THE UNITED REPUBLIC OF TANZANIA

NATIONAL AUDIT OFFICE

A PERFORMANCE AUDIT ON THE MONITORING, EVALUATIONS AND BUDGET ALLOCATION FOR MATERNAL HEALTH CARE ACTIVITIES IN TANZANIA

MINISTRY OF HEALTH AND SOCIAL WELFARE

A REPORT OF THE CONTROLLER AND AUDITOR GENERAL
OF THE UNITED REPUBLIC OF TANZANIA

THE UNITED REPUBLIC OF TANZANIA

National Audit Office

Vision

To be a centre of excellence in public sector auditing

Mission

To provide efficient audit services, in order to enhance accountability and value for money in the collection and usage of public resources

Core Values

In providing quality service, NAO shall be guided by the following Core Values:

Objectivity

To be an impartial entity, which offers services to our clients in an unbiased manner

We aim to have our own resources in order to maintain our independence and fair status

Excellence

We are striving to produce high quality audit services based on best practices

Integrity

To be a corrupt free organization that will observe and maintain high standards of ethical behaviour and the rule of law

Peoples' Focus

We focus on our stakeholders needs by building a culture of good customer care, and having a competent and motivated workforce

Innovation

To be a creative organization that constantly promotes a culture of developing and accepting new ideas from inside and outside the organization.

Best Resource Utilization

To be an organization that values and uses public resources entrusted to us in an efficient, economic and effective manner

THE UNITED REPUBLIC OF TANZANIA

NATIONAL AUDIT OFFICE

The United Republic of Tanzania

A PERFORMANCE AUDIT ON THE MONITORING, EVALUATIONS AND BUDGET ALLOCATION FOR MATERNAL HEALTH CARE ACTIVITIES IN TANZANIA

MINISTRY OF HEALTH AND SOCIAL WELFARE

A REPORT OF THE CONTROLLER AND AUDITOR GENERAL OF THE UNITED REPUBLIC OF TANZANIA

TABLE OF CONTENTS

REFERENCES

List of Figures

Appendix

PREFACE

The Public Audit Act No. 11 of 2008, Section 28 authorizes the Controller and Auditor General to carry out Performance Audit (Value-for-Money Audit) for the purposes of establishing the economy, efficiency and effectiveness of any expenditure or use of resources in the MDAs, LGAs and Public Authorities and other Bodies which involves enquiring, examining, investigating and reporting, as deemed necessary under the circumstances.

I have the honour to submit to His Excellency the President of the United Republic of Tanzania, Dr. Jakaya Mrisho Kikwete and through him to Parliament the second Performance Audit Report on the Ministry of Health and Social Welfare's (MoHSW) programs and activities.

The report contains conclusions and recommendations that are focusing mainly on monitoring maternal mortality, maternal health education, evaluation of components of the health system that relates to maternal health and allocation of funds for maternal health care that directly concerns the MoHSW in ensuring that the maternal health services are provided with economy, efficiency and effectiveness.

The management of MoHSW has been given the opportunity to scrutinise the factual contents and comment on the draft report. I wish to acknowledge that the discussions with the auditee have been very useful and constructive.

My office intends to carry out a follow-up at an appropriate time regarding actions taken by the auditees in relation to the recommendations in this report.

In completion of the audit, the office subjected the report to the critical review of the following experts namely; Dr. Simba Kalia, Dr. Projestine Muganyizi and Dr. Flora Kessy who came up with useful inputs in improving the output of this report.

This report has been prepared by George C. Haule, Warento N. Nyanchogu, Wendy W. Massoy and Godfrey B. Ngowi. I would like to thank my staff for their assistance in the preparation of this report. My thanks should also be extended to the auditees for their fruitful comments on the draft report.

Ludovick S. L. Utouh
Controller and Auditor General
Dar es Salaam,

March 2011

Acronyms/Abbreviations

AFROSAI-E	-	African Organization of Supreme Audit Institution for English Countries
AMREF	-	African Medical and Research Foundation
CBOs	-	Community Based Organizations
HMIS		Health Management Information System
MDGs	-	Millennium Development Goals
MMR	-	Maternal Mortality Reduction
MNCH	-	Maternal, Newborn and Child Health
MNCHTWG	-	Maternal, Newborn and Child Health - Technical Working Group
NBS	-	National Bureau of Statistics
PMNC	-	Partnership Maternal Newborn Child
PMO-RALG	-	Prime Minister's Office -Regional Authorities and Local Government
UN	-	United Nations
UNICEF	-	United Nations Children Fund
TDHS		Tanzania Demographic and Health Survey
TRCHS		Tanzania Reproductive and Child Health Survey
TShs	-	Tanzanian Shillings
WHO	-	Word Health Organization
VFM	-	Value for Money
LGAs	-	Local Government Authorities
MDAs	-	Ministries, Department and Agencies
MoHSW	-	Ministry of Health and Social Welfare
MDGs	-	Millennium Development Goals
UNFPA	-	United Nations Population Fund
NGOs	-	Non Governmental Organizations

Executive Summary

Over the years, maternal mortality has remained one of the major public health problems in developing countries. According to the World Health Organization (WHO, 2005[1]) half a million women are still dying annually as a result of pregnancy and complications related to pregnancy and childbirth. Available figures show that 99% of maternal births take place in the developing world, and 60% of maternal deaths take place in Commonwealth countries. In spite of the efforts taken globally and locally, Tanzania is among the top 20 countries with the highest maternal mortality rates[2]. Additionally, for each one woman who dies as a result of pregnancy or childbirth, a further 20 women suffer serious or chronic health consequences[3]. These can have severe physical, psychological, social and economic repercussions for both the woman and her family.

Experience from successful maternal health programmes shows that much of this death and suffering could be avoided if all women had the assistance of a skilled health worker during pregnancy and delivery, and access to emergency obstetric care when complications arise. The death of a mother during pregnancy or childbirth is a human tragedy at the individual, family and societal levels. The death of a mother significantly diminishes the chance of survival of the newborn child as well as any other older children still dependent on the mother.

The purpose of this audit was to assess whether the Ministry of Health and Social Welfare's systems for monitoring, evaluating, provision of maternal health education and budget allocation for activities related to maternal health care are done economically, efficiently and effectively.

The audit focused mainly on monitoring maternal mortality, maternal health education, evaluation of components of health system that relates to maternal health and allocation of funds for maternal health care. The selection of the above four mentioned areas are based on the fact that they are important for the development of Maternal Health Care.

1 www.who.int (retrieved on 20th October 2010)

2 www.unfpa.org/upload/lib_pub_file/717_filename_mm2005.pdf (retrieved on 20th October 2010)

3 www.unfpa.org/mothers/morbidity.htm (retrieved on 20th October 2010)

Major findings, conclusions and Recommendations

Audit findings and conclusions

Inadequate Monitoring of the level of Maternal Health Care in Tanzania

The Ministry of Health and Social Welfare is not adequately engaged in monitoring Maternal Health Care activities. The Ministry officials have not done monitoring focusing on the Maternal Health care services rendered by Health facilities in Tanzania and take necessary action to improve some of the areas which need the attention of the central government. This is manifested by lack of plans for monitoring maternal health, failure to carry out risk assessment on key issues identified, lack of established targets related to key issues on Maternal Health to be attained at different levels of the Health system in Tanzania, questionable reliability and inadequate timeliness of Maternal Health data.

Inadequate provision of guidance to health facilities on maternal health education

Health education is not adequately emphasized. Though the role of the MoHSW is to issue policy and guidelines regarding health issues, the Ministry has not adequately made follow up to ensure that maternal health education is appropriately delivered. This resulted into poor quality of Health education. It was also found out that there was lack of periodical Evaluations of the key components on Maternal Health System, non existence of Plans for Evaluation of maternal Health care provision, Lack of specific evaluation Criteria on maternal health.

Lack of Budget model for funds allocation on Maternal Health Care

The Ministry of Health and Social Welfare has failed to institute an appropriate budget model to allocate funds for maternal health care in Tanzania.

The budget for Reproductive and Child Health is done without having adequate or systematic way of allocating funds to maternal health. This is despite the fact that Maternal Health Care is a priority area in Reproductive and Child Health in Tanzania. It was also observed that the allocation of funds to maternal health activities did not match with the maternal death rate occurring in particular regions/districts.

Recommendations

The audit findings and conclusions point out that there are many weaknesses in the area of monitoring and evaluation of maternal health care in Tanzania. Similarly, weaknesses are surfacing on the maternal health education provided

to the population and also failure to have adequate budget model for allocation of maternal health fund to the identified key issues on the maternal health.
We recommend the following as the way forward

The Ministry of Health and Social Welfare should ensure that it appropriately monitors the level of maternal health care.

This can be done by ensuring that, there are:

- plans in place for monitoring maternal health;
- Identified key issues related to maternal health based on risk assessment;
- Established targets related to maternal health key issues to be attained at different levels of the Health system in Tanzania; and
- adequate information system and data in place that allows the Ministry to identify the possible points of intervention in the maternal health care system in Tanzania

The Ministry of Health and Social Welfare should provide adequate guidance to health facilities about Maternal Health education that should be provided to the population.

This can be done by ensuring that:

- the Ministry comes up with a plan for educating the population about the maternal health and ensuring compliance with that plan;
- There is an adequate timetable for the provision of maternal health education to the population; and
- Maternal health information issued during the health education is appropriate and sufficient enough to help the population.

The Ministry of Health and Social Welfare should ensure that periodically, it evaluates the components of the health system that relates to Maternal Health Care.

This can be done by ensuring that, the Ministry:

- establishes a timely risk based plan for the evaluation of the health facilities in the country,
- Provides the health facilities with the standards for antenatal care and appropriate standards for documentation and retention of health records related to antenatal care,
- Evaluations should include clinical procedures on a test basis, the effectiveness of the education programmes, assessment of resource level at health facilities, including location of the facility, adequacy of the equipments and levels of competency of care givers,

- Assesses whether corrective measures have been taken against the underperforming health facilities on maternal health issues, and
- Evaluates the extent of the communication of the results of evaluations to the health facilities.

The Ministry of Health and Social Welfare should ensure that there is an appropriate budget model in place for allocating funds for maternal health.

This can be done by ensuring that:

- The budget model defines how the MoHSW determines the amount of funding that is to be allocated to maternal health issues; and
- The budget model should also define how the funding for the identified key issues on the maternal health is allocate,
- There is an elaborated mechanism of the implementation follow up of the budget model used in maternal health facilities.

Chapter One

Introduction

1.1 Background

Maternal health care is a reliable measure of developmental achievements of any country. The most informative global impact indicator of maternal health care is the maternal mortality ratio. Over the past two decades, the international community has repeatedly declared the commitment to the high levels of maternal mortality in the developing countries. Thus there has been an international consensus on priority interventions:

- Good quality Emergency Obstetric Care (EMOC) should be universally available and accessible
- All women should deliver their infants in the presence of professional, skilled birth attendant
- These key services should be intergrated into health systems

In Tanzania, the Ministry of Health and Social Welfare (MOHSW) is responsible for the enforcement of the above deliberations and ensure monitoring and evaluation. It is therefore of paramount importance to assess how efficient and effectiveness is the MOHSW in undertaking this important role.

Maternal Health Care is one of the components of the National Package of Essential Reproductive and Child Health Interventions Package focusing on improving quality of life of women and adolescent mothers.

One of the areas the Maternal health care component addresses is reducing maternal deaths. Nearly 9,000 women in Tanzania die annually due to pregnancy related causes and about 250,000 women become disabled due to the same causes seriously compromising their reproductive health (HSSP 2003).
However, the preliminary results of Demographic and Health Survey (2010) which has been released shows that the Estimated Maternal Mortality Ratio is 454 for every 100,000 live births in Tanzania[4].

Major direct causes of maternal mortality includes Obstetric hemorrhages, obstructed labour, Pregnancy induced hypertension, Eclampsia, Sepsis and Abortions[5].

---

4 The HSSP 2003 presented the number of women die annually while the Demographic and Health Survey (2010) presented similar information on the form of maternal mortality ratio

5 The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008 - 2015

Some of the key elements of Maternal Health are such as Antenatal care, Care during Childbirth, Care of Obstetric Emergencies, Newborn care, Postpartum Care, Post abortion Care, Family Planning, HIV/AIDS and Sexually Transmitted Diseases (STD) Diagnosis and Management, Prevention and Management of Infertility,Prevention and Management of Cancer(Breast cancer, uterine, cervical and ovarian cancers) and Prevention and Management of Childhood illness.

The elements of Maternal Health are described below:

Antenatal care

The aims of antennal care[6] are to monitor the woman's physical and emotional condition and foetus' physical condition during pregnancy; ensure the early identification of common problems and complications; provide health education and treatment to prepare the woman physically and psychologically for childbirth.

According to the Tanzania Demographic and Health Survey - 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 from 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[7].

Challenges facing Antenatal Care services include inadequate essential screening services such as laboratory services for syphilis screening, testing for haemoglobin and albumin, as well as lack of privacy and few skilled service providers.

Care during childbirth, emergency obstetric care and postnatal care

The aim of care during labour and birth is to achieve a healthy mother and baby with as little intervention as possible.

The TRCHS of 1999, reports 44% of births occur at health facilities whereas 56% occur in home deliveries. Of all deliveries reported in health facilities only skilled personnel assist 36% deliveries. The high rates of home deliveries are attributed by poor access to health facilities, lack of functioning referral system, inadequate capacity in terms of skilled personnel, supplies and equipment and other socio-cultural factors surrounding the pregnant women. Additional factors include gender

---

6 According to WHO (2005), Antenatal Care (ANC) is a means of 'care before birth' and includes education, counseling, screening and treatment to monitor and to promote the wellbeing of the mother and foetus.

7 The National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015

inequalities in decision-making power and access to resources at house level contribute to poor access and use of available health services and delay in referrals.

Furthermore, emergency obstetric care services are still poor due to weak referral system, inadequate skilled personnel and equipments.

Postnatal mothers attending at least one postnatal visit is only 12% (TRCHS 1999). This is mainly due to lack of awareness of clients about the importance of the postnatal care services as well as providers' attitude and biases towards provision of this service.

Post-abortion care

Only less than 5% of all health facilities in Tanzania provide Post Abortion Care (PAC). Efforts to scale up Post Abortion Care services have started by the development of the National Post Abortion Care curriculum. However, Post Abortion Care services are still unknown by the expected target groups and the services are only limited at hospital levels.

Efforts taken by the Government to address challenges on the maternal health

In Tanzania, specific attempts have been made to address Maternal, Newborn and Child Health (MNCH) care challenges through the National Health Policy (revised in 2007), the Health Sector Reforms and the Health Sector Strategic Plan (2003-2007). Furthermore, Reproductive and Child Health Strategy(2005-2010) and the National Road Map Strategic Plan to Accelerate the Reduction of Maternal and Newborn Mortality(2008-2015) were also formulated to respond to these challenges.

Improving Maternal, Newborn and Child Health care is also 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 especially vulnerable groups. Under this goal, there are four operational targets related to maternal and child health for monitoring progress towards achieving the Millennium Development Goals number 4 and 5 (MDGs 4 and 5).

The Tanzania MNCH Partnership was officially launched in April 2007 to refocus 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[8].

[8] The National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015

Indication of the problem

According to the World Health Organization (WHO), 2005[9] half a million women die annually as a result of complications related to pregnancy or childbirth. The WHO further estimates that 99% of maternal deaths occur in the developing world. The WHO study ranked Tanzania's mortality ratio 153rd out of 171 countries in 2005, with an estimated mortality ratio of 950 maternal deaths per one hundred thousand live births.

According to the United Nations, most maternal deaths can be avoided, and one of the UN's millennium development goals is to reduce the maternal mortality ratio by three –quarters between 1990 and 2015.

The death of a mother during pregnancy or childbirth is a human tragedy at the individual, family and societal levels. The death of a mother significantly diminishes the chance of survival of the newborn child as well as any other older children still dependent on the mother.

For the purposes of this audit, we have defined maternal health care to include methods and procedures designed to reduce the deaths and related health complications that occur during pregnancy or within two months after pregnancy. It is therefore focused on antenatal, natal and postnatal care.

We have defined health facilities to mean those components of the health system that are involved with maternal health issues.

Furthermore, monitoring and evaluation are often combined in the general concept of program evaluation. We have separated these two components. The audit defines program evaluation as the systematic gathering, analysis and reporting of data about a program to assist in decision-making.

Trend of Maternal Mortality in Tanzania

The table below shows the trend of the maternal mortality ratio in Tanzania from the year 2000 to 2010.

Table 1: Trend of Maternal Mortality Ratio, 2000 – 2010

Year	2000	2005	2010
Estimated Maternal Mortality Ratio (WHO)	1500	950	N/A
Estimated Maternal Mortality Ratio (NBS)	529	578	454

Source: National Bureau of Statistics – Tanzania Demographic and Health Survey 2010

[9] www.who.int

The table above shows that, maternal mortality ratio has dropped significantly from year 2000 to 2010. Despite of the significant reduction, the ratio is still unacceptably high and in that sense the pregnant women seem to continue being in danger.

1.2 Objective and scope of the audit

1.2.1 Audit objective

The objective of this audit was to assess whether the Ministry of Health and Social Welfare's systems for monitoring, evaluating, provision of maternal health education and budget allocation for activities related to maternal health care are done economically, efficiently and effectively with the view of reducing the maternal mortality ratio by three quarters by 2015 in line with the United Nations millennium development goals.

1.2.2 Audit scope

This audit focused mainly on monitoring maternal mortality, maternal health education, evaluation of components of the health system that relates to maternal health care and allocation of funds for maternal health care. The selection of the above four mentioned areas are based on the fact that they are important for the development of Maternal Health Care. However, there are other important areas that have not been selected for the current audit.

The audit is also focused on three phases of the Maternal Health Care. These are Antenatal (before delivery), Natal (during delivery) and Post natal (after delivery).

This audit covered the Ministry of Health and Social Welfare in Tanzania being responsible for the Monitoring and Evaluation, provision of guidance on maternal health education and budget allocation for maternal health care activities. The audit also covered three financial years of 2006/07, 2007/2008 and 2008/2009.

1.3 Audit design

The audit work was designed by using the four audit questions as presented in sub-section 1.3.1. The questions were based on the monitoring, evaluation and education of maternal health care services provided and the budget allocation to maternal health care activities.

1.3.1 Audit questions

The audit questions used in this audit are[10]:

Audit question 1: *Is the Ministry of Health and Social Welfare appropriately monitoring the level of maternal health care, including maternal mortality, in the country?*

Audit question 2: *Does the Ministry of Health and Social Welfare provide adequate guidance to health facilities about the maternal health education information that they should be providing to the pregnant mothers and families attending antenatal services?*

Audit question 3: *To what extent does the Ministry of Health and Social Welfare evaluate the components of the health system that relate to maternal health issues?*

Audit question 4: *Does the Ministry of Health and Social Welfare have an appropriate budget model to allocate funds for maternal health care?*

1.3.2 Assessment criteria

As explained in section 1.3 the above, the audit questions were based on the following three key parameters:

1.3.2.1 Monitoring and evaluations

i.) Performance Monitoring Plan (PMP) and monitoring mechanisms were established consistent with central, region/districts decentralization;

ii.) Quality monitoring tools and indicators were developed, utilized consistently with the National Health Management Information System (HMIS). Data were generated periodically to monitor the improvement of services provided at the health facilities; and

iii.) Monitoring and evaluation were conducted periodically and reports were produced and used to rectify the weaknesses noted.

1.3.2.2 Maternal Health Education

Maternal Health Education has to be provided to different people. This can be provided to expected mothers, fathers and even the population at large. Similarly, Family planning should also be part of the education.

According to the four-visit Antenatal Care (ANC) model outlined by WHO, ANC clients should be given health education, advice, and counseling in different four visits.

[10] For more detail refer Appendix One

1.3.2.3 Budget allocation for maternal health

Allocation of funds to maternal health care activities depends on the amount allocated to the health sector in the total government budget. According to the Abuja Declaration, 15% of the country's budget is required to be set aside for the Heath Sector. The actual health expenditure had decreased from 11.8% 2006/2007 to 10.2% in 2008/2009. However the total government budget had increased slightly by 20% while the budget allocations to the health sector were increased by19%[11].

Similarly, budgeting should focus on key issues within the maternal health care.

1.3.3 Methods and implementation

In the performance of this audit, the audit team used varied methods of gathering data and information.

The formal picture of management and performance of the Maternal Health Care services provided was studied from the Ministry of Health and Social Welfare (MoHSW), United Nations Population Fund (UNFPA) and World Health Organizations (WHO) documents. This information was further analysed through information provided by interviews with auditee and different stakeholders.

Many kinds of documents were reviewed in order to get comprehensive, relevant and reliable picture of the performance of the Ministry of Health and Social Welfare in as far as the maternal health care services is concerned.

The following kinds of documents were reviewed:

i.) Health Sector Performance Profile Report 2009 & 2010 Update;
ii.) National Family Planning Costed Implementation Program 2010-2015;
iii.) The National Road Map Strategic Plan to Accelerated Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015 (One Plan);
iv.) Comprehensive Council Health Planning Guideline February 2007;
v.) National Package of Essential Reproductive and Child Health Interventions in Tanzania;
vi.) Reproductive and Child Health Strategy 2005 - 2015;
vii.) The Health Sector in Tanzania, 1999-2006-Joint External Evaluation;
viii.) Comprehensive Council Health Plan for the year July, 2009 to June 2010: Temeke Municipal Council;
ix.) Comprehensive Council Health Plan for the year 2008/2009: Tabora Municipal Council;
x.) Health Sector Strategic Plan III - JULY 2009 to June 2015;

[11] Health sector Performance Profile Report 2009 update – Indicator Number 36: Proportion of the National Budget spent on health

xi.) Rapid Assessment of Reproductive and Child Health Financial Resources At the Central and Local Level;
xii.) Inspection Report on the Health Finances and Plans in Mwanza Region Local Government Authorities for the financial year 2008/2009,07-20 march 2010;
xiii.) Tanzania Demographic and Health Survey 2010 - Preliminary Report; and
xiv.) The Millennium Development Goals Report 2010.

A lot of interviews were conducted for many reasons, mainly to:

- Confirm or explain information from the documents reviewed;
- Give clues to relevant information in cases where information in the formal documents was lacking or missing; and
- Provide context and additional perspectives to the picture from the Ministry of Health and Social Welfare documents.

Interviews and discussions were thus carried out with representatives of:

- Executives of the Health Policy and Planning Division, Preventive Health Services Division (Reproductive and Child Health Section and Health Education Section) from the Ministry of Health and Social Welfare;
- Experts in the Maternal Health Care;
- International Health organizations such as United Nation Population Fund (UNFPA), World Health Organization (WHO);
- Health Research Institutions such as African Medical Research Foundation (AMREF) etc.; and
- Service providers in the area of maternal Health such as Uzazi na Malezi Bora Tanzania (UMATI) and Marie Stopes.

1.4 Data validation process

The Ministry of Health and Social Welfare was given an opportunity by the Audit Team to go through the draft report. They confirmed the accuracy (situation they reflect) of the information presented in this report.

1.5 Structure of the Audit Report

The remaining part of the report covers the following:

Chapter two gives the account of the audit area with the Maternal Health system set up, procedures for monitoring, evaluation, provision of maternal health education and budget allocation for maternal health related activities and key actors.
Chapter three presents the findings on maternal health monitoring, education, evaluation and budget allocation.

Chapter four provides the conclusions and chapter five narrates the recommendations which can be implemented in order to improve the situation.

Chapter Two

Maternal Health Care – System Description

2.1 Key Actors on Maternal Health Care

This chapter deals with the actors (see the following sub sections) systems set up at the National, Regional and District levels with the support from international organizations, civil society and private sectors, as multi-sectoral strategy for comprehensive reproductive and child health implementation. The system of Maternal Health Care in Tanzania is as indicated in the Figure 1 below.

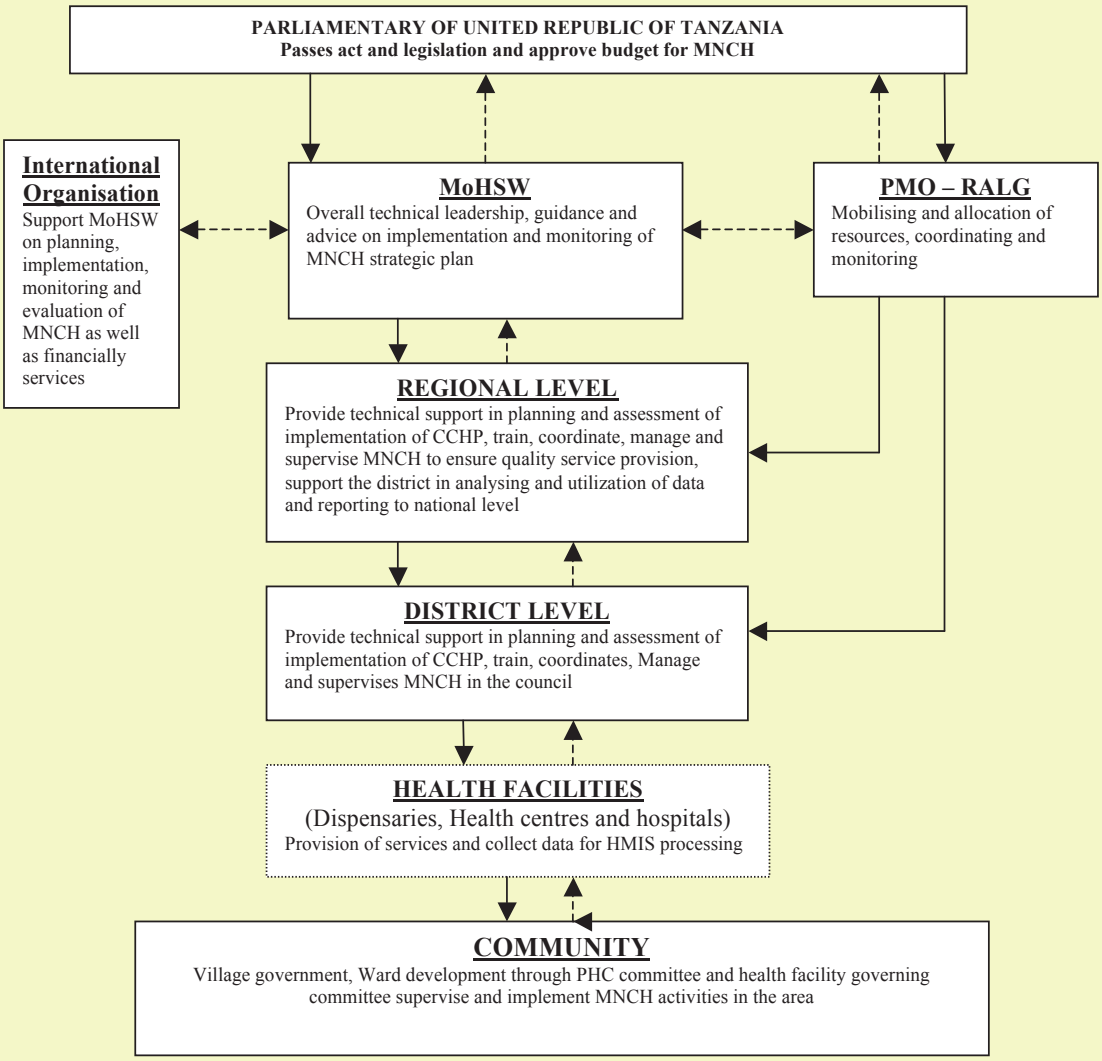

Figure 1: System Graph – Maternal Health Care provision in Tanzania

2.2 Specific Roles and Responsibilities of Key Actors on Maternal Health Care

2.2.1 Central Government

Ministry of Health and Social Welfare:
The Ministry of Health and Social Welfare (MoHSW) is responsible for developing policies and standards for health care entities. It is also responsible for the overall technical leadership, guidance and advice on the implementation and monitoring of the strategic plan.

The Ministry of Health and Social Welfare through the Directorate of Policy and Planning is responsible for ensuring adequate budget allocation for Maternal, Newborn and Child Health (MNCH) care and set indicators into policy frameworks. The Health Management Information System (HMIS) facilitates the monitoring of all indicators from routine data collection systems.

Similarly, the Directorate of Preventive Services of the Ministry is responsible for supervising and coordinating all activities with respect to Maternal, Newborn and Child Health care for the realization of the strategic plan objectives. Among many other activities, the Directorate advocates for:

- the implementation of the Maternal, Newborn and Child Health care Strategic plan by coordinating advocacy activities, Coordinate its implementation, monitoring of Maternal, Newborn and Child Health care activities.
- designing and developing Information Education and Communication (IEC) and Behavior Change Communication (BCC) materials with stakeholders and disseminate them to the intended users.
- identifying and propose disaggregate indicators and update monitoring data collection tools to include process indicators for Emergence Obstetric Care (EmOC), newborn care, nutrition, postnatal care, child care and Adolescent health
- functioning monitoring and evaluation system and user friend data bases and Facilitate integration of nutrition actions in maternal, newborn and child care programmes

The Prime Minister's Office - Regional Administration and Local Government:
The Prime Minister's Office – Regional Administration and Local Government (PMO-RALG) – deals with the implementation of the country's health policies. This task includes monitoring of the use of funds and also administration of human resources at the Regional and Council levels when it comes to the implementation of the Maternal health care policies.

2.2.2 Regional level (Regional Authorities)

Regional authorities (specifically the Regional Medical Officers) are supposed to:

- Provide technical support for effective planning and implementation of the integrated Maternal, Newborn and Child Health care activities in the Comprehensive Council Health Plan (CCHP);
- Coordinate, monitor and supervise Maternal, Newborn and Child Health care; and
- Support districts in the analysis and utilization of Maternal, Newborn and Child Health care data and disseminate/report to the national level.

2.2.3 District Level (Local Authorities)

Local Government Authorities (specifically the District Medical Officers) are responsible for:

- Disseminating Maternal, Newborn and Child Health care Strategic plan to all stakeholders in the District Council including Non Governmental Organizations (NGO), Faith Based Organizations (FBO) and other private sector partners;
- Incorporate Maternal, Newborn and Child Health care activities planned and implemented by all stakeholders in the district;
- Provide technical support for quality Maternal, Newborn and Child Health care services;
- Capacity development for facility and community Maternal, Newborn and Child Health care interventions;
- Follow up maternal, prenatal, neonatal and child death reviews at the health facility and communities level; and
- Council management teams and district health boards to ensure adequate resources allocation for implementation and monitoring of the Maternal, Newborn and Child Health care interventions.

2.2.4 Health Facility (Dispensaries, Health Centres and Hospitals)

Incharge of health facilities are responsible for:

- Incorporating Maternal, Newborn and Child Health care activities into facility health plans;
- Providing quality Maternal, Newborn and Child Health care services;
- Ensuring timely availability of essential equipments, supplies and drugs in providing services for Maternal, Newborn and Child Health care
- Conducting maternal, prenatal, neonatal and child death review by involving the community;
- Provide technical and supportive supervision to community interventions

2.2.5 Health facilities committees

Health facilities committees are responsible for:

- monitoring and ensuring quality Maternal, Newborn and Child Health care service provision;
- Providing technical and supportive supervision to community interventions; And
- Link community and Health Care facilities.

2.2.6 Development Partners

The development partners have a role to play by doing the following:

- Provide technical and financial support under coordination of the Ministry of Health and Social Welfare (MoHSW) for the planning, implementation, capacity development and monitoring and evaluation of Maternal, Newborn and Child Health care services;
- Advocate for increased global and national commitment to the reduction of maternal, newborn and child morbidity and mortality; and
- Mobilise and allocate resources for the implementation of the Maternal, Newborn and Child Health care intervention.

2.2.7 Private Sector

Equally the private sector has a role to play when it comes to maternal, newborn and Child health care by doing the following:

- Complement Government efforts in provision of quality Maternal, Newborn and Child Health care services; and
- Invest in commodities and supplies for Maternal, Newborn and Child Health care interventions.

2.2.8 Civil Society Organisation, NGOs, FBOs and CBOs

Work in close collaboration with the CHMT for the implementation of maternal, Newborn and Child care activities/ interventions.

2.2.9 Community

Maternal, newborn and Child health care principally touches on pregnant women and newly born babies who are living in the community. Therefore, the community has a responsibility when it comes to maternal, newborn and child health care and is expected to do the following:

- Participate in development and monitoring of community Maternal, Newborn and Child Health care actions plan;
- Participate in community interventions;
- Leverage community resources for implementation of Maternal, Newborn and Child Health care interventions;
- Link with Health Facilities; and
- Demand for Health Care in Maternal, New Born and Child Care.

2.3 Monitoring and Evaluation System at Central Government level

Regular and structural monitoring is an integral component of any government program. In order to know whether or not the program is effective, the government must monitor and evaluate the program.

There are two types of monitoring that we would expect the Ministry of Health and Social Welfare Services to do concerning maternal health. First is monitoring of maternal health services in general, including the performance of the health facilities. The second is specific monitoring of maternal deaths occurring during pregnancy, child birth or within the six weeks (Post Partum period) following child birth. This is done through the death review reports issued by health facilities based on the MOHSW Maternal and Perinatal death review guidelines.

The second type of monitoring is important to be able to identify specific interventions that can be used to reduce maternal mortality.

The approaches that are supposed to be used in monitoring and evaluating the maternal Health care activities include:

- Designing operational researches to collect quantitative and qualitative data from communities and Health Facility levels (Consultant Hospital, regional and district hospitals including health Centers and Dispensaries: Government. Faith Based and Private hospitals
- Establishment of performance Monitoring and Evaluation plans
- Development of integrated Reproductive Child Health Management Information System (RCH – MIS) database
- Strengthen/develop appropriate/standardized data collection tools at all levels
- Capacity building of Management Information System/Monitoring and Evaluation (MIS/M&E) implementers at all levels

Monitoring and evaluation measure progress made by using process and outcome indicators. Impact indicators describe progress towards overall achievement of objective of Reproductive and Child Health service delivery. Process indicators measure progress made towards attaining set targets under each priority areas.

Continuous monitoring of programme activities was supposed to be conducted throughout the implementation period together with the conduct of evaluation at least twice as follows:

- Mid term evaluation of the strategy implementation;
- Final evaluation of the implementation of the maternal health as one of the six categories of care.

2.4 Provision of Maternal Health Education at Central Government level

Education and health services provided during the Antenatal period can reduce pregnancy and delivery complications and improve birth outcomes in resource-poor settings; however, these benefits are contingent upon user compliance. Information like danger signs during and afterbirth complications, and plan for delivery is important to be given to the antenatal women. Health education provided in antenatal care is aiming at preparing the woman and family physically, psychologically and socially for birth, with emphasis on encouraging facility delivery[12].

2.5 Budget Allocation for Maternal Health related activities at Central Government level

Health Budget in relation to the Total Government Budget

The Ministry of Health and Social Welfare is responsible for preparing the budget for the entire health sector in Tanzania, Maternal Health Care being one of the area which is supposed to get funding from the National Budget. The set budget is normally based on the ceilings set by the Ministry of Finance and Economic Affairs.

Similarly, in setting its budget the Ministry of Health and Social Welfare is expected to follow various international declarations and agreements reached in this area. One of the declarations is the Abuja declaration which stipulates the percentages of the fund to be set aside for both health sector and maternal health care in country's national budget.

The table below shows the budget set aside for the entire health sector in Tanzania for the last three financial years. Total government expenditures (both, including and excluding the Consolidated Fund Service – CFS) over the period 2006/07 to 2008/09 are summarized in the Table 2 below.

Table 2: General Health Spending by Financing Sources (in Million TShs)

	2006/07		2007/08		2008/09
	Approved estimates	Actual expenditure	Approved estimates	Actual expenditure	Estimates
Total public spending excluding CFS	4,496,345	3,862,022	5,451,800	4,685,200	6,567,845
Total public spending including CFS	4,972,492	4,338,123	5,998,100	5,209,000	7,216,130
Total health spending	519,871	513,606	615,748	571,073	733,878
Health as % of Total public spending excluding CFS	11.6%	13.3%	11.3%	12.2%	11.2%
Health as % of Total public spending including CFS	10.5%	11.8%	10.3%	11.0%	10.2%

Source: Ministry of Health and Social Welfare – Health Sector PER Update 2008

12 Reproductive and Child health Strategy 2005-2010

Budget allocated for Maternal Health in Tanzania

The table below shows the monies allocated to activities related to maternal health in the last three financial years[12].

Table 3: Trend of Health and Maternal Health Care budget (in Million TShs), 2006/7 – 2008/9

Financial Year	2006/7	2007/8	2008/9
National Health Budget of MoHSW	286,836	311,502	440,225
Maternal Health Care Budget of MoHSW	7,805	31,423	27,540
Percentage of Maternal health care over budget	2.7%	10.09%	6.3%

Source: Ministry of Health and Social Welfare – Annual Budgets for the Financial Years 2006/7 – 2008/9

The table above shows that the budget for the Health Sector in Tanzania is increasing year after year while that of the Maternal Health care is still declining. This implies there is inconsistency in the allocation of funds to maternal health care activities.

[13] The amount shown exclude sources which are not captured in the MoHSW annual budget

2.6 System Organization in LGAs

This subsection looks at how the system of Maternal Health Care is organized in LGAs.

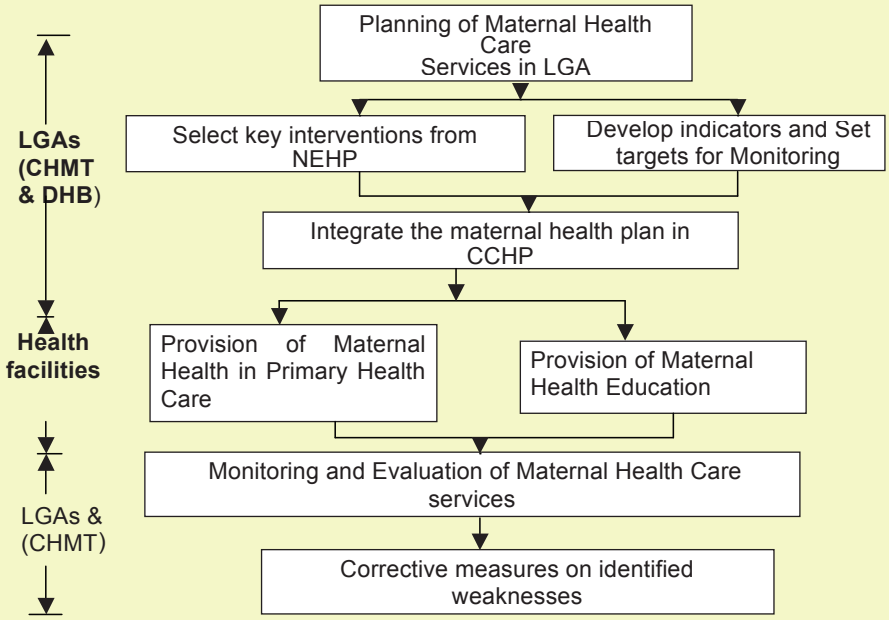

Figure 2: Flow of Maternal Health activities as organised in LGAs

As shown in the flow chart above, the monitoring and evaluation of the maternal health care provision in the health facilities is done both by the regional and Council levels (LGAs). Furthermore, councils coordinate health facilities within their respective areas and reports to the Region on a quarterly basis. The same report is consolidated at the regional level and sent to the national level. However, the preparation of CCHP is not a participatory one as it does not accommodate information from the grassroots (community level).

2.6.1 Provision of Maternal Health in Primary Health Care

The provision of maternal health in primary health care is determined by the planning and budget which originated from the primary health facilities. The planning from these facilities is guided mainly by the Essential Health Package (EHP) which addresses among other issues the overall national health policy and national health strategic plan.

The Essential Health Package contains the priority areas to be covered in the Comprehensive Council Health Plan (CCHP) and includes the main diseases and health conditions responsible for the burden of diseases in Tanzania. It is important that all activities planned are in line with this package. Among the priority areas in this package is Reproductive Child Health Promotion and Care.

The Comprehensive Council Health Plan has three aspects that are technical which include preventive, curative and rehabilitative aspect, financial deals with funds and structural aspect deals with health providers. Therefore the provision of the maternal health care to a large extent depends on the approved Comprehensive Council Health Plan.

2.6.2 Monitoring System in LGAs

The monitoring of district health services is expected to be realized through data that is collected using the poverty monitoring routine data system including HMIS tools and disease surveillance system, analysed and interpreted based on the 20 Council Health performance indicators. Other sources of information are surveys and researches. The monitoring has to be linked also with the Comprehensive Council Health Plan, Health Sector Strategic Plan, National Strategy for Growth and Poverty Reduction (MKUKUTA) and the Millennium Development Goals (MDGs).

In addition, the following methods were used to monitor the progress, this includes an assessment of the implementation of Comprehensive Council Health Plan to ensure quality and targets are attained, Council Health Management Team (CHMT) regular supportive supervision, preparation and submission of quarterly and annual progress reports, involvement of civil societies and health facilities governing committee in monitoring of service provision and financial resources and exchange of experiences through various forums and conferences.

2.6.3 Evaluation of the System in LGAs

Evaluation is a means of measuring the achievement obtained and identification of any problem encountered so as to find effective ways of correcting them. The evaluation of the Council health services is divided into two parts, i.e. internal and external evaluation.

Internal Evaluation is conducted by the Council Health Management Team (CHMT) by measuring the progress against the selected district health services targets based on the 20 Council Health Performance Indicators. These indicators are in harmony with poverty monitoring routine data system. The quarterly progress reports and other supervision reports were the inputs to the internal evaluation. The implementation team prepared a report as per their evaluation.

External Evaluation uses the same indicators used during the internal evaluation. The internal evaluation is input to external evaluation. The External Evaluators use all the progress reports, semi and annual reports and other reports relevant to the implementation of Council Health Services. This has to be done by an independent body once every year or after 3-5 years or as it may be determined from time to time by MoHSW, PMO-RALG and other stakeholders.

2.6.4 Provision of Maternal Health Education in LGAs (Health facilities)

Maternal health education at the district level is provided by the staff of health facilities under the supervision of the Council Health Management Team. The use of Information, Education and Communication (IEC)/Behaviour Change communication (BCC) approaches has to be intensified toward adoption of positive behaviours for quality MNCH including nutrition and adolescent sexual reproductive health.

The IEC/BCC activities target community-based initiatives particularly in addressing birth planning for individual couples, transport in case of emergency, and promotion of key Maternal, Newborn and Child Health care practices at the household and community levels.

According to the four-visit Antenatal Care (ANC) model outlined in WHO clinical guidelines, ANC clients are required to be given health education, advice, and counseling as explained on Table 3 below:-

Table 4: Antenatal Care clients visit

First visit 8-12 weeks	Self-care, alcohol and tobacco use, nutrition, safe sex, rest, sleeping under Insecticide Treated Nets (ITN), birth and emergency plan
Second visit 24-26 weeks	Birth and emergency plan, reinforcement of previous advice
Third visit 32 weeks	Birth and emergency plan, infant feeding, postpartum/postnatal care, pregnancy spacing (family planning), reinforcement of previous advice
Fourth visit 36-38 weeks	Birth and emergency plan, infant feeding, postpartum/postnatal care, pregnancy spacing (family planning), reinforcement of previous advice

2.6.5 Budget Allocation for Maternal Health related activities in LGAs

The LGAs are responsible for the provision of maternal health services in their Councils based on the approved Comprehensive Council Health Plan. The Comprehensive Council Health Plan is financed mainly by the Central government and donors through block grants and Health Basket Funds (HBF) respectively.[14]

The Health Sector is one of the priority sectors in resource allocation initiatives whereby Reproductive and Child Health is among the high priority areas. However, the share of Government budget is 11%, which is still far short of Abuja Declaration target of 15% of government spending on health.

According to the monitoring framework of the National Road Map strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008 – 2015, the indicators to assess the progress of MNCH includes the proportion of government budget allocated to health and proportional of government budget allocated to health and proportion of MOHSW district budget allocated to MNCH and family planning.

Therefore, relevant ministries such as the Ministry of Finance and Economic Affairs and the Ministry of Health and Social Welfare are expected to allocate at least 15% of government budget for health while MoHSW has to allocate 15 - 25%[15] of the allocated health budget for maternal health care which is not the situation currently. The current budget allocation situation in Tanzania is as reflected in Table 2 - Trend of Health and maternal Health Care Budget 2006/7 – 2008/9.

[14] The Comprehensive Council Health Guideline provide direction on how the resources at the council are managed as well as the guidance on formulating budget based on National Essential Health Package.

[15] This is according to different health experts interviewed and is yet to be agreed on the actual percentage of the Health budget to be allocated for Maternal Health Care in Tanzania

Chapter Three
Findings

INTRODUCTION

In this chapter, we present our findings as answers to the audit questions shown in chapter 1 of this report. The findings relate to the following aspects:

- Monitoring of Maternal Health Care;
- Provision of Maternal Health Education;
- Evaluation of Maternal Health Activities; and
- Budget allocation to Maternal Health Care activities

3.1 MONITORING OF MATERNAL HEALTH CARE

This section focus on how the MOHSW plans to monitor the level of maternal health care in the country. This includes determining whether risk areas in maternal health have been determined by the MOHSW, targets have been established as a basis for monitoring, reliable data are collected, analyzed and actions have been taken to ensure accurate reporting of maternal health.

3.1.1 PLANNING FOR MONITORING THE LEVEL OF MATERNAL HEALTH CARE

Monitoring plan is a management tool which enables the management to ensure the periodic oversight of the implementation of activity which seek to establish the extent to which input deliveries, work schedules, other required action and targeted outputs are proceeding according to plan, so that timely action can be taken to correct deficiencies detected. Additionally, routine data reporting, field visits, detailed activity plan and time table provide the monitoring frame work.

The RCHS is required to prepare the Performance Monitoring Plan once their strategic plans are approved[16]. The monitoring plan should be comprehensive taking into account key issues to be monitored and methodologies applied such as routine data collection, field observation, progress reports and rapid assessment. This enables the management to get a better picture on how monitoring is managed, gaps are addressed and prioritization is made easily in coming up with the corrective measures.

The MOHSW has developed the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Death in Tanzania 2008- 2015 in order to improve coordination, align resources and standardize monitoring. This strategy covers all major issues on maternal issues including the monitoring framework to ensure the goal set are achieved.

[16] Performance Monitoring and Evaluation Tips by USAID Center for Development Information and Evaluation (Reengineering guidance) number 7 1996.

However, according to the interviews with the Ministry officials, the RCHS has not developed the annual comprehensive monitoring plan specifically for monitoring the provision of maternal health care which covers issues like what should be monitored and how, who should be involved and when, what resources are needed and available.

Furthermore, it was acknowledged that there is a general monitoring plan in which maternal health is one of the items. It has not been given much weight despite of the fact that it is really a problem. Appendix Six shows that the MOHSW prepared an overall annual action plan for recurrent budget where RCHS activities were also included. However, according to interviews conducted, the RCHS had not prepared activity plan for conducting monitoring of the level of maternal health care in the health facilities despite the fact that it is their role. This was because the monitoring was conducted by the ministry's Monitoring and evaluation section which has the role of evaluating the overall performance of the MoHSW.

3.1.2 RISK AREAS IN MATERNAL HEALTH CARE

In order for the monitoring to be effective, the MOHSW under the RCHS is required to carry out assessment of the risk[17] on maternal health care so as to identify the gaps and prioritize the key issues to be monitored and the way to be monitored.

Each key issue has to be monitored by a different methodology and the basic source of information depends on the methodology used. The MOHSW applies several approaches of monitoring maternal health including HMIS, supportive supervision, progress reports, field observation and review of maternal death.

Knowing the level of maternal mortality is not enough, it is important to understand the underlying factors which led to the death[18] and find out the key interventions to be integrated in the health system and to make sure these interventions are effectively monitored in order to reduce the maternal deaths as planned.

According to the interview with the Division of Policy and Planning and Reproductive Child Health Section in the MOHSW, the key issues that contribute to the reduction of maternal mortality are antenatal care, family planning, skilled labour attendants and emergency obstetric care. The MoHSW has adopted these key issues in their strategic plan[19] for reducing maternal death. However the MOHSW has not yet carried out risk assessment on these key issues so as to determine the gaps and issues to be prioritized.

---

[17] Risk assessment is the determination of quantitative or qualitative value of risk related to a concrete situation and a recognized threat.

[18] Beyond Numbers, Reviewing maternal death and complication to make pregnancy safer by WHO, Geveva, 2004.

[19] National Roadmap Strategic Plan to Accelerate Reduction of Maternal Newborn and Child Death in Tanzania 2008-2015 - Reproductive and Child Health Section.

Furthermore, according to the Strategic Plan document - Accelerate Reduction of Maternal, New born and Child death[20] and CCHP Guidelines reviewed, the MOHSW depends mainly on HMIS (routine data) for monitoring the level of maternal health care. Regardless of the weaknesses associated with the HMIS such as data reliability and timeliness of information, the Ministry has not assessed the risks associated with each methodology applied and its impact in contributing towards reduction of the maternal mortality.

3.1.3 ESTABLISHED TARGETS RELATED TO KEY ISSUES ON MATERNAL HEALTH CARE

Establishing targets related to key issues on maternal health refers to a desired goal of progress towards an objective through a number and quality of specified activities that have to be carried out before the objective can be reached.

The development of the MNCH strategic plan to accelerate reduction of maternal, newborn and child deaths aimed to reduce maternal, newborn and child death in order to reach MDG 4 and 5. This plan is expected to contribute to the achievement of MKUKUTA[21] and MMAM[22] goals which are reduction of under five mortality rate by two-thirds and reduction of the maternal mortality ratio by three-quarters, by 2015. It also aimed at achieving objectives and targets of other existing national programmes, interventions and strategies which focus on improving MNCH.

The objective among others is to reduce maternal mortality from 578 to 193 per 100,000 live births by 2015.

The targets on the key issues are explained under operational targets to be achieved by 2015. These include:

- increased coverage of births attended by skilled attendants from 46 to 80 percent
- increased modern contraceptive prevalence rate from 20 to 60 percent
- hundred percent of hospitals and 50 percent of health centers provide CEMOC (Comprehensive Emergency Obstetric Care) and 70 percent of health centers and dispensaries provide BEmOC (Basic Emergency Obstetric Care)
- increased antenatal care attendance for at least 4 visits from 64 to 90 percent

[20] One Plan
[21] Mkakati wa Kukuza Uchumi na Kupunguza Umaskini
22 Mpango wa Maendeleo ya Afya ya Msingi

According to one plan[23], the maternal, newborn and child care programmes have to be evaluated based on an agreed set of indicators, both qualitative and quantitative. There are about seven categories of indicators to assess the MNCH progress.

At the level of LGAs, the MOHSW has issued the CCHP guidelines whereby the Councils are required to monitor the issues of maternal health care through the 20 Council performance indicators. In developing the CCHP, the CHMT help the facilities to plan for the interventions which come from the NEHP.

In reviewing documents, we found that the CCHP guidelines just mention the targets to be used by the Councils without more elaboration on how these targets are chosen or adjusted accordingly depending on different environment. However, the MOHSW has not documented the procedures on how and when these targets are established and when the targets have to be adjusted, changed or removed.

The targets which are developed at the national level are not inline with the Council's 20 performance indicators. The guidelines give room for each Council to set its target the way they want. By doing this, it results in more risk on the deviation between the national targets and those of the Councils.

Table 5: Comparison between the maternal heath's targets at national and council levels

Sn	Operational targets on key issues at national level by 2015	Council targets on key issues	Remarks
1	Increased coverage of births attended by skilled attendants from 46 to 80 percent	80 percent of deliveries are attended by skilled personnel in health facilities	The target at national level is in line with those of Council
2	Increased modern contraceptive prevalence rate from 20 to 60 percent	The number of new acceptors for family planning services increase by 2 percent per year	National targets is increament of 40% for seven years while Council is 2% per year.
3	• 100 percent of hospitals and 50 percent of health centers provide Comprehensive Emergency Obstetric Care and	Facilities for the provision of comprehensive emergency obstetric care are available to cater for needs of the District at Council hospital/designated District	The National target is not in line with the targets in the council in terms of percentage set. Council target is not specific

[23] The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008 - 2015

	• 70 percent of health centers and dispensaries provide Basic Emergency Obstetric Care	hospital and basic for health centers and dispensaries	Council does not target comprehensive EMOC for health centers
4	Increased antenatal care attendance for at least 4 visits from 64 to 90 percent	All health facilities provide ANC, syphilis screening, HB test, ITNs, Intermittent preventive treatment (ITP) for malaria prophylaxis and nutritional supplements and appropriate advice.	Council targets do not correspond to operational targets on key issues at national level council is not specific.

Source: Document review

In March 2010, the MOHSW set a target to complete revising the CCHP guidelines and the National Essential Health Package (NEHP) inline with the Health Sector Strategic Plan (HSSP3), MKUKUTA and other agreed sector strategies but has not yet managed to complete this exercise. According to the interviews held with the Ministry officials, the revision was at its final stage.

3.1.4 RELIABILITY OF MATERNAL HEALTH CARE DATA COLLECTED

Data reliability includes the following components; consistent results when measured or tested, Information which is clear, unbiased and accurate, all claims or factual statements being supported by the information, only certain factors are focused on and the one which is authoritative, timely and authentic.

The Maternal and Prenatal death review report revealed that, the reporting mechanism of maternal deaths review reports prepared at district level by District Medical Officer (DMO) is required to be submitted to the Regional Medical Officer (RMO) and Reproductive Child Health Section (RCHS) on a monthly basis[24].

Interview with officials from the Reproductive and Child Health section in the MOHSW acknowledged that there is a delay of receiving the maternal report (maternal death notification form B) from regions which are supposed to be submitted on a monthly basis. Furthermore, during the interview we found only one region out of twenty six regions which had submitted the maternal deaths notification report. By the virtue of these circumstances it is apparent that the Reproductive Child Health Section (RCHS) did not have timely and accurate data for making appropriate decisions on maternal mortality.

24 Maternal and Perinatal Death Reviews Guideline-July 2006

The Health Sector Strategic Plan III revealed weaknesses in the collection of data using routine systems (HMIS). Often data collection is delayed. Feedback to collecting facilities, particularly from the district level is practically nonexistent. The registration of vital events (births, deaths) does not have good coverage, while this information is required for the purpose of planning health services at both the Council and the national level.

The Councils are supposed to report on the 20 CCHP indicators annually. However, most of the Councils can not provide the information partly because the indicators are not well elaborated[25]. However, it was also acknowledged that misclassification of maternal deaths was a common phenomenon and all maternal deaths needed to be counted and investigated as the Ministry does not have the ability to capture all the maternal deaths, since a number of these occur in home deliveries[26].

3.1.5 ANALYSIS OF DATA

An effective performance monitoring needs to plan data collection, analysis, reporting and use. Analysis enables the highlighting of useful information, suggestion conclusion and supporting the decision making. Identifying data analysis techniques, presentation format to be used, analysis tools, time to be completed and submitted to other levels has to be taken into consideration during monitoring.

The major method used by MOHSW to monitor health issues is based on routine data collected through HMIS. Data are collected from the community level to the national level. According to HMIS guide, data are supposed to be analyzed in all levels and their aiming is to improve service delivery. However, according to the interview with Ministry officials, they acknowledged that data analysis is a very challenging exercise especially at lower levels of administration.

According to the Joint External Evaluation Report, it was found out that the council uses the HMIS to prepare CCHP, but the collected information is largely forwarded to higher authorities without an in-depth analysis at the lower levels. Districts and regions are treated more or less as collection points only with no analysis of such collected data.

---

[25] Health Sector Strategic Plan III

[26] Maternal Morbidity: an overview and a Tanzania Case Study-Commonwealth Secretariat

3.1.6 ACTION TAKEN TO ENSURE MATERNAL HEALTH CARE DATA ARE ACCURATELY REPORTED

The relevant information for monitoring of maternal health care interventions and outcomes is produced by the Health Management Information System (HMIS). An information system can be defined as a system that provides specific information support to the decision making process at each level of an organization. The ultimate objective of an HMIS is therefore not to "gain information" but to "improve action".

RCHS is required to generate information that can be used by health service providers, planners and managers to save women's lives by improving the quality of care providers and establish maternal mortality rate, rational classification of the cause plan of action to prevent further deaths[27]

The documents reviewed revealed that measuring maternal mortality rates resulting from the complications of pregnancy or child birth is challenging at best as a result of systematic underreporting and misreporting which are common, and the fact that the estimates lie within large ranges of uncertainty[28].

Furthermore, contemporary data is mostly gathered from health facilities, leaving aside many deaths occurring outside the health care system. However, the inaccuracy and unreliability of the data in those reports is compounded by underreporting, as maternal death is believed to be a natural phenomenon.

Also, maternal mortality data reporting from LGAs has not been timely or complete as the source of data to the RCHS. The system (HMIS) that is currently used to capture data, has problems of not capturing community based maternal deaths.

However according to interviews with health experts, monitoring maternal death accurately is difficult in developing countries where a reliable national electronic system for registering vital statistics does not exist.

3.2 MATERNAL HEALTH EDUCATION

Education of women and their families about danger signs during pregnancy and the need to seek immediate help from skilled health workers is very important in reducing maternal death.

---

[27] Maternal and Perinatal Death Reviews Guideline

[28] The Millennium Development Goals Report-Goal no 5

This section focuses on how the MOHSW oversees maternal health education provided by health facilities in the country. This includes determining whether the Ministry plans for education provision on maternal health issues, schedule for providing such education during antenatal care visits, appropriateness of the education information about maternal health issues provided to antenatal clients and compliance with education plans.

3.2.1 Plan for education about maternal health issues

The plan for provision of health education and counseling during Antenatal care visits is a tool which ensures the objectives of the education provided they are met accordingly and form the basis of evaluation. Therefore, to ensure quality provision of health education during antenatal care visit, there must be a specific plan at national and council's level. The MOHSW with the assistance of RHMT has the task of ensuring that all councils and their respective health facilities develop a plan for education about maternal health care issues and strictly and effectively adheres to it.

According to the interviews with the Ministry officials in the RCHS section, it was acknowledged that, there is no written plan on the Health education provided which shows clear objectives, targeted groups, appropriate training tools, time, venue, size of the class and other important issues such as the ways of evaluating the education provided to the clients.

From the review of documents done and interviews held with the Ministry officials it is apparent that the CHMTs does not give enough weight on ensuring the health facilities under them have plans for the provision of health education during the antenatal visits.

3.2.2 Timetable for providing education during antenatal care visits

Women are encouraged to begin Antenatal care early in pregnancy and attend a minimum of four visits by the end of the pregnancy. *Table 5* demonstrates the visits and expected services in each visit. (Refer Appendix Two for more details). In each visit, there are issues which the pregnant women have to be taught, counseled or advised.

Table 6: The four-visit ANC model outlined in WHO clinical guidelines

Period of visit	Service required
First visit 8-12 weeks	• Confirm pregnancy and EDD, classify women for basic ANC (Four visits) or more specialized care. • Screen, treat and give preventive measures. • Develop a birth and emergency plan • Advise and counsel.
Second visit 24-26 weeks	• Assess maternal and fetal well-being. • Exclude PIH and anaemia. • Advise on preventive measures. • Review and modify birth and emergency plan. • Advise and counsel.
Third visit 32 weeks	• Assess maternal and fetal well-being. • Exclude PIH, anaemia, multiple pregnancies. • Advise on preventive measures. • Review and modify birth and emergency plan. • Advise and counsel.
Fourth visit 36-38 weeks	• Assess maternal and fetal well-being. • Exclude PIH, anaemia, multiple pregnancy, malpresentation. • Advise on preventive measures. • Review and modify birth and emergency plan. • Advise and counsel.

Source: WHO clinical guidelines

According to the interviews with staff at the Preventive Service Division, they agreed that there are specific days for providing antenatal care in each health facilities. Normally, after ANC client register herself for each period of visits, education starts for all mothers. Counseling and advices are then given after examination since they are individualized. However, there is no enough guidance on evaluation of maternal Health Education.

Lack of proper guidance for evaluating the provision of maternal health education hampers the quality of education provided.

3.2.3 The practice of delivery of maternal health education, counselling and advices during Antenatal care

ANC service providers are expected to routinely counsel clients on special nutrition needs during pregnancy as well as signs and symptoms that may indicate a problem with pregnancy.

According to the four-visit ANC model outlined in WHO clinical guidelines, ANC clients are required to be given health education, advice, and counseling as follows:

Table 7: Health education required in Antenatal Care visits for pregnant women

Visit	Health education required
First visit 8-12 weeks	Self-care, alcohol and tobacco use, nutrition, safe sex, rest, sleeping under ITN, birth and emergency plan
Second visit 24-26 weeks	Birth and emergency plan, reinforcement of previous advice
Third visit 32 weeks	Birth and emergency plan, infant feeding, postpartum/postnatal care, pregnancy spacing, reinforcement of previous advice
Fourth visit 36-38 weeks	Birth and emergency plan, infant feeding, postpartum/postnatal care, pregnancy spacing, reinforcement of previous advice

In reviewing the Tanzania Service Provision Assessment Survey document of 2006, it was noted that the nutrition issues discussed during consultation was only 18 percent of first visit and 21 percent for follow up clients. The progress of pregnancy is discussed with 45 percent and 42 of the follow up clients. Delivery plans are discussed with only half of ANC clients who are at least 8 months pregnant. Family planning after birth is not widely discussed with ANC clients.

Furthermore, the interview conducted by the National Bureau of Statistics (NBS) regarding the topics discussed during current or past visit to the facility, it was found out that the providers discuss the delivery plans with 58 percent of the clients using family planning.

In general it has been observed that:

- Service providers do not commonly counsel pregnant women on nutrition, risk signs and symptoms or exclusive breast feeding during ANC consultations

- Delivery plans are discussed with less than 50 percent of all ANC and with only 50 percent clients who are at least 8 months pregnant.

3.2.4 Compliance with MoHSW and LGAs maternal health education guidelines

The WHO has set up a minimum standard of four visits for pregnant women to attend ANC, the service needed to be provided among others include physical examination, treatment, vaccination and health education. Each visit has a specific type of health education needed to be provided. The above mentioned education plans can be used to evaluate performance of the ANC services to pregnant women.

However, the MoHSW under RCHS does not have specific indicators for evaluating the provision of ANC to pregnant women in the health facilities in key areas such provision of health education to pregnant women and examination provided to pregnant woman in ANC. Other areas which have set indicators are treatment and vaccination provided to pregnant woman in ANC.

The RCHS evaluates MNCH progress based on the combination of ready made collected data by other players as indicators at the national level such as HMIS, surveys such as District Health Surveys, Households Surveys, Tanzania Service Provision Assessment Survey and M&E.

Reviewing of documents revealed that the percentage of deliveries done in the health facilities is very low as shown in Table 7 (For more details please refer Appendix Three).

Table 8 : Percentage of deliveries attended in health facilities

Delivery in Health Facility	Number of Regions
0% - 25%	0
26% - 50%	7
51% - 75%	12
76% - 100%	2

Source: Auditors Analysed data[29]

The data above shows that deliveries in health facilities in seven regions (out of 21 regions) are less than 50% percent while 12 regions falls between 51% and 75%. Two regions had deliveries in health facilities of above 75% of the total deliveries made. Less deliveries in health facilities might implies that less education on the risk of not delivering in health facilities is provided to pregnant women. However this indicator has some weaknesses since the uptake and implementation of health education lies in the hands of the woman and her family.

3.3 EVALUATION OF MATERNAL HEALTH CARE

Evaluation is a means of measuring the achievement obtained from a set of desired or agreed objectives and identification of any problems encountered so as to find effective ways of correcting them. There is internal and external evaluation. Internal evaluation is progressive and is carried out through monitoring and progress reporting through routine data system for the purpose of improving implementation. External evaluation uses progress reports, semi and annual reports and any other reports relevant to the implementation of health services.

29 Health Sector Performance Profile Report 2010 update

This section focus on how the MOHSW conducts evaluation of maternal health activities in the country. It includes how the Ministry plans the evaluation of maternal health activities, criteria used for evaluation, how is it conducted and actions taken on the evaluations conducted.

3.3.1 Written plan for Evaluation of maternal Health care provision

Preparation of plans for conducting an evaluation is very important for effective evaluation as it tells what is going to be evaluated, purpose of the evaluation, identifies users of the evaluation report, identifies what questions will the evaluation seek to answer, identifies what type of information needed such as indicators, specifies when is it going to be conducted and the resources to be needed in terms of time, money and human resources.

The MoHSW is required to plan for conducting an evaluation of their intervention and actions. These are essential to improving performance and achieving results. It gives a feedback as to whether activities have been implemented as planned, ensures accountability and transparency and enables timely feedback for support and improving strategic planning. According to other studies[30] evaluation can be done based on the impact indicators and process indicators.

However, according to interviews held, the MoHSW does not have appropriate plans for evaluating performance of maternal health care in the health facilities. The MoHSW has not carried out a risk based analysis specifically on maternal health that could be used as a basis for developing such plans.

3.3.2 Evaluation Criteria on maternal health (i.e compare with the best practices)

In order for the MoHSW to be able to assess the efficiency in the provision of the maternal health care to pregnant women, the Ministry is required to evaluate interventions that are known to be effective in reducing maternal mortality and morbidity.

According to interview and reviewing of documents[31], the RCHS and Inspectorate Unit under the MoHSW are responsible for conducting supportive supervision for maternal health in both the public, private and Faith Based health facilities (40% of Health facilities belong to Faith Based Organisation).

[30] 1993, a WHO technical working group

[31] The National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Death in Tanzania 2008-2015

The evaluation of maternal health care provision is done by the MoHSW through assessment of five CCHPs indicators (out of 20 indicators) annually on improving Reproductive Health Care, supervision visits conducted by the Ministry and also through HMIS data issued quarterly. The Ministry has also set indicators for measuring progress of MNCH strategic plan one being Biennial implementation report tracking progress on MNCH indicators listed.

The process indicators used is the proportion of health facilities receiving quarterly supportive supervision *(See Appendix Four)*. The evaluation criteria assigned to RCHS is too general. No indicator is assigned for measuring health education provided. The quality of supervision conducted is not evaluated if it aims at reducing maternal death. The set criteria for measuring progress of the strategic plan using Biennial implementation report tracking progress is not done as required. This resulted into the Ministry lacking relevant criteria for assessing/evaluating maternal health result into inadequate corrective action

3.3.3 Evaluation conducted on maternal health care services in the health facilities

The MoHSW under the RCH section is required to evaluate performance of health facilities on maternal health. Evaluation is scientifically based on collection of information about a program or intervention activities, characteristics and outcomes that determines the merit or worth of the program or intervention. According to stipulated roles, the section is required to co-ordinate, monitor and evaluate maternal, child, adolescent and community based health care including, expanded programme on immunization, school health, community based health care and family planning etc. (refer roles of RCH).

However, no joint evaluation has been conducted that evaluates the provision of maternal health care in detail. The Ministry has conducted one evaluation and it was on an ad-hoc basis. The evaluation focused only on administrative issues. The frequency of supportive supervision conducted as a means of evaluation is very minimal. The focus of supervision visit is mainly on the administrative issues and not the technical part to see if Instructions given in official guidelines, for example on screening of anaemia and syphilis, and the use of prophylaxis for neonatal tetanus were efficiently carried out.

This is due to lack of evaluation plan that stipulates the way the evaluation is supposed to be conducted at the national and lower levels of administration which may include what questions will the evaluation seek to answer, information needed such as indicators, when is it going to be conducted and resources needed in terms of time, money and human resources.

3.3.4 Basis used for evaluating key issues i.e clinical procedures, resource level, competency of care giver, education etc

The MoHSW as the technical Ministry and overseer of health issues in the Country is required to test clinical procedures together with other key issues such as resource level, competency of care giver, education used by health facilities when providing maternal health services. Testing provides more or less assurance that the service is being done efficiently and effectively by the health facilities.

The interview shows that evaluation conducted by the Ministry focused on administrative issues only such as whether the health facility prepares technical and financial reports and also compliance with financial regulations. The evaluation did not test technical aspects of the maternal health care issues. Financial commitment at the national level (15%) not reflected in the guide (CCHP) issued to councils for implementation. The effectiveness of the education in relation with the reduction of maternal death is not part of the criteria used in the evaluation.

This is due to lack of evaluation plan that could be used as a guide to assess efficiency in maternal health service delivery. This may result into interpretation of end results – evaluation report – misleading due to insufficient information captured.

3.3.5 Feedback on Evaluation conducted

Evaluation feedback is information about how an activity has been performed in relation with the stated goals. It tells what did or did not happen. After conducting an evaluation, the MoHSW is required to provide feedback to health facilities evaluated timely. It should be detailed, clear and focusing on how to improve the service.

However, the MoHSW does not issue appropriate feedback on evaluation/ supervision conducted on time. The Ministry has not issued feedback on the collected data from health facilities regarding maternal health through HMIS. Feedback on supervision is based on issues which are of more or less relevant in relation with the effective reduction of maternal death. It focuses more on for example administrative issues. In addition to that, the feedback can not easily be understood by the lower level administrative cadre due to the language and means used to provide feedback. There is no effective forum for discussing these important issues. According to the interviews held, the Ministry used to conduct health sector technical staff forums where health issues were discussed. But these forums had not been conducted due to lack of funds to facilitate them.

3.3.6 Action taken on Evaluation conducted

The MoHSW is required to take corrective action after conducting on evaluation of performance of health facilities on maternal health services as a means for improving service delivery. Evaluation studies provide credible information for use in improving programs or interventions, identifying lessons learned and informing decisions about future resource allocation. Action should aim at improving the services based on the lessons learnt after conducting an evaluation. It should be provided timely as a feedback to the person evaluated.

According to the interview, the MoHSW lacks documented lessons learnt on supervision conducted – as a means of evaluation – in the health facilities. The Ministry has not issued appropriate standard for documenting and retaining maternal health care records relating to ANC.

Lack of action plan resulted into problems noted in the evaluation not being documented for future follow up. This lead into less improvement on maternal health

3.4. BUDGET ALLOCATED TO FUND MATERNAL HEALTH CARE.

Analysis on the proportion of the total government expenditure going to the health sector has increased from 13.45% in 2006 to 13.87% in 2008/2009. The trend implies that the government has been allocating more financial resources to the health sector for many years now. Nevertheless, the proportional budget spent on health is still below the Abuja target of 15% by 2015 but it is within reach from the remaining time frame of five years to 2015.

This section focus on how the MOHSW funds the maternal health activities in the country. This includes determining whether allocation to maternal health activities are efficiently and effectively done.

3.4.1 Model for funding Maternal Health.

The Ministry of Health and Social welfare (MOHSW) is required to set 15% of the health budget for maternal and newborn care[32] The MoHSW allocates funds according to the objectives set by the Ministry.

[32] National Road Map Strategic Plan to Accelerated Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015

The Ministry has eight objectives in this regard, these are: to improve services; to reduce HIV & AIDS infection; to ensure equitable and gender sensitive health and social welfare services; to ensure quality essential health and social welfare services, research and training; to improve continuously professional development with the aim of improving policies, legislation and regulation for efficient and effective services delivery; to enhance performance of service delivery to reduce the, burden of disease; to enhance the institutional capacity and organization of the Ministry to implement its core functions; and to put in place an efficient and effective governance system for the delivery of services.

Interview with Ministry's officials and international organizations acknowledged that it is difficult to trace funds allocated to maternal health since it is scattered to other objectives. However, maternal health is a national priority number one which needs to have isolated budget for more commitment in maternal deaths reduction.

3.4.2 Allocation of funds to maternal health services

The Reproductive Child Health guideline is explicit on priority in which the Ministry should allocate funds and hence the Ministry must prioritize budget allocation to key issues concerning maternal health care: Antenatal care, Family Planning, Emergency Obstetric Care[33] (etc).

Regarding the information required for maternal health budget, officials from the Ministry acknowledged that there is a modality of fund allocation at the national level which is 15 percent of the health budget to be allocated to maternal health. However, this modality is not adopted by Councils when allocating funds to maternal health care issues. Furthermore, it is a discretion of the council to decide the percentage of funds to be allocated for maternal health care services which is a diversion from the national policy of 15% budget allocation to maternal health care.

Document review revealed that overall; there is no consistency in funds allocation to RCHS, only about 7% of the total regional health financial resources were allocated to RCHS. Allocations vary by region. Some regions allocate more than 10% of resources and others as low as 3.5%. While these allocations are meant to reflect the maternal and child burden in the Region, some regions have allocated very little financial resources to RCH despite having high Maternal Mortality Ratio (MMR). For instance, Tabora Region is reported to have high MMR (313/100,000 in 2008) but has allocated only 3.7% of its health budget to RCH interventions (See Appendix Five).

[33] Comprehensive Council Health Plan (CCHP) guideline 2007

Similarly, according to interviews with different Health experts it is extremely difficult to tell how much funds have been allocated to maternal health interventions because of service integration. At the central level, one can track resources mainly under the Preventive Services Department of MOHSW (and under objective E of the MOHSW) and few interventions from other departments.
Identifying and extracting amounts of money allocated to RCH related interventions in other Departments and objectives of MOHSW is difficult due to lack of appropriate level of disaggregation of details.

Chapter Four

Conclusions

Our audit findings presented in the previous chapter give us reasons to draw the following conclusions.

General conclusion
The RCHS under the MOHSW lack specific plans for monitoring and evaluating the maternal health care activities. The Monitoring and Evaluation Unit of the Ministry had not performed the monitoring and evaluation function focusing on maternal health services. The MOHSW lacks Health Education Guidance to be used by the health facilities when providing maternal health care services. Resource allocation to RCHS activities was not itemised enough to be able to determine the actual amount allocated to the maternal health care activities.

Specific conclusion
The following are specific conclusions:

4.1 There is inadequate Monitoring of the level of Maternal Health Care in Tanzania

The Ministry of Health and Social Welfare is not adequately engaged in monitoring the level of Maternal Health Care activities.

The Ministry of Health and Social Welfare officials reported to have done monitoring focusing on the Maternal Health care with the aim of taking necessary action to improve some of the areas which need the attention of the central government.

However, during the assessment the Audit team could not find any reports/ documents that showed monitoring activities on Maternal Health Care.

The above general conclusion is manifested by:

4.1.1 Lack of plans for monitoring the level of maternal health care
The Reproductive and Child Health Section of the MoHSW has not developed the annual comprehensive monitoring plan specifically for monitoring the provision of maternal health care in Tanzania. Failure to have adequate and comprehensive monitoring plans for maternal health care services resulted into not knowing exactly important issues to be monitored and how, who should be involved and when and resources needed and available.

The Ministry of Health and Social Welfare claimed to have a general monitoring plan that used to monitor the Ministry's performance as a whole. It is not specifically monitors specific items in which the maternal health is one of the items and it has not given much weight despite of the fact that it is a big challenge and serious problem facing Tanzanians at the moment.

Lack of monitoring plan specifically tailored for Maternal health hampers the effectiveness of monitoring system in making sure that the management of the Ministry of Health and Social Welfare has reliable information for controlling and making right decisions in attaining the goal set.

4.1.2 Failure to carry out risk assessment on key issues identified

Despite the fact that the Ministry of Health and Social Welfare has identified key areas/issues on the Maternal Health namely, antenatal care, family planning, skilled labor attendance and emergency obstetric care, there is no evidence showing that it has critically carried out risk assessment on these key issues so as to determine which ones should be given priority.

However, the Ministry of Health and Social Welfare has adopted these key issues in their strategic plan for reducing maternal death.

Failure to carry out risk assessment in those key issues identified resulted into the Ministry's failure to tackle the challenges which are happening in each key area. The ultimate result indeed was the failure of the Ministry to reduce the maternal death to a set target of 265 per 100,000 live births by the year 2010.

4.1.3 Failure to translate the national targets to LGAs level

The Ministry of Health and Social Welfare has not translated the national target related to key issues on maternal health to LGAs level. The only target set is for the entire country and for the general goal of reducing maternal death by 265 per 100,000 live births by the year 2010[34], but at the same time the Health Facilities are providing Maternal Health services in different areas with the expectation of reducing maternal death not knowing that key issues need to be addressed differently (depending on the nature of the issue and location) in order to reduce the maternal death in Tanzania.

However, Comprehensive Council Health Plan guide has just mentioned the targets to be used by Councils without elaborating on how these targets are chosen or adjusted accordingly depending on different environment and how they do link with the key issues on Maternal Health Care at the national level.

[34] From 950 per 100,000 live births in 2005 (WHO statistics)

Therefore, the Ministry of Health and Social Welfare and Health Facilities are operating without having strong benchmark which can be used to measure their performance and it becomes very difficult to assess in quantitative terms whether they are doing well based on the targets set.

4.1.4 Questionable reliability and inadequate timeliness of Maternal Health data

The audit revealed that feedback to collecting health facilities, particularly from the district level is practically non-existent. The registration of vital events (births, deaths) does not have good coverage, while this information is required for planning health services.

However, it was also acknowledged that mis-classification of maternal deaths was a common phenomenon and all maternal deaths needed to be counted and investigated as the Ministry does not have a means of capturing all maternal deaths, especially those that takes place in home deliveries.

Furthermore, the Health Management Information System (HMIS) requires provision of overall information of reasonable quality on the health status of the population, diseases and on health services provision. Additionally, documents revealed that in collection of data by using Health Management Information System the number of weaknesses related to reliability and timeliness of the information.

4.1.5 Inadequate analysis of data collected and submitted

Despite the fact that there are no enough data collected solely focusing on the maternal health care, the audit revealed that the Councils use the Health Management Information System (HMIS) to prepare Comprehensive Council Health Plan (CCHP), but the collected information is largely forwarded without an in-depth analysis at the lower level of administration. Districts and regions are treated more or less as the collection points with no analysis of the collected data done at this level.

An in-depth data analysis enables to highlight useful information, suggestion conclusion and support the decision making. Identifying data analysis techniques, presentation format to be used, analysis tools, time to be completed and submitted to other level has to be taken into consideration during monitoring.

According to the Health Management Information System guide, data is supposed to be analyzed at all levels of administration and their aim should be to improve service delivery.

An effective performance monitoring on maternal health care is to plan not only for data collection but also for data analysis, reporting and use, which has not been done by the Ministry of Health and Social Welfare.

4.1.6 Inadequate actions/steps taken to accurately report maternal health care issues

The audit revealed that contemporary data is mostly gathered from health facilities, leaving aside many deaths occurring outside the heath care system. However, the data in those reports collected are compounded by underreporting, as maternal death is believed to be a natural phenomenon. Decisions were based on incomplete data due to non incorporation of community based data. Feedback to collecting facilities, particularly from the district level of administration is practically nonexistent.

Although maternal mortality data reporting from Local Government Authorities (LGAs) have not been timely or complete as the source of data, the Reproductive and Child Health Section of the MoHSW has not taken enough steps to ensure that the problem of under-reporting, failure to get maternal health data on time and complete data are addressed.

The Ministry has not used the existing activities pointed out in the strategic plan to address this problem of inaccurate reporting. These activities which could be very helpful are such as produce, disseminate and distribute updated data collection tools at all levels, conduct supportive supervision, follow up training and documenting and share best practices on maternal, newborn and child health.

Failure to do the above mentioned actions resulted into its officials performing their work depending on inaccurate information or under-reported information.

4.2 Inadequate provision of guidance to health facilities on maternal health education

Health education is not adequately emphasized. Though the role of the MoHSW is to issue policy and guidelines regarding health issues, the Ministry has not adequately ensured that maternal health education is appropriately delivered. This has resulted into poor quality of education. For example, of the 95 percent women attending antenatal care services at least once, only less than half of them deliver in a health facility. This implies that the quality of education provided to pregnant woman is poor[35].

---

35 Health Sector Strategic Plan III of (July 2009 – June 2015)

However, other socio-cultural issues also contribute to fewer deliveries taking place in health facilities[36].

4.3. Lack of periodical Evaluations of the key components on Maternal Health System

The Ministry of Health and Social Welfare has not periodically conducted evaluation of the key components on Maternal Health Care activities.

The Ministry of Health and Social Welfare officials have not conducted evaluation focusing on the Maternal Health care services rendered by Health facilities in Tanzania and take necessary action to improve some of the areas which need the attention of the central government.

The Audit team has however not been able to find documentation from the Ministry of Health and Social Welfare showing that evaluation activities on Maternal Health Care key issues have taken place. The only report on evaluation seen by the audit team is that of the evaluation that took place in March 2010 which indeed focused only on general issues of the Ministry itself and not specifically on the technical aspects of Maternal Health Care issues.

The above general conclusion is manifested by:

4.3.1 Non existence of Plans for Evaluation of maternal Health care provision

The Ministry of Health and Social Welfare does not have plans for evaluating performance of maternal health care in the health facilities. This is due to the fact that, the Ministry of Health and Social Welfare has not carried out a risk based analysis specifically on maternal health that could be used as a basis for developing the plan.

It is well known that evaluation plans are of utmost importance as they help the evaluators to have a number of useful information such as identified data needs and standardized national indicators to monitor the achievement of program objectives and goals.

Such a plan also includes indicator baselines and targets to be achieved, methods of data collection, data sources, frequency of data collection and the partners responsible for data collection and management.

[36] Example of socio-cultural issues is woman living far from health facility, interference by the mother in law who block the woman not to go to the health facility for delivery, refusal of the husband to provide funds for transportation to health facilities etc.

The Maternal Health Care evaluation plans were supposed to also cover all components of the evaluation system, including evaluation needs and how they were addressed, data analysis and data use at different levels of the system.

4.3.2 Lack of specific evaluation Criteria on maternal health

The audit has noted that, the evaluation criteria assigned to Reproductive and Child Health Section (RCHS) are too general to be able to reflect the actual problems facing maternal health care in Tanzania.

No indicator is assigned for measuring health education provided on the Maternal Health. The quality of supervision conducted is not evaluated if it is aimed at reducing maternal death.

The set criteria for measuring progress of the strategic plan using Biennial implementation report tracking progress is not done as required.

This resulted into the Ministry lacking relevant criteria for assessing/evaluating maternal health result into inadequate corrective action

4.3.3 Evaluation conducted on maternal health services in the health facilities

The Ministry of Health and Social Welfare has not conducted an evaluation on the provision of maternal health care in Tanzania.

The ministry has conducted one evaluation. It was on an ad-hoc basis. The evaluation was too general which did not specifically focus on Maternal Health and indeed focused only on administrative issues.

Similarly, the frequency of supportive supervision conducted as a means of evaluation is very minimal and if conducted, the focus is mainly on the administrative issues and not technical part to see if instructions given in official guidelines were properly implemented and followed.

4.4 Budget model for funds allocation on Maternal Health Care

The Ministry of Health and Social Welfare has yet to institute an appropriate budget model to allocate funds for maternal health care in Tanzania.

The budget for Reproductive and Child Health is done without having adequate or systematic way of allocating funds to maternal health care. This is despite the fact that Maternal Health Care is a priority area in Reproductive and Child Health in Tanzania.

The reviewed budget show that there is no model which defines how the Ministry determines the amount of funding that is to be allocated to maternal health issues. Failure to this resulted into allocating very few funds to maternal health which amounted to about[37] 7.0% compared to the entire budget of Health in Tanzania. Failure to allocate enough funds in this area is contrary to the Abuja declaration as this area is of great importance in the Health Care provision in Tanzania.

Similarly, the little allocated to Maternal Health Care, there was no model which defines how the funding for maternal health issues was supposed to be allocated to the individual identified key issues.

4.4.1 Allocation of funds do not consider the maternal death ratio

Allocation of funds as analyzed regionally does not also consider the maternal death rate in the respective areas. The following is a model used to analyze maternal death against funds allocated to maternal health section. (For more details refer Appendix Five)

Figure 3: Model for analysis of funds allocation in Region against maternal death

		Budget allocation	
		0% - 7.5%	**7.6% - 15%**
Maternal Death	0 - 50	**(Category 1)** 7 Regions	**(Category 2)** 1 Region
	51 - 176	**(Category 3)** 7 Regions	**(Category 4)** 6 Regions

Source: Auditors Analysis

Category 1: Regions whose maternal death is less than 50 and its allocation is also less than half of the percentage required (i.e 15%). Seven regions have allocated low budget to maternal health and deaths occurred is also low. These regions are Coast, Arusha, Lindi, Kilimanjaro, Manyara, Tanga and Singida. Regions under category one are Coast, Arusha, Lindi, Kilimanjaro, Manyara, Tanga and Singida

[37] Refer Appendix 3 for further information on the average percentage of the RCH allocated budget in different regions of Tanzania.

Category 2: Refers to regions allocating more than 50 percent of the required amount while death mortality is relatively low. One region[38] has allocated high budget to maternal health while maternal deaths occurring were relatively low

Category 3: Refers to regions with high maternal mortality while allocation is very low. Seven regions were allocating low budget to maternal health while relatively high maternal deaths were recorded in those regions. However, the Abuja declaration requires the Ministry of Health and Social Welfare to allocate 15% of the health budget to reproductive and child health. This indicates that funds are not allocated properly with the intention of reducing maternal death. Regions under this category are Kagera, Mara, Dodoma, Dar-es-salaam, Shinyanga, Tabora and Mwanza.

Category 4: Refers to regions with budget allocation of above the half of the required amount while the maternal death is relatively very high. Six regions were allocating high budget to maternal health while deaths recorded also were relatively high. This indicates that funds allocated not properly focused on the key issues causing maternal death. Regions under this category are Mtwara, Rukwa, Iringa, Kigoma, Morogoro, Mbeya.

4.4.2 Lack of effective coordination between the LGAs and the Ministry.

There was lack of effective coordination between the health facilities in LGAs and the Ministry. Community data were not adequately captured in the locality and incorporated in the health system. Evaluation of the Councils' performance – which includes health facilities performance - was done at Regional level and report sent to the central level. No detailed assessment of maternal health care services was conducted at Regional level that was forwarded to the central government level.

The PMO-RALG deals with the implementation of the country's health policies in the health facilities. This task includes monitoring of the use of funds and also administration of human resources at the Regional and Council levels when it comes to the implementation of the maternal health care policies. The Ministry of Health and Social Welfare (MoHSW) is responsible for developing policies and standards for the maternal health care. It is also responsible for the overall technical leadership, guidance and advice on the implementation and monitoring health policies.

[38] Ruvuma Region – refer Appendix Five

Chapter Five

Recommendations

The audit findings and conclusions point out that there are many weaknesses in the area of monitoring and evaluation of maternal health care in Tanzania.

Similarly, weaknesses are surfacing on the maternal health education provided to the population and also failure to have adequate budget model for allocation of maternal health funds to the identified key issues on the maternal health.

Therefore, this chapter contains recommendations to the Ministry of Health and Social Welfare (MoHSW) regarding the weaknesses pointed out in the previous two chapters. The audit office believes that these recommendations need to be considered if the Maternal Health Care services/provision in Tanzania are to be better managed ensuring that the 3E's of Economy, Efficiency and Effectiveness are achieved in the use of public resources.

5.1 Monitoring the level of Maternal Health Care

The Ministry of Health and Social Welfare should ensure that it appropriately monitors the level of maternal health care.

This can be done by ensuring that, there are:

- plans in place for monitoring maternal health;
- Identified key issues related to maternal health based on risk assessment;
- Established targets related to maternal health key issues to be attained at different levels of the Health system in Tanzania;
- adequate information system and data in place that allows the Ministry to identify the possible points of intervention in the maternal health care system in Tanzania
- all maternal deaths are counted and investigated; and
- appropriate plans for data collection, analysis, reporting and use.

5.2 Provision of adequate guidance to health facilities on maternal health education

The Ministry of Health and Social Welfare should provide adequate guidance to health facilities about Maternal Health education that should be provided to the population.

This can be done by ensuring that:

- Ministry comes up with the Health Education plan for educating the population about the maternal health and ensuring compliance with that plan;
- There is an adequate timetable for the provision of maternal health education to the population; and
- Maternal health information issued during the education are appropriate and sufficient enough to help the population.

5.3 Evaluation of the key components on Maternal Health System

The Ministry of Health and Social Welfare should ensure that periodically, it evaluates the components of the health system that relate to Maternal Health Care.

This can be done by ensuring that, the Ministry:

- establishes a timely risk based plan for the evaluation of the health facilities
- Provides the health facilities with the standards for antenatal care and appropriate standards for documentation and retention of health records related to antenatal care
- Evaluations should include clinical procedures on the test basis, the effectiveness of the education programmes, assessment of resource level at health facilities, including location of the facility, adequacy of the equipment and levels of competency of care givers;
- Assesses whether corrective measures have been taken against the underperforming health facilities on maternal health issues; and
- Evaluates the extent of the communication of the results of evaluations to the health facilities.

5.4 Budget model for funds allocation on Maternal Health Care

The Ministry of Health and Social Welfare should ensure that there is an appropriate budget model in place for allocating funds for maternal health.

This can be done by ensuring that:

- The budget model define how the MoHSW determines the amount of funding that is to be allocated to maternal health issues;
- The budget model should also define how the funding for the identified key issues on the maternal health is allocated;
- Develop resource allocation formula to guide allocations at the LGAs level based on the maternal health problems burden; and
- It makes follow up of funds utilisation allocated to maternal health care by LGAs.

5.5 Compliance with the Abuja Declaration and Millennium Developme Goals

The MOHSW should institute more efforts to ensure that the Abuja Declaration and the Millennium Development Goal (MDG) 5 targets on maternal health are attained. This can be done by ensuring that it commits more funds to maternal health care.

References

1. Ministry of Health and Social Welfare (MoHSW) [Tanzania]. 2006. *Annual Health Statistical Abstract.* Dar es salaam, Tanzania.

2. Ministry of Health and Social Welfare (MoHSW) [Tanzania]. 2007. *Comprehensive Council health Planning Guidelines*. Dar es salaam, Tanzania.

3. Ministry of Health and Social Welfare (MoHSW) [Tanzania]. February 2003 *Health Sector Strategic Plan II, June 2003 - June 2008*. Dar es salaam, Tanzania.

4. Ministry of Health and Social Welfare (MoHSW) [Tanzania]. 2009. *Health Sector Strategic Plan III, July 2009 - June 2015* . Dar es salaam, Tanzania.

5. Ministry of Health and Social Welfare (MoHSW) [Tanzania]. 2009. *Health Sector Performance Profile Report 2009 Updated*. Dar es salaam, Tanzania.

6. Ministry of Health and Social Welfare (MoHSW) [Tanzania]. 2006. *Health Sector Performance Profile Report 2010 Updated*. Dar es salaam, Tanzania.

7. COWI. 2006. *Joint External Evaluation of the health sector in Tanzania, 1999-2006*. Dar es salaam, Tanzania.

8. Ministry of Health and Social Welfare (MoHSW) [Tanzania]. 2006. *Maternal and Perinatal Death Reviews Guideline* – Reproductive and Child Health Section. Dar es salaam, Tanzania.

9. Vice Presidents Office (VPO) [Tanzania]. 2005. *Mkukuta - National Strategy for Growth and Reduction of Poverty / (NSGRP)*, April 2005. Dar es salaam, Tanzania.

10. Ministry of Health and Social Welfare (MoHSW) [Tanzania]. 2010. *National Family Planning Costed Implementation Program 2010-2015*- Reproductive and Child Health Section. Dar es salaam, Tanzania.

11. Ministry of Health and Social Welfare (MoHSW) [Tanzania]. 2007. *National Health policy of June 2007*. Dar es salaam, Tanzania.

12. National Package of Essential Health Interventions in Tanzania-MOHSW, January 2000. Dar es salaam, Tanzania.

13. Ministry of Health and Social Welfare (MoHSW) [Tanzania]. 2006. *National Reproductive Health Strategy*. Dar es salaam, Tanzania.

14. Ministry of Health and Social Welfare (MoHSW) [Tanzania]. 2008. *National Roadmap Strategic Plan to Accelerate Reduction of Maternal Newborn and Child Death in Tanzania 2008-2015* - Reproductive and Child Health Section. Dar es salaam, Tanzania.

15. Ministry of Health and Social Welfare (MoHSW) [Tanzania]. 2006. *National Roadmap Strategic Plan to accelerate Reduction of Maternal and Newborn Deaths*. Dar es salaam, Tanzania.

16. Ministry of Health and Social Welfare (MoHSW) [Tanzania]. 2007. *Primary Health Services Development Programme (MMAM) 2007 – 2017*. Dar es salaam, Tanzania.

17. United Nations Population Fund (UNFPA). 2009. *Rapid Assessment of reproductive and Child health financial resources at the central and local levels*. Dar es salaam, Tanzania.

18. Ministry of Health and Social Welfare (MoHSW) [Tanzania]. 2005. *Reproductive and Child health Strategy 2005-2010*. Dar es salaam, Tanzania.

19. Ministry of Health and Social Welfare (MoHSW) [Tanzania]. 2004. *Demographic and Health survey 2004-05*. Dar es salaam, Tanzania.

20. Ministry of Health and Social Welfare (MoHSW) [Tanzania]. 2010. *Demographic and Health survey*. Dar es salaam, Tanzania.

21. National Bureau of Statistics (TBS). 2006. *Tanzania Service Provision Assessment Survey*. Dar es salaam, Tanzania.

22. United Nations (UN). 2010. *The Millennium Development Goals report*. New York, United States of America.

APPENDICES

Appendix One

Audit Questions and Sub Questions

This report provides the result from applying the following four audit questions:

1. **Is the ministry of health and social welfare appropriately monitoring the level of maternal health care, including maternal mortality, in the country?**

Sub Questions
1.1. Has the ministry identified the parts of the health system that relate to Maternal Health issues?
1.2. Does the ministry have a plan for monitoring maternal health?
1.3. Has the ministry identified the key issues related to maternal health?
1.4. Has the ministry established targets related to maternal health key issues?
1.5. Has the ministry identified the data that they need to collect related to the key issues?
1.6. Are the key issues and related data intended to provide information that allows the ministry to identify the possible points of intervention in the system?
1.7. Has the ministry collected the data?
1.7.1. Is the data collected reliable?
1.7.2. Is the data collection timely?
1.8. Have they analyzed the data in a way that relates to the key issues
1.9. Has the ministry taken steps to ensure maternal deaths are accurately reported?
1.10. Have they reported the data publicly?

2. ***Does the ministry of health and social welfare provide adequate guidance to health facilities about the maternal health education information that they should be providing to the population?***

Sub Questions
2.1. Does the ministry have a plan for educating the population about maternal health issues?
2.2. What is the timetable for providing education to the population?
2.3. Is the education information about maternal health issues appropriate?
2.4. Have they been complying, or ensuring compliance with their education plan?

3. *To what extent does the ministry of health and social welfare evaluate the components of the health system that relate to maternal health issues?*

Sub Questions
3.1 Does the ministry have a timely, risk-based plan for the evaluation of health facilities?
3.2 Has the ministry of health and social welfare provided the health facilities with standards for antenatal care?
3.3 Does the ministry keep up to date on best practices for maternal health care?
3.4 Do they suggest changes in the approach to maternal health care on a timely basis and are the changes based on lessons learned?
3.5 Have they provided the health facilities with appropriate standards for documentation and retention of health records related to antenatal care?
3.6 Has the ministry recently completed any evaluations of health facilities, and are they comparative?
3.7 Do the evaluations include evaluating clinical procedures on a test basis?
3.8 Do the evaluations include assessments of resource levels at the health facilities, including location of the facility, adequacy of equipment and levels of competency of care givers?
3.9 Do the evaluations include evaluating the effectiveness of education programs?
3.10 Have the results of the evaluations been provided to the health facilities?
3.11 Does the ministry have the mandate to put corrective measures in place for underperforming health facilities?

4. *Does the ministry have an appropriate budget model to allocate funds for maternal health care?*

Sub Questions
4.1 Does the model define how the ministry determines the amount of funding that is to be allocated to maternal health issues?
4.2 Does the model define how the funding for maternal health issues is allocated to the individual issues?

Appendix Two:

Focused antenatal care (ANC): The four-visit ANC model outlined in WHO clinical guidelines

	First visit 8-12 weeks	Second visit 24-26 weeks	Third visit 32 weeks	Fourth visit 36-38 weeks
	Confirm pregnancy and EDD, classify women for basic ANC (four visits) or more specialized care. Screen, treat and give preventive measures. Develop a birth and emergency plan. Advise and counsel.	Assess maternal and fetal well-being. Exclude PIH and anaemia. Give preventive measures. Review and modify birth and emergency plan. Advise and counsel.	Assess maternal and fetal well-being. Exclude PIH, anaemia, multiple pregnancies. Give preventive measures. Review and modify birth and emergency plan. Advise and counsel.	Assess maternal and fetal well-being. Exclude PIH, anaemia, multiple pregnancy, malpresentation. Give preventive measures. Review and modify birth and emergency plan. Advise and counsel.
History (ask, check records)	Assess significant symptoms. Take psychosocial, medical and obstetric history. Confirm pregnancy and calculate EDD. Classify all women (in some cases after test results)	Assess significant symptoms. Check record for previous complications and treatments during the pregnancy. Re-classification if needed	Assess significant symptoms. Check record for previous complications and treatments during the pregnancy. Re-classification if needed	Assess significant symptoms. Check record for previous complications and treatments during the pregnancy. Re-classification if needed
Examination (look, listen, feel)	Complete general, and obstetrical examination, BP	Anaemia, BP, fetal growth, and movements	Anaemia, BP, fetal growth, multiple pregnancy	Anaemia, BP, fetal growth and movements, multiple pregnancy, malpresentation
Screening and tests	Haemoglobin Syphilis HIV Proteinuria Blood/Rh group* Bacteriuria*	Bacteriuria*	Bacteriuria*	Bacteriuria*
Treatments	Syphilis, ARV if eligible, Treat bacteriuria if indicated*	Antihelminthic**, ARV if eligible Treat bacteriuria if indicated*	ARV if eligible Treat bacteriuria if indicated*	ARV if eligible If breech, ECV or referral for ECV Treat bacteriuria if indicated*
Preventive measures	Tetanus toxoid Iron and folate+	Tetanus toxoid, Iron and folate IPTp, ARV	Iron and folate IPTp, ARV	Iron and folate, ARV
Health education, advice, and counseling	Self-care, alcohol and tobacco use, nutrition, safe sex, rest, sleeping under ITN, birth and emergency plan	Birth and emergency plan, reinforcement of previous advice	Birth and emergency plan, infant feeding, postpartum/postnatal care, pregnancy spacing, reinforcement of previous advice	Birth and emergency plan, infant feeding, postpartum/postnatal care, pregnancy spacing, reinforcement of previous advice

Record all findings on a home-based record and/or an ANC record and plan for follow-up

Acronyms: (EDD=estimated date of delivery; BP=blood pressure; PIH=pregnancy induced hypertension;ARV=antiretroviral drugs for HIV/AIDS; ECV= external cephalic version; IPTp=intermittent preventive treatment for malaria during pregnancy; ITN=insecticide treated bednet)

*Additional intervention for use in referral centres but not recommended as routine for resource-limited settings

** Should not be given in first trimester, but if first visit occurs after 16 weeks, it can be given at first visit

+Should also be prescribed as treatment if anaemia is diagnosed

Appendix Three

Percentage of birth attended in health facilities by region 2009

S/n	Region	Percentage of birth attended in health facilities	Percentage of birth attended at home[39]
1	Tabora	28	72
2	Shinyanga	36	64
3	Manyara	37	63
4	Mbeya	40	60
5	Kigoma	44	56
6	Mara	44	56
7	Rukwa	49	51
8	Mtwara	51	49
9	Arusha	55	45
10	Tanga	58	42
11	Dodoma	59	41
12	Singida	61	39
13	Lindi	61	39
14	Mwanza	65	35
15	Morogoro	66	34
16	Coast	67	33
17	Kagera	68	32
18	Ruvuma	69	31
19	Kilimanjaro	72	28
20	Iringa	76	24
21	Dar-es-salaam	80	20

Source: Health Sector Performance Profile Report 2010 Update

[39] Percentage of birth delivered at home is 100 percent less delivery at health facilities in the respective region

Appendix Four:

STRATEGIC PLAN AND ACTIVITIES: 2008 – 2015 (STRATEGIC OBJECTIVE/OUTPUT 5.2.7)

SN.	Activity	Process indicators	Responsible
1	Orient health service provider on maternal health M&E framework and effective data management	Number of health service providers oriented on data management	MoHSW (HMIS) RHMTs CHMTs
2	Conducting supportive supervision for maternal health in both public and private health facilities	Proportion of health facilities receiving quarterly supportive supervision	MoHSW (Inspectorate unit, RCHS) RHMTs CHMTs CSOs
3	Conduct follow up of health workers after training on Maternal health package	Proportion of health workers that received follow up	
4	Conduct periodic survey on quality of care, client satisfaction and care seeking behaviour in selected districts and factors facilitating or hindering access for maternal care	Number of surveys conducted on quality assurance of service delivered	MoHSW PMORALG Development partners Research Institutions, NBS, Academic Institution, Health Professional Associations, CSOs
5	Conduct Biennial Review meeting to assess progress on the implementation	Number of review meeting conducted	

Appendix Five

SUMMARY OF ALLOCATION TO RCH SERVICES BY REGION, FY 2009/2010

Given the improvement of maternal and child health is one of the current focus of the health sector strategic plan, it has become a custom to report average budget allocation to RCH intervention per region and as summarized from the Comprehensive Council Health Plans (CCHPs):

Budget Allocated For RCH Services by Region, FY 2009/10

Region	Total allocated (TSHS)	RCHS budget (TSHS)	Percentage share (%)	Maternal deaths in 2009
Mbeya	27,190,363,080	3,986,519,247	14.7	110
Kigoma	14,504,704,331	1,568,486,335	10.8	73
Mtwara	13,044,143,501	1,331,206,882	10.2	58
Morogoro	25,105,784,479	2,423,510,270	9.6	103
Iringa	22,273,169,929	1,950,922,283	8.8	71
Ruvuma	13,244,931,998	1,086,225,850	8.2	44
Rukwa	13,287,609,523	1,051,424,202	7.9	63
Coast	17,593,851,883	1,285,281,838	7.3	30
Mwanza	37,741,899,652	2,681,230,016	7.1	176
Dodoma	26,275,224,390	1,842,498,288	7.0	98
Singida	18,446,447,307	1,262,970,643	6.8	49
Shinyanga	33,218,193,635	2,152,609,430	6.5	153
Kagera	23,830,140,103	1,379,962,926	5.8	59
Arusha	19,359,527,693	1,085,297,140	5.6	32
Kilimanjaro	27,799,182,855	1,514,949,625	5.4	42
Lindi	11,441,985,096	606,502,962	5.3	39
Manyara	19,241,223,997	815,910,050	4.2	45
Mara	19,070,890,084	795,133,924	4.2	71
Tanga	26,737,169,877	1,031,671,126	3.9	48
Tabora	19,264,946,924	705,147,794	3.7	164
Dar-es-salaam	32,308,968,172	1,138,459,357	3,5	137
Grand total	**460,980,358,510**	**31,695,920,188**	**6.9**	**1665**

Source: UNFPA Report on Rapid Assessment of Reproductive and Child Health Financial Resources at the Central and Local Levels

Appendix Six

MOHSW's Action Plan for Recurrent Budget for the Year 2010/11 under the DPS-RCHS

Target Code and description	Activity description	Plan finished date	Approved budget (TZS)
F10S: Capacity of RCHS office built for efficient and effective delivery of core functions strengthened by June 2011	F10S01: Support central running costs of the reproductive and child health section for effective management and coordination of RCH services in the country annually	June 2011	229,596,000
F11S: Capacity of reproductive and child health section and RCH zonal offices strengthened to coordinate and monitor RCH services provision by June 2010	F11SO1: Support 8 RCH Zonal offices running cost and supervision for effective coordination and management of the zones	June 2010	85,504,000
	F11SO2: Integrate with Zonal resource centers to develop integrated tools for monitoring Reproductive and child health services provision and guideline for RCH zonal monitoring and annul reports	January 2011	21,498,000
	F11S03 Conduct monitoring of distribution and use of contraceptives and other reproductive and child health commodities	June 2011	22,100,000
	F11SO4: Procure specialized medical supplies for RCH	June 2011	500,000,000
F13S:Strenthern early detection and control of reproductive health cancers	F13S01: Outsource The Development of the Strategy for Prevention, Control and Management of Reproductive health cancers and policy guidelines for screening Breast and Prostate cancers	June 2011	20,000,000
F14S:Strengthen disease management and health service delivery for under five children by 2011	F14S01: Support central running cost of the integrated management of child hood illness (IMC) services annually	June 2011	59,900,000
TOTAL			**938,598,000**

THE UNITED REPUBLIC OF TANZANIA

National Audit Office

Our ethical values

The National Audit Office – Tanzania, being a Supreme Audit Institution, is a member of International Organization of Supreme Audit Institutions (INTOSAI)

We have a code of ethics which guides our daily audit work. In addition, employees are obliged to observe the Tanzania Public Service code of ethics and conduct and their respective professional codes of ethics.

Controller & Auditor General
National Audit Office
Samora Avenue/Ohio Street
P.O. Box 9080
Dar es Salaam
Tanzania
Telephone: +255 22 2115157/8
Fax: +255 22 2117527
Email: ocag@nao.go.tz
website:http//www.nao.go.tz