supports the expansion of community-based referral

systems to improve parental care-seeking behaviors for sick children. PEPFAR supports a pediatric AIDS initiative through Baylor University through which a center of excellence in pediatric care is being established in Mwanza, in the Lake Zone, with a considerable outreach to health professionals and children in the community.

In line with the GHI principle of smart integration, the severe febrile illness and the HIV pediatric care programs in the Lake Zone can achieve greater synergies in pediatric health through improved coordination. Specifically, the programs will achieve greater coverage and quality of pediatric services through: defined roles and relationships in the field; improved community identification and referrals of sick children; increasing the percentage of children identified as HIV-infected through the Early Infant Diagnosis (EID) program; improved case management in health facilities; and disseminating information on maternal, infant and young child nutrition in the community- and health facility.

Illustrative Interventions

- Expand the Feed the Future and GHI nutrition communication platform to improve nutrition services throughout the country, such as referrals through agricultural extension workers
- Integrate existing health facility- and community-based programs for management of severe febrile illness, EID, and nutrition in the three Lake Zone regions:
  - Strengthen facility-based identification and categorization of severe febrile illness, case management including laboratory services (e.g. promote availability and use of malaria, HIV and other diagnostic tests)
  - Strengthen community-based identification and referral of sick and malnourished children
  - Strengthen coordination between PMI- and PEPFAR-funded partners in the Lake Zone for facility- and community-based activities
- Scale up developed tools and methodologies to other MCH, Feed the Future, PMI, and PEPFAR-funded regions as results are demonstrated and funding allows
- Support on-going preventive interventions (e.g. nutrition counseling and food supplementation for infants and young children; sanitation and hygiene; technical assistance to MOHSW Expanded Program of Immunizations to introduce pneumococcal and rotavirus vaccines; Vitamin A supplementation and de-worming campaigns, maintain national gains in ownership and use of ITNs by children under-five)

Table 3: IR 1 Quality Integrated Services Five Year Indicators

IR 1.1 Integration of Family Planning into the Full Range of Health Services
15% increase from baseline in the Contraceptive Prevalence Rate (3 percentage points per annum) in to-be-determined focus regions by 2015
IR 1.2 Increased Access to Quality Delivery and Newborn Care
80% of USG-supported facilities in the to-be-determined focus regions implement the integrated supervision tool by 2015
50% of maternal and newborn deaths are audited in a standardized fashion in USG-supported facilities in the to-be-determined focus regions by 2015 (baseline under collection)
50% of USG-supported facilities with PMTCT programs in the to-be-determined focus regions provide BEmONC services performed to standard by 2015 (baseline under collection)
IR 1.3 Improved Quality of Integrated Services for Women and Newborns
Increase in percentage of women attending 4+ ANC visits, from 43% (TDHS 2010) to 60% in the to-be-determined focus regions by 2015
Increase in percentage of women receiving IPTp2, from 26% (TDHS 2010) to 60% in the to-be-determined focus regions by 2015
30% increase from baseline in the percentage of pregnant women receiving HIV counseling, testing, and results in the to-be-determined focus regions by 2015 (aligned to the national target of 80% by 2015; baseline under collection)
30% increase from baseline in the percentage of HIV-infected pregnant women in USG-supported

facilities in the to-be-determined focus regions who received ARVs by 2015 (aligned to the national target of 90% by 2015; baseline under collection)
IR 1.4 Improved Quality of Primary Prevention of Childhood Illnesses & Case Management of Children Under-Five
Establishment of quality assurance systems for the malaria rapid diagnostics test program in 80% of USG supported facilities in the Lake Zone by 2015
35% decrease (from 109/1,000 to 70/1,000) in all-cause under-five mortality in the three Lake Zone regions by 2015
70% of eligible infants in USG-supported facilities in the Lake Zone tested for HIV and appropriately referred by 2015 (baseline under collection)
80% of eligible children immunized with pneumococcal vaccine (2015)

IR 2: Improved Health Systems to Strengthen the Delivery of Healthcare Services

The USG is committed to strengthening systems to ensure the greatest potential for service improvements and program sustainability, protect investments made to date in health programs, and ensure the efficient and rational allocation of human, financial, and other resources. GHI support will target improvements in health systems, focusing on the WHO Building Blocks. Specifically, the areas of focus are: improved human resources for health for efficient, quality service delivery; improved integration and effectiveness of monitoring and evaluation systems; strengthened governance, management, financing, and accountability in advancement of national policies and systems; and improved health support systems, including commodities and laboratories. Because of the enormity of systems issues, the USG works closely and in harmony with other donors to leverage investments.

The proposed systems strengthening issues are consistent with GHI principles, and are inextricably linked to the achievement of the two other intermediate results related to quality integrated services and improved healthy behaviors. Systems strengthening efforts will build on work already underway through PEPFAR, PMI, and other Health programs, as well as on the Feed the Future initiative. Efforts will also build on partnerships and investments that contribute to national health workforce goals, such as the USG's Medical Education Partnership Initiative and those of the Touch Foundation, a public-private partnership that has contributed significantly to pre-service training of nine cadres of health workers over the last four years.

Through GHI, the USG will support the prioritized health systems strengthening activities detailed below, further expanded in *Annex 3: Intermediate Results Frameworks.*

IR2.1 Improved Human Resources for Health for Efficient Quality Service Delivery

The USG team will work with the URT to address the severe shortage of health workers essential for effective service delivery. Critical elements include the training of new health workers, strengthening recruitment and retention, and optimizing the workforce—particularly through methods to improve productivity and effectively address the distribution of skilled health workers. Through GHI, the USG will focus on training the cadres that contribute most directly to improving emergency and neonatal services and newborn and child health, including nurse-midwives, clinical officers, and assistant medical officers. In addition, attention will be paid to cooperating with the President's Office for Public Services Management and the MOHSW to introduce new healthcare cadres that do not require clinical training. These cadres can help improve laboratory and commodity services or reduce the administrative burdens of those providing clinical services. All USG interventions will leverage significant contributions from the URT and other donors (particularly Canada, Germany, Japan, and the Global Fund) that support implementation of the Mainland's Health Workforce Initiative, a framework laid out to achieve the national HRH Strategic Plan. All efforts address objectives from the HSSP III and ZHSRSP II, and will comply with Tanzanian regulations and frameworks.

Illustrative Interventions

- Expand pre-service training of health workers through infrastructure investments at a minimum of seven prioritized health training institutions per year
- Strengthen faculty by updating an integrated pre-service training curriculum, teaching materials, and teaching methods
- Improve deployment and retention of health workers to underserved districts by strengthening overall staff forecasting and retention and increasing non-financial incentives for remote areas, including orientation, work climate improvements, performance management, and employee morale
- Expand the health workforce by supporting the establishment/training of additional cadres for specific roles that do not require previous clinical training (e.g. logisticians, data clerks, medical records clerks, biomedical engineers, health managers)

IR 2.2 Improved Integration and Effectiveness of Monitoring and Evaluation Systems

The USG will support implementation of the URT's monitoring and evaluation (M&E) strategies and improved integration and effectiveness of M&E systems for data use that contributes to improved health outcomes. The USG will leverage its funding with that of other donors (particularly Global Fund, Netherlands, Norway, Japan, and Germany) to support the Mainland's M&E Strengthening Initiative in the health sector. The USG will achieve this integration and effectiveness through a multi-donor, coordinated approach that ensures all USG investments in routine data collection, surveys and surveillance, vital registration of births and deaths, and research are aligned with URT systems and vision.

A key component of the URT vision is a data warehouse or central repository that brings together data from all vertical program service delivery, and information from separate management systems including finance information, procurement, distribution of medical supplies and human resources. USG will support the data warehouse through technical assistance and by aligning a wide range of information system investments across the USG portfolio with the URT vision.

USG investments in M&E will focus on fostering a culture of data use at health facility, district, and national levels and the USG will aim to evaluate the effectiveness of M&E investments according to their ability to impact use of information. Data will be utilized to assist with planning, the continuous improvement of service delivery, and facilitating supply systems, with data use by local stakeholders reinforced through the strengthened supervision system.

Illustrative Interventions

- Support national expansion of the Integrated Disease Surveillance and Response System and reporting of Core Indicators to ensure effective flow of quality information
- Support national population surveys, studies, or evaluation activities that provide evidence to multiple health programs and support sharing of evidence through a URT data warehouse
- Institutionalize a culture of data use and evidence-driven decision-making by establishing, implementing, and continuously improving a data use and dissemination strategy
- Promote on-the-job mentoring of URT staff on data collection, compilation, analysis, interpretation, and data use

IR 2.3 Strengthened Governance, Management, and Financing in Advancement of National Policies and Systems

Strengthened governance, and the leadership and management that underpins it, is essential for effective program implementation at all levels. In particular, local government is responsible for managing and delivering public services, including health services. Under this GHI strategy, regional, district, and local government authorities will be supported with technical assistance to ensure that essential health services are prioritized and budgeted according to risk factors and burden of disease, and integrated for more cost-

effective service delivery. The USG will collaborate with other development partners in this effort, including the Swiss, WHO, Germany, Japan, and others.

At the same time, limited health sector funds necessitate consideration for a broader base of funding, such as alternate funding platforms, i.e. insurance. The USG will support the development of a Health Financing Strategy, which will identify options for financing that are not so donor dependent. Options will include such approaches as the expansion of pre-paid community health insurance options that can help local authorities and facilities cover the cost of basic health services such as MNCH and non-communicable disease management. In partnership with the Mainland's MOHSW and other donors (particularly World Bank, Swiss, WHO, Germans), the USG will pursue innovative financing and payment schemes to increase equitable access to and sustainability of quality service programs, and help to develop a robust regulatory environment. Similar options will be explored in Zanzibar.

Illustrative Interventions

- Strengthen leadership and management at the national and local levels to prioritize, execute, and be accountable for health programs
- Support the expansion of healthcare financing options, particularly for the poor, to ensure access to essential health services that will reduce maternal, child, and infant morbidity and mortality
- Participate in the planning, development, and piloting of provider payment schemes that promote efficiency, quality, and results
- Link with other programs, such as Democracy and Governance and Feed the Future, to foster an informed and active citizenry engaged as stakeholders to ensure accountability for funded local health programs

IR 2.4 Improved Health Support Systems

Through GHI, the USG will continue to support the URT commodity and logistics systems, investing in storage facilities, training, technical assistance, and transport. Specifically, GHI efforts will continue to strengthen the URT's ability to forecast, quantify, procure, and distribute essential health commodities and pharmaceuticals in a timely manner. This includes the development and application of a new operating system to re-engineer the way work is done at the Medical Stores Department (MSD)and its nine zonal warehouses throughout the country. In the last 10 years, the volume of facilities served has doubled, vertical programs have increased ten-fold, and ordering methods have completely changed. This fully integrated business computerized system, called the Enterprise Resource Program, will reduce waste and enhance both the efficiency and effectiveness of MSD.

With USG support, the quality of laboratory services will improve through comprehensive laboratory management strengthening, funded in collaboration with the Mainland's MOHSW, the Global Fund, and the Abbott Foundation (with whom the USG works in an informal public-private partnership). The overall goal is to achieve quality diagnostics with nationally and internationally accredited laboratories. Where necessary, USG funds and other donor inputs will be used for the renovation or construction of laboratories to assure that minimum facility requirements are met. The introduction of a preventive maintenance culture and the training and involvement of biomedical engineers will also help reduce the proportion of equipment that is out of order.

Illustrative Interventions

- Integrate vertical program commodities processes and systems, including procurement forecasting, quantification, regulation, and delivery, to create a highly cost-effective system
- Assist the URT to cascade a standard set of laboratory services across all levels
- Increase the quality of lab services at all levels and the number of accredited labs, including the promotion of preventive maintenance and use of URT's service agreements

Table 4: IR 2 Health Systems Strengthening Five Year Indicators

IR 2.1 Improved Human Resources for Health for Efficient Quality Service Delivery
Healthcare worker productivity increased by 10% by 2015 (baseline at 40% in 2007; NIMR Assessment; PFIP indicator))
Nurse-Midwives per 10,000 population increased to 3.5/10,000 population in 65 underserved target districts by 2015 (baseline at 2008 = 2.8; MOHSW Department of Human Resources)
Training slots increased by 1,250 with USG funds by 2015 (baseline 5,800 in 2011)
Vacancy rate reduced by 2015 (baseline data under collection by MOHSW)
IR 2.2 Improved Integration and Effectiveness of Monitoring and Evaluation Systems
60% of 133 districts using Integrated Disease Surveillance and Response System by 2015 (baseline 1 district in 2010; MOHSW M&E Department)
75% of USG-funded management or data collection information systems submitting aggregate data to national Health Information System by 2015 (baseline under collection; USG-collected data)
60% of 133 district councils use HMIS core indicators to develop annual Comprehensive Council Health Plans by 2015 (baseline under collection; MOHSW Health Resource Secretariat)
3 cross-cutting (> than health issue) evaluations or studies per year receive joint funding or serve the needs of multiple health issues by 2015 (e.g. THMIS, SAVVY; USG-collected data)
IR 2.3 Strengthened Governance, Management, and Financing in Advancement of National Policies and Systems
20% of the population is covered with a pre-paid insurance by 2015 (baseline at 8.6%; MOHSW Dept. of Policy and Planning)
70% of all districts receive a clean Overall Financial Audit report by 2015 (baseline 48%; Basket Finance Audit Committee Reports)
70% of all districts submit plans that exceed the national Comprehensive Council Health Plans assessment criteria with a score of at least 70% by 2015 (baseline under collection; MOHSW Health Resource Secretariat)
IR 2.4 Improved Health Support Systems
85% of districts have state of the art Medical Stores Department Enterprise Resource management system by 2015 (baseline = 0%; MOHSW/USG partner reporting)
National costed quantification of total product need across program areas developed for entire country by 2015 (MOHSW/USG partner reporting)
Increase the number of laboratories with national accreditation to 39 (baseline = 0) and with international accreditation to 5 (baseline = 0; MOHSW) by 2015

IR 3: Improved Adoption of Healthy Behaviors including Healthcare-Seeking Behavior with Focus on Girls and Women

A core objective of GHI is to improve health outcomes among women and girls. The USG has selected healthy behaviors and healthcare-seeking behaviors as an area of emphasis under GHI, highlighting the importance of this area to significantly contribute to positive health outcomes among women and girls in Tanzania. A number of opportunities suggest this focus area will benefit from enhanced USG efforts. These include strong country leadership and a robust and multi-sectoral USG platform to promote healthy behaviors and mitigate harmful social norms that may put women at a disadvantage in achieving positive health outcomes for themselves and their families. There are possibilities for linking into and leveraging resources outside the health sector to address healthy behaviors and positive social norms, including Feed the Future, education, governance, and other non-health USG programs. This focus area is well matched with GHI principles and approaches. Improved Adoption of Healthy Behaviors including Healthcare-Seeking Behavior with Focus on Girls and Women will:

- Facilitate sustainable outcomes in GHI target areas and diseases by addressing cultural norms to empower women and increase men's positive involvement in decision making
- Contribute to demand creation for quality preventive and curative health services and serve as a critical component of multiple service packages, including HIV prevention and treatment adherence, MNCH, and FP/RH

- Link with health, education, governance, and agriculture platforms with a strong focus on women, girls, and gender equity, including increasing men's individual knowledge and skills
- Build on synergies across development sectors, moving away from supporting vertical disease-specific programs to more integrated and comprehensive health programming within the USG
- Enhance partnerships and resource leveraging with other non-USG stakeholders

In recent years, the URT has highlighted the importance of social and behavior change communication (SBCC) throughout its major national strategies and plans. The HSSP III and ZHSRSP II stress community participation and SBCC as tools to enhance adoption of healthier lifestyles and early healthcare-seeking behaviors. In addition, the Mainland's National Multi-Sectoral HIV Prevention Strategy (NMPS) and the URT and USG *Partnership Framework* demonstrate the commitment of both governments to address high-risk behaviors and supportive gender norms in order to improve health outcomes for Tanzanians.

The four areas of focus under this IR include: increased uptake of healthy behaviors and utilization of preventive health services and products with a focus on women and girls; improved early healthcare-seeking behaviors; strengthened social norms and female economic empowerment embedded within a supportive policy and regulatory environment; and strengthened coordination between public and private sector SBCC implementers with the requisite capacity to conduct quality SBCC. Each of these is associated with a URT target and is further described in *Annex 3: Intermediate Results Frameworks.*

IR 3.1 Increased Uptake of Healthy Behaviors and Utilization of Preventive Health Services and Products with a Focus on Women and Girls

Activities aim to increase uptake of preventive health practices, services and product use, especially among women and girls. For girls, these include immunizations, nutrition, and age-appropriate youth health education programs and life skills. For women, practices, services and products include regular antenatal care, immunizations, safe motherhood and reproductive health education and services, modern family planning, including condoms, and nutrition. Other preventive health services oriented to the family include couples communications, couples HIV testing and counseling, ART, adherence, and male circumcision. Attention will be paid to women's empowerment and ability to access these services with support from their spouses and communities. Strategies include formative research to improve the quality of targeted communications, scaling up of culturally appropriate community and facility based health communication programs, increased male involvement and access for male partners to sexual and reproductive health services, and scaling up evidence-driven SBCC interventions to address harmful gender norms.

The USG recognizes the importance of a country-led platform to foster an enabling environment for sustainable impact. The goal is to support capacity building of Tanzanian Civil Society Organization's (CSOs) and CSO networks, such as non-government organizations (NGOs) including any non-profit or voluntary organizations, print and broadcast media, religious groups, labor unions, academic institutions, consulting firms and for-profit private companies to contribute towards realizing conditions that will enable women and girls to achieve positive health outcomes. In addition to SBCC interventions these groups can be used to provide outreach services in rural hard to reach areas of the country.

Illustrative Interventions

- Support stakeholders to conduct formative research and develop state-of-the-art SBCC messages for target audiences
- Promote uptake of reproductive and MNCH services through increased use of modern and inexpensive technology (e.g. community radio, cell phone SMS)
- Increase coverage of reproductive health education and subsequent uptake of modern family planning, including condoms through capacity building of local civil society organizations and networks

- Scale-up existing Tanzanian and regional models of high quality and evidence-driven SBCC interventions focused on women and girls, such as the *Fataki* mass media campaign to reduce cross-generational sexual relationships and *Mama Ushauri* serial radio drama addressing multiple integrated health issues
- Strengthen male involvement and men's access to sexual and reproductive health services through community-level interventions and invitations to health facility-level initiatives

IR 3.2 Improved Early Healthcare-Seeking Behaviors by Mobilizing Individuals, Families and Communities

Approaches focus on early care-seeking behaviors for specific diseases and the development of community health literacy for early identification of signs and symptoms that warrant immediate care and treatment. Attention will focus on early detection of signs and symptoms, basic awareness to improve management of health conditions in the home (for example oral rehydration salts); women's empowerment and ability to seek services with support from their spouses and communities, and increased access to facilities (for example, support systems for transportation for patients and pregnant women from the community to health facilities). Finally, activities will aim to increase the accountability of council-level coordinating bodies to their respective communities (reference IRs 1.1 and 2.3).

Illustrative Interventions

- Expand mass communication and community outreach programming to educate communities and families about danger signs and symptoms, with a focus on safe motherhood, newborn and child survival, HIV/AIDS, malaria, and TB
- Build partnerships with Community Health Agents, including traditional leaders, to improve detection of warning signs and facilitate fast and effective referrals
- Strengthen Council Health Management Teams' and Council Multi-Sectoral AIDS Committees' capacity to make services and facilities user-friendly and enhance facility accountability
- Assess facilitators and barriers to early health-seeking behaviors and develop SBCC messages and programming to address these issues
- Create linkages to Feed the Future nutrition interventions to interlink nutrition and health messages and outreach programs.

IR 3.3 Strengthened Social Norms and Structural Environment for Empowerment of Women and Girls

Findings from the 2010 TDHS highlight the importance of GHI support to address GBV and women's empowerment. One in five women (20%) in Tanzania has experienced sexual violence, and 10% of women had their first sexual intercourse against their will. More than one-third of all women (39%) have suffered from physical violence at some point since age 15, and 33% of all women suffered from acts of violence during the past twelve months. Three in five women have sole or joint decision making power about their own healthcare, though only 39% participate in decisions about major household purchases.

Under this sub-IR, programs will employ SBCC approaches to increase individual, family, and community awareness of gender dynamics impacting health status and facilitate adoption of positive gender norms. Programs will support men as key change agents in parallel with empowerment strategies for women and girls. Services for GBV survivors will be established and expanded at both health facility and community levels in select regions. Programs will link to other sector activities as feasible, including education, democracy and governance, and agriculture.

Illustrative Interventions

- Utilize mass communication and community outreach programming to increase awareness and facilitate supportive gender norms that affect positive health outcomes (e.g. scale up Men as Partner's curriculum)
- Strengthen legal and regulatory framework to promote and enforce gender equity (e.g. support advocacy for review of the 'Sexual Offence Special Provisions Act' to raise the legal marital age from 14 years to 18 years)

- Harness interpersonal communication programming to increase dialogue about gender norms among key change agents (e.g. men to men/boys, couples, cultural gatekeepers)
- Establish and expand health facility- and community-based response and services for survivors of GBV in selected regions

IR 3.4 Strengthened Coordination and Capacity of Public and Private Sector SBCC Implementers

Approaches focus on SBCC coordination and capacity building within the MOHSW, Tanzania Commission for AIDS (TACAIDS), other government units, and civil society stakeholders involved in SBCC activities. SBCC interventions are expected to contribute to overall reductions in morbidity and mortality. Future discussions between the URT and USG will look at formulating measurable indicators to improve the monitoring and evaluation of specific behavior change interventions and the effect of SBCC as a component of an integrated service package. Existing national plans have identified indicators to measure progress specifically attributable to this intermediate result:

- Expanded and strengthened behavioral prevention programming, including capacity building of behavior change professionals, host country counterparts, and professional and lay counselors (*Partnership Framework Implementation Plan*)
- Community participation in MNCH, including nutrition, is increased through behavior change communications and strengthened advocacy (HSSP III)
- Partnerships at all levels, including with communities, are put in place to stimulate healthier lifestyles and early treatment of ill health conditions (HSSP III)
- National and local leaders are supported to become active change agents driving gender and socio-cultural transformation within their communities (NMPS and PFIP)

Illustrative Interventions

- Support a situational analysis of existing SBCC efforts
- Reinvigorate Information Education Committees / Health Education Units within the MOHSW and TACAIDS
- Establish, through the Information Education Committees / Health Education Units, a formal review process for communication materials and curricula
- Strengthen coordination to promote and scale up health education activities at national, regional and district levels
- Conduct training and mentoring for SBCC implementers at national, regional, and district levels
- Build local civil society capacity to develop and conduct context specific community based SBCC campaigns, with a focus on interpersonal communications
- Strengthen/establish M&E systems for SBCC efforts
- Establish new private-public partnerships (e.g. the Challenge Account linking education, health/HIV/AIDS, and girls' empowerment)

Table 5: IR 3 Healthy Behaviors Five Year Indicators

IR 3.1 Increased Demand and Utilization of Preventive Health Services and Products with a Focus on Women and Girls
Increase in percentage of women attending 4+ ANC visits, from 43% (TDHS 2010) to 60% in the to-be-determined focus regions by 2015 (refer to 1.3)
Increase in percentage of women receiving IPTp2, from 26% (TDHS 2010) to 60% in the to-be-determined focus regions by 2015 (refer to 1.3)
Increase in percentage of children under-five who slept under an ITN, from 64% (TDHS 2010) to 75%
Increase in percentage of currently married women who use modern contraceptive methods, from 24% (TDHS 2010) to 30%
Increase in percentage of women receiving HIV counseling and testing, from 55% (TDHS 2010) to 75% by 2015
Increase in percentage of men who have received HIV counseling and test results, from 40% (TDHS 2010) to 60%
IR 3.2 Improved Early Health-Seeking Behaviors
Increase in percentage of women receiving HIV counseling and testing from 55% (TDHS 2010) to 75% by 2015

Increase in percentage of men who have received HIV counseling and test results, from 40% (TDHS 2010) to 60%
70% of eligible infants in USG-supported facilities in the Lake Zone tested for HIV and appropriately referred by 2015 (refer to 1.4)
IR 3.3 Strengthened Social Norms and Structural Environment for Empowerment of Women and Girls
Increase in the percentage of married women who participate in decision-making over their own healthcare, major household purchases, and visits to their family or relatives, from 30% (TDHS 2010) to 35% by 2015
1 in 5 women have ever experienced sexual violence (TDHS 2010) reduced to 1 in 6 (2015) in GBV three regions
Decrease in percentage of men/women aged 15-49 who agree that a husband is justified hitting or beating his wife for specific reasons, from 38%/54% (TDHS 2010) to 32%/48% by 2015
IR 3.4 Strengthened Coordination and Capacity of Public and Private Sector SBCC Implementers
80% of trained national, regional, and district level SBCC implementers perform to a standard level of quality
Number of District Councils that have incorporated SBCC into their Comprehensive Council Health Plans and coordination fora
Post-graduate SBCC Masters level training initiated and 30 students graduated

3.3. Approaches in Tanzania that Demonstrate "Smart Integration"

The USG supports the GHI principle of "smart integration" or the organization, management, and coordination of programs that add value to the overall intent of GHI and specific activities. This includes linkages to non-health programs, such as education, democracy and government, agriculture, and economic development. The following are examples of smart integration that cut across all three IRs:

IMCI and Community-Case Management: GHI will help contribute towards a thorough integration of services addressing childhood illnesses embedded within functional facility-community linkages. Specific components include the integration of febrile illness diagnosis, referral, and management and the HIV pediatric care programs with coordinated community identification and referrals to facility-based programs and EID (refer to *1.4 Primary Prevention of Childhood Illnesses and Case Management of Children Under-Five*). Community Health Agents will bolster case identification and referrals, with Council Health Management Teams providing service quality oversight at the community level (refer to *3.2 Improved Early Health-Seeking Behaviors*). Required services and supplies will be available to clientele, even in remote areas (refer to *2.1 Improved Human Resources for Health* and *2.4 Improved Health Support Systems*). Healthy childhoods start with healthy births, a complete regimen of childhood vaccination, and good family nutrition (refer to *1.1 Family Planning Services* and *1.3 Improved Quality of Integrated Services for Women and Newborns*). As USG-supported partners continue program implementation under the GHI framework, they will link into other USG and non-USG supported programs available at the community level, such as Feed the Future nutrition and de-worming projects, education, and agriculture. Greater coverage and quality of comprehensive pediatric and family services should contribute to reductions in under-five mortality over the next five years.

Improved Livelihoods for Young Women and Girls: Under GHI, the USG has enormous potential to continue to foster a multi-sectoral approach addressing issues around health and life choices for young women and girls. Currently, USG-supported programs have integrated health, HIV, GBV reduction, and education programming to address adolescent pregnancies, school drop-out, HIV prevention, and life skills. In line with GHI principles, the USG will expand its girl platform to scale up age-appropriate multisectoral approaches for adolescent and pre-adolescent girls to incorporate education, democracy and governance, and economic opportunities, health, and reproductive health. USG-supported programs are engaged in legal and human rights issues to promote changes to the Marriage Act, such as raising the legal age of marriage, and are linked into the new USG Democracy and Governance strategy. USG support for education, girls' mentoring, and women champion programs will also connect into the GHI platform through a grants program that focuses on women's empowerment. As programs scale up, they will link to resources under all three IRs: quality integrated services, health systems strengthening, and healthy behaviors.

Integrated Services for Women of Reproductive Age: Under GHI, women of reproductive age will have more access to quality comprehensive healthcare services through linkages found within their communities. More

resources, including communications and education, products, and services, will be available to women and their partners as they make key decisions about their family and children (refer to *3.1 Increased Demand and Utilization of Preventive Health Services and Products with a Focus on Women and Girls* and *1.1 Family Planning Services*). As women have their children, available resources will include antenatal care, malaria prevention and control, HIV prevention and HIV testing, PMTCT, post-partum family planning, maternal nutrition, and delivery services (refer to *1.2 Increased Access to Quality Delivery and Newborn Care* and *1.3 Improved Quality of Integrated Services for Women and Newborns)*. Programs will link into other resources available at the community level, such as economic development, education, and GBV reduction. Widely scaled-up integrated services targeted to women in their reproductive years should help reduce maternal mortality.

4. Monitoring, Evaluation, and Metrics

The USG in Tanzania developed a GHI Results Framework (Annex 2), individual frameworks for each IR (Annex 3), and a GHI Strategy Matrix (Annex 4) to guide implementation of the GHI Strategy and the measurement of key outcomes, outputs, and processes. Under this framework, the USG seeks to reduce under-five and maternal mortality through three intermediate results. The USG will utilize the cross-cutting GHI indicators that are still in development and will report on selected URT country-level indicators from existing URT systems as much as possible. This is in line with the spirit of the "three ones" – one national plan, one coordination authority, and one national M&E system - that govern international HIV/AIDS efforts.

The TDHS will serve as the primary tool for collecting data on impact-level indicators, including neonatal, under-five, and maternal mortality levels. The latest TDHS was conducted in 2009/10 and the data from this round serves as a baseline for many of the outcome indicators in this strategy. As such, the next round of TDHS in 2015 is the best source of data for comparison purposes to measure the effect of GHI on a range of mortality outcomes following approximately five years of implementation.

Tanzania's health management information system (HMIS) and routine program reports will serve as the primary source of information for most of the output and process level indicators. The Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) and the TDHS will also act as information sources for these level indicators, especially for IRs 1 and 3. Special studies will be an integral part of the M&E effort. Specific surveillance systems will be utilized for selected indicators, such as HIV and malaria. The USG in Tanzania will report performance metrics to headquarters on an annual basis, using the Performance Plan and Report submitted each December through the Foreign Assistance Coordination and Tracking System (FACTS).

The USG has significant resources for metrics and research under existing initiatives and programs, including PEPFAR, PMI, Feed the Future, and Health projects. These resources include operational research and evaluations, and the USG will identify opportunities to look at measurement in a more systematic manner across health issues and programs. The USG will coordinate through existing research and M&E coordination bodies, including the PEPFAR public health evaluation team and the Development Partners Group's M&E technical working group.

5. GHI Management, Coordination, and Communications in Tanzania

5.1 GHI Management

The management of GHI in Tanzania will launch from and utilize established inter-agency coordination structures. Under PEPFAR, the Department of State, the United States Agency for International Development (USAID), the Department of Health and Human Services (HHS)/Centers for Disease Control and Prevention (CDC), the Walter Reed Army Institute of Research (WRAIR), and the US Peace Corps have established multi-layered planning, implementation, and reporting systems through well-choreographed technical and management teams. The structure ensures both technical and managerial participation from all agencies at all levels. PMI has an effective planning and implementation process in place between USAID, CDC, and

WRAIR. Additionally, all partner agencies ensure partner and URT program coordination and alignment with national roadmaps on MNCH, FP/RH, HIV, and other health issues through established technical working groups and partner meetings.

A core GHI coordination team, chaired by the GHI Coordinator with multi-agency participation, will work within integrated health planning structures. This group will replace the Mission Strategic Reporting and Planning Health Goal Group. This core group will be complemented by three inter-agency GHI Results Units representing each of the intermediate results. Each Result Unit will consist of relevant inter-agency technical staff and be responsible for program planning, coordination, and reporting by working through existing PEPFAR, PMI, Feed the Future, and Health operating structures. The GHI Coordinator's team will be responsible for national-level strategic policy and cross-cutting program matters.

This arrangement will respect each agency's internal operating environment and utilize existing inter-agency coordination mechanisms. At the same time, this approach will construct a distinct GHI coordination and planning structure to foster inclusive collaboration among all USG agencies with the lightest possible management and staffing footprint. It will leverage the technical capacities and strengths of each agency, and increase program efficiencies and integration in the pursuit of GHI public health impact. The GHI management model will be flexible, particularly during program start-up, and will work to simplify joint planning, coordinated implementation and program evaluation burdens.

The Chief of Mission and his representative, the Deputy Chief of Mission (DCM), will provide overall policy guidance to the GHI team. The DCM and the GHI Coordinator will provide day-to-day management guidance and operate through the existing Tanzania Country Health Team mechanism to report on GHI progress and issues. The Tanzania Country Health Team ensures broad representation of all relevant or interested USG agencies and provides a pre-existing assembly point to hold periodic planning and coordination meetings. The GHI Coordinator, in close consultation with the DCM, will represent GHI in Tanzania at senior URT levels and to GHI headquarters leadership. The Coordinator will request support from interagency technical experts as appropriate.

5.2 GHI Coordination

A well-defined and effective bilateral relationship is critical to the success of a genuine Tanzania-USG partnership and all Presidential initiatives. The Chief of Mission will set the tone and broad direction through regular bilateral dialogue at the highest levels of government, with the Chief of Mission as the US President's representative together with representatives of the President of Tanzania. These dialogues will address commitment, partnership, and reforms as they pertain to joint URT and USG health and development objectives in Tanzania. Engagement and regular communications on specific initiatives will cascade into existing bilateral political and technical fora and host-country management and coordination structures.

GHI will also build on and leverage the substantial multi-lateral partners and coordination structures and resources already in place in Tanzania. Partner governments and international agencies, including Canada, Denmark, Germany, Ireland, Japan, Netherlands, Norway, Switzerland, the World Bank, and the UN agencies, already collaborate on a number of health and development activities with the URT. These include the Health Basket Committee, the Tanzanian National Coordination Committee for Global Fund Grants, the Technical Committee of the Sector-Wide Approach (SWAp), and numerous technical working groups. Under the SWAp, GHI will align and leverage programs through these channels, and the central donor-government health coordination and information dissemination forum for GHI will be the Development Partners Group.

5.3 GHI Communications

The Embassy's Public Affairs Office (PAO), the USAID Development Outreach and Communications Officer, and HHS/CDC's and WRAIR's Public Affairs Officers will provide collective support to GHI public education efforts. Together, they will lead the development of a clear, mission-wide communication and outreach

strategy aligned to forthcoming guidance on GHI branding. Activities outlined in this GHI Communications Strategy will seamlessly meld into the USG's broader public diplomacy, outreach, education, and policy reform efforts. The PEPFAR, PMI, Feed the Future, and other Health programs will build on already active media, social networking, policy and advocacy programs, and civil society networks to share information, issue key messages, and maximize the use of innovative media.

PAO staff will work with the GHI Coordinator's team to produce supportive and clear documentation to improve communications, the flow of information to headquarters' stakeholders, civil society, and bilateral USG-Tanzania dialogue. The USG's high level of focus and engagement in Tanzania results in frequent high-level missions, of which GHI will be a future focus, and PAO staff are essential in supporting these visits.

6. Linking High-Level Goals to Programs

The USG in Tanzania plans to implement GHI programs and activities through existing USG programming. *Table 6: High Level Activities Critical to Implementing the Tanzania GHI Strategy* presents the broad technical activities on which the USG will focus in each of the three areas of focus, or intermediate results, with supporting benchmarks and 18 month indicators. The chart also indicates from which programs resources are available, be it funding, technical assistance, or both. The USG will incorporate detailed planning for all to support the achievement of GHI targets in each of the annual country plans, including PEPFAR's Country Operational Plan, PMI's Malaria Operational Plan, and the Health Operational Plans (OP).

Table 6: High Level Activities Critical to Implementing the Tanzania GHI Strategy

Broad Technical Approaches	Key Activities	18 Month Indicators
IR 1: Increased Access to Quality Integrated Services with Focus on MNCH and FP/RH		**Resources Available:** OP (FP); OP(MNCH); PEPFAR; PMI; Feed the Future
Strengthen the provision of integrated prevention of childhood illnesses and maternal health programs and services: • Scale up a comprehensive service supervision tool tied to standards-based quality improvement • Strengthen staff capacity at primary facilities to provide integrated services • Strengthen district oversight, referral, and transport systems • Expand facility-based case management	Years 1-2 • Pilot comprehensive service supervision tool, quality improvement system, and facility-based case management model • Pilot Council Health Management Teams service oversight and Community Agent case identification/ referral model • Update pre- and in-service training curricula • Roll out FP/RH integration in all HIV/AIDS service platforms • Integrate severe febrile illness program with EID and nutrition Years 3-5 • Scale up supervision tool/quality assurance system in focus regions • Roll out integrated women and newborn services in focus regions	• Percentage of staff trained in integrated women/newborn services, BEmONC, FP/RH integration (25% in focus regions), and severe febrile illness & pediatric care (20% in 3 Lake Zone regions) • Percentage of facilities with quality improvement standards and receive supervision visits (20% in focus regions; 15% in 3 Lake Zone regions) • Percentage of facilities in selected regions providing integrated women/newborn services, BEmONC, FP/RH (50% in focus regions), and severe febrile illness & pediatric care (30% in 3 Lake Zone regions) • 40% of districts with Council Health Management Team oversight • 40% of facilities in focus regions receive Community Agent referrals • 45% of HIV/AIDS sites offer FP/RH services as a core component
IR 2: Improved Health Systems to Strengthen the Delivery of Healthcare Services		**Resources Available:** OP (FP); OP(MNCH); PEPFAR; PMI
• Strengthen staff capacity through infrastructure investments and training • Strengthen health workforce through deployment policies and non-financial incentives for remote areas, i.e., orientation, work climate improvements, performance management, and employee morale • Institutionalize a culture of evidence-driven decision-marking • Investigate financing & payment schemes • Strengthen civil society oversight in service delivery • Ensure effective procurement and supply chain management systems • Strengthen comprehensive laboratory management systems and accreditation	Years 1-2 • Initiate infrastructure improvements & staff training • With the URT update staff retention and deployment policies • Expand use of Integrated Disease Surveillance and Responses System with data use incorporated into URT planning • Support the roll out of district Financial Audits • Provide technical assistance for developing the health financing strategy and regulatory framework • Provide technical assistance to improve stock availability Years 3-5 • Support the roll out of staff retention and deployment policies • National laboratory accreditation program established • National commodities processes and systems integrated	• Infrastructure improvements support 7 training institutions • Training slots increased by 250 with USG Funds • District strengthening for improved retention underway in 65 districts • 10% of districts use Integrated Disease Surveillance & Response System • 10% of districts develop Comprehensive Council Health Plans using data from the HMIS • 70% of 27 districts receive a clean Overall Financial Audit report • 70% of 27 targeted districts submit plans that exceed Comprehensive Council Health Plans assessment criteria with a score of at least 70% • A health financing strategy and regulatory framework for health insurance is approved • A fully operational Enterprise Resource Program operational in all 9 Medical Stores Department zonal warehouses
IR 3: Improved Adoption of Healthy Behaviors including Healthcare-Seeking Behavior with Focus on Girls and Women		**Resources Available:** OP (FP); OP (MNCH); PEPFAR; PMI; Feed the Future
Strengthen behaviors and social norms to facilitate positive health outcomes: • Expand evidence-driven SBCC • Engage traditional & community leaders in SBCC and linkages/referrals to care • Promote gender equity in accessing resources & services and male involvement, and mitigate harmful social norms • Strengthen implementers' capacity and coordination in state-of-the- art SBCC	Years 1-2 • Conduct SBCC situational analysis • Pilot innovative technology SBCC solutions to service uptake • Scale up evidence-driven SBCC focused on women, girls, and men • Pilot Community Health Agent and Council Health Management Teams SBCC oversight program • Roll out GBV response and services project Years 3-5 • Partnerships between communities & local government authorities result in locally-driven SBCC initiatives	• Revised HIV Testing & Counseling Register in place and monitoring of couples counseling and testing started • Complete 19 trainings for SBCC implementers at all levels • Protocol for situational analysis of existing health education efforts completed and submitted for approval • Evidence-driven SBCC models developed and disseminated • Three technology SBCC solutions tested and taken to scale • Roll out coordinated multiple concurrent partnership SBCC initiative • SBCC integrated into Feed the Future and the new nutrition, agriculture, and economic strengthening project

Annex 1: Key Health and Health System Indicators in Tanzania

Indicator		Source
Population	43,739,051	World Bank World Development Indicators (WDI 2009)
GDP per capita (constant 2000 US$)	354.17	WDI 2009
2008 per capita total expenditure on health (adjusted for purchasing power parity in $)	57	World Health Organization World Health Statistics (WHO WHS 2011)
Life expectancy at birth, total (years)	52	WDI 2009
Fertility rate, total (births per woman)	5.4	Tanzania Demographic Health Survey (TDHS 2010)
Annual population growth rate	2.7%	WHO WHS 2011
Contraceptive prevalence (of women ages 15-49)	34%	TDHS 2010
Unmet need for family planning, currently married women	20.7%	TDHS 2010
Births attended by skilled health personnel	51%	TDHS 2010
Mortality rate, infant (per 1,000 live births)	51	TDHS 2010
Mortality rate, under-five (per 1,000 live births)	81	TDHS 2010
Maternal mortality ratio (per 100,000 births)	454	TDHS 2010
Pregnant women who received 1+ antenatal care visits	96%	TDHS 2010
Pregnant women who received 4+ antenatal care visits	43%	TDHS 2010
Fully vaccinated by 12 months of age, children age 12-23 months	66.2%	TDHS 2010
Households with at least one insecticide treated net (ITN)	63.8%	TDHS 2010
Pregnant women who slept under an ITN the previous night	56.9	TDHS 2010
Children under-five sleeping under an insecticide treated bed net (ITN / long-lasting insecticide net)	64%/ 24%	Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) 2010
Children under-five with diarrhea received oral rehydration	63%	WDI 2009
Number of orphans and vulnerable children, age 0 – 17	1,300,000	UNAIDS 2009
TB incidence (all forms; new cases per year)	120,000	WHO 2009
Malaria mortality rate (per 100,000 population)	87	WHO WHS 2011
HIV prevalence (of population aged 15-49)	5.8%	THMIS 2007/08
Men age 15-49 who report having been circumcised	72%	TDHS 2010
Number of people living with HIV (PLHIV)	1,400,000	UNAIDS 2009
Number of HIV-infected people receiving Anti-retroviral theory (ART)	255,000	PEFAR Semi-Annual report 2011
Pregnant women counseled and tested for HIV and received test results during antenatal care visit	55%	TDHS 2010
Population using improved drinking water sources	54%	WHO WHS 2011
Population using improved sanitation	24%	WHO WHS 2011
Physician density (per 10,000 population)	0.4	HSSP III
Nursing and midwifery personnel density (per 10,000 pop.)	2.6	HSSP III
Pharmaceutical personnel density (per 10,000 population)	<0.05	WHO WHS 2011
Hospital beds (per 10,000 population)	11	WHO WHS 2011

Annex 2: Global Health Initiative Results Framework

Tanzania Global Health Initiative Results Framework

Health Goal: Improved Health Status for All Tanzanians

Expected Impact: Reduced Under-Five Mortality ♦ Maternal Mortality

Critical Assumptions

- URT continues its commitment to building a sustainable, financed national health program, including health sector reform and increased budget support for health and the health workforce
- Through 2015, USG funding remains level or increases (PEPFAR, PMI, Feed the Future, and other health programs)
- The support from critical partners, including the Global Fund and other donors, is well-coordinated and disbursed as planned
- Non-USG Investments in Tanzania's health workforce, materials, supplies, and commodities continue to increase and are prioritized towards the achievement of MDGs 4 and 5

IR 1 Increased Access to Quality Integrated Services with Focus on MNCH and FP/RH

IR 1.1 Integration of Family Planning into the Full Range of Health Services

IR 1.2 Increased Access to Quality Delivery and Newborn Care

IR 1.3 Improved Quality of Integrated Services for Women and Newborns

IR 1.4 Improved Quality of Primary Prevention of Childhood Illness and Case Management of Children Under-Five

IR 2 Improved Health Systems to Strengthen the Delivery of Healthcare Services

IR 2.1 Improved Human Resources for Health for Efficient Quality Service Delivery

IR 2.2 Improved Integration and Effectiveness of Monitoring and Evaluation Systems

IR 2.3 Strengthened Governance, Management, and Financing in Advancement of National Policies and Systems

IR 2.4 Improved Health Support Systems

IR 3 Improved Adoption of Healthy Behaviors, Including Healthcare-Seeking Behaviors with a Focus on Women and Girls

IR 3.1 Increased Uptake of Healthy Behaviors and Utilization of Preventive Health Services and Products with a Focus on Women and Girls

IR 3.2 Improved Early Healthcare - Seeking Behaviors by Mobilizing Individuals, Families and Communities

IR 3.3 Strengthened Social Norms and Structural Environment for Empowerment of Women and Girls

IR 3.4 Strengthened Coordination and Capacity of Public and Private Sector SBCC Implementers

GHI will strengthen integration between USG-funded programs in HIV/AIDS, malaria, maternal, newborn, & child health, nutrition, TB, family planning & reproductive health

GHI contributes to the United Republic of Tanzania's Millennium Development Goals 4 & 5:
By 2015: Reduce Under-Five Mortality to 48 per 1,000 ♦ Reduce Maternal Mortality to 265 per 100,000

Annex 3: Intermediate Results Frameworks

Tanzania GHI Results Framework

IR 1 Increased Access to Quality Integrated Services with More Focus on MNCH and FP/RH

IR 1.1 Integration of Family Planning Services into the Full Range of Health Services

ACTIVITIES

- Use the national HIV/AIDS platforms to accelerate critical services throughout the country
- Finalize the integration of family planning and health services training curricula
- Expand USG support to the RCHS service integration technical working group: develop accelerated work plan, management tools, and costed plan for services development
- Include FP/RH integration in national pre- and in-service training
- Expand FP/RH integration activities to five regions
- Conduct research to inform policy and service delivery

IR 1.2 Increased Access to Quality Delivery and Newborn Care

ACTIVITIES

- Use the national PMTCT platform to accelerate critical services throughout the country
- Roll out national BEmONC curriculum:
  - Train supervisors and staff in BEmONC; establish an on-site, standards-based quality improvement system; conduct a BEmONC needs assessment; and establish an integrated facility supervision system
- Strengthen district referral and transport systems for higher-level lifesaving interventions (e.g. Cesarean section and blood transfusions)
- Prioritize BEmONC in districts' annual budgeting and planning

IR 1.3 Improved Quality of Integrated Services for Women and Newborns

ACTIVITIES

- Use the national PMTCT platform to accelerate critical services throughout the country
- Expand the HIV supervision tool to incorporate standards of care in MNCH, FP/RH, and nutrition
- Pilot the expanded comprehensive supervision tool in five areas
- Develop a provider quality improvement feedback system and response mechanism
- Disseminate the tool to all HIV partners and the Regional and District Health Management Team

IR 1.4 Improved Quality of Primary Prevention of Childhood Illness and Case Management of Children Under-Five

ACTIVITIES

- Use the Feed the Future and GHI nutrition platform to accelerate critical services throughout the country
- Develop facility- and community-based programs for integrated management of severe febrile illness, EID, and nutrition in three Lake Zone regions:
  - Strengthen facility-based case management; community-based identification and referrals; and coordination between PMI and PEPFAR partners for facility- and community-based activities
- Scale up developed tools and methodologies to other PMI- and PEPFAR-funded regions
- Support on-going preventive health interventions

Critical Assumptions

Human Resources & HMIS: Personnel shortages will remain a critical issue for the next few years; a functioning HMIS will continue to be developed and utilized

Commodities: While individual supplies will receive support, overall this is a critical area with insufficient financial support

Demand: There is continued demand creation for services

Comprehensive care: There is a continued upgrading of referral hospitals, including blood banking, equipment and infrastructure

Governance and Funding: Planning, budgeting, and execution will be supported by work with Regional/District Health Management Teams

Tanzania GHI Results Framework

IR 2 Improved Health Systems to Strengthen the Delivery of Healthcare Services

IR 2.1 Improved Human Resources for Health for Efficient Quality Service Delivery

ACTIVITIES

- Expand pre-service training of health workers through infrastructure investments
- Strengthen faculty: update integrated pre-service training curriculum, teaching materials, and teaching methods
- Improve deployment and retention of health workers to underserved districts
- Support the establishment and training of additional cadres for roles that do not require previous clinical training

IR 2.2 Improved Integration and Effectiveness of Monitoring and Evaluation Systems

ACTIVITIES

- Support national expansion of the Integrated Disease Surveillance and Response System
- Support national population surveys, studies, or evaluation activities and support sharing of evidence through a URT data warehouse
- Institutionalize a culture of data use and evidence-based decision-making
- Promote on-the-job mentoring of URT staff on data collection and use

IR 2.3 Strengthened Governance, Management, and Financing in Advancement of National Policies and Systems

ACTIVITIES

- Strengthen leadership, management, and accountability at the national and local levels to prioritize, execute, and be accountable for health programs
- Support the expansion of health care financing options
- Participate in the planning, development, and piloting of provider payment schemes
- Link with other programs, such as Democracy and Governance and Feed the Future, to foster an informed and active citizenry engaged as stakeholders to ensure accountability for funded local health programs

IR 2.4 Improved Health Support Systems

ACTIVITIES

- Integrate vertical program commodities processes and systems to create a highly cost-effective system
- Assist the URT to cascade a standard set of laboratory services across all levels
- Increase the quality of lab services at all levels and the number of accredited labs

Critical Assumptions

Strategic Information: Continued URT commitment to improve HMIS system and use of data

Leadership, Management, and Governance: Continued progress towards decentralization by devolution and greater transparency; greater political will to implement health financing options

Human Resources: Scale up of health workers remains a high priority for the URT; leveraging with other donors remains viable

Commodities: Procurement plans executed on a timely basis

Laboratory: the URT continues to embrace the need for preventive maintenance within laboratories

Tanzania GHI Results Framework

IR 3 Improved Adoption of Healthy Behaviors including Healthcare-Seeking Behavior with Focus on Girls and Women

IR 3.1 Increased Uptake of Healthy Behaviors and Utilization of Preventive Health Services and Products with a Focus on Women and Girls

ACTIVITIES

- Promote uptake of reproductive and MNCH services through increased use of modern and inexpensive technology
- Support stakeholders to conduct formative research and develop SBCC messages for target audiences
- Scale existing Tanzanian and regional models of high quality and evidence-driven SBCC interventions
- Strengthen male involvement and men's access to sexual and reproductive health services

IR 3.2 Improved Early Healthcare - Seeking Behaviors by Mobilizing Individuals, Families and Communities

ACTIVITIES

- Expand mass communication and community outreach programming to educate communities and families
- Build partnerships with Community Health Agents to improve detection of warning signs and facilitate referrals
- Strengthen Council Health Management Teams' and Council Multi-Sectoral AIDS Committees' capacity to make services and facilities user-friendly and enhance facility accountability
- Assess facilitators and barriers to early health-seeking behaviors and develop SBCC messages and programming to address these issues

IR 3.3 Strengthened Social Norms and Structural Environment for Empowerment of Women and Girls

ACTIVITIES

- Utilize mass communication and community outreach programming to increase awareness and facilitate supportive gender norms
- Strengthen legal and regulatory framework to promote and enforce gender equity
- Harness interpersonal communication programming to increase dialogue about gender norms among key change agents
- Establish and expand health facility- and community-based response and services for survivors of GBV in three regions

IR 3.4 Strengthened Coordination and Capacity of Public and Private Sector SBCC Implementers

ACTIVITIES

- Support a situational analysis of existing SBCC efforts
- Strengthen coordination to promote and scale up health education activities at national, regional and district levels
- Conduct training and mentoring for SBCC implementers at national, regional and district levels
- Strengthen/establish M&E systems for SBCC efforts

Critical Assumptions

Leadership: Strong and continued URT leadership to operationalize effective SBCC components of national strategy and policy documents

Referrals: Increased linkages and effective referrals between community and facility public health interventions as a foundation to health programs

Accountability: The URT holds Council Health Management Teams and Council Multisectoral AIDS Committees accountable to ensure user friendly and high quality services

Annex 4: Global Health Initiative Matrix

Tanzania Global Health Initiative Matrix					
Tanzania GHI Intermediate Result	**Relevant Key National Priorities & Initiatives**	**Key Priority Actions & Activities Likely to Have Largest Impact**	**GHI Tanzania Baseline Information & Five Year Targets**	**Tanzanian and GHI Health Goals**	**Key GHI Principles**
IR 1: Increased Access to Quality Integrated Services with Focus on Maternal, Newborn, and Child Health, Family Planning, and Reproductive Health					
IR 1.1 Integration of Family Planning into the Full Range of Health Services	Increase modern contraceptive prevalence rate from 20% to 60% in 2015 (*Roadmap*)	Use the national HIV/AIDS platforms to accelerate critical services throughout the country Finalize the integration of family planning and health services training curricula for supervisory personnel who manage health facilities and specific provider cadres; develop pre- and in-service training materials and health facilities guidance Expand USG support to the RCHS service integration technical working group and develop an accelerated work plan, management tools, and a costed plan for integrated service delivery Include FP/RH integration in national pre- and in-service training, including the certification of master trainers Expand current FP/RH integration activities to five regions Conduct research to inform policy and service delivery, including a study to investigate the cost and cost-savings of family planning and health integration, the impact of accelerated FP update, and ongoing services delivery programs midterm evaluations	15% increase from baseline in the Contraceptive Prevalence Rate (3 percentage points per annum) in 5 TBD focus regions by 2015	**Child Health** GHI goal: Reduce under-five mortality rates by 35% across assisted countries TZ MDG 4: 20% reduction in all-cause under-5 mortality from baseline (2010 estimate of 81/1000) **Maternal Health** GHI goal: Reduce maternal mortality by 30% across assisted countries TZ MDG 5: Reduce maternal mortality by more than 40% from 454/100,000 (TDHS 2010) to 265/100,000 live births by 2015 **Family Planning and Reproductive Health** GHI goal: Prevent 54 million unintended	Prioritize comprehensive integrated services and BEmONC in districts' annual comprehensive planning and budgeting activities to promote **sustainability** of program Increase impact through **strategic coordination and integration** between USG and PEPFAR partners to incorporate MNCH, FP/RH, malaria, and nutrition interventions into the current supervision and mentorship activities Reproductive and child health services are delivered in an **integrated** model Interventions will be evaluated and disseminated to promote **learning and**

Tanzania Global Health Initiative Matrix

Tanzania GHI Intermediate Result	Relevant Key National Priorities & Initiatives	Key Priority Actions & Activities Likely to Have Largest Impact	GHI Tanzania Baseline Information & Five Year Targets	Tanzanian and GHI Health Goals	Key GHI Principles
IR 1.2 Increased Access to Quality Delivery and Newborn Care	Increase birth by skilled attendants from 46% to 80% by 2015 (*Roadmap*) Increase coverage of comprehensive BEmONC from 64% to 100% of hospitals, and basic BEmONC from 5% to 70% of health centers and dispensaries by 2015 (*Roadmap*) Increase the provision of essential newborn care to 75% of facilities (*Roadmap*)	Use the national PMTCT platform to accelerate critical services throughout the country With technical assistance and facility-based support from PMTCT partners, roll out the national BEmONC curriculum: • Train supervisors and staff in BEmONC at established regional training sites • Establish an on-site, standards-based quality improvement system to promote facility practices • Conduct a BEmONC basic equipment and supplies needs assessment • Establish an integrated facility supervision system (refer to IR1.1) Increase the availability of and strengthen district referral and transport systems to higher-level lifesaving interventions additional to BEmONC (e.g. Cesarean section and blood transfusions) Prioritize BEmONC in District Councils' annual budgeting and planning to promote program sustainability	80% of USG-supported facilities in the to-be-determined focus regions implement the integrated supervision tool by 2015 (aligned to HSSP III's goal of 80% of deliveries are facility- based; baseline under collection) 50% of maternal and newborn deaths are audited in a standardized fashion in USG-supported facilities in the to-be-determined focus regions by 2015 (baseline under collection) 50% of USG-supported facilities with PMTCT programs in the to-be-determined focus regions provide BEmONC services performed to standard by 2015 (baseline under collection)	pregnancies **Contribute to other goals:** **HIV/AIDS** GHI goals: Prevent more than 12 million new infections; Provide support for more than 5 million orphans and vulnerable children; Provide direct support for more than 4 million on treatment and care **Nutrition** Reduce child under-nutrition by 30% **Malaria** Halve the burden of malaria for 450 million people	**accountability** **Prioritizing women's** right to health by focusing on improved child and maternal health **Strategic coordination** with other partners Interventions will be evaluated and disseminated to promote **learning and accountability**
IR 1.3 Improved Quality of Integrated Services for Women and Newborns	Maternal health priorities: *National Roadmap Strategic Plan to Accelerate Reduction of Maternal, Newborn, and Child Deaths in Tanzania (2008-2015)* and other guiding documents:	Use the national PMTCT platform to accelerate critical services throughout the country Expand the current HIV supervision tool, developed under PEPFAR and now part of the national program, to incorporate standards of care in MNCH, FP/RH, and nutrition	Increase in percentage of women attending 4+ ANC visits, from 43% (TDHS 2010) to 60% in the to-be-determined focus regions by 2015		

Tanzania Global Health Initiative Matrix

Tanzania GHI Intermediate Result	Relevant Key National Priorities & Initiatives	Key Priority Actions & Activities Likely to Have Largest Impact	GHI Tanzania Baseline Information & Five Year Targets	Tanzanian and GHI Health Goals	Key GHI Principles
	Women attending 4+ ANC visits increased from 64% to 90% by 2015 (*Roadmap*) Increase the % of pregnant women with HIV receiving ART for PMTCT to 80% by 2015 (*Roadmap*) 75% of villages have community health workers offering MNCH services by 2015 (*Roadmap*)	Pilot the expanded comprehensive supervision tool in focus regions (four Mainland regions and Zanzibar) Disseminate the comprehensive supervision tool to all HIV partners and conduct integrated supervision and track impact in focus regions with the Regional and District Health Management Teams Develop a provider feedback system and response mechanism that incorporates quality improvement: • Facilities create plans to address deficiencies identified during supervision • Issues identified in supervision visits are reviewed in subsequent visits to ensure they are addressed in a timely manner	Increase in percentage of women receiving IPTp2, from 26% (TDHS 2010) to 60% in the to-be-determined focus regions by 2015 30% increase from baseline in the percentage of pregnant women receiving HIV counseling, testing, and results in the to-be-determined focus regions by 2015 (aligned to the national target of 80% by 2015; baseline under collection) 30% increase from baseline in the percentage of HIV-infected pregnant women in USG-supported facilities in the to-be-determined focus areas who received ARVs by 2015 (aligned to the national target of 90% by 2015; baseline under collection)		
IR 1.4 Improved Quality of Primary Prevention of Childhood	Key child health priorities from the *National Roadmap Strategic Plan to Accelerate Reduction of Maternal, Newborn, and Child Deaths in Tanzania (2008-2015)*	Use the Feed the Future and GHI nutrition platform to accelerate critical services throughout the country Integrate existing health facility- and community-based programs for management of severe febrile	Establishment of quality assurance systems for the malaria rapid diagnostics test program in 80% of USG- supported facilities in the Lake Zone by 2015		

Tanzania Global Health Initiative Matrix

Tanzania GHI Intermediate Result	Relevant Key National Priorities & Initiatives	Key Priority Actions & Activities Likely to Have Largest Impact	GHI Tanzania Baseline Information & Five Year Targets	Tanzanian and GHI Health Goals	Key GHI Principles
Illnesses & Case Management of Children Under-Five	Increased immunization coverage of DTP-HB3 and measles to above 90% in 90% of districts (*Roadmap*) Introduce new vaccines to EPI (Hib, pneumococcal, HPV, and rotavirus) (*Roadmap*) Among U5, reduce stunting from 38% to 22%, and reduce underweight from 22% to 14% by 2015 (*Roadmap*) Increase exclusive breastfeeding from 41% to 80% by 2015 (*Roadmap*) 90% of sick children seeking care at facilities are appropriately managed by 2015 (*Roadmap*) Increase U5 sleeping under ITNs from 16% to 80% by 2015 Increase the provision of essential newborn care to 75% of facilities (*Roadmap*)	illness, EID, and nutrition in the three Lake Zone regions: • Strengthen facility-based case management including laboratory services (e.g. malaria and HIV diagnostic tests) • Strengthen community-based identification and referral of sick and malnourished children • Strengthen coordination between PMI- and PEPFAR-funded partners in the Lake Zone for facility- and community-based activities Scale up developed tools and methodologies to other PMI- and PEPFAR-funded regions as results are demonstrated and funding allows Support on-going preventive interventions (e.g.: nutrition counseling and food supplementation for infants and young children; sanitation and hygiene; technical assistance to MOHSW Expanded Program of Immunizations to introduce pneumococcal and rotavirus vaccines; maintain national gains in ownership and use of ITNs by children under-five)	35% decrease (from 109/1,000 to 70/1,000) in all-cause under-five mortality in the three Lake Zone regions by 2015 70% of eligible infants in USG-supported facilities in the Lake Zone tested for HIV and appropriately referred by 2015 (baseline under collection) 80% of eligible children immunized with pneumococcal vaccine (2015)		

Key Partners
Collaborating partners: MOHSW, ZMOH, EU, Royal Netherlands Embassy, CIDA, DfID, EKN, AUSAID, WB, SDC, GFATM, GAVI, WHO, Ifakara Health Institute, UNICEF and UNFPA
Implementing partners: AIDS Relief, Harvard, JHU, TCCP, Abt/Wajibika, FHI, JHPIEGO, Engender Health, PSI, AMREF,MUHAS, Pathfinder, CU/ICAP, EGPAF, Africare, Tanzanian Interfaith Partnership (TIP), World Lung Foundation, Mbeya HIV Network, KIHUMBE, RODI, SONGONET, RMOs in Mbeya, Rukwa & Ruvuma, MHNT, Mbeya Referral Hospital, CSSC, MDH, and Peace Corps

Tanzania Global Health Initiative Matrix

Tanzania GHI Intermediate Result	Relevant Key National Priorities & Initiatives	Key Priority Actions & Activities Likely to Have Largest Impact	GHI Tanzania Baseline Information & Five Year Targets	Tanzanian and GHI Health Goals	Key GHI Principles
IR 2: Improved Health Systems to Strengthen the Delivery of Healthcare Services					
2.1 Improved Human Resources for Health for Efficient Quality Service Delivery	*URT Human Resource for Health Strategic Plan 2008-2013*; *HSSP III* both include key priorities related to: • Scale up of health workers • Improving recruitment/ retention/ productivity • Establishing an HR Information System • Improving workforce management and utilization National Targets: Nurse Midwives per 10,000 population increased to 4.5/10,000 nationwide (baseline at 2008 = 2.8) Training slots increased to 10,000 (baseline 2011 = 5800	Expand pre-service training of health workers through infrastructure investments at a minimum of seven prioritized health training institutions per year Strengthen faculty by updating an integrated pre-service training curriculum, teaching materials, and teaching methods Improve deployment and retention of health workers to underserved districts by strengthening overall staff forecasting and retention and increasing non-financial incentives for remote areas, including orientation, work climate improvements, performance management, and employee morale Expand the health workforce by supporting the establishment/training of additional cadres for specific roles that do not require previous clinical training (e.g. logisticians, data clerks, medical records clerks, biomedical engineers, health managers)	Healthcare worker productivity increased by 10% by 2015 (baseline at 40% in 2007; NIMR Assessment) Nurse-Midwives per 10,000 population increased to 3.5/10,000 population in 65 underserved target districts by 2015 (baseline at 2008 = 2.8; MOHSW annual profile report) Training slots increased by 1,250 with USG funds by 2015 (baseline 5,800 in 2011; MOHSW Dept. of Human Resources) Vacancy rate reduced by 2015 (baseline data under collection; MOHSW data)	**Child Health** GHI goal: Reduce under-five mortality rates by 35 percent across assisted countries TZ MDG 4 goal: 20% reduction in all-cause under-5 mortality from baseline (2010 estimate of 81/1000) **Maternal Health** GHI goal: Reduce maternal mortality by 30% across assisted countries TZ MDG 5goal: Reduce maternal mortality by more than 40% from 454/100,000 (TDHS 2010) to 265/100,000 live births **Family Planning and Reproductive Health** GHI goal: Prevent 54 million unintended pregnancies	All human resources for health will be conducted by **leveraging partner engagement** with the URT and other development partners in a multi-donor funded Health Workforce Initiative **Country ownership:** MOHSW leads the Health Workforce Initiative and all other health systems strengthening activities in the country **Sustainability and health systems strengthening** through expanded workforce, productivity, and training quality and capacity
IR 2.2 Improved Integration and Effectiveness of Monitoring and Evaluation Systems	From *HSSPIII* M&E priorities: • Develop a comprehensive M&E and Research Strategy for health and social welfare • Strengthen integrated systems for disease surveillance	Support national expansion of the Integrated Disease Surveillance and Response System and reporting of Core Indicators to ensure effective flow of quality information Support national population surveys, studies, or evaluation activities that provide evidence to multiple health programs and support sharing of	60% of 133 districts using Integrated Disease Surveillance and Response System by 2015 (baseline: 1 district;) 75% of USG-funded management or data		**Sustainability** through **health systems strengthening** of national data systems

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	• Strengthen integrated routine HMIS • Introduce data aggregation and sharing systems based on ICT • Enhance surveys and operational research National Targets: Health facilities submitting timely and complete HMIS reports to the district (number and percentage): 2400 by 2013 (Global Fund proposal target) Increase modern contraceptive prevalence rate from 20% to 60% in 2015 (*Roadmap*)	evidence through a URT data warehouse Institutionalize a culture of data use and evidence-driven decision-making by establishing, implementing, and continuously improving a data use and dissemination strategy Promote on-the-job mentoring of URT staff on data collection, compilation, analysis, interpretation, and data use	collection information systems submitting aggregate data to national Health Information System by 2015 (baseline under collection; MOHSW Health Resource Secretariat) 60% of 133 district councils use HMIS core indicators to develop annual Comprehensive Council Health Plans by 2015 (baseline under collection; MOHSW Health Resource Secretariat) 3 cross-cutting (> than health issue) evaluations or studies per year receive joint funding by 2015 (e.g. THMIS, SAVVY; USG-collected data)	**HIV/AIDS** GHI goals: Prevent 12 million new infections; Provide support for 5 million orphans and vulnerable children; Provide direct support for 4 million on treatment and care **Nutrition** Reduce child under-nutrition by 30 percent **Malaria** Halve the burden of malaria for 450 million people **Tuberculosis** Contribute to the treatment of 2.6 million new cases of TB and a 50% reduction in TB deaths and disease burden	**Leveraging partner engagement** with the URT and other development partners in a multi-donor funded M&E Initiative **Strategic coordination** of M&E Investments Promote learning and accountability through **M&E** Accelerate results through **research and innovation** including data for decision making as an integral component of programming
IR 2.3 Strengthened Governance, Management, and Financing in Advancement of National Policies and Systems	From the *HSSP III*: Provide equitable access to quality health services for all Ensure a governance system that ensures accountability, transparency, and adherence to leadership ethics Strengthen and decentralize management of District Health	Strengthen leadership and management at the national and local levels to prioritize, execute, and be accountable for health programs Support the expansion of healthcare financing options, particularly for the poor, to ensure access to essential health services that will reduce maternal, child, and infant morbidity and mortality Participate in the planning, development, and	20% of the population is covered with a pre-paid insurance by 2015 (baseline 8.6% in 2011; MOHSW Dept. of Policy and Planning) 70% of all districts receive a clean Overall Financial Audit report by 2015 (baseline 48%; Basket		Increased programmatic and fiscal accountability will strengthen the ability to use host country systems and improve **country ownership** Strengthening decentralization and its

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	Services and harmonize MOHSW and PMO-RALG management procedures Reduce the budget gap in the health sector by mobilizing adequate and sustainable financial resources National Targets: Increase complementary financing for health services to 10% by 2014 45% of the population is covered with a pre-paid insurance (baseline 8.6%)	piloting of provider payment schemes that promote efficiency, quality, and results Link with other programs, such as Democracy and Governance and Feed the Future, to foster an informed and active citizenry engaged as stakeholders to ensure accountability for funded local health programs	Finance Audit Committee Reports) 70% of all districts submit plans that exceed the national Comprehensive Council Health Plans assessment criteria with a score of at least 70% by 2015 (baseline under collection; MOHSW Health Resource Secretariat)		success is related to accountability for provision of quality services and for the funds provided for that purpose will **strengthen health systems** Accelerating the expansion of pre-paid insurance for essential maternal and child services will help to achieve a **woman/girl centered approach**
IR 2.4 Improved Health Support Systems	Key priorities from the *HSSP III*: Percentage of public health facilities with any stock outs of 5 tracer drugs and 1 vaccine and medical devices and supplies (representing laboratory, theatre, ward and clinic) (no baseline or target) Key priorities from the *Five Year Partnership Framework in Support of the Tanzanian National Response to HIV and AIDS, 2009-2013* Strengthen logistic management systems to provide drugs,	Integrate vertical program commodities processes and systems, including procurement forecasting, quantification, regulation, and delivery, to create a highly cost-effective system Assist the URT to cascade a standard set of laboratory services across all levels Increase the quality of lab services at all levels and the number of accredited labs, including the promotion of preventive maintenance and use of URT's service agreements	85% of districts have state of the art Medical Stores Department Enterprise Resource management system by 2015 (baseline 0%; MOHSW/USG partner reporting) National costed quantification of total product need across program areas developed for entire country by 2015 (MOHSW/USG partner reporting) Increase the number of laboratories with national		USG work integrated with PMO-RALG, MOHSW, and other donors will **leverage partner engagement** Reducing critical stock outs and improving lab quality will **strengthen the health system** and provide improved health services Combining the efforts for strengthening the commodities/logistics and lab systems for all essential health services

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	supplies, and commodities for the management of HIV & AIDS patients through the supply chain (Goal 4, Objective 1) Ensure the procurement of all quality drugs, supplies, and commodities based on the MOHSW Procurement Plan and associated schedule (Goal 4, Objective 2) Goal 4, Objective 4: Strengthen logistic management systems to support the procurement of non-medical supplies and commodities, and medical supplies used outside of clinical services		accreditation to 39 (baseline 0) and with international accreditation to 5 (baseline = 0; MOHSW) by 2015		(HIV/AIDS, PMTCT, MNCH, etc) represents **strategic integration**

Key Partners

Collaborating human resources for health partners: MOHSW, ZMOH, POPSM, PMO-RALG, GFATM, JICA, GIZ, and CIDA

Implementing human resources for health partners: MUHAS, AIHA, JHPIEGO, UW/I-TECH, RPSO, Touch Foundation, Engender Health, IntraHealth, UCSF, FELTP, Tulane, and KCMC (MEPI)

Collaborating M&E partners: MOHSW, Netherlands, Norway, JICA, and GIZ

Implementing partners: m-health, Pathfinder, RTI, UCC, NG, SCMS, UW/I-TECH, UCSF, JSI Deliver, and IntraHealth Capacity Plus

Collaborating governance partners: MOHSW, PMO-RALG, SDC, GIZ, WHO, and World Bank

Implementing governance partners: Abt Associates, Inc and Kyela PPP

Collaborating health systems partners: MSD, MOHSW, Abbott Fund, CHAI, and the Global Fund

Implementing health systems partners: SCMS, JSI Deliver, AMREF, AFENET, CLSI, APHL, AIHA, ASCP, ASM, FIND, MSH, UW/I-TECH, NIMR, RPSO, AME-TAM, Space Solutions, and Dar Institute of Technology

Tanzania Global Health Initiative Matrix

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IR 3: Improved Adoption of Healthy Behaviors including Healthcare - Seeking Behavior with Focus on Girls and Women					
IR 3.1 Increased Uptake of Healthy Behaviors and Utilization of Preventive Health Services and Products with Focus on Women and Girls	Relevant URT priorities: Community participation in MNCH, including nutrition, is increased through SBCC and strengthened advocacy (*HSSP III*, pg 59) Partnerships at all level, including community, put in place to stimulate healthier lifestyles and early treatment of ill health conditions (*HSSP III*, pg 63)	Promote uptake of reproductive and MNCH services through increased use of modern and inexpensive technology (e.g. community radio, cell phone SMS) Support stakeholders to conduct formative research and develop state-of-the-art SBCC messages for target audiences Scale up existing Tanzanian and regional models of high quality and evidence-driven SBCC interventions focused on women and girls, such as the *Fataki* program to reduce cross-generational sexual relationships and *Mama Ushauri* serial radio drama addressing multiple integrated health issues Strengthen male involvement and men's access to sexual and reproductive health services through community-level interventions and invitations to health facility-level initiatives	Increase in percentage of women attending 4+ ANC visits, from 43% (TDHS 2010) to 60% in the to-be-determined focus regions by 2015 (refer to 1.3) Increase in percentage of women receiving IPTp2, from 26% (TDHS 2010) to 60% in the to-be-determined focus regions by 2015 (refer to 1.3) Increase in percentage of children under-five who slept under an ITN, from 64% (TDHS 2010) to 75% Increase in percentage of currently married women who use modern contraceptive methods, from 24% (TDHS 2010) to 30% Increase in percentage of women receiving HIV counseling and testing from 55% (TDHS 2010) to 75% by 2015 Increase in percentage of men who have received	**Child Health** GHI goal: Reduce under-five mortality rates by 35% across assisted countries TZ MDG 4: 20% reduction in all-cause under-5 mortality from baseline (2010 estimate of 81/1000) **Maternal Health** GHI goal: Reduce maternal mortality by 30% across assisted countries TZ MDG 5: Reduce maternal mortality by more than 40% **HIV/AIDS** GHI goals: Prevent 12 million new infections; Provide support for 5 million orphans and vulnerable children; Provide direct support for 4 million on treatment and care	Inculcates a w**omen/girl-centered approach** through improved healthy behaviors and supportive social norms, including gender equity, male involvement, and reduction of gender-based violence A strengthen legal and regulatory framework to promote and enforce gender equity increases **sustainability** URT-led initiatives and oversight ensure **country ownership and strategic coordination** among multi-sectoral stakeholders A thorough integration of programs addressing healthy behaviors and supportive social norms with quality integrated services and health

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			HIV counseling and test results, from 40% (TDHS 2010) to 60%		systems strengthening **strengthens and leverages other health efforts**
IR 3.2 Improved Early Healthcare - Seeking Behaviors	Partnerships at all level, including community, put in place to stimulate healthier lifestyles and early treatment of ill health conditions (*HSSP III*, pg 63) National and local leaders supported to become active change agents driving gender and socio-cultural transformation within their communities (*NMPS* 12; 21; 6 and *PFIP* p101)	Expand mass communication and community outreach programming to educate communities and families about danger signs and symptoms, with a focus on safe motherhood, newborn and child survival, HIV/AIDS, malaria, and TB Build partnerships with Community Health Agents, including traditional leaders, to improve detection of warning signs and facilitate fast and effective referrals Strengthen Council Health Management Teams' and Council Multi-Sectoral AIDS Committees' capacity to make services and facilities user-friendly and enhance facility accountability Assess facilitators and barriers to early health-seeking behaviors and develop SBCC messages and programming to address these issues	Increase in percentage of women receiving HIV counseling and testing from 55% (TDHS 2010) to 75% by 2015 Increase in percentage of men who have received HIV counseling and test results, from 40% (TDHS 2010) to 60% Achieve 70% coverage with EID for HIV-exposed infants through improved case detection in febrile illness program in three Lake Zone regions by 2015 (refer to 1.4)		**Sustainability** is enhanced through strengthening the requisite capacity of public, private, and civil society stakeholder to implement state-of-the-art SBCC, as well as the capacity of regional and district health stakeholders to coordinate and oversee health and SBCC activities in their communities A strengthened public sector M&E system that incorporates BSCC **promotes learning and accountability** A renewed focus on developing evidence-driven SBCC that incorporates formative research **accelerates results through research and innovation**
IR 3.3 Strengthened Social Norms and Structural Environment for Empowerment of Women and Girls	Expanded and strengthened behavioral prevention programming, including capacity building of behavior change professionals, host country counterparts, and counselors (lay and professional) (*PFIP* p 86)	Utilize mass communication and community outreach programming to increase awareness and facilitate supportive gender norms that affect positive health outcomes Strengthen legal and regulatory framework to promote and enforce gender equity Harness interpersonal communication programming to increase dialogue about gender norms among key change agents (e.g. men to men/boys, couples, cultural gatekeepers)	Increase in the percentage of married women who participate in decision-making over their own healthcare, major household purchases, and visits to their family or relatives, from 30% (TDHS 2010) to 35% by 2015 1 in 5 women have ever experienced sexual		

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		Establish and expand health facility- and community-based response and services for survivors of GBV in Dar es Salaam, Iringa, and Mbeya regions	violence (TDHS 2010) reduced to 1 in 6 (2015) in GBV three target regions Decrease in percentage of men/women aged 15-49 who agree that a husband is justified hitting or beating his wife for specific reasons, from 38%/54% (TDHS 2010) to 32%/48% by 2015		
IR 3.4 Strengthened Coordination and Capacity of Public and Private Sector SBCC Implementers	Expanded behavioral prevention programming and capacity (*Partnership Framework Implementation Plan*) Community participation in MNCH, including nutrition, is increased through behavior change communications and advocacy (HSSP III) Partnerships at all levels, including community, is put in place to stimulate healthier lifestyles and early treatment of ill health conditions (HSSP III) National and local leaders become active change agents driving gender and socio-	Support a situational analysis of existing SBCC efforts Strengthen coordination to promote and scale up health education activities at national, regional and district levels Conduct training and mentoring for SBCC implementers at national, regional, and district levels Strengthen/establish M&E systems for SBCC efforts	80% of trained national, regional, and district level SBCC implementers perform to a standard level of quality Number of district Councils that have incorporated SBCC into their Comprehensive Council Health Plans and coordination fora Post-graduate SBCC Masters level training initiated and 30 students graduated		

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	cultural transformation (NMPS and PFIP)				
Key Partners ***Collaborating human resources for health partners:*** MOHSW, ZMOH, POPSM, PMO-RALG, GFATM, JICA, GIZ, and CIDA ***Implementing human resources for health partners:*** MUHAS, AIHA, JHPIEGO, UW/I-TECH, RPSO, Touch Foundation, Engender Health, IntraHealth, UCSF, FELTP, Tulane, and KCMC (MEPI) ***Collaborating M&E partners:*** MOHSW, Netherlands, Norway, JICA, and GIZ ***Implementing partners:*** m-health, Pathfinder, RTI, UCC, NG, SCMS, UW/I-TECH, UCSF, JSI Deliver, and IntraHealth Capacity Plus ***Collaborating governance partners:*** MOHSW, PMO-RALG, SDC, GIZ, WHO, and World Bank ***Implementing governance partners:*** Abt Associates, Inc and Kyela PPP ***Collaborating health systems partners:*** MSD, MOHSW, Abbott Fund, CHAI, and the Global Fund ***Implementing health systems partners:*** SCMS, JSI Deliver, AMREF, AFENET, CLSI, APHL, AIHA, ASCP, ASM, FIND, MSH, UW/I-TECH, NIMR, RPSO, AME-TAM, Space Solutions, and Dar Institute of Technology					