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Targeting Big Results in Maternal, Neonatal, and Child Health

A Trip Report of the CSIS Delegation to the United Republic of Tanzania, February 2015

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Katherine E. Bliss and Cathryn Streifel[1]

Overview

The year 2015 will be significant for maternal and child health for several reasons: Late January saw the historic replenishment of Gavi, the Vaccine Alliance, with donor commitments of more than $7.5 billion over five years. June will mark the third anniversary of the multi-partner "Call to Action: A Promise Renewed," focused on accelerating global progress toward ending preventable child and maternal deaths by 2035. And at the end of December, countries around the world will mark the culmination of the Millennium Development Goals (MDGs), which have focused the international community's attention on reducing child and maternal deaths through goals four and five over the past 25 years.

While the world has made considerable progress on reducing the mortality of children under the age of five, realizing important reductions in maternal mortality and neonatal mortality has proven more of a challenge. In sub-Saharan Africa, in particular, many countries are on track to meet the international community's child health goals but have made much slower progress when it comes to improving maternal and neonatal outcomes.[2] The United States has supported maternal, neonatal, and child health programs in sub-Saharan Africa for several decades, starting with nutrition and family planning programs

[1] Katherine E. Bliss is a senior associate with the CSIS Global Health Policy Center. Cathryn Streifel is a program manager and research associate with the CSIS Global Policy Center. The authors would like to thank the U.S. Embassy in Dar Es Salaam and the U.S. government agencies, including the U.S. Agency for International Development, the U.S. Centers for Disease Control and Prevention, the Peace Corps, and the President's Emergency Plan for AIDS Relief, all of which supported the delegation's activities. We also wish to thank the Secretariat of Gavi, the Vaccine Alliance, for its help and support. We are grateful to the representatives of the government of Tanzania, including the Ministry of Health and Social Welfare, particularly the Immunization and Vaccines Division, the Medical Stores Department, the Ministry of Finance, and the Regional Secretary and Regional Medical offices in Mwanza Region, who facilitated or participated in our site visits and meetings. Representatives of U.S.-funded nongovernmental and faith-based organizations also took time out of their schedules to arrange or join us on site visits. Numerous health care providers, program managers, patients, and community members shared their perspective and ideas with the delegation, for which we are also extremely grateful.

[2] Countdown to 2015: Maternal, Newborn, and Child Survival, "Fulfilling the Health Agenda for Women and Children: The 2014 Report," http://www.countdown2015mnch.org/documents/2014Report/Countdown_to_2015-Fulfilling%20the%20Health_Agenda_for_Women_and_Children-The_2014_Report-Conference_Draft.pdf.

in the 1960s and 1970s and growing to include vaccine activities and work on HIV/AIDS by the 1980s.[3] In the last two decades, the United States has expanded its work to support other countries' maternal, neonatal, and child health efforts through disease-focused programs such as the President's Emergency Plan for AIDS Relief (PEPFAR) and President's Malaria Initiative (PMI). U.S. engagement in public-private partnerships, including Gavi, the Vaccine Alliance, has also deepened.

To better understand the factors in sub-Saharan Africa contributing to improvements in child health, on the one hand, and persistent challenges related to maternal and neonatal health, on the other, the CSIS Global Health Policy Center organized a delegation to the United Republic of Tanzania in February 2015. CSIS identified Tanzania, a largely rural, lower-income economy country with a population of more than 49 million, as a promising site for a delegation visit for several reasons:

- The United States has had a comprehensive and longstanding relationship with Tanzania on health.[4]

- Tanzania has made strong progress in extending vaccine coverage in all regions and is considered "on track" to meet its MDG target of reducing under-five mortality.[5]

- To accelerate progress on reducing maternal and neonatal mortality, Tanzania has prioritized Maternal, Neonatal, and Child Health (MNCH) through the launch of two new government programs, the Sharpened One Plan and "Big Results Now."

At the same time, the government of Tanzania has articulated ambitious plans to improve the population's access to health services by aggressively training and deploying health workers and bolstering domestic financing for health through a national health insurance scheme aimed at covering a greater proportion of the population with access to quality health services.

The CSIS delegation included bipartisan staff from two congressional offices, representatives of the ONE Campaign, the Bill & Melinda Gates Foundation, and the Rabin Martin global health strategy firm, and staff from the CSIS Global Health Policy Center. The program, activities, and analysis built on a series of delegation trips CSIS has led over the past decade to examine U.S. global health policy in sub-Saharan Africa and elsewhere in the world.[6] Over six days in Dar es Salaam and the city of Mwanza, on Lake Victoria, the

[3] USAID, *50 Years of Global Health: Saving Lives and Building Futures* (Washington, DC: USAID, 2014), http://www.usaid.gov/what-we-do/global-health/50-years-global-health.
[4] USAID, "Tanzania: History," http://www.usaid.gov/tanzania/history.
[5] Countdown to 2015: Maternal, Newborn and Child Survival, "Fulfilling the Health Agenda for Women and Children," 180–81.
[6] J. Stephen Morrison et al., *Myanmar: Regressed, Stalled, or Moving Forward?* (Washington, DC: CSIS, 2014), http://csis.org/files/publication/141019_Morrison_Myanmar_Web.pdf; Janet Fleischman and Alisha Kramer, *Family Planning and Linkages with U.S. Health and Development Goals* (Washington, DC: CSIS, 2014), http://csis.org/files/publication/140417_Fleischman_FamilyPlanningEthiopia_Web.pdf; Janet Fleischman and Alisha Kramer, *Strengthening U.S. Investments in Women's Global Health* (Washington, DC: CSIS, 2013),

delegation conducted site visits and held meetings with representatives of national, regional, and district public health agencies, as well as U.S.-supported partner organizations.

During its week on the ground, the delegation gained knowledge about many important accomplishments in the areas of maternal, neonatal, and child health in Tanzania. The success of vaccination programs and activities to prevent and treat malaria among children was particularly noteworthy. Members also observed that limited infrastructure and poor quality of care; low presence of trained health workers in the most remote areas; and reduced availability of necessary commodities, including supplies for facility-based childbirth and blood in the event of postpartum hemorrhage, were key reasons for Tanzania's more modest achievements in reducing maternal and neonatal deaths. The delegation learned that the government of Tanzania has outlined a three-pronged approach for ending preventable deaths of women, newborns, and children: provision of voluntary family planning services, improving quality care at birth, and continuing progress on child health.[7]

Yet with public spending on health in Tanzania accounting for only 8.1 percent of the overall government budget, in 2015, the Ministry of Health and Social Welfare (MOSHW) estimated a funding gap of $169.5 million for Reproductive, Maternal, Neonatal and Child Health (RMNCH) services alone.[8] At the same time, according to the World Bank, external resources as a percentage of the total expenditure on health in Tanzania increased from 11.3 percent in 2002 to 38.5 percent in 2012.[9] Considering Tanzania's recent economic growth and stated ambition to be classified as a middle-income country by 2025, careful planning and partnership to build capacity, promote sustainability, and mobilize domestic resources for health will be essential to ensure that gains in MNCH accompany and reinforce the government's vision for long-term development.

The delegation's observations over the course of the week led to four broad recommendations for U.S. policymakers to consider in planning future efforts to support

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https://csis.org/files/publication/130521_Fleischman_ZambiaDelegation_Web.pdf; Suzanne C. Brundage, *Terra Nova: How to Achieve a Successful PEPFAR Transition in South Africa* (Washington, DC: CSIS, 2011), http://csis.org/files/publication/111205_Brundage_TerraNova_WEB.pdf.

[7] United Republic of Tanzania Ministry of Health and Social Welfare, "Women and Children First: Countdown to ending preventable maternal, newborn and child deaths in Tanzania," http://www.countdown2015mnch.org/documents/tanzania/Tanzania_Policy_Brief_FINAL.pdf.

[8] Health Policy Project, "Snapshot: Tanzania's Health System," shared with CSIS, February 2015; Health Policy Project, "Prospects for Sustainable Health Financing in Tanzania," shared with CSIS, February 2015. See also United Republic of Tanzania Ministry of Health and Social Welfare, "National Health Accounts, Year 2010: With sub-Accounts for HIV and AIDS, Malaria, and Reproductive and Child Health," https://www.hfgproject.org/wp-content/uploads/2015/02/Tanzania-National-Health-Accounts-Year-2010-with-Sub-Accounts-for-HIV-and-AIDS-Malaria-Reproductive-and-Child-Health.pdf; and USAID, the World Bank, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria, "Domestic Resource Mobilization for Tanzania: Leveraging Economic Transition," presentation shared with CSIS, February 2015.

[9] World Bank, "World Development Indicators," http://databank.worldbank.org/data/views/variableselection/selectvariables.aspx?source=World-Development-Indicators.

improvements in maternal, neonatal, and child health in Tanzania, and elsewhere in the region:

- Focus health system strengthening support for MNCH on activities at the community level, where the majority of mothers and children will seek care and where human resources and supplies are often lacking.

- Strengthen bilateral and multilateral dialogue on domestic resource mobilization for health to encourage long-term planning for sustaining and accelerating progress on MNCH challenges.

- Use successful vaccine programs as models for other services meant to reach mothers and children in urban, peri-urban, and rural areas and identify opportunities to integrate vaccine programs with other MNCH services for enhanced success.

- Recognize that MNCH gains realized through PEPFAR programs are important but that reducing maternal, neonatal, and child mortality will require financial and technical resources beyond HIV/AIDS programs; U.S. support for MNCH must be strengthened in a manner that is not PEPFAR-dependent.

As the global community looks beyond 2015 and considers how to build on successful efforts to reduce child mortality while scaling up programs to tackle persistent challenges in improving maternal and neonatal health, the lessons from Tanzania offer inspiration and suggest opportunities for enhanced collaboration in the future.

Prioritization of MNCH in Tanzania: The Sharpened One Plan and Big Results Now

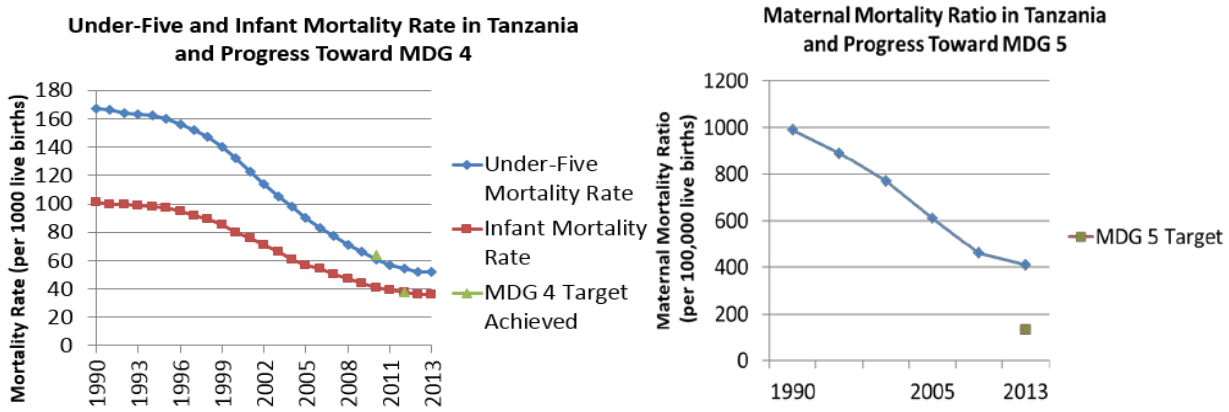
Over the past year, the government of Tanzania has launched two efforts to focus the attention of national, regional, and district-level authorities on improving maternal, neonatal, and child health outcomes. It has placed particular emphasis on accelerating progress in regions of the country that have faced the greatest challenges.

In April 2014, the government launched the "Sharpened One Plan" aimed at reducing maternal, newborn, and child mortality.[10] The plan was developed following a 2013 review of the country's 2008–2015 National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Death, also known as the One Plan. During the assessment, it became clear to health authorities that while Tanzania had made rapid progress on

[10] World Health Organization-AFRO, "The United Republic of Tanzania launches the Sharpened One Plan and the RMNCH Score Card to prevent Maternal, Newborn and Child Mortality," http://www.afro.who.int/en/tanzania/press-materials/item/6565-the-united-republic-of-tanzania-launches-the-sharpened-one-plan-and-the-rmnch-score-card-to-prevent-maternal-newborn-and-child-mortality.html.

reducing child mortality since 1990, it has experienced significantly slower progress on reducing maternal and neonatal deaths.

In 2013, Tanzania, was judged "on track" to reach its target within MDG 4 of reducing by two-thirds since 1990 the mortality rate of children under the age of five. But the percentage of newborn deaths among that group has remained stubbornly stable at around 40 percent, and the maternal mortality ratio has fallen slowly.[11] Compounding these challenges are the facts that Tanzania has a relatively high total fertility rate of 5.3 and a low national contraceptive prevalence rate of around 34 percent.[12]



Source: World Bank, "World Development Indicators."

The Sharpened One Plan emphasizes accelerating progress in the regions of the country where that forward movement has been slowest—the Lake and Western zones—and focuses on strengthening health systems in rural and underserved urban areas to increase access to reproductive, maternal, and child health services for women and girls in the most vulnerable communities. The plan also emphasizes access to and quality of family planning services and commodity security.[13] The refinements made to the One Plan emphasize transparency and accountability for maternal and child health outcomes at the regional level. Through the new RMNCH Score Card, which is associated with the Sharpened One Plan, regional commissioners (who are similar to state governors in the United States) are required to submit quarterly reports showing the percentage of women using contraceptives; the percentage of pregnant women attending antenatal clinics; and the percentage of women who deliver their babies in the presence of a skilled attendant.

[11] Debbie McGill, Nicole Perales, and Arin Dutta, "Prognosis for Maternal, Newborn, and Child Health in Tanzania: Plans for Interventions in the Short, Medium, and Long Term," Health Policy Project, shared with CSIS, February 2015, http://www.healthpolicyproject.com/pubs/805_TanzaniaOnePlanbriefFINAL.pdf.
[12] Countdown to 2015: Maternal, Newborn, and Child Survival, "Fulfilling the Health Agenda for Women and Children: The 2014 Report," http://www.countdown2015mnch.org/documents/2014Report/TanzaniaURep_Country_Profile_2014.pdf; USAID, "Family Planning," http://www.usaid.gov/tanzania/family-planning.
[13] United Republic of Tanzania Ministry of Health and Social Welfare "The National Road Map Strategic Plan to Accelerate Reduction of Maternal, New born and Child Deaths in Tanzania 2008–2015," April 2014, http://advancefamilyplanning.org/sites/default/files/resources/RMNCH%20Plan%202014%20to%202015.pdf.

Sharpened One Plan and the Reproductive, Maternal, Newborn, and Child Health Scorecard

- The Sharpened One Plan is a costed plan covering the 500-day period until the 2015 MDG deadline to accelerate the reduction of maternal, neonatal, and child deaths.
- The Sharpened One Plan focuses on five strategic areas: geographic vulnerability, high-burden populations, high-impact interventions, enabling environment, and accountability.
- Prioritized interventions aim to: expand access to safe deliveries and increase family planning users in the Lake and Western zones; reduce stock-outs of maternal, neonatal, and child health commodities at the facility level; and improve accountability mechanisms through the use of tools such as the RMNCH scorecard.
- Through this scorecard, progress toward key maternal, neonatal, and child health indicators is tracked at the subnational level on a quarterly basis and regional leaders are accountable.

The inclusion of MNCH in Tanzania's high-profile "Big Results Now Initiative" reflects the recognition that improved MNCH is essential to Tanzania's future economic growth. In 2013 the government of Tanzania launched the multisector development strategy to guide its quest to reach middle-income country status during the next decade. Modeled on the Malaysian development plan called "The Big Fast Results Initiative," the Tanzanian program initially focused on six priority areas: energy and natural gas; agriculture; water; education; transportation; and mobilization of resources.[14] In October 2014, health was added as a seventh area of emphasis.[15]

The health-related component of Big Results Now (BRN) identifies four priorities for the health sector: human resources for health, system management, commodities management, and reproductive, maternal, neonatal, and child health. In January 2015, the government announced the results of a "lab" carried out over the previous months to determine RMNCH goals and strategies under BRN. Strategies will include improving community outreach about and demand for basic and comprehensive emergency obstetric and newborn care services; upgrading facilities to offer these services; and expanding voluntary blood-donation services to address needs associated with the expansion of emergency obstetric care.[16] As under the Sharpened One Plan, the Lake and Western zones are the focus of the BRN MNCH efforts. The government has set a goal of reducing maternal and neonatal mortality in five regions by 20 percent by June 2018.[17]

As the government of Tanzania determines how best to finance these high-profile MNCH initiatives, it has invited bilateral partners and multilateral agencies to align their programming with, and then provide support for, the Sharpened One Plan and Big Results

[14] United Republic of Tanzania, "Big Results Now: BRN," http://www.pmoralg.go.tz/quick-menu/brn/.
[15] "'Big Results' initiative now focuses on health sector," *The Citizen*, October 12, 2014, http://www.thecitizen.co.tz/News/national/-Big-Results--initiative-now-focuses-on-health-sector/-/1840392/2483604/-/9pe3xlz/-/index.html.
[16] Basic Emergency Obstetric and Newborn Care and Comprehensive Emergency Obstetric and Newborn Care are often referenced by the acronyms BEmONC and CEmONC. For more information, see McGill, Perales, and Dutta, "Prognosis for Maternal, Newborn, and Child Health in Tanzania: Plans for Interventions in the Short, Medium and Long Term."
[17] Ibid.

Now. According to a recent assessment, realizing the BRN MNCH goals alone will cost US$66 million.[18]

U.S. Support for Maternal, Neonatal, and Child Health Programs in Tanzania

The U.S. government has maintained bilateral relations with Tanzania since 1961, when the mainland, Tanganyika, achieved independence from the United Kingdom. (The United Republic of Tanzania was formed in 1964 after the island of Zanzibar gained independence and united politically with the mainland.) U.S.-funded development assistance programs began shortly thereafter. The U.S.-Tanzania relationship on health and development has experienced political highs and lows over the last six decades, with a challenging period being the phase-out of the USAID mission in the mid-1980s in response to Tanzania's failure to make regular loan payments.[19] Since the resolution of debt payment negotiations and the reopening of the mission in 1987, however, the bilateral relationship on development has generally been strong.[20] The U.S-Tanzania Country Development Cooperation Strategy for 2015–2019 identifies women and youth empowerment; sustainable, inclusive broad-based economic growth; and improved democratic governance as overarching goals.

In 2014, overall spending by the United States on health activities in Tanzania reached more than US$450 million. The principal U.S. government agencies carrying out work on health in Tanzania are USAID and the U.S. Centers for Disease Control (CDC). The Peace Corps and the Department of Defense's Walter Reed Army Institute of Research play important roles in the areas of training and research.

The vast majority (62 percent) of U.S. health assistance to Tanzania is channeled through PEPFAR to support HIV/AIDS activities. Since 2004, Tanzania has received more than US$2.4 billion in PEPFAR-related assistance.[21] PEPFAR-funded activities that support MNCH include scaling up prevention of mother-to-child transmission (PMTCT) programs and pediatric HIV services.[22] The Office of the U.S. Global AIDS Coordinator reported that in 2014, thanks to U.S. support, 65,604 HIV-infected pregnant women in Tanzania received antiretroviral drugs to reduce the risk of infecting their babies with HIV during pregnancy and delivery.[23] The United States has recently announced a strategy shift (called PEPFAR 3.0) for responding to the HIV/AIDS epidemic in collaboration with partner countries, including

[18] Ibid.
[19] USAID, "Tanzania: History."
[20] Allegations of the mishandling of public funds by the Independent Power Tanzania Limited (IPTL) company led the Board of the Millennium Challenge Corporation to issue a statement in December 2014 that "Tanzania must take firm, concrete steps to combat corruption before a new compact is approved." Millennium Challenge Corporation, "MCC Statement on Board of Directors' Discussion of Tanzania at the December 2014 Meeting," December 10, 2014, https://www.mcc.gov/pages/press/release/statement-121014-tanzania-selection.
[21] PEPFAR, "Partnership to Fight HIV/AIDS in Tanzania," http://www.pepfar.gov/documents/organization/199593.pdf.
[22] PEPFAR, "Five-Year Partnership Framework in Support of the Tanzanian National Response to HIV and AIDS, 2009–2013," March 4, 2010, http://www.pepfar.gov/documents/organization/138931.pdf.
[23] PEPFAR, "New Data," http://data.pepfar.net/newData.

Tanzania. Under this new approach, PEPFAR will maximize its impact by using improved data to target populations at greatest risk, in areas of greatest HIV incidence, with evidence-based interventions.[24]

The USAID mission oversees the lion's share of U.S.-supported health activities in Tanzania. In 2014, the mission's funds for health programming totaled US$273 million, a figure that includes PEPFAR funds channeled through USAID to support HIV/AIDS activities. Several distinct program areas contribute to maternal, neonatal, and child health improvements. Direct funding for USAID maternal and child health programs totaled US$12 million in 2014, and activities to strengthen immunization services received an additional US$1.2 million. The President's Malaria Initiative (PMI), which supports maternal and child health through its focus on indoor residual spraying (IRS) and preventing malaria infection, was funded at US$45 million. In 2014, USAID funding for voluntary family planning activities, which contribute to maternal health through emphasis on healthy timing and spacing of pregnancies, totaled $US26 million.[25]

Tanzania is one of 24 MNCH priority countries under USAID's effort to address preventable maternal and child death. The new USAID Maternal and Child Survival Program (MCSP), which was launched in 2014 and is in line with the agency's "vision for action" on maternal health, is currently scaling up activities in Tanzania, where it is administered by the country office of the Baltimore-based NGO Jhpiego, as well as John Snow International (JSI).[26] The overarching goal of MCSP is to end "preventable child and maternal deaths (EPCMD) within a generation."[27]

MCSP activities in Tanzania include working with the MOHSW to "improve the environment for RMNCH services through technical leadership and coordination; strengthen key health systems to deliver quality RMNCH services; and strengthen the involvement of civil society, support institutions in RMNCH, and improve uptake of

[24] U.S. Department of State, "PEPFAR 3.0: Controlling the Epidemic: Delivering on the Promise of an AIDS-Free Generation," 6, http://www.pepfar.gov/documents/organization/234744.pdf. PEPFAR collaborates closely with the Global Fund to Fight AIDS, Tuberculosis, and Malaria in Tanzania. While PEPFAR focuses on services and systems strengthening, the Global Fund procures HIV/AIDS commodities. In 2010, the United States and Tanzania signed a Partnership Framework on HIV/AIDS, which articulates expected respective contributions and high-level goals and objectives to build a country-led sustainable response to HIV and AIDS for the 2010-to-2015 period. The framework emphasizes building the capacity of local organizations to strengthen Tanzanian civil society. PEPFAR activities focus on the following six key areas: service delivery and scale-up; prevention; leadership, management, accountability, and governance; sustainable and secure drug and commodity supply; human resources; and evidence-based and strategic decisionmaking. PEPFAR, "Tanzania: Operational Plan Report, FY 2013," http://www.pepfar.gov/documents/organization/222184.pdf.
[25] USAID-Tanzania Health Office, "Health Status of Tanzanian Families Improved," presentation to CSIS Global Health Policy Center delegation February 17, 2015.
[26] USAID, "Ending Preventable Maternal Mortality: USAID Maternal Health Vision for Action," June 2014, http://www.usaid.gov/sites/default/files/documents/1864/MCHVision.pdf.
[27] USAID, "Maternal and Child Survival Program," http://www.mcsprogram.org/wp-content/uploads/2015/02/MCSP_brochure_English-2.5.15.pdf. The full list of partner organizations includes Jhpiego, Save the Children, John Snow International (JSI), ICF International, Results for Development Institute (R4D), Population Services International (PSI), PATH, and CoreGroup.

innovations."[28] In Tanzania, MCSP builds on Jhpiego's earlier work with the MAISHA (Mothers and Infants Safe, Healthy, Alive) initiative. Through MAISHA, which also means "life" in Ki-Swahili, technical assistance in collaboration with the MOHSW and medical and nursing schools was focused on strengthening "antenatal care, basic emergency obstetric and newborn care, and community-level services to reduce maternal and neonatal morbidity and mortality."[29]

The CDC office in Tanzania contributes to maternal, neonatal, and child health activities through its PEPFAR-funded activities. CDC provides the government of Tanzania with technical assistance on early infant diagnosis of HIV (HEID), PMTCT programs, and Option B+, the WHO-recommended program under which all HIV+ pregnant women are offered antiretroviral therapy (ART) for life.[30] CDC provides technical assistance to the MOHSW in assessing vaccine programs and has worked closely with the MOHSW to establish the National Health Laboratory and Quality Assurance Training Center. CDC also supports the government of Tanzania's efforts to strengthen and ensure the safety of blood transfusion programs, an important element of postpartum hemorrhage care.

The Peace Corps contributes to U.S.-supported maternal, neonatal, and child health programs through the PEPFAR-funded Global Health Service Partnership, which also involves Seed Global Health and the Touch Foundation. This initiative places seasoned professional obstetrician/gynecologists, nurse-midwives, and pediatricians in education and training facilities to contribute to the professional development of Tanzanian health care providers.[31] The Walter Reed Army Institute of Research-Tanzania, through the U.S. Military Health Research Program (MHRP), also facilitates some programs related to HIV vaccine research and service provision, including PMTCT and pediatric HIV programs.[32]

During its time in Tanzania, delegation members learned that representatives of U.S. government agencies coordinate with the government of Tanzania on supporting the nation's MNCH priorities by participating in technical working groups and coordination committees overseen by the MOHSW. The United States also coordinates its activities in the health area with other bilateral and multilateral organizations through the Tanzania Development Partners' Group.[33]

[28] Jhpiego, "Jhpiego in Tanzania," http://www.jhpiego.org/files/Tanzania%20Country%20Profile_1.pdf.
[29] Ibid.
[30] Presentation to CSIS Global Health Policy Center delegation at roundtable with representatives of U.S. agencies working on health in Tanzania, February 17, 2015.
[31] Peace Corps, "Tanzania: 2013 Annual Report," and Seed Global Health literature provided to CSIS delegation, February 18, 2015.
[32] Presentation to CSIS Global Health Policy Center delegation at roundtable with representatives of U.S. agencies working on health in Tanzania, February 17, 2015.
[33] Development Partners Group Tanzania, "DPG Members," http://www.tzdpg.or.tz/dpg-website/dpg-tanzania/dpg-members.html.

Vaccines in EPI Program in Tanzania
BCG (Bacillus Calmette–Guérin) vaccine (tuberculosis)
Hepatitis B vaccine
HPV* (human papillomavirus demonstration)
Inactivated polio vaccine*
Measles*
Measles-Rubella*
Oral polio vaccine
Pentavalent vaccine* (diphtheria-tetanus-pertussis; hepatitis B; Haemophilus influenza type B)
Pneumococcal conjugate vaccine (PCV)* (pneumonia)
Rotavirus*
Tetanus vaccine

* With GAVI support.

Several global public-private partnerships that the United States supports are also actively engaged on MNCH issues in Tanzania. These include the Global Fund to Fight AIDS, Tuberculosis, and Malaria, as well as Gavi, the Vaccine Alliance. Since its inception, the Global Fund, to which the United States is the largest bilateral donor, has provided more than US$1.3 billion to Tanzania.[34]

Since 2001, Gavi, to which the United States is among the top-five donors, has supported the introduction of new and underutilized vaccines to prevent childhood illness, along with grants for health and immunization systems strengthening. The Gavi total disbursement to Tanzania, through the end of February 2015, was nearly US$275 million, with the government of Tanzania contributing 20 cents a dose, or US$14.8 million since the partnership began funding work in the country.[35] And while the U.S. contribution goes only to the procurement of vaccine, through other donor funding, Gavi is also providing support to strengthen health systems in Tanzania.

From the Community Health Center to the Referral Hospital: Maternal, Neonatal, and Child Health Challenges in Tanzania

In Tanzania, the point of entry for mothers and children into the public health system is the community-level dispensary, where patients can receive exams, seek advice from a clinical officer or nurse, and procure medicines, medical supplies, and immunization services. Some dispensaries are equipped for labor and delivery; many offer PMTCT services and treatment options for those infected with HIV. For more comprehensive services, or to consult with a physician, however, mothers and their children must visit a health center, which may serve several communities and typically offers a broader range of services than the dispensary. Patients who arrive at dispensaries or health centers with more complicated cases are referred to the district hospital and regional referral hospitals, although long distances and transportation costs can pose an obstacle to accessing that care. Particularly challenging cases may be referred to one of a handful of specialized

[34] The Global Fund, "Tanzania (United Republic)," http://portfolio.theglobalfund.org/en/Country/Index/TZA.
[35] Communication to CSIS from Gavi Secretariat, April 17, 2015.

national referral hospitals in Dar es Salaam. Those patients who live closer to a referral facility than a dispensary, and those who prefer to visit a more distant health center or district hospital because they believe the services will be of higher quality, may bypass community-level facilities altogether.

Over the course of the February 2015 visit, the CSIS delegation learned about U.S. support for MNCH programs in Tanzania through visits to and discussions with staff at a range of facilities, including health centers, a district hospital, and a regional referral hospital, as well as warehouses for storing and distributing essential medicines. In Dar es Salaam, the country's largest city with a population of about 4.5 million, delegates visited Mnazi Mmoja Health Center, which serves nearly three-quarters of a million people in the central district of Ilala. The delegation also visited the central Medical Stores Department, where all commodities destined for use in public health programs are initially housed. Because more than 70 percent of the Tanzanian population lives in rural areas, and because the government has prioritized RMNCH activities in the Lake Zone in response to the challenging indicators there, the delegation spent two and a half days visiting the Mwanza Region on the southern shore of Lake Victoria.

Mwanza has a population of around 600,000 and is an important commercial center in East Africa. For decades fishing and fish exports have supported a strong economy in the region, which also serves as a trade hub and point of access to neighboring countries Uganda, Kenya, Rwanda, and Burundi. Gold mines employ laborers from the region, and, because of Mwanza's proximity to Serengeti National Park, tourism plays an important role in the area's economy, as well.[36] Yet despite economic growth and diversification in recent years, as of 2013 more than 75 percent of women and 70 percent of men in Mwanza were working in small-scale agriculture and living on less than US$1 a day.

Compounding the challenge of reaching dispersed rural populations with health services is the fact that Mwanza encompasses at least 60 islands, inhabitants of which engage in fishing and frequently migrate to follow fish stocks at least some part of the year. At just 11.7 percent, the contraceptive prevalence rate in Mwanza Region is low compared to the mainland rate of 27.8 percent (2010), and the HIV prevalence is 4.2 percent, slightly lower than the average for the mainland.

In Mwanza, the delegation visited the comparatively rural Kabila Health Center, which serves a population of roughly 90,000 and Magu District Hospital, a 150-bed facility that serves a population of 300,000. In the city of Mwanza, the delegation visited the government-operated Sekou Toure Referral Hospital, serving the 2.5 million people in the

[36] United Republic of Tanzania, Prime Minister's Office, Regional Administration and Local Government, "Mwanza Investment Profile: 2013," October 2013, http://lakezoneinvestmentforum.go.tz/sites/default/files/Mwanza%20Investment%20Profile%20Consolidated_1.pdf.

region, and Bugando Medical Center, a Catholic Church-run facility serving 14 million people in a nine-region catchment area.[37]

Social and Demographic Indicators in Mwanza Region		
Indicator	**Mwanza Region**	**Mainland**
Gini coefficient (income distribution)	0.59	0.46
Median years of education among women (ages 15–49)	6.3	6.4
Median years of education among men (ages 15–49)	6.5	6.5
Income from agriculture among women (ages 15–49)	75.7%	69.4%
Income from agriculture among men (ages 15–49)	68.7%	63.2%
Women *without* health insurance (ages 15–49)	93.7%	93.3%
Percentage of households with a mosquito net	98.5%	74.5%
Contraceptive prevalence rate	11.7%	27.8%
Unmet need for family planning among currently married women (ages 15–49)	38%	25.1%
Women (ages 15–49) receiving antenatal care from a skilled provider	85.9%	95.8%
Women giving birth in a health facility	45.9%	50.2%
Women *not* receiving a postnatal check-up	87.7%	64.6%
Anemia among children	62.8%	58.3%
Anemia among women	51.9%	39.5%
HIV prevalence	4.2%	5.3%

Source: Tanzania Demographic and Health Survey 2010 and HIV/AIDS and Malaria Indicator Survey 2011–12.

In Mwanza Region, the delegation also visited two community-level sites—a project focused on economic empowerment activities for caregivers of most vulnerable children in the village of Nyashigue in Kongolo Ward, which is part of Magu District, and a household-level Indoor Residual Spraying (IRS) program near Kabila Health Center.

[37] Touch Foundation, "A Healthcare Perspective from Mwanza," http://touchfoundation.org/news-&resources/news/a-healthcare-perspective-from-mwanza.html.

Key Observations and Challenges

Over the course of our visits and meetings, the delegation made three overarching observations:

- *The United States is investing resources in critical training programs, mentorships, and supply chain reform to help improve maternal, neonatal, and child health, but the needs in Tanzania—particularly at the community level—remain great*. Over the course of its week in Tanzania, the delegation became convinced that accelerating progress on maternal and neonatal health will depend on raising the skill level of care providers so that they can recognize problems during the antenatal period and at the time of delivery and ensure mothers and babies get the care they need without delays. At the same time, ensuring the availability of commodities, including blood, as well as medicines and instruments for emergency obstetric and neonatal care, is critical.

  We learned that providing health providers with adequate training and continuing professional development, including ensuring that there are well-trained care providers and sufficient commodities at the remotest rural sites, remains a challenge. We observed successful U.S.-supported education and mentoring programs at several junctures. At Magu District Hospital, we learned about the University Research Corporation (URC)-administered Tibu Homa project, through which pediatric specialists teach clinical officers and nursing staff how to better diagnose malaria and distinguish it from other febrile illnesses. And in Mwanza, we learned how the U.S. Peace Corps, through the Global Health Service Partnership, has placed seasoned U.S. health providers in teaching hospitals and educational facilities to share their expertise in obstetrics and gynecology, pediatrics, and midwifery, with local providers.

  At Mnazi Mmoja Health Center in Dar es Salaam and Sekou Toure Hospital in Mwanza, we learned about past and current U.S.-supported emergency obstetric and newborn care training for providers working on the labor wards.

  Yet in some cases these relatively well-resourced facilities are overwhelmed with patients because community-level dispensaries and health centers are not equipped to manage deliveries, particularly complicated ones, because of the providers' lower level of skills. During our visit to Sekou Toure Referral Hospital, we observed up to three women, plus newborns, sharing the same bed in the crowded, 24-hour postpartum observation area. And despite the fact that providers at this referral hospital have benefited from advanced training to provide emergency obstetric care, even Sekou Toure faces challenges. The operating theater is some distance from the labor and delivery area, making rapid preparation for cesarean sections during complicated deliveries difficult. At the same time, there is no blood bank at the hospital to facilitate the provision of blood in the event of postpartum hemorrhage.

- In the long term, accelerating progress in this complex field will require that care providers, facilities, and supply chain managers have the support needed to provide quality maternal and neonatal care around the clock.

- *Programs to expand vaccine coverage have been highly successful, but reaching the most remote populations remains a challenge:* Through a roundtable on Gavi hosted by the MOHSW Immunization Coordination Committee, and at almost all health facilities we visited, we learned about Tanzania's successes in extending vaccine coverage through the introduction and expansion of new and underused vaccines into the routine immunization program. We learned that vaccines are provided to mothers and children free of charge. Tanzania's success in maintaining immunization coverage above 90 percent and commitment to co-financing the introduction of new and underutilized vaccines with Gavi support is exemplary and offers a model for the region. During site visits, we witnessed firsthand mothers bringing their children to the clinic for vaccinations—and sometimes being vaccinated, themselves. The confidence of providers and patients in vaccine programs appeared quite high.

  Challenges in Tanzania, as elsewhere, include reaching children living in urban, peri-urban, and remote rural settlements. In discussions with medical personnel in Magu, we learned that the district maintains motorbikes and boats to transport vaccines to remote villages and island communities. And, at the Medical Stores Department (MSD) in Dar es Salaam we learned that transporting vaccines, which must be stored at a consistent temperature, from the central storage facility to the country's more remote areas can be a challenge because MSD has only two refrigerated trucks.

  The United States, through JSI, has been working with MSD to support the development of an electronic records-keeping system to better manage vaccines and other medical commodities. This represents an important step toward anticipating needs at the zonal level, where warehouses may not have enough capacity to store goods long term, and being able to deploy new shipments as stocks run low.

- *Although not explicitly framed as MNCH initiatives, PEPFAR-supported programs are nevertheless helping to link women and children to other MNCH services. However, there are limits to the extent to which PEPFAR programs can address the broader population's MNCH needs.* PMTCT programs appear to be successfully boosting pregnant women's access to other essential health care services for mothers and children. In Dar es Salaam at Mnazi Mmoja Health Center, which is a national center of excellence for HIV care and training, the delegation observed women and children moving easily down a hall from station to station as they sought antenatal care and PMTCT counseling; received postpartum family planning advice and HIV treatment; and sought immunizations for themselves and their children. Similarly, at Sekou Toure Regional Referral Hospital in Mwanza, the delegation toured a series of rooms bordering a courtyard where women could take their children for immunizations and at the same time access PMTCT services and schedule cervical cancer screening, also supported by PEPFAR funds.

At Baylor Children's Foundation in Mwanza, which partners with the nearby Catholic-run Bugando Medical Center to provide care for infants, children, and adolescents infected with HIV, the delegation saw young HIV-infected patients being immunized against a host of other illnesses and learned about initiatives for "expert mothers" to encourage each other regarding the importance of PMTCT testing for their own health, as well as the health of their children. We observed important economic empowerment initiatives for adolescents infected with HIV and had a chance to speak with them about their plans for future income-generating activities. Yet the delegation also learned of some shortcomings when it came to protecting children's health: test kit shortages, the facility's inability to test for viral load to determine the success or failure of children's treatment regimes, and the challenges of providing treatment for children diagnosed with some opportunistic infections and AIDS-associated cancers.

The ongoing PEPFAR refocus on geographic areas with the highest burden of HIV/AIDS, under "PEPFAR 3.0," raises questions about the sustainability of MNCH gains realized as a result of the PEPFAR platform, particularly if PEPFAR programs are eventually scaled down in areas with lower HIV incidence.

Recommendations for Strengthening U.S.-Tanzania Cooperation on MNCH

With the launch of the Sharpened One Plan and Big Results Now, an enormous opportunity exists for the United States to reinforce its support for Tanzania's efforts to improve maternal, neonatal, and child health. Often overshadowed by the sheer magnitude of PEPFAR investments, U.S. program support for MNCH, channeled largely through USAID, is a modest but nevertheless critical element of U.S. bilateral engagement on health in Tanzania. Yet despite general bipartisan agreement on the importance of supporting global programs to protect the health of mothers and children, as well as the magnitude of the need, U.S. bilateral support for MNCH programs has remained relatively flat in recent years.[38] To be sure, vaccine programs, basic and comprehensive emergency obstetric care training activities, malaria prevention, diagnosis, and treatment initiatives, and PEPFAR-associated MNCH programs, have shown impressive results. But more can be done, and efforts must now be placed on consolidating the gains realized; identifying innovative approaches to accelerate progress on strengthening human resource capacity and supply chain management; and encouraging continued domestic, as well as international partner, resource mobilization for MNCH. The United States, working with the government of Tanzania and other bilateral and multilateral partners, can help consolidate MNCH gains already realized while considering ways to help Tanzania plan continued investments in MNCH during its anticipated economic transition.

[38] See Kaiser Family Foundation, "Maternal and Child Health Funding: Interactive Budget Tracker," http://kff.org/interactive/budget-tracker/summary/Filter-Program-Area/Maternal_Child-Health/Agency/?view=range-years&startYear=2006&endYear=2016&filters=U.S.-Agency-for-International-Development.

1. Focus health system strengthening support for MNCH on activities at the community level: The vast majority of Tanzania's population is rural, and while there is supposed to be a functioning dispensary in every community, those located in the most impoverished or remote communities are frequently undersupplied. Training, placing, and retaining health care workers in those areas is a persistent challenge. Tanzania is currently working to formalize a cadre of community health workers (CHW), who can be a key asset in improving MNCH outcomes in local communities. But building the technical capacity necessary to realize significant gains on maternal and neonatal health, particularly at the local level, will require more than community health workers alone. *The United States should continue to partner with the government of Tanzania and support efforts to build capacity to address maternal, neonatal, and child health challenges, as outlined in the Sharpened One and Big Results Now plans. The United States can share lessons learned from its engagement with CHWs in other contexts with the government of Tanzania and find ways to build on the training model embodied in the Global Health Service Partnership to help strengthen human resources for MNCH in Tanzania. At the same time, the United States can strengthen technical assistance programs to help Tanzania gather data to better evaluate current MNCH service providers and facilitate their engagement in continuing professional development.*

2. Use successful vaccine partnership as a model for other services and other programs: The reductions in under-five mortality in Tanzania have resulted from high vaccine coverage rates, as well as Vitamin A supplementation and malaria prevention and treatment. The fact that Tanzania, a largely rural society, has achieved such high vaccine coverage suggests that commodities can reach even the most remote communities.

Given the low contraceptive prevalence rate and estimates (2010) that only 58 percent of demand for family planning is being satisfied, *it is worth examining the success of vaccine programs in raising awareness and extending coverage to remote and rural areas to determine if lessons can be shared as Tanzania prepares to expand access to and uptake of voluntary family planning through the Sharpened One Plan, whether through mobile outreach services, to which the United States has contributed, or through other means*. To be sure, there are cultural norms around childbirth and family size, and technical aspects associated with contraceptive storage and use, that make increasing uptake of voluntary family planning different from increasing immunization coverage in important ways. Nevertheless, there may be important lessons in the areas of health education, behavior change communication related to family health, and commodity management that may be shared across program areas.

At the same time, identifying opportunities to integrate immunization and voluntary family planning services may prove helpful in increasing the uptake of voluntary family planning, as well.

The United States has been a longtime supporter of Gavi at the global level, and at the mission level, in Tanzania, there appears to be close coordination between the Expanded

Program on Immunizations and U.S.-supported immunization activities. *The close coordination between the USAID mission and government vaccine programs in Tanzania, through the ICC, as well as the cooperation on laboratory strengthening, and supply chain management, can be an example for other USAID missions in countries where the partnership with Gavi can play a strong role in extending immunization coverage and ending preventable child deaths.*

3. Consolidate and protect MNCH gains realized through PEPFAR, but recognize that they are not sufficient to fulfill the long-term human resource, commodity, and financial needs required for further reductions in maternal, neonatal, and child mortality: PEPFAR-funded programs, such as PMTCT initiatives and pediatric HIV diagnosis and treatment activities, have served as valuable platforms for promoting the access of mothers and their children to a variety of other reproductive, maternal, and child health programs. As PEPFAR undergoes geographic realignment to focus on areas of high HIV burden and "rationalizes" the allocation of partner contracts in specific regions and facilities, *it will be important to ensure that the MNCH gains realized as a result of association with strong PMTCT and pediatric AIDS platforms are not "lost in transition."*

In conversations with health officials at all levels, from the MOHSW to Magu District, we heard concerns that the PEPFAR realignment means that the United States is essentially "pulling out," and that patients in lower-burden areas, like Mwanza Region, might be lost in the process. At one meeting officials worried the transition could lead to social instability. *Careful communication with the government of Tanzania, with health care providers, and with patients, themselves, as well as planning for the sustainability of MNCH gains realized as a result of PEPFAR programs, will be essential. In the longer term, this will mean strengthening more direct U.S. engagement on MNCH and bolstering support for the Sharpened One Plan efforts underway.*

4. Strengthen the dialogue on domestic resource mobilization for health: The government of Tanzania's contribution to total health expenditures in the country is around 8.1 percent, well short of the Abuja Declaration target of 15 percent. As Tanzania's economy grows, more funds will enter the health sector, but there are still large gaps. Tanzania's dependence on donor financing to support government health spending is unsustainable.

The MOHSW is currently developing a health care financing strategy, which focuses on strengthening health insurance options for Tanzanians. It has a goal of moving toward universal health coverage and rationalizing the patchwork of private and state-run insurance schemes and community health funds that protect a limited number of Tanzanians against catastrophic out-of-pocket spending on health. Currently only children under the age of five, adults over age 65, and pregnant women receive health care services free of charge, yet if Tanzania is to reduce maternal mortality, it must improve women's health before pregnancy, including increasing uptake of voluntary family planning services to allow for the healthy timing and spacing of pregnancies. At the same time, protecting the

health of women beyond their childbearing phase remains essential. *The United States can help share lessons from other countries where it has supported the development of national health insurance schemes and be a partner to Tanzania to help develop a process for better promoting access to preventive care and treatment services for women from pre-pregnancy through adulthood.*

To protect the impressive gains in reducing child mortality as a result of expanded vaccine coverage, the United States can encourage Tanzania to start working with Gavi to establish best practices for the country's future graduation process and begin building the appropriate mechanisms to ensure a timely and successful graduation. In accordance with Gavi's graduation policy, when a country's GNI per capita crosses the Gavi eligibility threshold (currently US$ 1,580), it enters a graduation process and begins to phase out of Gavi support. During this five-year period, Gavi intensifies its efforts to help graduating countries be in the best position to financially sustain their routine programs and new vaccines.

Currently classified as a low-income country (in 2014 GNI per capita was $630), Tanzania pays 20 cents per dose for the vaccines procured with Gavi support, and Gavi pays the remainder. But with rapid economic growth in recent years, the discovery of natural gas reserves, and Tanzania's own stated goals of reaching middle-income status by 2025, starting to plan now would give the country time to build a solid foundation for this transition. Once Tanzania completes the five-year Gavi graduation process, it will assume 100 percent responsibility for paying for vaccines. *It will be important for the government to develop a long-term plan for strengthening budget support for that kind of financial commitment. The United States can be a partner to the government of Tanzania in planning for the Gavi transition and can facilitate networking with other countries that have already entered, or will soon enter, the Gavi graduation phase, to share lessons from earlier experiences.*

Assuming the country's continued economic growth, the Tanzanian public health sector will need to transition from heavy dependence on donor funds. As the government deliberates how best to move toward universal health coverage and develops plans for mobilizing additional domestic resources for health, another promising step may be the proposed Global Financing Facility (GFF). Announced by the World Bank, along with the governments of Canada, Norway, and the United States at the United Nations General Assembly in September 2014, the GFF is intended to support countries' efforts to realize reproductive, maternal, neonatal, child, and adolescent (RMNCAH) health goals by 2030 through the development of "financing roadmap[s] informed by a rights-based, results-focused, fully costed RMNCAH national plan linked to national strategies for health and other sectors."[39] *During the delegation visit to Tanzania, we learned that there have been discussions about the possibility of launching GFF activities in the country. We did not have a*

[39] World Bank, "Global Financing Facility in Support of Every Woman, Every Child," http://www.worldbank.org/content/dam/Worldbank/document/HDN/Health/GFFExecutiveSummaryFINAL.pdf.

chance to learn much more about the potential rollout of GFF in Tanzania but, based on our conversations, found that this may prove to be a useful modality in strengthening Tanzania's long-term planning around financing MNCH services.

Conclusion

As the world looks ahead to the September discussions of A Promise Renewed, the culmination of the MDG process in December, the launch of a new strategic period at Gavi in 2016, and the potential rollout of GFF in Tanzania, the United States has multiple opportunities to showcase the strong partnership with Tanzania on MNCH goals and to plan for future engagement as the country prioritizes MNCH within the Sharpened One and Big Results Now plans and anticipates its own economic transition.

These opportunities for partnership include:

- Intensifying support for MNCH activities at the community level and through capacity building and supply chain management activities.
- Helping Tanzania analyze and share lessons learned from successful vaccine programs with program areas in which success depends on extending services to the community level.
- Carefully communicating and planning about the sustainability of MNCH gains realized through PEPFAR support as the program is realigned to focus on high-burden areas with high HIV incidence.
- Strengthening bilateral dialogue regarding long-term planning and domestic resource mobilization for reaching maternal, neonatal, and child health goals.

During the CSIS delegation's visits to health facilities in Dar es Salaam, Mwanza, and Magu District on Lake Victoria, and in conversations with public officials, care providers, hospital patients, and clinic attendees, the eagerness of mothers to ensure the best possible care for themselves and their children was undeniable. We saw women arriving at clinics early in the morning, with one child or with several, and sometimes from great distances, to wait patiently to meet with providers, ask questions, and receive advice.

As the global community looks beyond 2015 and considers how to build on successful efforts to reduce child mortality while scaling up programs to tackle persistent challenges in improving maternal and neonatal health, the lessons from Tanzania both offer inspiration and suggest opportunities for enhanced collaboration in the future.

Appendix A: Delegation Members

Dr. Katherine E. Bliss, Senior Associate, CSIS Global Health Policy Center

Ms. Ashley Coulombe, Special Assistant and Legislative Aide, Office of Senator Elizabeth Warren (D-MA)

Ms. Dana DeRuiter, Senior Program Officer, Bill & Melinda Gates Foundation

Ms. Talia Dubovi, Deputy Director and Senior Fellow, CSIS Global Health Policy Center

Mr. Michael J. Gerson, Fellow, The ONE Campaign

Ms. Sarah Hanck, Vice President, Rabin Martin

Ms. Barbara J. Riley, Communications Director, Office of Representative Ander Crenshaw (R-FL)

Ms. Cathryn Streifel, Program Manager and Research Associate, CSIS Global Health Policy Center

Appendix B. Delegation Agenda

Sunday, February 15, 2015: Dar es Salaam

Working Lunch: Overview of Trip and Agenda

City Tour: Overview of History, Politics, and Culture in Dar es Saalam

Working Dinner: Overview of Tanzanian Politics, Economy, and Society

Ms. Sala Lewis, Managing Director, Verve Photography

Mr. Attilio Tagalile, Media Consultant

Monday, February 16, 2015: Dar es Salaam

Site Visit: Mnazi Mmoja Health Center

Dr. Grace Makende, Regional Medical Officer, Dar es Salaam

Ms. Lucy Mabada, Midwifery Adviser, Jhpiego–Tanzania

Dr. Caroline Akim, Regional Immunization Adviser, John Snow International (JSI)

Site Visit: Medical Stores Department

Mr. Cosmas Mwaifani, Acting Director General, Medical Stores Department

Ms. Dorothy Matoyo, Deputy Director, JSI Country Office–Tanzania

Dr. Dafrossa Lyimo, Program Manager, Immunization and Vaccines Development, Ministry of Health and Social Welfare

Meeting with Representatives of the Immunization Coordinating Committee: Gavi, the Vaccine Alliance Support for Immunizations in Tanzania

Dr. Donan Mmbando, Permanent Secretary, Ministry of Health and Social Welfare

Dr. Dafrossa Lyimo, Program Manager, Immunization and Vaccines Development, Ministry of Health and Social Welfare

Dr. Stefano Lazzari, Senior Country Manager, Anglophone Africa Team, Gavi

Dr. Sudha Sharma, Chief, Health and Nutrition, UNICEF

Dr. Rufaro Chatora, Country Representative, WHO

Dr. Raz Stevenson, Senior Maternal Child Health Adviser, USAID–Tanzania

Dr. Caroline Akim, Regional Immunization Adviser, JSI Country Office–Tanzania

Working Dinner: Role of Private Sector in Addressing Maternal and Child Health in Tanzania

Ms. Melissa Higbie, Deputy Programs Director, PSI Tanzania

Mr. Jafary Liana, Senior Technical Adviser, Management Science for Health (MSH)/Accredited Drug Dispensing Outlet (ADDO)

Dr. Andre Pemba, President, Association of Gynecologists and Obstetricians of Tanzania

Dr. Stefano Lazarri, Senior Country Manager, Anglophone Africa Team, Gavi

Tuesday, February 17, 2015: Dar es Salaam and Mwanza

Site Visit: Lab at National Health Laboratory and Quality Assurance Training Center

Dr. Fausta Mosha, Director, National Health Laboratory Quality Assurance and Training Centre (NHLQATC)

Ms. Lilian Shija, U.S. Centers for Disease Control and Prevention (CDC)–Tanzania

Meeting with U.S. Government Interagency Team: Goals for U.S.-Supported Programs on Maternal and Child Health in Tanzania

Ms. Miriam Lutz, Health Office Director, USAID–Tanzania

Dr. Raz Stevenson, Senior Maternal Child Health Adviser, USAID–Tanzania

Dr. Michelle Roland, Country Director, CDC–Tanzania

Dr. Xiomara Brown, Country Director, Walter Reed Institute for Infectious Disease Research (WRAIR), U.S. Department of Defense

Dr. Elizabeth O'Malley, Country Director, Peace Corps

Meeting with Mwanza Regional Authorities: Overview of Regional Maternal, Newborn, and Child Health Challenges

Regional Administrative Secretary, Mwanza Region

Regional Medical Officer, Mwanza Region

Working Dinner: Role of Nongovernmental Organizations in Addressing Maternal, Newborn, and Child Health in Mwanza Region with Representatives from Jhpiego, JSI, University Research Company (URC), RTI International, Baylor Children's Foundation, Christian Social Services Commission, Aga Khan Foundation/Development Network, Pact, and Bugando Medical Center

Wednesday, February 18, 2015: Mwanza

Site Visit: Zonal Medical Stores Department

Ms. Dorothy Matoyo, Deputy Director, JSI–Tanzania

Site Visit: Magu District Hospital

Dr. Athuman Pembe, District Medical Officer, Magu District

Dr. Festus Kalokola, Technical Director, Tibu Homa Project, URC

Site Visit: Kabila Health Center and Indoor Residual Spraying Demonstration

Mr. Simon Nhogola, Medical Officer, Kabila Health Center

Mr. Moses Ringo, Christian Social Services Commission

Mr. Stephen Magesa, RTI

Mr. George Greer, Resident Adviser, President's Malaria Initiative, USAID–Tanzania

Site Visit: Pamoja Tuwalee Project Site in Nyashigue, Magu District, to Observe Community Approaches to Most Vulnerable Children

Mr. Norbert Massay, Zonal Program Manager, Pact

Working Dinner: Opportunities to Improve Health Outcomes at Community Level in Mwanza

Ms. Deborah Goldman, Volunteer, Peace Corps/Global Health Service Partnership

Ms. Cathleen O'Connor, Volunteer, Peace Corps/Global Health Service Partnership

Dr. Jeanne Cheshier-Alvarado, Volunteer, Peace Corps/Global Health Service Partnership

Mr. Alex Leger, Response Volunteer, Peace Corps/Global Health Service Partnership

Dr. Renae Stafford, Program Director, Academic and Clinical Services, Touch Foundation

Dr. Kiran Mitha, Regional Director of Programs and Partnerships, Seed Global Health

Thursday, February 19, 2015: Mwanza and Dar es Salaam

Site Visit: Sekou Toure Referral Hospital Pediatric and Maternity Wards

Dr. Onesmo Rwakyendera, Medical Officer, Sekou Toure Referral Hospital

Ms. Gaudiosa Tibaijuka, Senior Technical Manager, Jhpiego

Site Visit: Bugando Medical Center's HIV Care and Treatment Center and Lab

Dr. Samuel Kaluvia, Director of HIV Program, Bugando Medical Center

Dr. Josephine Balat, Chief of Party, Christian Social Services Commission

Site Visit and Working Lunch: Baylor Children's Foundation

Dr. Shannon Shea, Deputy Clinical Director, Baylor Children's Foundation

Dr. Mwita Lumumba, Executive Director, Baylor Children's Foundation

Dr. Mercy Minde, Clinical Director, Baylor Children's Foundation

Working Dinner: CSIS Delegation Internal Debrief

Friday, February 20, 2015: Dar es Salaam

Outbrief with Mr. Mark Childress, U.S. Ambassador to Tanzania; Ms. Virginia Blaser, Deputy Chief of Mission; and representatives from USAID, CDC, Peace Corps, and PEPFAR

Meeting with Representatives of Ministry of Finance and Ministry of Health and Social Welfare: Domestic and International Resource Mobilization for Health

Mr. Adolf Mkenda, Deputy Permanent Secretary, Ministry of Finance

Dr. Donan Mmbando, Permanent Secretary, Ministry of Health and Social Welfare

Dr. Susna De, Health Systems Strengthening Team Lead, USAID

Dr. Raz Stevenson, Senior Maternal Child Health Adviser, USAID

Outbrief with Dr. Stephen Kebwe, Deputy Minister of Health and Social Welfare

Working Lunch: CSIS Delegation Internal Debrief

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