IMPROVING MATERNAL, NEWBORN AND CHILD HEALTH IN TANZANIA: FROM SCIENCE TO ACTION

THIRD PROFESSOR HUBERT KAIRUKI MEMORIAL LECTURE

PRESENTED

BY

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ON

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I. 0 INTRODUCTION

When a woman undertakes her biological role of becoming pregnant and undergoing childbirth, the society has an obligation to fulfill her basic human rights and that of her child.

When we talk about improving Maternal Newborn and Child Health, we are actually talking about the progress of Millennium Development Goals 4 and 5. We are trying to find out how far or how near are we in achieving these two MDGs that relate to women, Newborn and children. Most African countries are on the whole off track to achieving the MDGs 4 and 5 for maternal, newborn and child health by 2015. Reducing Maternal, newborn and child mortality in Africa is a challenge of the New Millennium. Each year in Sub Saharan Africa 279,000 women die due to complications of pregnancy and another 4.5 million children die before their first birthday, 1.2 million of them die in the first month of life. Additional 880,000 babies are stillbirths. In Tanzania 13,000 women die each year from pregnancy related causes and another 157,000 children die before their first birthday out whom 45,000 babies die before they are one month. Yet, progress in some low income countries has demonstrated that these goals could still be attained through immediate strategic investments in selected evidence-based interventions together linked with health systems strengthening. Maternal Mortality can be reduced without first achieving high level of economic development as observed in Sri- Lanka, Malaysia, Singapore and Mauritius. Attention and investment for MNCH are increasing but time for achieving success is short.

Science has developed many effective health interventions such as medicines, immunizations, insecticide treated bed nets, essential equipment for emergency obstetrics care, and numerous others. Yet, many of African countries are underutilizing the existing scientific knowledge to save lives. For example there is now widespread agreement among health systems researchers that high impact interventions are most effectively and efficiently delivered when integrated into existing health service delivery packages along the continuum of care for mothers, newborns, and children. Of course each country's response will vary depending on local epidemiology, existing coverage, health systems, and community capacity. As Africa struggles to improve the MNCH in order to meet the MDG4 and 5 by the year 2015, it is critical that we use data to set priorities and accelerate action.

The Millennium Development Goals are drawn from the actions and targets contained in the Millennium Declaration that was adopted by 189 nations and signed by 147 heads of state and governments during the United Nations Millennium Summit in September 2000 a) MDG4 requires countries to Reduce the under-five mortality rate by two thirds by 2015 while b) MDG5 requires countries to Reduce the maternal mortality ratio by three quarters and achieve universal access to reproductive health by 2015.

H.E President J.E. Kikwete, during the opening ceremonies of the Launch of Deliver Now for Women and Children Campaign, 22 April 2008 had this to say “Maternal and child mortality rates in Tanzania are too high. Significant new resources are needed to scale up known effective interventions if we want to reduce them. I am calling on all bilateral and multilateral partners, national and international, to align their resources and support this plan to make the attainment of MDG 4 and 5 a reality in Tanzania.”

Improving maternal, newborn and child deaths is a high priority for all, given the persistently high maternal, newborn and child morbidity and mortality rates. It is one of the major concerns addressed by various global and national commitments, as reflected in the targets of the Millennium Development Goals.
(MDGs), Tanzania Vision 2025, the national strategy for growth and Reduction of Poverty (NSGRP-Mkukuta), and the Primary Health services Development Program PHSDP-MMAM), among others.

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

Scaling up these high impact interventions to save the lives of mothers, newborn children requires attention and action from many actors including: government, health policy planners, health care professionals, development partners, researchers, civil society, and communities. The analysis of potential lives saved and cost helps identify priority actions and generates evidence that can be used to inform MNCH policy. By working together, hundreds of thousands of lives can be saved within a very short time period and millions of lives would be saved in the long term.

**Below are the five big health challenges facing MNCH in Sub Saharan Africa**

1. **Pregnancy and childbirth complications**
   - More than half of maternal deaths take place within one day of birth.
   - Approximately one third of stillbirths occur during labour
   - Nearly half of all newborn deaths are on the first day of life.

2. **Newborn illnesses:**
   - One in four child deaths are of newborns.
   - Preterm babies have a much greater risk of dying
   - Many die from lack of simple care such as warmth, feeding, Hygiene and early treatment of infections.

3. **Childhood infections:** Nearly 50% of child deaths are caused by pneumonia, diarrhea, and malaria, which are preventable and also very feasible to treat

4. **HIV/ AIDS:** With two-thirds of the global HIV/AIDS population living in Africa, HIV/AIDS accounts for 6% of maternal deaths and 5% of under-five deaths

5. **Malnutrition:** Maternal anemia, iodine deficiency, and poor quality diet are associated with higher maternal mortality and higher incidence of stillbirths and congenital abnormalities. Over 31 million African children are underweight, and Nutritional risk factors, including vitamin A and zinc deficiencies, and sub-optimal breastfeeding, contribute to more than one-third of child deaths

**Maternal, Newborn and Child health in Tanzania**

The total population of Mainland Tanzania is estimated to be 39,384,223 (as of July 2007). Most of the population (75%) resides in the rural area. The annual growth rate is 2.9% with life expectancy at birth being 54 years for males and 56 years for female. The total fertility rate in Tanzania has been consistently high over the past ten years currently stands at 5.7 children per woman. There are regional variations with urban-rural disparities, where rural women have higher fertility rates than their urban counterparts. The Maternal Mortality Ration (MMR) has remained high for the last 10 years without showing any decline and is currently estimated to be 578 per 100,000 live births. While significant progress has been made to
reduce child mortality in Tanzania, the neonatal mortality rate remains high at 32 per 1,000 live births, and accounts for 47% of the infant mortality rate which is estimated at 68 per 1,000 live births.

Health indicators of Maternal, Newborn and Child health

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Figure</th>
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</thead>
<tbody>
<tr>
<td>Population (mainland Tanzania 2007)</td>
<td>39,384,223</td>
</tr>
<tr>
<td>Population living in rural areas</td>
<td>75%</td>
</tr>
<tr>
<td>Annual Growth rate</td>
<td>2.9%</td>
</tr>
<tr>
<td>Life Expectancy at birth</td>
<td>54% male 56% females</td>
</tr>
<tr>
<td>Total Fertility rate</td>
<td>5.7 children per woman</td>
</tr>
<tr>
<td>Maternal Mortality rate</td>
<td>578/100,000 deliveries</td>
</tr>
<tr>
<td>Neonatal Mortality Rate</td>
<td>32/1000 live birth (it accounts for 47% of the IMR)</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>68/1000 live births</td>
</tr>
<tr>
<td>Under five mortality rate</td>
<td>112/1000 live births</td>
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</tbody>
</table>


Why do pregnant mothers die?
More than half of maternal deaths in Africa are due to direct obstetric complications which occur around the time of childbirth. Hemorrhage, hypertensive diseases, sepsis/infection and prolonged labour. Non-pregnancy related infections, such as HIV/AIDS, malaria and pneumonia account for about a quarter of all deaths. Abortion complications contribute 20% of maternal deaths worldwide. Induced abortion is illegal in Tanzania, hence the actual magnitude of the problem is not known. According to Mswia 2003, nearly one third of maternal deaths are related to unsafe abortion. Post abortion care services can reduce deaths due to unsafe abortions? However, only 5% of health facilities in Tanzania provide post abortion care.

Direct Causes of Maternal Deaths in Tanzania, 2006

<table>
<thead>
<tr>
<th>CAUSE</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemorrhage</td>
<td>28%</td>
</tr>
<tr>
<td>Unsafe Abortion</td>
<td>19%</td>
</tr>
<tr>
<td>Eclampsia</td>
<td>17%</td>
</tr>
<tr>
<td>Other causes</td>
<td>14%</td>
</tr>
<tr>
<td>Infections</td>
<td>11%</td>
</tr>
<tr>
<td>Obstructed Labour</td>
<td>11%</td>
</tr>
</tbody>
</table>

NOTE: 8.7% of pregnant women are HIV positive. Source: The world Health Report 2009

Why do Newborns die?
About a quarter (1/4) of all under five deaths in Africa take place in the first month of life and this proportion is increasing. In Tanzania infections, including sepsis/pneumonia, tetanus and diarrhea, intrapartum related birth asphyxia and preterm births account for 88% of all newborn deaths. Up to 90% of newborns who die are low birth weights (<2.5kg) with preterm babies at highest risk

Causes of Neonatal Deaths in Tanzania 2006

<table>
<thead>
<tr>
<th>Cause</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infections</td>
<td>29%</td>
</tr>
<tr>
<td>Asphyxia</td>
<td>27%</td>
</tr>
</tbody>
</table>
Low birth, Preterm | 23%
---|---
Other causes | 8%
Congenital | 7%
Diarrhoeal | 3%
Neonatal Tetanus | 3%

Source: WHO Report 2009

**Why do the under five children die?**

After the first month of life, two thirds of child deaths in Africa are due to pneumonia, Diarrhea and Malaria. Malnutrition is also important as it increases the risk of children dying from infections. The cause of death profile varies between countries. For example even though HIV/AIDS accounts for approximately 5% of child deaths in our region overall, more than half of child deaths in S.A are due to HIV/AIDS.

**Causes of Deaths for Children Aged less than Five Years, in Tanzania in 2006**

<table>
<thead>
<tr>
<th>Causes</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal</td>
<td>26.9%</td>
</tr>
<tr>
<td>Malaria</td>
<td>22.7%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>21.1%</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>16.8%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>9.3%</td>
</tr>
<tr>
<td>Injuries</td>
<td>2%</td>
</tr>
<tr>
<td>Measles</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

*malnutrition is an underlying cause of death in about 50% cases.*

Source: WHO 2009

**Current initiatives to improve MNCH in Tanzania**

Maternal and child health services were established in Tanzania since 1974 followed immediately in 1975 by EPI. Since then Tanzania has initiated many programmes towards, improvement of MNCH including the SMI in 1989, the IMCI in 1996 and baby friendly hospital initiatives in 1992 to mention just a few. Tanzania is one of the African countries with beautiful health plans and policies for all its citizens including mothers, newborn and children.

Currently, MNCH is a major priority area in the National Strategy for Growth and Poverty Reduction (NSGPR/MKUKUTA) 2005-2010 which has three major interlinked clusters. One of the goals clearly outlined in the second cluster of the strategy is to improve the survival, health and well being of all children and women and of especially vulnerable groups. Under this goal, there are four operational targets related to maternal and child health for monitoring progress towards achieving MDGs 4 and 5.


ii. The newly initiated Primary Health Service Development Programme, (PHSDP/MMAM) 2007 – 2017, addresses the delivery of health services to ensure fair, equitable and quality services to the community and is envisioned to be the springboard for achieving good health for Tanzanians.
iii. The Tanzania Maternal Newborn and Child health Partnership launched in April 2007 re-focuses the strategies for reducing the persistently high maternal, newborn and child mortality rates, through adopting the One Plan and setting clear targets for improved MNCH. One Plan is about using health system packages to deliver life saving care.

Tanzania is committed to achieving the Millennium Development Goals 4 and 5 by the year 2015. To that effect Tanzania has developed the MNCH Strategic Plan to accelerate reduction of MNC deaths in response to the New Delhi Declaration of April 2005. The mission of the plan is to promote, facilitate and support in an integrated manner the provision of comprehensive reduction of maternal, newborn and child morbidity and mortality. The goal is to accelerate the reduction of MNC mortality and morbidity in line with MDG 4 and 5.

**Objectives of the Plan are three:**
- To reduce maternal mortality from 578 to 193/100,000 deliveries
- To reduce neonatal mortality from 32 to 19/1000 live births
- To reduce under five mortality from 112 to 54/1000 live births

**Operational targets to be achieved by 2015**
- Increased coverage of birth attended by skilled attendants from 46 to 80%
- Increased immunization coverage of DTP-Hb3 and measles vaccines to above 90% in 90% of the districts.

However, the year 2015 is next door and in order to reduce the current MMR of 578 to 193/100,000 by 2015. The Maternal mortality rate has remained persistently high in the past 10 to 15 years and we are expecting to reduce it by two thirds in 5 years.

Maternal, newborn and child health care is one of the key components of the National Package of Essential Reproductive and Child Health Interventions (NPERCHI) focusing on improving the quality of life for women, adolescents and children. The major components of the package include Antenatal care; Care during childbirth; Care of obstetric emergencies; Newborn care; Postpartum care; Post abortion care; Family planning; Diagnosis and management of HIV/AIDS including PMTCT, other sexually transmitted infections and reproductive tract infections (STI/RTI); Prevention and management of infertility; Prevention and management of cancer; Prevention and management of childhood illness; Prevention and management of immunizable disease; Nutrition care.

However, In spite of the good coverage of health facilities, not all components of the services are of good quality and provided to scale. Most indicators for improvement of maternal health including Antenatal care services, Malaria in pregnancy, Intra partum care, and postnatal care, Prevention of Mother-to-Child Transmission of HIV, Nutrition, Anaemia and Family planning remained unmet. The picture confirms that maternal, newborn and child mortalities remains a major public health challenge in Tanzania.

**Current situation of the health of women, newborn and children**

**Antenatal care** - According to TDHS (2004/05), 94% of pregnant women make at least one antenatal care (ANC) visit and 62% of women have four or more ANC visits. The number of pregnant mothers in Tanzania making four or more ANC visits appears to have declined slightly 70% in 1999. However, the quality of antenatal care provided is inadequate. About 65% of the women have their blood pressure
measured and 54% have blood samples taken for haemoglobin estimation and syphilis screening. About 41% have urine analysis done and only 47% are informed of the danger signs in pregnancy. Approximately 80% of pregnant women received at least 1 dose of tetanus toxoid (TT), and 56% of women received two or more TT doses. Younger mothers, women in their first pregnancy, women of the higher education and wealth strata and urban women are more likely to receive two or more doses of TT. Despite high ANC attendance, only 14% of pregnant women start ANC during the first trimester as per the national guidelines. One third of women do not seek ANC until sixth month or later. However, early booking has and advantage for proper pregnancy information sharing and pregnancy monitoring.

Coverage of interventions along the Continuum of Care in Tanzania

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Percentage</th>
</tr>
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</table>
| Antenatal care                                   | 94.3 one visit, 62% >4 visits
Started ANC 1st trimester 14%                    |
| Births that take place in health facilities      | 47%                                            |
| Births that take place elsewhere                 | 53% (assisted by relatives 31% and by TBAs 19%) |
| Informed about danger signs of pregnancy         | 47%                                            |
| Received postnatal care                          | 15%                                            |
| Blood pressure taken                             | 65%                                            |
| Hb and Syphilis tested                           | 54%                                            |
| Urine taken                                      | 41%                                            |
| Received DPT3 doses                              | 86%                                            |
| Women who received TT                            | 80 one, 56 two doses                            |
| Exclusive breast feeding                         | 41%                                            |

1/3 of pregnant women do not seek ANC until after 6 months

Coverage of interventions along the continuum of care in Tanzania

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births delivered by C/S</td>
<td>3% (WHO recommends 5-15%) C/S</td>
</tr>
<tr>
<td>Public Hospital providing Comprehensive Emergency Obstetric Care (CEmOC)</td>
<td>64.5%</td>
</tr>
<tr>
<td>Health centers providing basic emergency obstetric care (BEmOC)</td>
<td>5.5%</td>
</tr>
<tr>
<td>Women who delivered outside the health facility and did not receive postnatal care</td>
<td>83%</td>
</tr>
<tr>
<td>Women examined two days after giving birth as recommended</td>
<td>13%</td>
</tr>
</tbody>
</table>


The critical challenges in reducing maternal, newborn and child morbidity and mortality comprise two categories:

(a) **Health system factors** – inadequate implementation of pro-poor policies, weak health infrastructure, limited access to quality health services, inadequate human resource, shortage of skilled health providers,
weak referral systems, low utilization of modern family planning services, lack of equipment and supplies, weak health management at all levels and inadequate coordination between public and private facilities.

A closer analysis of the referral system shows some serious challenges including: limited number of ambulances, unreliable logistics and communication systems; and inadequate community-based facilitated referral systems. The high rate of home deliveries is attributable to a malfunctioning referral system, inadequate capacity of health facilities in terms of available space, skills attendants and commodities, and other socio-cultural aspects affecting the pregnant women. Additional factors include gender inequalities in decision-making and access to resources at household-level. On the other hand the major barriers perceived by women in accessing delivery health services were: lack of money (40%), long distance to health facility (38%), lack of transport (37%), and unfriendly services (14%).

**b) Non health system factors** – inadequate community involvement and participation in planning, implementation, monitoring and evaluation of health services, some social cultural beliefs and practices, gender inequality, weak educational sector and poor health seeking behavior.

**Use health system packages to deliver life-saving care**

Maternal, newborn and child outcomes are interdependent; maternal morbidity and mortality impacts neonatal and under-five survival, growth and development. Thus service demand and provision for mothers, newborns and children are closely interlinked. Integration of MNCH services demands reorganization and reorientation of components of the health systems to ensure delivery of set of essential interventions for women, newborns and children. A focus on the continuum of care replaces competing calls for mother or child, with a focus on high coverage of effective interventions and integrated MNCH services packages as well as other key programmes such as Safe Motherhood (SM), Family Planning (FP), and Prevention of Mother to Child Transmission (PMTCT) of HIV, Malaria, EPI, IMCI, Adolescent Health and Nutrition. Sustained investment and systematic phased scale up of essential MNCH interventions integrated in the continuum of care are required.

Research suggest that single or vertical interventions, such as an immunization or bed nets to prevent malaria can reduce mortality; yet a more sustainable solution is to integrate effective interventions and delivery strategies within existing health system packages. Bridging the artificial divided between vertical approaches, which focus on specific disease priorities and interventions, and horizontal ones, which aim to strengthen the overall structure and functions of the health system may increase efficiency of delivery and build a results-focused health system. There is increasing evidence to suggest that when MNCH interventions are packaged and provided through various service delivery modes tailored to suit existing health systems, cost-effectiveness is enhanced and available human resources are maximized.

The continuum of care is a core organizing for health systems that emphasizes seamless linkage between health care packages across time and through various service delivery strategies. An effective continuum of care addresses the needs of mother, newborn, and child throughout the life cycle, wherever care is provided: at home, primary care level and district and regional hospitals.

Schematic matrix of the following eight basic health packages that are present in almost every health system:
1. Reproductive health clinical care package.
2. Reproductive health packages for outpatient and outreach services.
3. Antenatal care package for outpatient or outreach service.
5. Postnatal care package for outpatient or outreach service.
7. Child health package for outpatient or outreach service.
8. Family and community care package.

**AN EFFECTIVE CONTINUUM OF CARE ADDRESSES THE NEEDS OF MOTHER, NEWBORN, AND CHILD THROUGHOUT THE LIFE CYCLE, WHEREVER CARE IS PROVIDED: AT HOME, PRIMARY CARE LEVEL, AND DISTRICT AND REGIONAL HOSPITALS. THIS IS THE CORE OF AN EFFECTIVE HEALTH SYSTEM.**

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**Partnerships and Coordination**

Maternal, newborn and child health interventions need to be addressed in the context of a multi-sectoral approach. In order to be able to reach the MDGs 4 and 5, Partnerships, resources and more effective and coordinated programmes at all levels is important.

**Steps to action** – Improving health systems and promoting high impact interventions involves everyone, everybody and especially requires partnership between scientists and health care providers with government, development partners, policy makers civil society and communities. Four key actions include:

- **Invest and track resources** – increase funding and accountability for financial promises and fiscal commitments
- **Implement** – apply current knowledge to carry out policies and programmes equitably
- **Innovate** – Develop new research and new technologies and adopt a paradigm shift to implementing science through health systems research
- **Inform** – use evidence as a basis for health policy and resource allocation

**Key actions for the various stakeholders:**

I. Action for the Ministries (MoF and MHSW)
II. Actions for health policy planners and implementers
III. Actions for health care professionals
IV. Actions for development partners
V. Action for household, civil society and community

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**I. Action for Ministry of finance and Ministry of Health and Social Welfare**

**How many lives can we save?**

**Invest and track resources:** Invest in healthy by meeting the Abuja target set in 2001 to devote at least 15% of government spending to the health sector. Tanzania and other Africa countries are spending less than 10% of their total expenditure on health. Government should also hold development partners accountable for promised funding.

**Implement** - Implement promised MNCH commitments. Ensure the implementation of the national action plan for MNCH through accountable leadership and good stewardship of resources.

**Innovate** - Take ownership of MNCH and pioneer change. Tanzania government and all governments of Africa have an obligation to save lives of mothers, newborns, and children in their country. Cost-effective
interventions have proved to work with the right support and financial backing of governments as demonstrated by numerous countries including Tanzania

**Inform**: - Inform lower and mid level health facilities on national policy by improving communication lines between strategic planning at the national level and action in districts. The gap between national policy and district implementation can be bridged through improved information sharing

### II. Actions for health policy planners and implementers

**Invest and track resources** - Invest in district level health systems; Allocate financial resources and responsibility to districts in order to encourage local ownership and problems solving.

**Implement** - Strengthen health systems at a district level and maximize human resource potential, including the use of community cadres where appropriate. The global shift towards, decentralized health systems decisions to be made closer to where care is provided. Due to the human resource shortage in Tanzania, health policy planners need to incorporate skills development and task shifting into their district level plans.

**Innovate** – Investigate and support new research and home grown solutions and apply recommendations. It is important for health policy planners to stay abreast of new research, evidence and tools, in order to set priorities effectively. Policy planners should use different approaches to identify struggling institutions for getting tailor-made technical support and where appropriate additional support with resources. They should create programmes and policies that will benefit from the participation of Civil Society Organizations and communities.

**Inform** – Monitor coverage and evaluate effect and cost. When scaling up services, it is crucial to increase the availability and quality of information to monitor progress and inform decision making.

### III. Actions for health care professionals

**Are you practicing evidence-based high quality care?**

**Invest and track resources** – Invest time and resources to train more health care professionals and communities. This includes pre service training for various levels of health workers, upgrading of skills and provision of competency based education, as defined by the specific professional group e.g. the nurses associations, the midwives associations and physicians associations.

**Implement** – Set standards for care. Health care professionals need to be aware of, maintain competency in and adhere to standard care protocols, including correct assessment of patients and lifesaving skills, especially during labour, childbirth (e.g. neonatal resuscitation) and the management of childhood illness.

**Innovate** – Partner with research institutions and other professional bodies and government. Identify proven effective interventions and make them known to country-level professional groups and their members, promote linkages with academic institutions to undertake research, education and monitoring through existing networks

**Inform** – Report cases and incorporate research in health care practice- Supervisors at all levels must be accountable for quality of patients care, recording cases, and identify gaps in the health system in order to improve care. Monitoring and evaluation needs to be embedded within primary health care activities, especially the documentation of MNCH interventions.

### IV. Actions for development partners

Does your investment count to maximize lives saved now and systematically strengthen health systems
**Invest and track resources:** Invest in essential maternal, newborn and child health (MNCH) interventions. Donors committed to denote 0.7% of their gross national product to the Abuja target as their official development assistance to developing countries and to cancel Africa’s external debt. Donor countries need to be reminded to fulfill their commitment. There needs to be follow through on recent commitments to improving maternal, newborn and child health

**Implement** – Implement the principles of the Paris Declaration on aid effectiveness: one plan, one coordinating mechanism, and one monitoring system to lighten the management and reporting load. Donor convergence allows for better decision making and more efficient use of resources and the country level.

**Innovate** – Renew commitment to primary health care and invest in strengthening health systems. MNCH and overall health system strengthening in the long term relies on development partner support for an integrated continuum of care rather than a vertical strategy of promoting single interventions that are not linked to the health system

**Inform** – Align MNCH targets with country specific needs. While research identifies specific gaps in MNCH and guides country policy, Tanzania still relies on the support of development partners to implement services. Vertical aid programmes are often too narrow to address MNCH effectively. Donors are encouraged to fund initiatives that are locally relevant.

**V. Action for household, civil society and community**

What Can I do as a citizen to improve maternal, newborn and child health?

**Invest and track resources:** - Advocate for increased investment in maternal, newborn and child health. E.g. Government of Tanzania and development partners have made financial commitments, but have not followed through with actual budget allocation. Civil society has a responsibility to ensure that commitments are met and money is spent effectively

**Implement** - Engage in activism and monitor maternal and child health activities. It is up to civil society to hold government and health providers accountable for progress towards, the MDGs especially 4 and 5. Actions may include signaling mismanagement of health services and working for equitable, efficient and sufficient resource allocation

**Innovate:** - Build partnerships with government and development partners to create an environment whereby civil society can engage in policy dialogue and share lessons learnt.

**Inform:** - Educate communities about how to access health care and empower them, especially poor and marginalized families, to demand quality health care for themselves and their children

**7.0 Conclusion.**

Most African Countries including Tanzania are off track to achieving the MDGs 4 and for MNCH by the year 2015. In Tanzania the MMR and Neonatal Mortality rates have remained unchanged since 1990. The year 2015 is only 5 years from now and what is needed now is strategic, data-based prioritization of interventions to accelerate the progress. It is important that we use science evidence-based interventions to reduced maternal newborn and child deaths. It is critical that funding and human resources should be focused on rapid scaling up of the highest impact interventions.

Maternal, newborn and child outcomes are interdependent; maternal morbidity and mortality impacts neonatal and under-five survival, growth and development. Challenges in reducing MNC death comprise
the healthy system and non health system factors. Integration of MNCH services demands reorganization and reorientation of components of the health systems to ensure delivery of set of essential interventions for women, newborns and children.

There is increasing evidence to suggest that when MNCH interventions are packaged and provided through various service delivery modes tailored to suit existing health systems, cost-effectiveness is enhanced and available human resources are maximized. The continuum of care is a core organizing for health systems that emphasizes seamless linkage between health care packages across time and through various service delivery strategies. An effective continuum of care addresses the needs of mother, newborn, and child throughout the life cycle, wherever care is provided: at home, primary care level and district and regional hospitals.

Improving health systems and promoting high impact interventions involves everyone, everybody and especially requires partnership between scientists and health care providers, the government, the development partners, the policy makers, civil society and communities and household. Four key steps to actions include: Increase funding and accountability for financial promises and fiscal commitments, Apply current knowledge to carry out policies and programmes equitably, Develop new research and new technologies and adopt a paradigm shift to implementing science through health systems research and use evidence as a basis for health policy and resource allocation.

Hon. Gertrude Mongela the former President of the Pan African Parliament once said “Everyone has a role to play in saving the lives of African mothers, newborns and children” Indeed, we all have a role to play in reducing the high maternal, newborn and child mortality. The interventions needed are simple and affordable. It can be done, just play your part.

Birth of baby is generally a joyful occasion, it is a reason to celebration.

THANK YOU FOR THE COMMITMENT!!!