4. Health Strategic Objective

A. Strategic Objective Statement

The Health strategic objective (SO) for the period 2005-2014 is "Health Status of Tanzanian Families Improved". It will be measured by improved nationwide indicators for total fertility rate and the under-five mortality rate. The Outcome Intermediate Result (IR) that contributes to the Health SO goal is "Target Health Practices Improved and Use of Health Services Increased". Three IRs contribute to the Outcome IR: 1) Communities empowered to practice healthy behaviors and use services for targeted health problems; 2) Family level access to target health services increased; and 3) Sustainability reinforced for target health programs.

By 2014 our vision is one of greatly improved reproductive health services, including long term contraceptive methods, widely available and used by couples in Tanzania who wish to limit or space their children. It also includes continued high use of Vitamin A through routine services, and a reduced impact of malaria on the population, especially pregnant women and their young children. Close collaboration with the HIV/AIDS SO will lead to strengthened health services, especially perinatal care and services for young children. Services for people-level impact will be improved thanks to work at the district and regional levels, including public private cooperation, greater community mobilization through new marketing and communications efforts, and collaboration with the Democracy and Governance (DG), Economic Growth (EG), and Environment and Natural Resources (ENR) SOs within the framework of the PSO.

B. Situation Analysis

Tanzania continues to face serious health challenges. Positive trends in family planning, child survival, and malaria may have leveled off or even reversed in recent years, in part due to the effect of HIV/AIDS[44] and to institutional transformations in the health care system. Tanzania's population is very youthful with about 60% of the 35 million Tanzanians under age 25. The annual population growth (1988-2002) is about 2.9%, with infants and under-five children constituting about 5% and 20% of the total population respectively. Due to past high levels of fertility, large and growing cohorts are entering their reproductive ages each year, meaning that reproductive health services need to expand just to keep pace.

During the 1990s, the total fertility rate (TFR) decreased from 6.3 to 4.6 children per woman, yet births are often poorly timed and contribute to maternal and child deaths. More than one-quarter of women have their first birth before age 18; 20% of births are spaced less than two years apart. Life expectancy has declined considerably in the country due to rising mortality rates. Communicable, yet preventable diseases are the main cause of morbidity and infant mortality. Among older children and adults, tuberculosis (TB), anemia, and HIV/AIDS have become more frequent causes of death; for women, many deaths are due to complications related to pregnancy.

[44] See Tanzania Conflict Vulnerability Assessment, 2003, p. 13.

A nurse consults with a new mother at a maternal Child Health Clinic.
Photo by: John Dunlop
USAID/Tanzania

Family Planning: The modern contraceptive prevalence rate (CPR) among married women has more than doubled since the early 1990s, reaching 17% by 1999. Still, over one-quarter of women currently not using family planning either want no more children or want to space their next birth by two or more years. Forty percent of this unmet need is represented by women who want no more children, for which long-term methods (i.e., injectables, inter-uterine devices (IUDs), implants and sterilization) would be appropriate options. While the contraceptive prevalence rate for modern methods is higher among urban women (29% compared to 11% among rural women), unmet need for modern methods is higher among rural women (26% compared to 18% among urban women). The number of couple years of protection (CYP) generated as a result of USAID interventions has grown modestly in the last few years. Except for injectables, long-term method rates did not increase appreciably in the 1990s.

Child Health: Infant (99/1000) and under-five (147/1000) mortality rates reported in the 1999 Reproductive and Child Health Survey (RCHS) are increasing due to worsening poverty and the HIV/AIDS epidemic. About one quarter of all under-five deaths occur within the first month and two-thirds within the first year after birth. Tanzania is not on track to meet its Millennium 2015 targets of reducing under-five mortality by two thirds unless urgent actions are taken. The leading causes of infant and child deaths in Tanzania are preventable illnesses such as malaria, pneumonia, diarrhea, malnutrition, HIV/AIDS, and complications of low birth weight. Eight out of ten children die at home and six of them without any contact with formal health services. There are large rural-urban and income disparities with the rural poor being the most disadvantaged.

Malnutrition: Malnutrition rates are unacceptably high among children. Sixteen percent of Tanzanian children are born with low birth weight (below 2500 grams). Low birth weight is also a proxy indicator of maternal deprivation, thus perpetuating the inter-generational cycle of deprivation and malnutrition. Anemia contributes to low birth weight. The onset of malnutrition starts soon after birth and peaks by 12-18 months of age. Significant chronic malnutrition is indicated by the 44% of children who are stunted and the 30% who are underweight. Food insecurity, inadequacies in frequency of feeding, micronutrient deficiencies (iron, iodine, zinc, and Vitamin A) and frequent illness predispose children to malnutrition. Micronutrient malnutrition is prevalent among women, about 14% in the highlands and nearly 80% in coastal areas are anemic during pregnancy -- and nearly 70% are Vitamin A deficient. About 25% of maternal deaths are associated with anemia.

Maternal Mortality: Tanzania has very high maternal mortality with a ratio of 529 maternal deaths per 100,000 births, translating to nearly 9,000 maternal deaths annually due to pregnancy-related causes. Another 250,000 women become disabled due to the same causes, seriously compromising their reproductive health. Births to mothers under age 18

and births that are closely-spaced pose additional risks to maternal illness and deaths. The proportion of women receiving antenatal care and delivering with skilled attendants varies considerably across income levels and urban/rural residence.

Malaria and Infectious Diseases: Malaria is endemic in almost all parts of Tanzania, with over 90% of the population considered at-risk. There are an estimated 14-19 million malaria cases leading to 100,000 -125,000 estimated deaths per year of which about 80,000 are children under age five. Malaria is the major cause of under-five mortality, particularly among children under age two. It also contributes to anemia, maternal mortality and low birth weights. Malaria drug resistance is a problem throughout Tanzania. Polio has not been reported in Tanzania since 1999 and so National Immunization Day programs are phasing out. TB has increased five-fold since 1983, mainly due to the HIV/AIDS epidemic. HIV was present in 44% of tuberculosis cases at last report. The annual increase is between 5-10% and the majority of cases appear among the 15-45 age group.

HIV/AIDS: As discussed in the preceding section on the HIV/AIDS strategy, HIV/AIDS is a major health problem in Tanzania which requires multisectoral responses. The epidemic is having an important impact of the health care system, putting great pressures on staff, supplies, logistics and management, thereby weakening the ability to deal with many important health needs. The Mission is committed to support a broad range of activities to mitigate the impact of the epidemic and many linkages are being developed between the Health and HIV/AIDS SOs, notably in the areas of focused antenatal care (FANC), family planning, logistics support, community based activities, and strengthening the district and regional health care systems.

Context: Tanzania has a fairly well distributed health care system. About 80% of the population has access to health services and about 90% of the population lives within ten kilometers of a health care facility. There are nearly 5,000 registered health care facilities in Tanzania of which 59% are operated by government, 18% by voluntary faith based organizations (FBOs), 12% by other private entities and 5.6% by parastatals. Parastatal and private facilities are mostly urban-based. FBOs are believed to provide health care services to over 40% of all Tanzanians and are mostly serving rural areas. Although significant efforts have been made to establish standards of care, improve the supply of drugs and train health care staff, the quality of health services delivery is still considered to be low with few exceptions.

The Government of Tanzania's (GOT) Response: The Ministry of Health (MOH) is in the second phase of a major donor-supported health sector reform program, with most planning, budgeting, management, and program implementation responsibilities decentralized to district health management teams (DHMTs). Most districts have shown only limited capacity to take on their new responsibilities. The speed and effectiveness of the reform is affected by a significant reduction of government cadre through a major civil service reform program. The majority of skilled health workers work in the large towns leaving facilities in rural areas understaffed. There are just 39 nurses and 2.5 physicians per 100,000 population, a low ratio even by African standards. Government budget allocations to health increased by 9% over the period 1999-2002 – below its target of 15%. Staff compensations comprise about 80% of the government financial allocation to health expenditure. In the last five years, with additional HIV-AIDS program requirements, dependency on donor funds to finance health has increased considerably. Donor funds,

especially sector support or "basket funds", have supplemented the government's budget allocations for health.

C. Prior USAID/Tanzania Experience in Health

Under the previous two health strategies, USAID has focused on family planning and maternal and child health (FP/MCH) interventions and supported an escalating program addressing HIV/AIDS prevention and mitigation. Key achievements for the FP/MCH component of the program include meeting benchmarks for CYP which increased from 1.2 million in 2002 to 1.5 million in 2003. USAID has repeatedly met its target of 80% of children receiving Vitamin A supplementation and tetanus inoculation. The Mission-supported pilot introduction of intermittent presumptive treatment (IPT) of malaria in pregnancy went nationwide in under two years, with coverage up from 29% in 2001 to 65% in 2003.

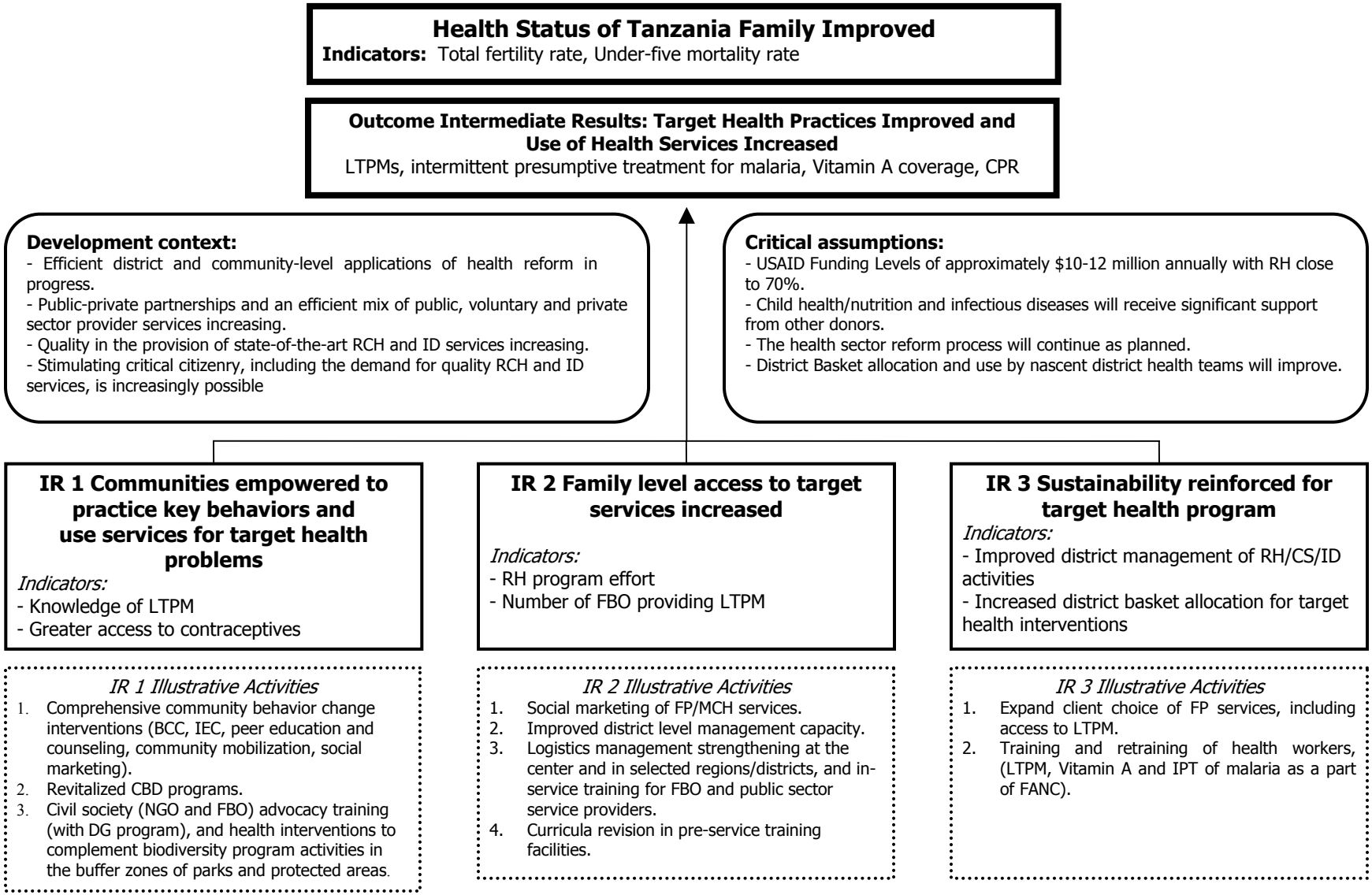
USAID is recognized as Tanzania's major donor for family planning and a leading donor for maternal and child health (where UNICEF, WHO, and a number of bilateral donors have played a more substantial funding role). USAID has a comparative advantage in: partnering with non-governmental organizations (NGOs); strategic planning with a "results" focus; state-of-the-art technical leadership with a quality focus; training and capacity-building; policy, leadership and management; behavior change; commodities, drugs, and logistics management; contraceptive security; survey, census, and operations research; and the ability to target assistance "outside the basket".

Over the past five years, most bilateral and some multilateral donors have shifted their assistance to a "central basket" that is used by the MOH for both central activities and procurements as well as for district-level health activities managed by DHMTs. A combined government and donor working group develops annual plans and conducts annual assessments of fund use. USAID has played a strategic role in providing resources to fund non-government activities and to flexibly respond to emergency needs in the sector. USAID has also worked to try to ensure that "basket" funding ultimately increases available resources for FP/MCH activities, that it includes essential drugs and contraceptives, that allocations be results-focused, and that it incorporates support for non-government programs.

D. Consultative Process

USAID/Tanzania undertook an extensive and highly-consultative process to identify priorities and weigh them against potential impact, USAID comparative advantages, and cost. The GOT, implementing partners, other donors, other USAID/Tanzania SO teams, USAID/Washington and customers all participated in various aspects of this year-long strategic planning process. The process included the review of relevant analyses and evaluations of the Tanzania health sector reform process, donor projects and GOT documents. Several special studies were commissioned to gather detailed information on specific activities and issues, including an evaluation of the Voluntary Sector Health Program (VSHP), an assessment of the social marketing program, a review of constraints to long-term and permanent contraceptive methods, a study of constraints to logistics management of family planning and HIV/AIDS commodities, and a review of community-based contraceptive distribution programs.

Figure 5: Results Framework for Health Strategic Objective



E. Development Hypothesis and Results Framework

This health strategy follows a traditional USAID hypothesis that has proven successful in many countries in the past, namely that individuals that know and practice healthy behaviors and use health services will attain improved health status if those basic health services are accessible and of acceptable quality. USAID/Tanzania's Health SO of "Health Status of Tanzanian Families Improved", contributes to USAID/Tanzania's overarching goal to "help accelerate Tanzania's progress toward sustainable development and reduced poverty and to improve the quality of life in Tanzania". USAID's program will build on the positive features of Tanzania's health system: a) the availability and reach of existing health facilities, b) an institutionalized process of health sector reform that has the potential for major improvements in health service delivery, and c) the strong and long-standing multi-donor presence. USAID's program vision for the next ten years is to build on these features to strengthen FP/MCH programs that improve the health status of Tanzanian families. Key elements of this vision are to:

- Support efficient district and community-level application of health reform;
- Encourage public-private partnerships and an efficient mix of public, voluntary and private sector provider services;
- Foster quality in the provision of state-of-the-art FP/MCH services; and
- Stimulate critical citizenry, including the demand for quality FP/MCH services.

The Health program activities included in this SO are family planning, child health and nutrition, infectious diseases, and safe motherhood. In addition, this strategy has many important linkages and synergies with the Mission's HIV/AIDS SO. This SO aims to improve the health status of Tanzanians by reducing total fertility and under-five mortality rates, and the incidence of malaria. These results will be achieved together with USAID/Tanzania's main partners, including the GOT, and other donors and implementing agencies.

A number of critical assumptions underlie the Mission's ten-year health strategy and affect programming decisions. These assumptions will be reviewed periodically and the elements of the strategy may be revised to ensure strategic success. The most critical assumptions are:

Data: A Demographic and Health Survey will be conducted in 2004 or 2005 to verify previous health trends that have helped target this strategy. It will be repeated in 2009. The 2003-04 Tanzania HIV Indicators Survey (THIS) also includes questions which will allow estimates of CPR and contraceptive method mix. It will be repeated in 2006. These surveys will help solidify baseline data and provide the basis for more specific five- and ten-year strategic targets and inform policy and program decisions.

USAID Funding Levels: This strategy assumes a relatively stable USAID health (excluding HIV/AIDS) budget of approximately $10 -12 million annually with the bulk of funding for family planning (close to 70%) and lesser amounts for child health/nutrition and infectious diseases (approximately 30%).

Other Donor Funding: Other donor funding will supplement USAID funding. Central Basket funding will be allocated for the Ministry's Reproductive and Child Health Section (RCHS)

and increasingly for contraceptives; other donors will take the lead on implementing a national quality assurance program being instituted by the MOH; other donors will continue support for social marketing and logistics management activities; and child health/nutrition and infectious diseases will continue to receive significant support from other donors.

Decentralization: The health sector reform process will continue as planned. The role of the Zonal Training Centers (ZTCs) will be officially broadened to encompass greater support responsibilities for district-level health sector reform (especially the coordination of health reform training for their zones). Meanwhile, it is assumed that the regional health teams will continue to focus attention and resources on FP/MCH and will include a dedicated reproductive and child health specialist on their teams.

SO Indicators and 2009 and 2014 Targets

Several causal relationships that lead to the Health SO outcome are illustrated in the results framework. When family level access to information and health services increases (IR 2) communities can be empowered to practice key behaviors and use services. The availability of quality services encourages greater use of those services, but also is responsive to community and individual demands for the health services which meet their needs at reasonable cost (in terms of access and financial cost). Given limited resources, the Mission has decided to focus carefully on a limited number of target health practices and services, to improve key behaviors, and to deal with target health problems.

USAID/Tanzania's Health SO will hold itself accountable for nationwide (impact level) reductions in total fertility and under-five mortality rates.

- Total Fertility Rate Target: Total fertility rate will decline from 5.6 children reported in the 1999 RCHS to 5 in 2009 and 4.5 in 2014.

The proposed target is similar to the actual decline in the total fertility rate (TFR) which occurred in neighboring southern African countries between 1985 and 1995 where the TFR declined from an average 5.8 to 4.9 (see USAID, Health and Family Planning Indicators: A Tool for Results Frameworks, vol. I, p. 15). These countries witnessed increases in contraceptive prevalence as family planning programs were strengthened, and improvements in socioeconomic conditions took place similar to those expected to occur in Tanzania in the next decade.

- Under-five Mortality Rate Target: The under-five mortality rate (U5MR) will decline from 147 per 1000 live births reported in the 1999 RCHS to 140 per 1000 live births in 2009 and 120 per 1000 in 2014.

An almost 18% drop in the U5MR over fifteen years is a realistic target since our strategy will focus on maintaining high levels of Vitamin A supplementation. This is a highly cost-effective core child survival intervention and has led to reductions of U5MR of 20-25% that have been documented in a number of countries, notably Zambia, Nepal, Vietnam and the Philippines thanks to high-coverage Vitamin A programs on a national basis. In addition, our HIV/AIDS SO will devote significant effort to PMTCT, which, along with other activities to protect orphans and vulnerable children, should reduce the impact of HIV on U5MR.

Outcome IR: Target health practices improved and use of health services increased

Achievement of the Outcome IR, as monitored by its indicators, is expected to lead directly to the achievement of the SO.

Illustrative Indicators:

- Percentage of women of reproductive age (15-49) who are currently using (or whose partner is currently using) a modern method of contraception (national). Target: current use of modern contraceptives for women aged 15-49 will increase from 15.6% in the 1999 RCHS to 30% in 2009 and 40% in 2014.

Generally, an annual increase of 1-2 percentage points in the CPR indicates a strong family planning program making significant progress. Many USAID missions have been able to report a doubling of the CPR with a five-year span, including Tanzania when it initiated it program in the early 1990's, as well as many of its neighbors (See USAID, Health and Family Planning Indicators: A Tool for Results Frameworks, vol. I, p. 21):

Tanzania: 6.7% in 1991 13.3% in 1996
Kenya: 9.7% in 1984 27.3% in 1998
Malawi: 7.4% in 1992 14.4% in 1996

The Mission's commitment to repositioning family planning in Tanzania, and helping the MOH, FBOs and the private sector accelerate progress to increase the access and use of quality reproductive health services, given an already high demand, should produce significant results in the next decade.

- Presumptive treatment of malaria will increase from 65% in target areas to 70% nationally in 2009 and 90% in 2014.

Significant progress in initial phases of malaria prevention activities and strong donor, government, FBO, and private sector support for continuing activities should assure that the nationally-recommended course of prophylaxis/intermittent therapy for prevention of malaria during pregnancy, which USAID has promoted through its program of focused antenatal care (FANC), will expand.

Vitamin A coverage (achieved through national immunization days in 2003) for children 6-59 months will be maintained at over 80% through routine services. Coverage in 2009 will be at this level, and will be maintained at this level in 2014, despite the expected growth in population.

Tanzania's success in achieving over 80% Vitamin A coverage for children 6-59 months indicates its strong commitment to this important intervention. The Mission's focus in child survival will be to work with key technical partners to find ways to strengthen supplementation through routine services and to use innovative approaches, such as child health weeks, to assure coverage in difficult to reach populations.

IR 1: Communities empowered to practice key behaviors and use services for target health problems.

Illustrative Indicators:

- increase in number of non-MOH (FBO, social marketing, private sector, CBD) sites providing contraceptive services;
- % increase in knowledge of long term contraceptive methods as measured in the DHS;
- increase in number of women receiving long term contraceptive methods in non-MOH facilities;
- % increase in knowledge of source of supply of long term methods as measured in the DHS; and
- % of under 5 children attending community health weeks.

In Tanzania, knowledge about family planning, child health, and infectious diseases varies widely. Even where health facilities are available, they are underutilized; low expectations of service quality often contribute to low use of services. (For example, only 44% of women delivered in health facilities in 1999 compared with 53% in 1991-92.) Despite Tanzania's socialist history, community health programs and community mobilization activities are not as effective as they should be. Behavior change communication (BCC) efforts are episodic and generally do not follow a deliberate multi-dimensional strategy where BCC messages are mutually reinforcing. Some family planning and child health information, education, and communications (IEC) materials are outdated and hard to find.

IR 1 will empower communities to practice key health-seeking behaviors in a number of ways. First, it will revitalize community outreach and mobilization programs (using clinics as focal points), by utilizing a variety of organizations (voluntary agencies/NGOs, FBOs, the public sector, social marketing programs) to help communities to diagnose their own healthcare needs and issues, and identify solutions to their problems. Community outreach efforts will provide information and motivate clients to seek services for a focused set of FP/MCH interventions, including family planning (with a focus on clinic-based methods); post abortion care (PAC); focused antenatal care (FANC) (including intermittent presumptive treatment (IPT) and syphilis in pregnancy interventions); timely obstetric care; and child health services, especially the need for Vitamin A. The need for HIV/AIDS testing and counseling, and FP/MCH integration within PMTCT programs will also be explored in conjunction with the AIDS SO. Health programs may complement other Mission programs, such as environmental programs focused in buffer zones of protected areas.

Second, clinic-based programs will be linked with community efforts to expand the service network available to clients and improve their knowledge and practice of preventive and positive behaviors. (Examples of unhealthy or dangerous practices include female genital cutting (FGC), multiple sexual partners, and late treatment of STIs or malaria.) This will be done through a broad range of carefully structured BCC interventions. BCC channels include mass media social marketing and generic IEC campaigns, peer education, counseling, community, folk and small media approaches. Messages on FP, HIV/AIDS and MCH will be both branded and generic. Finally, IR 1 will increase participation of communities and villages in Tanzania's health sector reform process. Health services are being decentralized

down to the district level and below. Accountability and transparency will be stressed, and training, policy, and advocacy work will be done in concert with the Mission's DG program (see Section G, Linkages, Themes and Tools (LTT) Approach) to enable better interaction between villages and decision-makers.

Certain approaches used in the Health SO are innovative and will need to be tested and evaluated in demonstration areas before going to scale throughout the country. Consequently, activities will often occur in two phases. The first will focus on implementation in a specific region, followed by an assessment and recommendations for modifications to improve activities. These will be incorporated in an improved and expanded approach in Phase II.

Illustrative Activities:

Phase I: In target regions:

- Clinic-based outreach, and community outreach programs, and focused community-based distribution (CBD);
- Comprehensive behavior change interventions (BCC, IEC, peer education and counseling, community mobilization, social marketing); and
- Civil society (NGO and FBO) advocacy training (with DG program), and health interventions to complement biodiversity program activities in the buffer zones of parks and protected areas.

Phase II: Replication of Successful Activity Models by NGO/FBOs in other NGO/FBO Sites Nationwide

IR 2: Family-level access to target services increased.

Illustrative Indicators:

- Reproductive Health (RH) program effort index;
- Number of NGOs and FBOs providing clinic-based methods;
- Number of stock outs for contraceptives and other commodities;
- Percent of health sites reporting regularly (every two months) on family planning use
- Number of health workers trained in providing long term methods; and
- Percent of focus district health facilities with Child Health Weeks (CHWs).

IR 2 seeks to improve the access of families to a selected package of essential FP/MCH services (linked to selected HIV/AIDS prevention, care and treatment services), especially in targeted geographic areas. Access to health care in Tanzania is through three primary avenues: the home/community; health facilities (dispensaries, health centers, and hospitals); and private sector sites, including social marketing outlets. IR 2 will work through all of these avenues to support a package of essential services and commodities.

NGOs and FBOs already play an important role in delivering more than 40% of Tanzania's health services. They are often hampered by poor management and lack of supplies. If these organizations are strengthened at the clinic and community level, they can provide an "essential package" of services, including FP services (with a focus on clinic-based

methods); post-abortion care (PAC); FANC (including IPT and syphilis in pregnancy interventions); referrals for obstetric care; child health weeks for Vitamin A supplementation and delivery of other FP/MCH products and services. Also key will be development of complementary HIV/AIDS-related services, ranging from post-Voluntary Counseling and Testing (VCT) counseling, treatment of STIs and opportunistic infections (OIs) to ARV treatment and clinical care, nutritional care and support and PMTCT and infant feeding.

Further, both public and private sector service delivery points suffer from a lack of contraceptives, drugs and other supplies which are essential to improving access to quality health services. Commodity and systems support to both the public and private sectors will be provided to ensure the supply of critical commodities. Social marketing avenues will be used to provide selected contraceptives, condoms (for FP and AIDS prevention among "high risk" groups), and selected MCH commodities (e.g., insecticide-treated nets (ITNs), point-of-use water treatment, oral rehydration salts). Assistance to the logistics management system will strengthen public sector forecasting, ordering and distribution of contraceptives, condoms and a variety of essential drugs from the central to the district level. Critical commodities, such as contraceptives for the social marketing program, and IUDs and other selected contraceptives (as needed) will be provided to the pubic sector program by the Health SO.

Finally, well-trained service providers at the community and clinic (or hospital) levels are essential for providing quality FP/MCH (and HIV/AIDS) services. They are often the same nurse or clinical officer. Both in-service and pre-service training needs for the public and private sector will be addressed. Approaches will utilize the Performance Improvement Approach (PIA) to strengthen the capacity of selected Zonal Training Centers (ZTCs) and DHMT/district-level trainers; and work with selected preservice training institutions, if funds permit. Curricula, standards and guidelines, job aids and supervisory systems will all improve performance of staff.

Illustrative Activities:

Phase I:

- Support to NGO/FBO service sites to enable them to deliver an essential package of services;
- Social marketing of selected FP/MCH services and messages (linked with the AIDS social marketing program);
- Provision of limited contraceptive commodities and work with key partners to develop a eight to ten year contraceptive security plan;
- Logistics management strengthening at the center and in selected regions/districts;
- Strengthening of ZTC and district level training capacity;
- In-service training for NGO/FBO and public sector service providers; and
- Strengthen NGO capacity and improve coordination with MOH and other government agencies through collaboration with DG program for greater civil society involvement at the community level.

Phase II: Curricula revision in pre-service training facilities (if funding is available)

IR 3: Sustainability reinforced for target health programs.

Targets are currently being developed for the following indicators:

- Indicators of improved district management and financial support for CS, RH and ID;
- Percent of district basket funding in target regions allocated for long-term methods community-based distribution, child health weeks.

IR 3 will work at both national and geographically-focused levels. A variety of ministries (including Health, Local Government, Finance, Office of the President) as well as district or local authorities, are key to improving target health programs. The IR will support activities that contribute to sustainability of health programs, and create a positive enabling environment for service delivery. The Tanzania health system has a pervasive lack of regular data at all levels for program design, monitoring of implementation progress, and impact evaluation. There is also a weakness in the analysis and use of data for planning and decision making, especially at the district level. District planners and managers require training, guidelines and tools to improve planning, management and budgeting. Further, management and leadership skills are often lacking and are critical to good project or program implementation. Finally, resources are often adequate, but not efficiently or effectively used. Many of these systems issues are also relevant to the AIDS SO (IRs 2 and 3). The AIDS IR 2, for example, has a health sector system strengthening component and the same needs for population-based surveys and data. IR 3 notes the need for strategic leadership for local, district, and national GOT officials and team building training.

To improve the quality of data and information and to foster utilization of data for decision making, resources will be provided to support national surveys and to pilot test health information systems at the district level. Because of the lack of data and information, and despite the availability of increasing "district basket" funding, many of the new district health teams are unable to plan, budget, and manage these resources in an efficient and effective manner. IR 3 will provide technical resources to assist districts to better assess and utilize their resources, through training and pilot testing new approaches. Many of the strong Tanzanian leaders in family planning and child survival of the past decades have retired, and there has been little emphasis on fostering a replacement corps of dynamic leaders who might serve in both government and NGO health systems. This IR will seek to develop the leadership essential to reinvigorating FP/MCH programs in Tanzania, and provide specialized training and professional development for young, dynamic professionals who might eventually assume high level positions.

Adequate levels of financing for health sector programs are not yet available in Tanzania despite modest gains in recent years. Key personnel are also lacking. IR 3 will leverage other donor funds to help districts and regions to better allocate their basket funding, including funds for the private sector. Finally, USAID Mission staff will, through sector-wide approach (SWAp) related policy and donor dialogue, continue to encourage the GOT to move closer to meeting its own target of 15% budget allocation to health. More effective use of these health funds can be facilitated if the SWAp program moves towards a "results" approach to program monitoring, and away from the present expenditure approach.
Illustrative Activities:

Phase I:

- Periodic national surveys, such as the DHS and the Tanzania HIV/AIDS indicators survey (THIS), in collaboration with the AIDS SO;
- Technical assistance and training in management and budgeting at the national level through the medium-term expenditure forecast (MTEF) and at the district level through cooperating agencies;
- Management and leadership training, such as supporting in-country MPH degree;
- Donor dialogue and fora, and activities to evaluate the impact of the SWAp and basket funding;
- Policy, advocacy and awareness for health professionals; and
- Development of innovative public/private partnerships.

Phase II: Scale up initial geographical focus

Geographic Focus

In consonance with the present stage of Tanzania's health sector reform process, this strategy shifts the balance of USAID activities from the national-level to geographic–specific regions where much of the activities will be focused at the district level.

National Scope Activities: USAID will continue support for a number of key activities with national-level scope, including technical assistance to the Reproductive and Child Health Section (RCHS) and the Infectious Disease Unit (IDU) of the MOH in strategic planning, setting standards and central commodity procurement planning. USAID will continue to support the MOH Medical Stores Department (MSD) in national-level forecasting and logistics related to contraceptives and other key health commodities. Activities will also encompass both the collection of data through household surveys, censuses, and infectious disease surveillance and use of data for planning, programming, monitoring and evaluation. The social marketing program will continue to support national scope contraceptive and health commodity distribution and advertising, though it may focus special attention to specific regions. Additional national-level activities include support for national-level behavior change communication strategies and implementation and strengthening policy awareness and leadership related to FP/MCH issues. Both behavior change and policy will likely incorporate elements that have a geographic and community-level focus.

Geographic-specific Activities: The ongoing decentralization of the health sector reform responsibilities in Tanzania leads USAID to focus more of its resources in this strategy on geographic-specific activities in focus regions and districts. Final selection of focus regions and districts will be made in consultation with the MOH based on a number of criteria, including USAID program experience, co-location of activities of other SOs (see Section G, LTT Approach), need and socio-economic considerations, ethnic and geographic balance, capacity of ZTCs, strength of the community-based organization (CBO)/NGO sector, and leadership considerations, such as "readiness" to undertake changes and openness to public-private partnerships. Given the MOH's current position, USAID is likely to be asked to provide much of its field-level support to two adjoining regions which fit the selection criteria (Arusha and Manyara) in the north, Kigoma region in the West, and to Iringa region in the center of the country.

Geographic-specific activities will contribute directly to improving national indicators of FP/MCH and to numerical objectives in the IRs. More significantly, these activities will improve access to services at the community-level and support long-term capacity building and critical citizenry, in addition to people-level impact. An important cross-cutting theme of all geographic-specific activities will be the development of cost-effective approaches with a view towards long-term sustainability locally and the ability of Tanzania to "scale-up" proven interventions nationally. Efforts to scale-up nationally will be an emphasis especially during the second phase of this strategy period. For example, current facility-based PAC activities are likely to scale-up during the second phase.

Four categories of activities are particularly well-suited for geographic focus. They include: a) strengthening in-service training capacity of district health teams personnel at zonal training centers (ZTCs); b) strengthening access to quality FP/MCH services, c) improving supervision and coordination of activities; and d) improving services and community outreach through NGOs and FBOs and mobilization of communities.

Phasing: Near the end of the first phase of this strategy, the program activities will be carefully evaluated and revised as needed in concert with program results, and any significant changes in the program setting, e.g., GOT health priorities, donor programs. It is anticipated that many of the successful phase I field-level activities will be expanded within their regions and into other regions of Tanzania with both USAID and other donor support.

In spite of limited financial resources, the Health SO believes it can significantly impact key indicators in Tanzania over the next ten years through a policy of focused interventions and resources to support effective, high impact, proven interventions and activities. Child Survival interventions will include supplementation of Vitamin A and zinc through child health weeks, as well as building concurrent efforts to improve routine supplementation; leverage of PMTCT funds to support improved perinatal service delivery including treatment of malaria and syphilis in pregnancy; increasing linkages between the perinatal services and insecticide treated net programs and improving perinatal nutrition through promotion of exclusive breastfeeding, prenatal iron supplementation and postnatal Vitamin A supplementation. Family planning/reproductive health interventions will follow the same focused strategy and concentrate resources to improve clinical service delivery for interventions such as post abortion care and long term and permanent methods including IUDs and injectables. Working in concert with other partners such as United Nations Children's Fund (UNICEF) and United Nationals Population Fund (UNFPA), leveraging HIV and other donor funding, and providing high level, cutting edge technical assistance from our cooperating agencies and USAID's specialized staff are highly effective approaches which will result in maximum impact and cost effectiveness.

Customers/Beneficiaries

One of the objectives of the consultative planning process was to ensure that Health SO activities address the needs of USAID/Tanzania's customers. These include the people of Tanzania who are the ultimate beneficiaries of activities, intermediate beneficiaries (such as service providers), development partners and stakeholders. The primary beneficiaries or end-users of USAID/Tanzania's health program are men and women of reproductive age

and children under five years of age. The vast majority of these Tanzanian beneficiaries are poor, given Tanzania's projected per capita income of $280 as estimated by the World Bank in 2004. These Tanzanians rely on public sector, NGO and FBO health services for FP and MCH services, while more wealthy Tanzanians utilize private sector providers.

Development Impact

FP/MCH services contribute not only to good health and one of two key elements of human capital (along with education), but they also contribute to broader efforts to alleviate poverty. Limiting family size and birth spacing are recognized as elements of a family's strategy for ascending out of poverty enabling families to be healthier and to invest more in their children. Likewise, poor child health and nutrition, maternal mortality, and the effects of infectious diseases too often trigger a family's or an individual's descent into poverty or chronic poverty. Increases in contraceptive use and declines in fertility will also help slow population growth and help relieve pressures placed on the environment and natural resources, place lower demands on health and education systems, and lower dependency ratios that contribute to rising savings and investment.

F. Synergies

i. With US Department of State/USAID Joint Strategic Plan

The SO is consistent with the US Department of State/USAID Joint Strategic Plan by working to reduce the threat of infectious disease, reduce infant and child mortality and support reproductive and maternal health care under the Social and Environmental Issues Objective.

ii. With Relevant USAID Pillars

The Health SO falls under the Agency Global Health Pillar and supports multiple Agency strategic objectives of: unintended and mistimed pregnancies reduced, death and adverse health outcomes to women as a result of pregnancy and child birth reduced, infant and child health and nutrition improved and infant and child mortality reduced, HIV transmission and the impact of HIV/AIDS pandemic reduced, and the threat of infectious diseases of major public health importance reduced. The SO is also in concert with the objectives of the Global Health Bureau.

G. Linkages, Themes, and Tools (LTT) Approach

As a Mission, we have developed an innovative approach to maximize our resources and deepen the impact of our development activities. We call it the Linkages, Themes, and Tools (LTT) approach. With this approach, all of our Mission SO teams commit to the strategic integration of LTT into and across SOs.

- **L: Linkage:** a shared result (as defined by a common indicator/s) between two or more SOs. The result appears in two or more results frameworks.
- **T: Cross-Cutting Theme:** a development problem that the Mission has determined requires integration into and across all SOs. The Mission's themes are gender, HIV/AIDS, and governance.
- **T: Tool:** an implementation approach (or a way of doing business) adopted by the Mission as an effective means to deepen development results. The Mission's tools are information and communications technology (ICT), capacity building, and public-private alliance building.

Previous Mission experience with cross-fertilization of SOs resulted in improved performance in our current strategy. Therefore, in developing the new strategy, the Mission decided to conceptualize and institutionalize the approach. Mission teams collaborated to identify linkages, themes, and tools that offered opportunities for synergy and increased program effectiveness. The Mission will use a Program Support Objective (PSO)[45] as the principal mechanism to coordinate and integrate LTTs into and across the five SOs. Given that our PSO supports all of the Mission's SOs, it is described in more detail in a PSO section (section 8) that follows the SO sections. In it, we describe how individual SOs contribute to the achievement of shared results and how cross-cutting themes and tools are integrated into the program. This is our "anti-stovepiping" approach to development.

For example, NRM, Health, and the AIDS SOs have begun working with the Jane Goodall Institute in Kigoma to continue its pioneering efforts to maintain the integrity of the Greater Gombe Ecosystem through initiating and sustaining community involvement in improving the local environment as a means to contributing to long-term conservation goals as part of the Lake Tanganyika Catchment Reforestation and Education Project (TACARE) project. Health and AIDS SOs will build on successful, family planning community-based delivery activities by extending the range of long-term methods available to families in the project area, and in developing HIV activities including care and support.

The Health and HIV SOs will continue working closely together to strengthen access to services including mutually supported product logistics/delivery systems, and expanded, focused antenatal care for both HIV+ and HIV- women, who will be tested, counseled, and increasingly treated with ART, so that a broad range of services intended to save lives of women and their children will be available to all.

Efforts at community empowerment and behavior change communication will focus on women in the reproductive ages, especially those needing family planning services, those who are pregnant and need antenatal and postpartum care, adolescents beginning their reproductive careers and women who want to limit their fertility. We are also developing activities focusing on men as partners in reproductive health activities, with the goal of improving men's support for and acceptance of family planning efforts.

[45] ADS 201.3.7.10 Defines the Program Support Objective (PSO) as an activity implemented to support the achievement of other existing SOs. The results of PSO activities are visible through and attributable to other SOs. This is distinct from Program Development and Learning (see ADS 201.3.3.5), which is intended to support activities and learning efforts that do not fit with the scope of an existing SO.

For a more detailed examination of the Mission's PSO and the LTT approach, please see the PSO Section 8 as well as the LTT Tables in Annex 18.

H. Implementation Modalities

USAID will use a mix of mechanisms to support activities in the new health strategy which may include collaborating agencies, field support, contracts, leader with associate awards, cooperative agreements with international and Tanzanian organizations, and grants to government of Tanzania. In keeping with the Mission's targeted, focused, selective approach in this strategy, it will minimize its management burden by limiting the number of contracting mechanisms. USAID/Tanzania will also ensure that its contractors and grantees include in their scopes of work the mandate of creating substantive linkages with other Mission SO teams.