CHILD HEALTH LEADERSHIP AND NETWORKS IN TANZANIA FROM 2000 TO THE PRESENT: COUNTRY PERSPECTIVES

CASE STUDY REPORT

MARCH 2020

ACKNOWLEDGEMENTS

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CONTENTS

ACRONYMS

CHW	Community Health Worker
DAH	Development Assistance for Health
DPG-Health	Development Partners Group - Health
GF	The Global Fund
GFF	Global Financing Facility
HBB	Helping Babies Breathe
HLSCN	High Level Steering Committee for Nutrition
IDI	In-depth Interview
IMCI	Integrated Management of Childhood Illnesses
INGO	International Non-Government Organization
ITN	Insecticide-Treated Nets
KMC	Kangaroo Mother Care
MDG	Millennium Development Goals
MNCH	Maternal, Newborn, and Child Health
MOH	Ministry of Health
MoHCDEC	Ministry of Health, Community Development, Gender, Elderly and Children
MOH_NCH	Ministry of Health, Newborn and Child Health
MOH_RCHS	Ministry of Health, Reproductive and Child Health Services
NGO	Non-Governmental Organization
NMR	Neonatal Mortality Rate
ONA	Organization Network Analysis
PMTCT	Prevention of Mother-to-Child Transmission
PORALG	President's Office - Regional Administration and Local Government
RCHS	Reproductive and Child Health Services
RMNCH	Reproductive Maternal, Newborn, and Child Health
RMNCH TWG	Reproductive Maternal, Newborn, and Child Health Technical Working Group
SDG	Sustainable Development Goals
TWG	Technical Working Group
U5MR	Under-Five Mortality Rate
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

INTRODUCTION

Tanzania has achieved significant improvements on key child health indicators since 2000, including reductions in maternal, newborn and child mortality and early achievement of the Millennium Development Goal (MDG) 4 target in 2012. The annual rate of reduction of Under Five Mortality (U5MR) was 8.5 percent from 2000 to 2012, and the U5MR dropped to 56.7 per 1000 live births in 2016. However, the rate of decline has slowed in recent years. If the Sustainable Development Goal (SDG) target for U5MR is to be met, the country must intensify efforts to move forward more rapidly. To this end, there is a need to identify and understand barriers, facilitators, and contextual factors impacting continued progress on child health outcomes. As a follow-on to the 2015 global mapping of child health, this study sought to understand the effectiveness of leadership and stakeholder networks in improving child health in Tanzania since 2000. The study also aims to identify barriers and enablers of child health progress, and to suggest how they and other drivers of change might help advance child health going forward.

Using a mixed methods approach, we completed a desk review of published data and literature, and conducted 24 in-depth interviews (IDIs) and 25 organizational network analysis (ONA) surveys with child health experts at the national level. The IDI informants provided historical information on drivers and constraints to child health progress, leadership, and stakeholder coordination, while the ONA more explicitly characterized relationships and interactions among organizations since 2015. IDI data were analyzed by evaluation question and aligned with a framework on the effectiveness of global health networks first proposed by Shiffman.[1] ONA data were compiled using specialized analysis and visualization software. All country data and conclusions were reviewed in a joint meeting of researchers and country representatives. Findings are intended to inform investment, policy, and programmatic decisions as well as enhance stakeholder collaboration to improve child health outcomes.

KEY FINDINGS AND CONCLUSIONS

CHILD HEALTH SUCCESSES AND FAILURES

Tanzania's most notable child health success story was the rapid reduction of the U5MR and thus the early achievement of MDG 4. The most successful child intervention program was reported to be immunization, followed by the use of insecticide-treated nets to prevent malaria, integrated management of child illness (IMCI), and the use of oral rehydration solution and zinc. However, preventable child deaths especially those due to pneumonia and diarrhea remain an ongoing challenge. Interventions to reduce neonatal mortality have been introduced but rates have declined slowly and remain above

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[1] Shiffman, Quissell, Schmitz, et al. A framework on the emergence and effectiveness of global health networks. Health Policy and Planning 20\15: 1-14.

targets. IMCI performance started strongly but has been variable at scale, and there has been inadequate progress in nutrition reflected in high stunting prevalence.

FACTORS THAT ENABLED AND CONSTRAINED PROGRESS

Respondents identified strategies and factors that enabled or inhibited progress toward improving child health. These are grouped into three categories: national priority and resources; health systems; and community engagement.

Category	Enabling Factors	Constraining Factors
National Priorities and Resources	• President Kikwete's championing and ensuring accountability for child health • Coordination mechanisms • Inclusive planning and review processes • High density, centralization, and clear leadership of the child health network • Recent decentralization of funding • Expansion of public-private partnerships • Local evidence for situation analyses and cost-effectiveness of interventions • Early adoption of new interventions	• Lack of long-term planning projections (population growth, urbanization, financing commitments) • Frequent turnover of leaders at all levels • Shifts in politically supported signature issues • Amounts and allocation of financing • Hidden costs of "free care"
Health Systems	• Integration of interventions into service packages (IMCI) • Availability of trained health professionals • Robust data systems that take advantage of technology • Strong, supportive supervision • Steady, sequenced health systems strengthening within a program • Centrality of the Ministry of Health, Reproductive and Child Health Services	• Shortages of human resources and adequate training and supervision • Capacity building network limited • Inadequate performance and quality in programs • Shortages of medicines • Hard to establish reliable estimates of some important data • Weak data systems • Declining performance as programs scaled up (IMCI)
Community Engagement	• Campaigns that raise awareness and engagement • Community health workers	• Rapid social change (urbanization) • Lack of timely care-seeking especially for newborns in communities

LEADERSHIP

Respondents identified the government health directorates under the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDEC) and the President's Office - Regional Administration and Local Government (PORALG) as well as the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) as the leading organizations in the child health network in Tanzania. The United States Agency for International Development (USAID) and other bilateral agencies are second tier, and non-governmental organizations (NGOs) and academic institutions were seen as more peripheral. The Ministry of Health, Reproductive and Child Health Services (MOH_RCHS) chairs most working groups and with its newborn health and immunization sub-offices, approves government guidelines and plans, convenes stakeholders, and reviews performance. UNICEF is considered the most influential and the best source of robust evidence for child health. All organizations engaged in child

health have a high level of connectivity, and the lead organizations effectively link almost everyone together. Nutrition leadership resides outside the MoHCDEC at the level of PORALG, which allows multisectoral engagement.

Top national leadership significantly contributed to commitment and action on child health in Tanzania. Former President Kikwete, who led from 2000-2015, was widely recognized as a champion for maternal, newborn, and child health (MNCH). His leadership was effective because he was well versed in MNCH politically and technically, and he focused on outcomes. In addition, his role at the global level for child health elevated the importance of Tanzania's performance and raised further support. Tanzania's new administration has focused more on broader priorities and health infrastructure.

Turnover of leaders at multiple levels in the government health sector is common and results in changing priorities and gaps in decision making. It has required a considerable investment of time spent in reorientation and advocacy, sometimes slowing child health program progress.

POLITICAL COMMITMENT

Political commitment to child health has fluctuated over the past 15 years. Child survival outcomes, most clearly communicated through the MDGs, drove commitment early on. A high level of political commitment under President Kikwete contributed to increased resources, activity, and accountability. However, after 2008 attention turned to neonatal and maternal health, and the health of older children under five years became lower priority . This narrower focus was still important for reducing child mortality overall but may have slowed progress with children 1 to 59 months. In the last few years, investment has been in expanding the scope of services to include facilities and higher-level care for mothers and sick newborns.

While respondents, generally from multilateral agencies, mentioned examples of broader interventions aimed at helping children thrive, most did not perceive Tanzania to have a commonly held, expanded vision for child health under the Sustainable Development Goals (SDGs) or that such a vision drove decisions.

STAKEHOLDERS, GOVERNANCE AND COORDINATION

Respondents articulated positive outcomes from working in coordination with others. There is consonance around policies and guidelines; overlap and duplication are minimized; resources are mobilized and allocated efficiently and equitably; and common goals are readily achieved. Of four key coordinating groups identified, the Reproductive Maternal, Newborn, and Child Health Technical Working Group (RMNCH TWG) has been most central to child health. Among the organizational network agencies, the MOH_RCHS, UNICEF, and WHO have been the most central and have exercised the most management of network activity. While USAID's location in the network is one level out from the core, this is important positioning for ensuring closer participation of other bilaterals and NGO partners.

However, the effectiveness of these and other structures in governing and acting in concert at the national level has varied, depending on the strength and credibility of leadership at the time, whether convening was consistent, whether stakeholders were held accountable for commitments, and whether interactions were transparent and respectful. At different times, government leaders have had stronger

convening power and corresponding levels of partner engagement. Leaders will always change and in addition to educating them as they come on board, members of the broader network need to reinforce the collaboration process among network partners. Donors and technical agencies can play a more active role in network strengthening, especially in times of transition.

In reviewing governance at the national level, it became clear that the full value of that collaboration would not be realized unless more attention and action is given to building child health networks and better coordination at regional and district levels, which are the locus of active management, service delivery, and community engagement. National organizations and the national network have their own important roles but also an obligation to build and help ensure this coordination. This is likely to need considerably more commitment and resources to be successful.

RECOMMENDATIONS

Findings suggest that children are valued and their health is of critical importance to Tanzania's future. Tanzania's citizens, government, and development partners share these norms, and these recommendations are offered in the spirit of achieving demonstrable improvements in children's lives in the future. Three priority, overarching recommendations are summarized below with some detail, followed by additional recommendations from respondents.

PRIORITY RECOMMENDATIONS

An Inspirational Vision and Reframing Child Health Inclusively

Recommendation 1: Based on Tanzania's aspirations for development and commitments made to the principles of the SDGs, clarify the overall national vision for child health, reframe the approach to be more inclusive of all children under five years and operationalize both in the Sharpened Plan III.

During the MDGs era, Tanzania mobilized commitment, resources, and people to reach the motivating common goal of child mortality reduction and more recently has signed on to SDGs. While current plans document technical goals and indicators, they do not rise to the level of a new vision that inspires people to innovate and reach for the more complex set of SDGs related to children. To galvanize greater government and public commitment, and to better align partner participation in the child health network, government and partners should undertake a rapid adaptation of their 10 year child health vision that will also help guide decisions on the new Sharpened Plan III. It may be possible to integrate such an activity into the Sharpened Plan III development process as it involves government leadership and partner stakeholders.

To support communication of this clarified vision (or SDG 3), child health is likely to need to be reframed in-country. There are multiple ways to reframe it, but the new framing will be more effective if it is more inclusive – of newborns and children under five; and of health (e.g. illness) and well-being (e.g. nutrition, early child development). In addition to adapting the vision and reframing how child health is presented, it is equally important to effectively communicate both, including throughout government and to regions, districts, and communities.

Effective Collective Action through Collaboration

Recommendation 2: Starting with the RMNCH TWG as the core child health network:

a) **Choose one or two priorities that the national child health network will work on together. Plan, implement, and monitor a more collaborative process that demonstrates tangible results and strengthens network capacity.**
b) **Help build or strengthen child health networks at regional and district levels so that they are capable of more effective collaboration for child health.**

At the national level, the child health network is well interconnected and *coordinates* most work. This is a good foundation on which to build a stronger, *collaborative* network more capable of enhancing child health. One way to build understanding of collaboration is to try it out. The RMNCH TWG could agree to go beyond coordination for a specific activity that is on their agenda – one or two priority areas of work that matter for the national network and for regional or council health management teams. This might be addressing lack of utilization of community based services by unreached families (equity) or improving the quality of care provided to children in facilities or expanding the use of better quality data and information. In addition to the technical plans for these activities, the national network organizations would have to work to strengthen how they interact, work together, monitor process and make improvements such that they are also enhancing each other's capacity and actions. This effort would demonstrate the concrete benefits of collaboration, empower government leadership and illuminate the advantages of more effective partnership.

While focusing on the national level child health network will be more manageable at the outset, respondents made it clear that there is a pressing need to enhance coordination and collaboration at implementation levels (regions, districts, facilities). Local level management teams need to be expected to coordinate operationally and to build nascent networks into collaborative bodies. (Governance and management structures and policies already exist.) Organizations in the national child health network often support activities at local levels – through staff or other groups so they are in a position to set expectations for how people will work together and to support leadership of the local network. The capacity of existing child health networks at these local levels may not be clear. In this case it can be useful to start with network assessment.

Recommendation 3: Bring the private sector more directly into the vision and plans for child health now, as it is likely to provide a higher proportion of services and influence health-related choices and behaviors as the economy grows and urbanization increases.

Respondents noted that plans and projections for the future of child health need to better account for likely changes in the environment and country context. Two changes that were noted were rapid urbanization and the growth of supply and demand for private sector health care. This study was not designed to explore the status of the private sector; thus recommendations are best left to other activities. However, the study did identify a pressing need to include the private sector in the vision, plans, and child health network strengthening already proposed.

Building and Leveraging Political Commitment

Recommendation 4: Take action to raise national political attention to the health of children and actively collaborate for accountability in pursuit of country health goals.

- Prioritize embedding the most important bundle of child health programs, via the appropriate channels (PORALG, MoHCDEC), into the national statement of priorities (party manifesto).
- Highlight and publicize information from existing accountability mechanisms (such as scorecards and reporting to PORALG) at district and national levels to rebuild a sense of urgency for progress in child health.
- As part of strengthening district child health networks, build capacity and support stronger accountability activities.

Because child health has not been as high on the national political agenda as it was during the previous decade, it is critical to identify and bundle the most important child health priorities, and to engage advocates to embed them in the most effective processes of political prioritization and resource allocation. The health ministry and regional administration/local government leaders drive these processes, but other partners in the child health network need to work more cooperatively to forward the same agenda.

ADDITIONAL RECOMMENDATIONS

The following recommendations are more programmatic in nature and emerged as key themes from the respondents.

Recommendation 5: Ensure that evidence and research is applied to improve health programs and services.

- Measures to coordinate and collate research have been put in place but they lack linkages to those who can apply them in regions and districts. Set up and activate these linkages, such as between PORALG and the MoHCDEC.
- Set up spaces to bring together implementers and researchers to adapt evidence into practice.

Recommendation 6: Double down on improving neonatal health.

- Target more resources explicitly to neonatal interventions, especially postnatal visits in the first week and the introduction of chlorhexidine to first-line services.
- Ensure CHWs and community health programs are providing effective newborn-related interventions for the "last mile."
- Strengthen human resources for neonatal health including revision of midwifery curriculum and adding specialist nurses,
- Expand neonatal centers in facilities.

Recommendation 7: Improve the quality of child health programs and services.

- Make improving quality the key agenda for child health.
- Aim for long-term system change, not just training of personnel.
- Use performance-based contracts to incentivize better quality.

- Strengthen data and information to improve health services. Build on promising systems in key programs such as immunization and projects such as the Better Data Initiative.

Tanzania has made remarkable progress in child health over the past 30 years. However, the task is far from complete. Thanks to the active engagement and deep commitment of a broad range of individual actors and networks, the country has a strong and dedicated foundation to build further meaningful progress over the next decade. Leveraging existing child health networks and other coordinated efforts to identify a limited set of clear actions and deliverables will be the key to continued progress and healthy prospects for Tanzania's children.

INTRODUCTION AND STUDY BACKGROUND

STUDY OBJECTIVE AND RESEARCH QUESTIONS

In 2015, the United States Agency for International Development (USAID) commissioned a mapping of global child health leadership to better understand the evolution of child health since 2000, the current network of global stakeholders and leaders, and the potential implications for USAID's future investments in child health. This landscaping exercise explored how the global child health community might strengthen leadership and reposition child health to improve outcomes.

To reach this vision and Sustainable Development Goals (SDGs) for 2030, it was strongly recommended that countries be at the center of reframing the future child health agenda, and that in-depth country reflections on child health progress, leadership, and the effectiveness of stakeholder networks be more systematically documented.[2]

This report presents findings from Tanzania, one of three sub-Saharan African countries selected for the landscaping exercise to document child health leadership, networks, and political commitment for child health at the national level. Findings are intended to contribute to investment, policy, and programmatic decisions of stakeholders and to enhance collaboration such that children survive and thrive.

RESEARCH QUESTIONS

For the purposes of this study, child health is defined as the health of children from birth to 5 years. Quantitative measures and trends have been drawn from existing published sources. The under-five mortality rate (U5MR), the infant mortality rate, and the neonatal mortality rate (NMR) have been used to describe overall impact-level change in child health over the past decade. While changes in impact are the result of improvements in multiple sectors including health, the economy, and education, this study considers possible health contributors only. Changes in child health activities and results in Tanzania were reviewed for approximately 15 years, starting in 2000.

STUDY GOAL. The study goal was to understand the effectiveness of leadership and stakeholder networks in improving child health over the past 15 years in Tanzania. The study also suggests how USAID and other stakeholders might harness these and other drivers of change to advance child health going forward. More specifically, the study examined the following questions:

• What strategies have been employed to improve child health over time? (Strategies are defined as policies, plans of action, implementation, and their results)
• What have been the key facilitators and barriers to progress in child health since 2000?
• Who were important leaders and organizations in child health in Tanzania and what role did they play to influence progress and results?

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[2] Taylor, Schumacher, and Davis. Mapping Global Leadership in Child Health. MCSP Program, USAID, April 2016.

      a.   Applying organization network analysis theory,[3] what have been the structure, relationship characteristics, and dynamics of country child health organizations and networks since 2015?

      b.   What role did USAID contributions play in progress in child health, especially with the Call to Action for Child Survival,[4] A Promise Renewed,[5] and Ending Preventable Child and Maternal Death[6] initiatives?

- Applying a conceptual framework developed by Shiffman and others,[7] what factors shaped the development of child health networks? What was their influence on priorities, policy, and results in Tanzania?

- What might be done next by USAID and others to enhance progress on child health over the next 5 to 10 years in Tanzania?

RESEARCH METHODOLOGY

Methods utilized in the Tanzania analysis included a desk review and secondary data analysis, in-depth interviews (IDIs) with national-level child health stakeholders, and an organizational network survey and analysis (ONA). In-depth interview questionnaires were modeled on those used in the global study and adapted to the Tanzanian country context. These interviews used open-ended questions and were recorded and transcribed, then coded to a set protocol. To deepen understanding of change over time, a few child health interventions were traced in detail to explore how leadership, networks, and political commitment affected changes in program performance. These interventions included Integrated Management of Child Illness (IMCI), child immunization, newborn health, and child nutrition.

Organizational Network Analysis is a methodology developed to study how individuals, communities, organizations, and other entities connect and interact with one another.[8] The ONA survey used a set of standard forms to determine how organizations are communicating around key themes of interest, the dynamics of their interactions, and which key organizations are involved in strategy development, capacity building, accountability,[9] and implementation networks related to child health.

Twenty-four IDIs were conducted with respondents from a mix of child health-related organizations in Tanzania. These respondents reported expertise in IMCI, immunization, newborn health, nutrition, and HIV/AIDS (Figures 1 and 2). Twenty-five ONA surveys were conducted with representatives from

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[3] For a review of these efforts, see Varda, D., Shoup, J.A., and Miller, S. 2012. A systematic review of collaboration and network research in the Public Affairs literature: Implications for public health practice and research. *American Journal of Public Health*, 102: 564—571.

[4] https://www.unicef.org/childsurvival/index_62639, accessed June 4, 2018.

[5] https://www.apromiserenewed.org, accessed June 4, 2018.

[6] https://www.usaid.gov/ActingOnTheCall, accessed June 4, 2018.

[7] Shiffman, Quissell, Schmitz, Pelletier, et al. A framework on the emergence and effectiveness of global health networks. Oxford University Press: Health Policy and Planning, August 29, 2015.

[8] Valente, T.W., Coronges, KA, Stevens, GD, and Cousineau, MR. 2008. Collaboration and competition in a children's health initiative coalition: A network analysis. Evaluation and Program Planning, 31:392-402.

[9] Accountability was used broadly to include public accountability such as between government and its citizens, technical accountability such as between the MOH and development partners, service accountability such as between providers and clients, and accountability between donors and national governments. In addition, accountability was recognized to have multiple levels such as communities, districts, and the country.

government, multilateral/United Nations (UN), bilateral, academic, and non-governmental organizations (NGOs) (See Figure 3). NGOs were further categorized into international (INGOs) and national NGOs for some of the analysis.[10] Respondents were selected for knowledge and experience of interorganizational working relationships in child health. Respondents for all interviews were identified by local researchers, well known child health leaders from Tanzania, the USAID Mission, and other development partners. Some respondents were suggested by early interviewees.

Figure 1. In-depth Interview Respondents' Topic Area of Expertise

Reported Topic Area Expertise of IDI Respondents
Tanzania Child Health Leadership and Networks Study, 2019
(Respondents may have more than one area of expertise)

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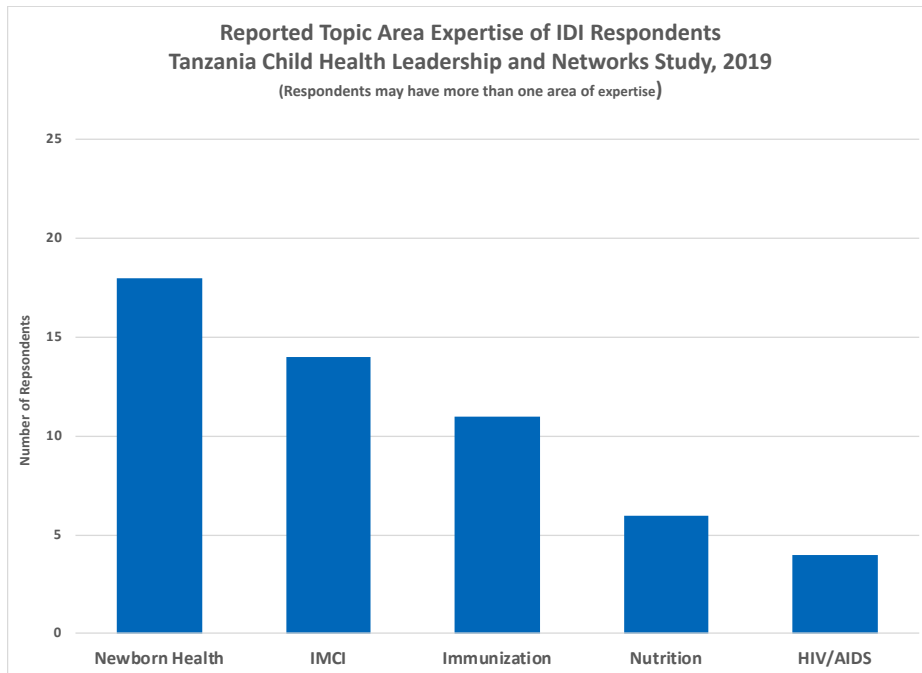
[10] Non-governmental organizations included private voluntary organizations, faith-based organizations, technical assistance organizations contracted by donors or others, and foundations.

Figure 2. In-depth Interview Respondents by Organization Type

Number of Indepth Interview Respondents from Each Type of Organization
Tanzania Child Health Leadership and Networks Study, 2019

Bilateral 2
NGOs 4
Academic 8
Multilateral 4
Government 6
N = 24
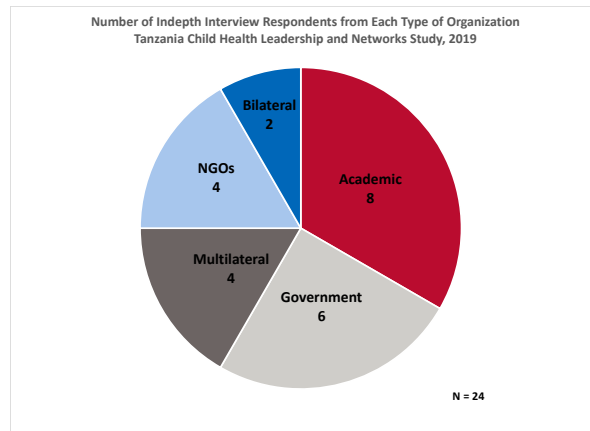
Figure 3. Organizational Network Survey Respondents by Organization Type

Number of Organizational Network Survey Respondents by Type of Organization
Tanzania Child Health Leadership and Networks Study, 2019

Bilateral 3
Academic 4
NGOs 10
Multilateral/UN 4
GOV 4
N = 25

NGOs · GOV · Multilateral/UN · Academic · Bilateral
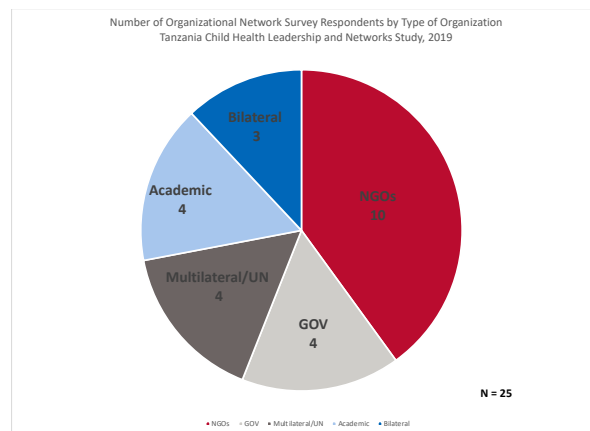
In-depth interviews were coded and excerpted in Dedoose, a web-based qualitative data analysis platform.[11] The in-depth interviews provide historical information on stakeholders, stakeholder engagement, and coordination over the whole time period of interest. Coding was based on the questionnaires and on the Shiffman framework (see Figure 4). This framework organizes 10 factors that can be used to help assess the effectiveness of health networks into three broad categories as illustrated in the circles: network and actor features, the policy environment (in Tanzania), and characteristics of the issue (child health).

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[11]Dedoose Version 8.0.35, web application for managing, analyzing, and presenting qualitative and mixed method research data (2018). Los Angeles, CA: Socio Cultural Research Consultants, LLC. www.dedoose.com.

Figure 4. Summary of Shiffman Framework for Effectiveness of Global Health Networks
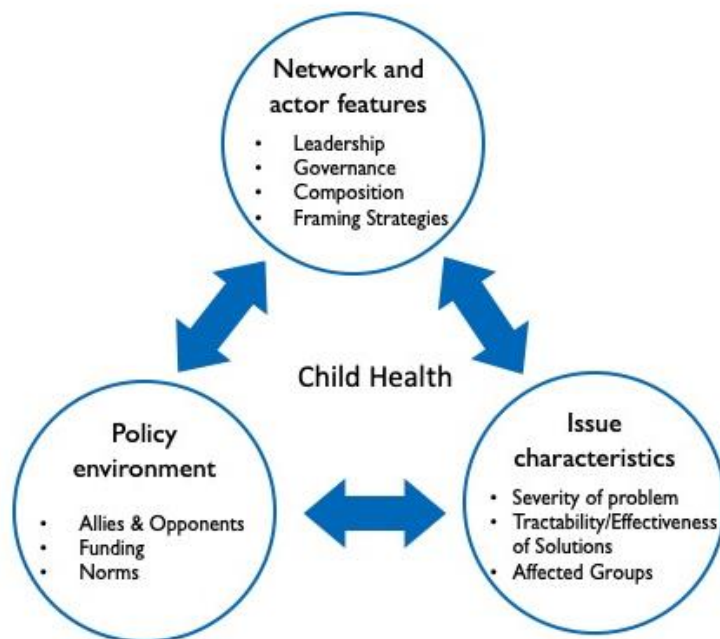
Source: Shiffman, Quissell, Schmitz, Pelletier, et al. A framework on the emergence and effectiveness of global health networks. Oxford University Press: Health Policy and Planning, August 29, 2015;p.5.

This framework was developed from case studies of the emergence of global health networks such as those for maternal health, newborn health, and child pneumonia. These studies found that networks were more likely to be effective if the central issue was perceived to be severe (high mortality or cost), tractable (solutions perceived to be effective and acceptable), and if the affected group was generally viewed with sympathy. Further, effective networks tended to have capable and respected leadership and active governance mechanisms with diverse participation. The organizing issue was framed and positioned to engage political leaders. Finally, networks were more likely to be effective when the policy environment was conducive including having aligned interests among the major groups involved, funding, and supportive norms.

The ONA data were analyzed using UCINet software and visualization of network plots used NetDraw. A confirmation process was used to validate relationships. The ONA more explicitly characterizes connections and interactions over the recent past (see Annex A for the Desk Review, Annex B for Detailed Methodology, and Annex C for Study Instruments).

The study protocol was submitted to institutional review boards in the United States and Tanzania. The study received ethical approval in the United States on April 19, 2019 and from Tanzania on December 11, 2018.

STUDY LIMITATIONS

The results of this study are drawn from a limited number of interviews with individuals and organizations focused on child health in Tanzania. Generally, the respondents reflected the spectrum of child health and active organizations. Triangulation of results from the desk review and IDIs was intended to increase reliability of the results and reduce possible bias. ONA data reflect only those organizations for which there were full responses.

The study focused on child health, but interviews had to be limited in length and this may have excluded deeper consideration of related, but broader, health topics including HIV/AIDS and malaria. While interviews related to child nutrition were conducted, we did not interview across sectors or in great depth. Also, given the resources available, it was not possible to interview at district or community levels. This might have provided more direct information on the effects of national programs, the differences that might arise from inequities, and the strength of local leadership and local networks.

The study focused on enablers and barriers to progress, leadership, political commitment, and networks. There were insufficient resources to explore funding or funding flows for child health in depth over the time period of interest. While the IDIs provided some insight into funding constraints, additional data from secondary sources would have been more definitive.

There was provision in the study to consult with a small group of key informants for feedback on the evolution of tracers and the relative timing of policy, program and coordination changes. However, it was not feasible to gather this group for review in the time needed. Instead, findings were discussed with small groups that participated in a cross-country case study review meeting later.

Despite these limitations, the information provided does assist in understanding the effectiveness of leadership and stakeholder networks in improving child health over the past 15 years in Tanzania.

CHILD HEALTH IN TANZANIA: DESK REVIEW FINDINGS

HEALTH STATUS

MORTALITY

Tanzania has achieved significant improvements in an array of child health indicators since 2000 even as it has simultaneously addressed the challenges of poverty and inequalities. Maternal, newborn, and child mortality were reduced and the Millennium Development Goal (MDG) 4 target was achieved three years early, in 2012.[12] The annual rate of reduction of U5MR was 8.5 percent from 2000 to 2012, and the U5MR dropped to 56.7 per 1000 live births in 2016 (Figure 5). However, the rate of decline has slowed in recent years. Efforts to reduce child mortality must be intensified if the SDG target of 14 deaths per 1000 live births is to be met.

Figure 5. Trends in U5MR and U5 Deaths, Tanzania, 1990 – 2016

Source: UN Inter-agency Group for Child Mortality Estimation, 2017 (http://data.unicef.org)
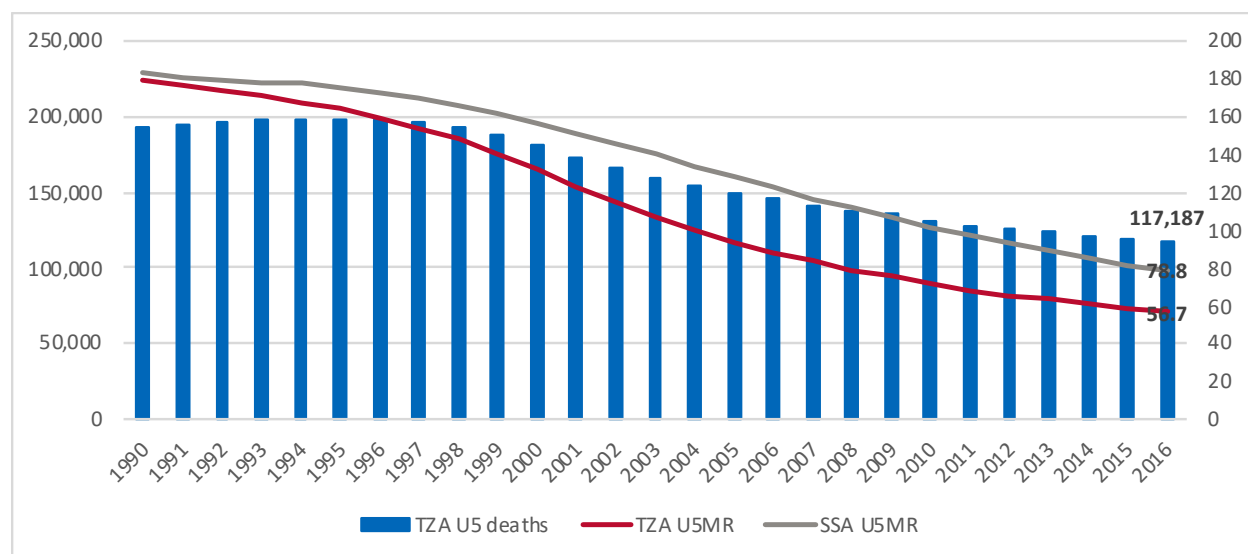
Between 2000 and 2012, NMR decreased at a substantially slower rate than U5MR. The annual rate of reduction was 4.3 percent (half of the U5MR decline) and was down to 21.7 deaths per 1000 live births by 2016 (Figure 6). During this time, the NMR has grown to 38 percent of child mortality and accounted for around 46,000 deaths in 2016. A situation analysis of newborn health attributed the more recent stagnation of mortality decline to lack of equitable access to and utilization of health services, challenges in facility readiness and quality of care, and lack of robust information to help target improvement

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[12] Afnan-Holmes, H., et al., Tanzania's Countdown to 2015: an analysis of two decades of progress and gaps for reproductive, maternal, newborn, and child health, to inform priorities for post-2015. The Lancet Global Health, 2015. 3(7): p. e396-e409.

efforts.[13] The SDG NMR target of 12 deaths per 1000 live births may be attainable but will require intensified efforts for both maternal and newborn care. Progress in preventing stillbirths has also been limited, with around 47,550 stillbirths per year. Of these, an estimated 47 percent are intrapartum, usually indicating inadequate quality care at birth.

Figure 6. Trends in NMR and Neonatal Deaths, Tanzania, 1990 – 2016

Source: UN Inter-agency Group for Child Mortality Estimation, 2017 (http://data.unicef.org)
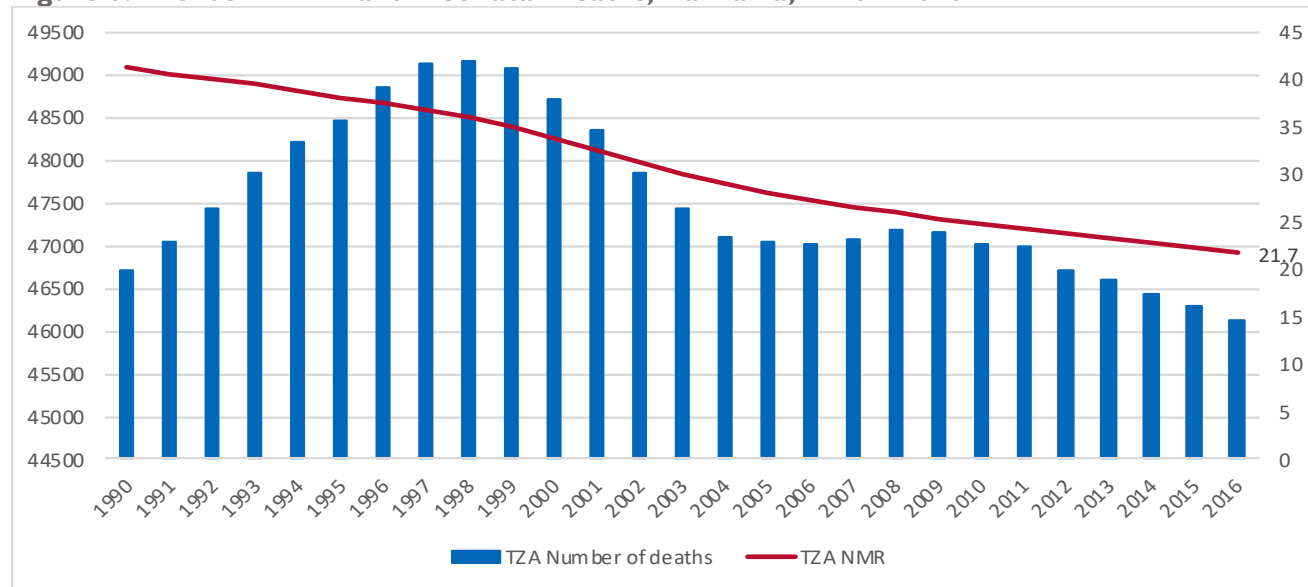
CAUSES OF DEATH

Among children ages 1-59 months (Figure 7), childhood infections accounted for most deaths in 2000 (nearly 73 percent) but sharply declined to 49 percent by 2016. Among infections, pneumonia continues to be the most persistent and accounts for just over 20 percent of childhood deaths in 2016.

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[13] MoHCDEC, UNICEF et al Tanzania Newborn Health Situation Analysis Desk Review, 2000-2019. June 2019.

Figure 7. Cause of Death in Children 1-59 months (%), Tanzania 2000 & 2016
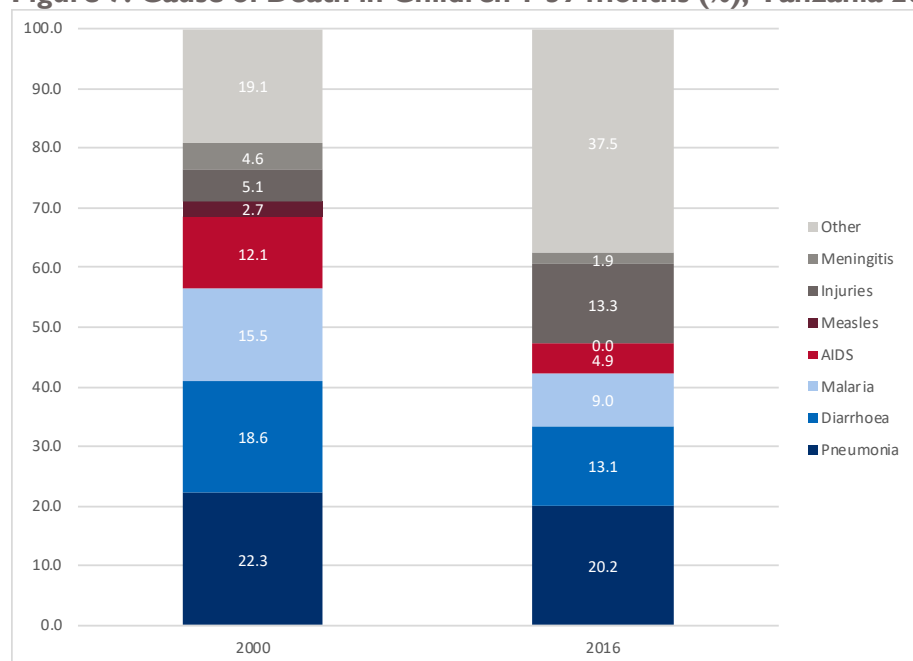
Source: WHO and Maternal and Child Epidemiology Estimation Group (MCEE), 2017. (http://data.unicef.org)

In neonates (Figure 8), causes of mortality included intrapartum-related events (especially birth asphyxia: 31 percent), preterm complications (24 percent), and sepsis (19 percent). These three conditions account for three-quarters of newborn deaths without much change between 2000 and 2016. More than 80 percent of neonatal deaths occur in low birthweight, mainly preterm babies.

Figure 8. Cause of Death in Newborns (%), Tanzania 2000 & 2016

Source: WHO and Maternal and Child Epidemiology Estimation Group (MCEE), 2017 (http://data.unicef.org)

CHILD NUTRITION

Figure 9 presents indicators of malnutrition for children under 5 years of age from 1991 to 2015. While there was an overall downward trend in the proportion of children stunted and underweight, that trend has flattened since 2011. Stunting has remained around 34 percent and underweight at 13 percent. Contributors to stunting include social determinants such as disparities in income and poverty, limited education, and food insecurity as well as health-related factors. These include inadequate diet, the impact of repeated disease, and traditional health and feeding practices. Lack of policy and systems support within the health sector and limited multisectoral collaboration have also hindered progress.[14]
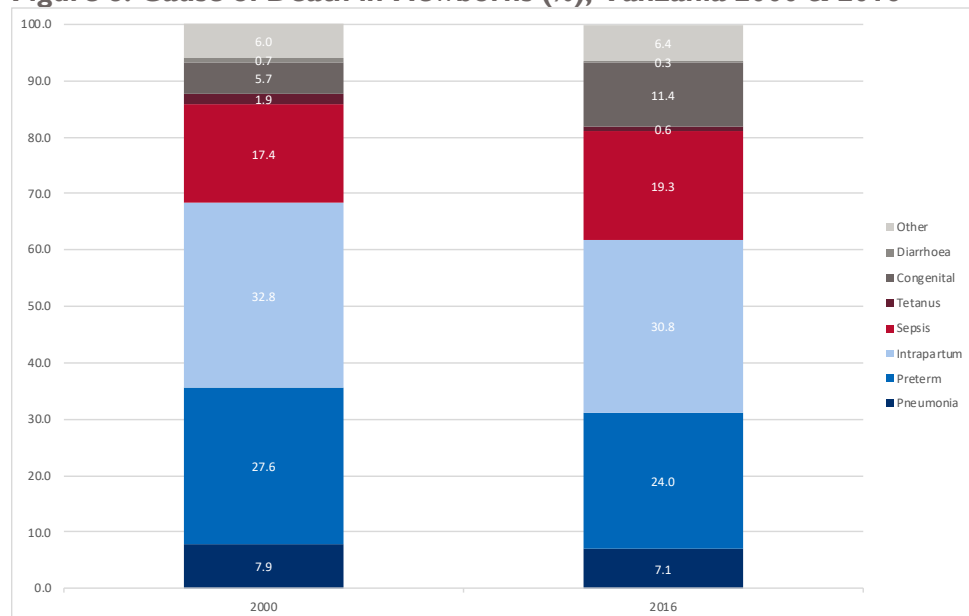
Figure 9. Malnutrition Estimates, Children <5 Years, Tanzania

Source: MICS (http://data.unicef.org)
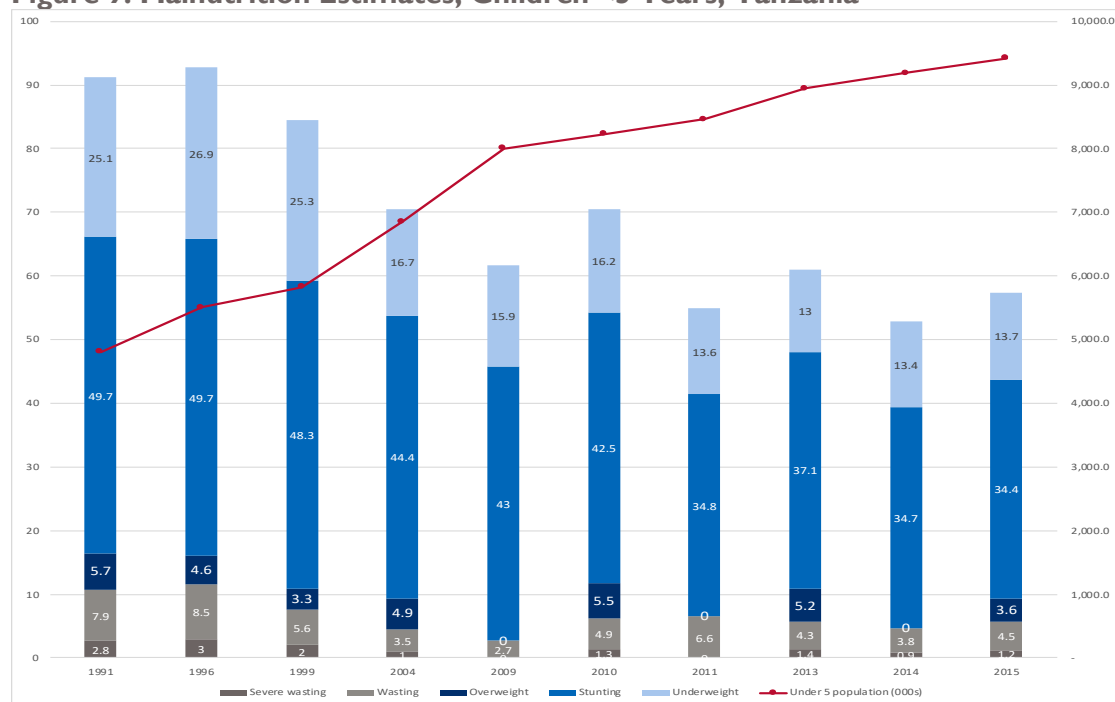
HEALTH POLICY EVOLUTION

The timeline in Figure 10 illustrates the evolution of Tanzania's overarching health policies and maternal, newborn, and child health (MNCH) policies more specifically.

Tanzania began investing in maternal and child health services in 1974. The services included care during pregnancy, delivery, and family planning. In 1975 the Expanded Program of Immunization was initiated, and in 1989 the country adopted the Safe Motherhood Initiative and National Family Planning Services.

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[14] United Republic of Tanzania (2016): National Multisectoral Nutrition Action Plan (NMNAP) for the period July 2016 – June 2021

In 1994, Tanzania committed to provide free MNCH services and in 1996, the country adopted IMCI for care of common childhood illnesses.

Figure 10. Tanzania Health Policy Timeline, 2000-2020

KEY POLICY TIMELINE
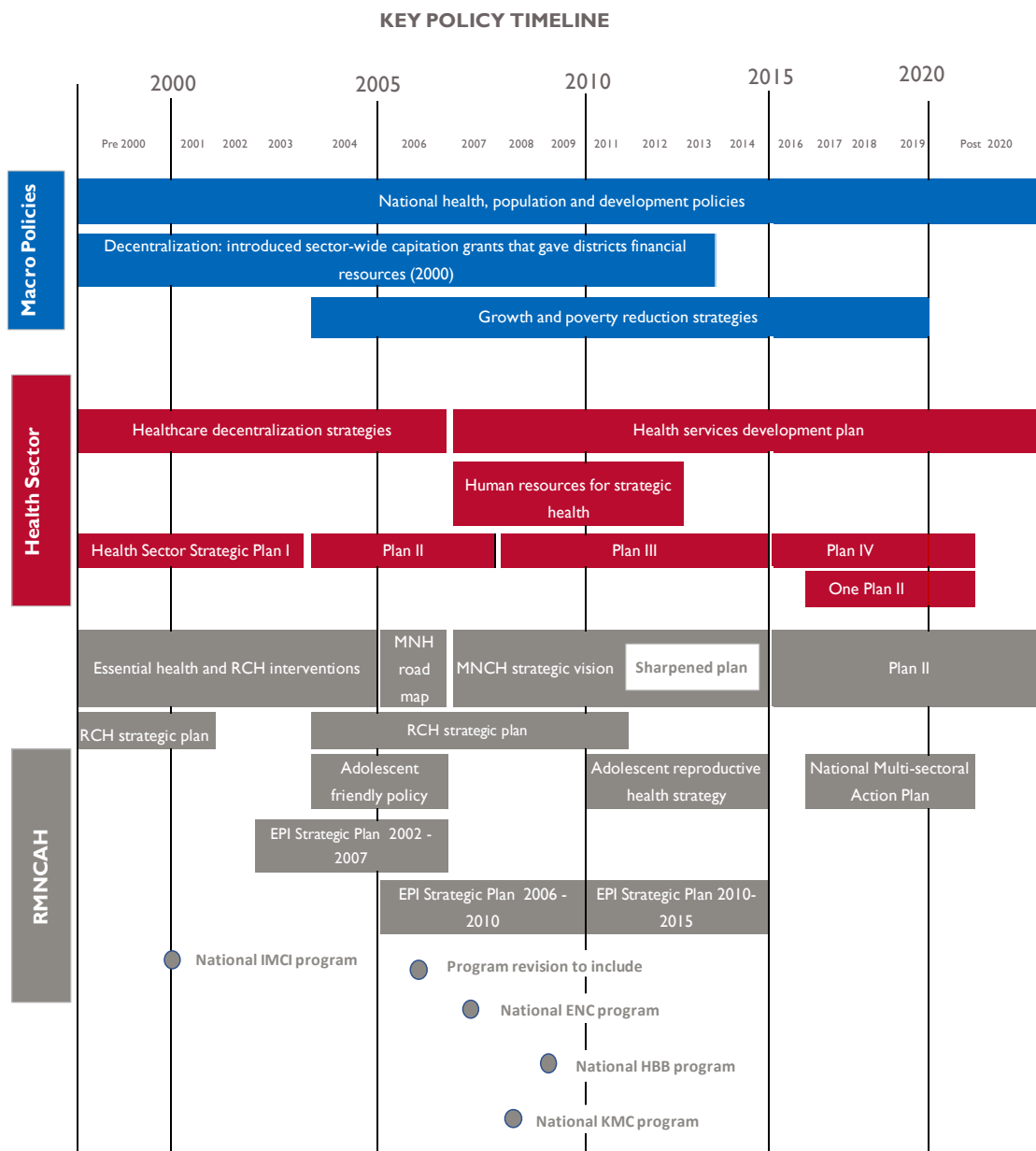
In 2005, in line with the poverty-reduction strategy, the ministry scaled up several child survival interventions including IMCI, immunization, vitamin A supplementation, and insecticide-treated nets (ITNs). The period of the 2000s therefore witnessed progress in child health, more so than maternal and newborn health, particularly those interventions delivered through primary care. This period also saw the adoption of prevention of mother-to-child transmission (PMTCT).

Even though Tanzania has had policies on childhood nutrition since the 1960s, the challenge has been to translate government commitment to evidence-based interventions. In 2016, the National Multi-sectoral Nutrition Action Plan 2016-2021 was launched to improve breastfeeding practices and promote the introduction of complementary foods.

In 2008, the first National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (One Plan) was developed. The plan provides guidance on the implementation of MNCH programs across different levels of service delivery and was meant to help coordinate interventions and quality service delivery across the continuum of care. The plan was reviewed leading up to the MDGs, resulting in the Sharpened One Plan, which focused on two of the country's poorest and rural zones (Lake and Western).

In 2014, Big Results Now (BRN), a multisectoral initiative supported by the World Bank, was introduced. BRN focused on the distribution of human resources for health, health commodities, performance management, and RMNCH. For RMNCH, the objective was to increase demand for emergency obstetric care; upgrade facilities to offer these services; use mobile phone messaging to support use of the services; and increase voluntary blood donations. The inclusion of MNCH in Tanzania's high-profile BRN initiative reflected the recognition that it was essential to Tanzania's economic growth.

The One Plan II was rolled out in 2016. It has five strategic objectives and multiple operational targets covering the areas of MNCH, adolescent health, family planning, PMTCT, immunization and vaccine development, reproductive cancers, reproductive health, gender, and cross-cutting programs.

The One Plan II sets targets for each program area along the RMNCH continuum of care. While these cover the spectrum of child health needs in Tanzania, priority commitment appears to remain with newborn and maternal health interventions, reflecting the priority of the President's Office - Regional Administration and Local Government (PORALG) in the MOH.

FINDINGS: PERCEPTIONS OF CHILD HEALTH SUCCESSES AND FAILURES

These findings summarize IDI respondents' perceptions of child health achievements. At the outcome level these perceptions align with published data and evidence. They add more detailed, expert opinion on specific interventions and changes over time.

The most remarkable success in child health for Tanzania has been the reduction in the U5MR and attaining MDG 4 early. Nearly all respondents noted this with pride and expressed optimism for the future.

> *"I think as I mentioned for Tanzania, we were very proud to reach the MDG 4 targets, especially for child health. This has been a real catalyst to us and gave the country the courage to move forward to post-MDGs."* [Multilateral agency]

Respondents felt that the most effective interventions include immunization, IMCI, the use of long-acting insecticide-treated nets to prevent malaria, oral rehydration solution and zinc for diarrhea, and focused

interventions for newborns. Immunization was reported to be the strongest program reaching the periphery first and sustaining coverage even while introducing new vaccines.

"The immunization program really, really helped reduce mortality. When I was a resident….I used to see children dying with measles. Now, if I see a child with measles, I call all my 40 residents to come because they have never seen it. So, this is a very important tool - the vaccine preventable diseases." [Academic]

Tanzania was an early adopter of the IMCI strategy, and it featured in descriptions of successes as well as failures. As the program was introduced and initially expanded in the early 2000s, it succeeded in reaching children because it offered integrated services, engaged communities, and was well supported with medicines and supervision. As it moved to national scale with the goal of sustaining services, adjustments were made such as the shifting of training from in-service to pre-service systems, and new interventions were sequentially added. This had the effect of reducing the targeted attention that had originally boosted it and currently it still suffers from inequitable access, limited supplies and supportive supervision, and challenges with adherence to guidelines. As a whole, however, IMCI was reported to have been a net positive for child health outcomes in Tanzania.

"So IMCI really helped the grassroots people to understand and identify very sick children - treating them sooner and therefore preventing mortality because sick children used to die within 48 hours of reaching the health facility. Now those deaths have significantly gone down with IMCI." [Academic]

All of these interventions succeeded in this timeframe because they aimed to reach a national scale early, political will was high, national plans sharpened the focus on them, and campaigns were held to educate the public and raise awareness. For some interventions, particularly IMCI, the growth of public-private partnerships was reported to have increased access and coverage. Respondents offered examples such as adapting the IMCI package to accredited drug dispensing outlets and integrating IMCI guidelines into private sector clinics and hospitals.

Some respondents were disappointed with the performance of some interventions. The biggest challenge is that the NMR remains too high, likely due at least in part to the slow pace of growth and equity in the use and quality of facility-based delivery care. While Helping Babies Breathe (HBB) and kangaroo mother care (KMC) interventions have been introduced and newborn care added to IMCI, care may be inadequate and is not widely available for premature babies. Gaps in newborn services occur because of lack of resources, shortages of specialized human resources, lack of medicines, and limited quality of care. Geographic and economic inequities translate to limited access for those at highest risk, and data systems are not yet of high enough quality or reliability to develop the evidence needed to guide steps to address gaps.

"From 2006 we began to strengthen the newborn care component because that was an area where the statistics had shown that it was falling between the cracks. So, we also have been able to have a national program for neonatal resuscitation… and also introduced kangaroo mother care which is mainly covering … hospitals. For that one I think still the coverage is not there - there are still gaps in terms of coverage." [Government]

FINDINGS: EVOLUTION OR MOMENTUM OF CHILD HEALTH

Figure11. Overall Timeline

Mkakuta II (2010)

SM Parliamentarian Group (2010)

NHIF (1999)

MNCH Exemption Policy (1999)

Mkapa to Kikwete transition (2005)

Mkukuta (2005)

Health Basket Fund (2008)

PPP guidelines health sector (2010)

Pay for Performance (2013)

GFF Launched (2015)

Health Data Collab (2017)

GAVI first funds TZ (2000)

PMTCT (2006)

IMCI in all Districts (2008)

Every Woman Every Child (2010)

SARA (2012)

Global Strategy for RMNCAH 2.0 (2015)

National Nutrition Action Plan (2017)

Community Health Fund Act (2001)

Lancet Child Newborn Series (2004)

National Population Policy (2006)

Kikwete re elected (2009)

Kikwete COIA chair (2011)

Tanzania achieves MDG 4 (2012)

Magufuli elected (2015)

TZ ENAP (2014)

Digital Health Roadmap (2017)

2000   **2005**   **2010**   **2015**   **2020**

National IMCI Program (2000)

National ITN Program (2003)

TDHS (2005)

Certified Polio Free (2007)

HBB (2009)

Launch of SUN (2011)

A Promise Renewed (2012)

TZ DHS (2015/16)

Desk review NB situation analysis (2019)

National Package of Essential Health Interventions (2000)

HIV/AIDS Sector Plan III (2003)

Lancet Newborn Series (2005)

NB situation analysis (2009)

TDHS (2010)

National Malaria Strategy (2015)

National Guideline for Neonatal Care & Establishment of Neonatal Care Unit (2018)

National Malaria Medium Term Plan (2003)

Medium term Malaria Plan (2008)

National Policy on HIV/AIDS (2010)

EPCMD (2014)

TFDA est (2003)

HRH Strategic Plan (2008)

ENC introduced (2013)

Lancet Child Survival Series (2003)

KMC (2008)

Pneumo; Rotovirus Immunization (2013)

Nutrition National Action Plan (2008)

Neonates integrated into IMCI (2013)

IMMUNIZATION

Immunization has the longest history of the interventions reviewed. Initiated in 1975, services were expanded to achieve Universal Child Immunization coverage in 1990 and Gavi, the Vaccine Alliance (hereafter referred to as Gavi) support for vaccines and systems strengthening was obtained in 2000 and continues with the introduction of new vaccines to this day. The country was certified polio-free in 2007, is committed to measles elimination by 2020, and coverage for major antigens exceeds 90 percent in most districts. Beginning in 2001 with hepatitis B, new vaccines (pentavalent, PCV, rotavirus, measles-rubella, HPV) have been rapidly introduced over the intervening years. During this time, as part of its agreements with Gavi, the government has phased in domestic financing of some vaccines. More recently there has been a focus on applying information technologies for program management, including logistics for vaccines and cold chain, coverage data, and disease surveillance. By focusing on systems strengthening and outcomes, the immunization program has been able to achieve and maintain high coverage.

IMCI

Integrated management of childhood illness (IMCI) was first discussed in Tanzania in 1995. Through 1996-97, materials were developed, and training was conducted in early use districts. In 1998, a two year roll-out plan was initiated. In the same time period, the concept of community IMCI was developed and tested. An IMCI unit and coordinator were put in place in the Division of Reproductive and Child Health section for oversight. As the constraints of large-scale in-service training became apparent, the training course was moved into pre-service curricula in 2001. IMCI was introduced in accredited drug dispensing outlets to expand access in 2004, and a stronger focus on malaria was added. After this time, the priority has been to scale up IMCI to all regions with attention to performance and quality in the application of guidelines. Over time, individual interventions for newborns, HIV/AIDS, and nutrition have been added and others have been updated. Digital technology for distance training, health worker decision support, and information systems has been tested and incorporated into the program. Today, IMCI is the standard of care for children across public and private sectors.

CHILD NUTRITION

In the 1970s, Tanzania experienced high levels of malnutrition and child mortality. Separate nutrition units in health, agriculture, and education ministries led programs to address these problems. During this time, the semi-autonomous Tanzania Food and Nutrition Centre was created and exists to this day to bridge the work of health workers and researchers across sectors. The first national food and nutrition policy was developed in 1980 and adopted in 1991. During this time, the government and partners implemented smaller-scale nutrition programs, the most well-known of which was in Iringa. In 1988, salt iodization was introduced and in 1997 child vitamin A supplementation was implemented. In the early 2000s, Tanzania updated its National Food and Nutrition Policy and developed a national action plan for 2008-2015 including the dissemination of guidelines to local governments and health teams. The country was an early participant in the Scaling Up Nutrition movement (2011) and by 2014 had undertaken a series of country nutrition reviews. These led to the elevation of nutrition above the ministry level to PORALG. PORALG now has a nutrition section that coordinates a multisectoral high-level steering committee for nutrition (HLSCN) and supports similar regional and district-level committees. A new national multisectoral nutrition action plan was put in place in 2016 along with strengthened monitoring, additional staff at local levels, and dedicated budget line items. In the last several years, nutrition has

been increasingly prioritized as evidenced by consolidated strategy, dedicated investment, higher level leadership with reach across sectors and into the field, and more robust monitoring.

NEWBORN HEALTH

Policies and programs that address newborn health appeared later than the other tracer areas reviewed. Around 2004, the challenge of newborn mortality began to be highlighted, culminating in a situation analysis in 2009 that brought it high-level attention. Strong local leadership and global support helped the rapid introduction of targeted intervention programs including the updating of IMCI to include care for the first week of life (2006), Essential Newborn Care in 2007, KMC in 2008, and HBB in 2009. These programs were phased into districts with financial support, but by 2015 had not achieved the coverage needed to accelerate mortality reduction. More recently, the government has invested in expanding higher-level facility-based care for premature and sick newborns. A new situation analysis was conducted in 2019, leading to a series of recommendations to improve newborn health that include improving facility readiness, raising community demand, strengthening relevant data systems, addressing inequities especially in chronically low performing regions, and developing approaches to disadvantaged urban environments.[15]

FINDINGS: STRATEGIES AND FACTORS THAT AFFECTED MOMENTUM OF CHILD HEALTH

IDI respondents identified strategies and factors that facilitated or inhibited positive momentum of child health. The strategies or factors may have operated from the global or country level, with most embedded in the country. They can be grouped into three categories: national priorities and resources; health systems; and community engagement.

ENABLING STRATEGIES AND FACTORS AT COUNTRY LEVEL

Table 1. Summary of Child Health Progress Enablers

Category	Enabling Factors
National Priorities and Resources	• President Kikwete's championing and ensuring accountability for child health • Coordination mechanisms • Inclusive planning and review processes • High density, centralization, and clear leadership of the child health network • Recent decentralization of funding • Expansion of public-private partnerships • Local evidence for situation analyses and cost-effectiveness of interventions • Early adoption of cutting-edge interventions

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[15] MoHCDEC, UNICEF et al Tanzania Newborn Health Situation Analysis Desk Review, 2000-2019. June 2019.

Category	Enabling Factors
Health Systems	• Integration of interventions into service packages (IMCI) • Ensuring availability of trained human resources • Robust data systems that take advantage of technology • Strong, supportive supervision • Steady, sequenced health systems strengthening within a program • Central role of the MOH_RCHS
Community Engagement	• Campaigns that raise awareness and engagement • Various community participation approaches • Community health workers

NATIONAL PRIORITY AND RESOURCE ENABLERS

During the decade leading to 2015 and the MDG targets, President Kikwete's interest in and attention to child health significantly enhanced action and momentum. He was charismatic, well-versed in the technical aspects of child health, and rigorously applied a system of accountability with local and national government that included a score card. He showcased Tanzania's progress at the global level, where he sat on UN committees overseeing accountability for country achievements.

"So, this is an integrated RCH score card which was based on the ALMA score card for malaria. And what we again loved and we are very happy for was Kikwete handed this score card to regional commissioners and said, 'you know look at this, it shows you know how your region is falling on various child and maternal health indicators, and when I come to your regions this will be the top most on my agenda. This the first thing I will ask you. I want to see your progress and see what is happening.' And he said that he wanted a report. It was supposed to be a quarterly report, he wanted it to be sent to his desk directly and not to his assistant... So, he will be able to see at a glance immediately and hold them accountable." [Multilateral Agency]

The structure and process of coordination at the national level also facilitated progress. Led by the government at either PORALG or health directorate levels (MOH_RCHS), coordination was reported to enhance the allocation of resources. The government and stakeholders worked together on various planning processes in annual and five-year cycles. After the 2014 performance review, including the Countdown case study,[16] the process used for the Sharpened Plan and Plan II enabled better technical approaches and greater alignment with global strategies.

"In 2014, we did a meeting review of the implementation of the integrated MCH strategy… At the same time in Tanzania, we developed the second integrated strategy which is 2016 to 2020 but in line with the Global Strategy for Women, Children and their Adolescents Health." [Multilateral Agency]

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[16]Afnan-Holmes, H., et al., *Tanzania's Countdown to 2015: An analysis of two decades of progress and gaps for reproductive, maternal, newborn, and child health, to inform priorities for post-2015.* The Lancet Global Health, 2015. 3(7): p. e396-e409.

"The One Plan, which is now the One Plan II... those things weren't in place before. After having them in place really helped to mobilize focus. Also, there are definitely efforts on measuring changes over time which is an important component." [NGO]

These findings are further illuminated by ONA results on how organizations work together on strategies, policies, plans and legislation (the "strategy" network). The strategy network, illustrated in Figure 12, is dense and centralized. This means that only a few organizations are leading, the most important of which are the MOH_RCHS and WHO (21 connections each). The set of organizations with the most direct relationships with others are UNICEF, MOH_NCH (newborn and child health), PORALG, and MOH_IMMUN. (The next layer includes USAID and the World Bank.) Generally, direct relationships are more effective as they indicate more activity and less reliance on intermediaries to access information or resources.

The government and multilateral/UN agencies occupy the center of the strategy network, with the MOH_RCHS and WHO set apart with the highest measure of "betweenness centrality." This centrality means they are organizations with power and can mediate the flow of information or resources for other organizations in the network. USAID has the highest number of connections out of the bilateral group and is close to MOH_RCHS and MOH_IMMUN. Most of the NGOs and academic institutions form the peripheral outer layer of the network with the least connectivity. Three organizations are very loosely connected (KNCV Tuberculosis Foundation, University of Dar es Salaam (UDAR), Christian Social Services Commission) with few connections, indicating low engagement.

The positions of organizations in this network may reflect their own organizational priorities, as strategy development may be more efficiently managed by a few key organizations. In reporting on their organizational activities and priorities, even though most organizations (84 percent) listed strategy development and design as an area of work, only 32 percent identified it as one of their top three activities. (See Annex D for complete results).

Figure 12. Confirmed strategy relationships with nodes sized by betweenness centrality
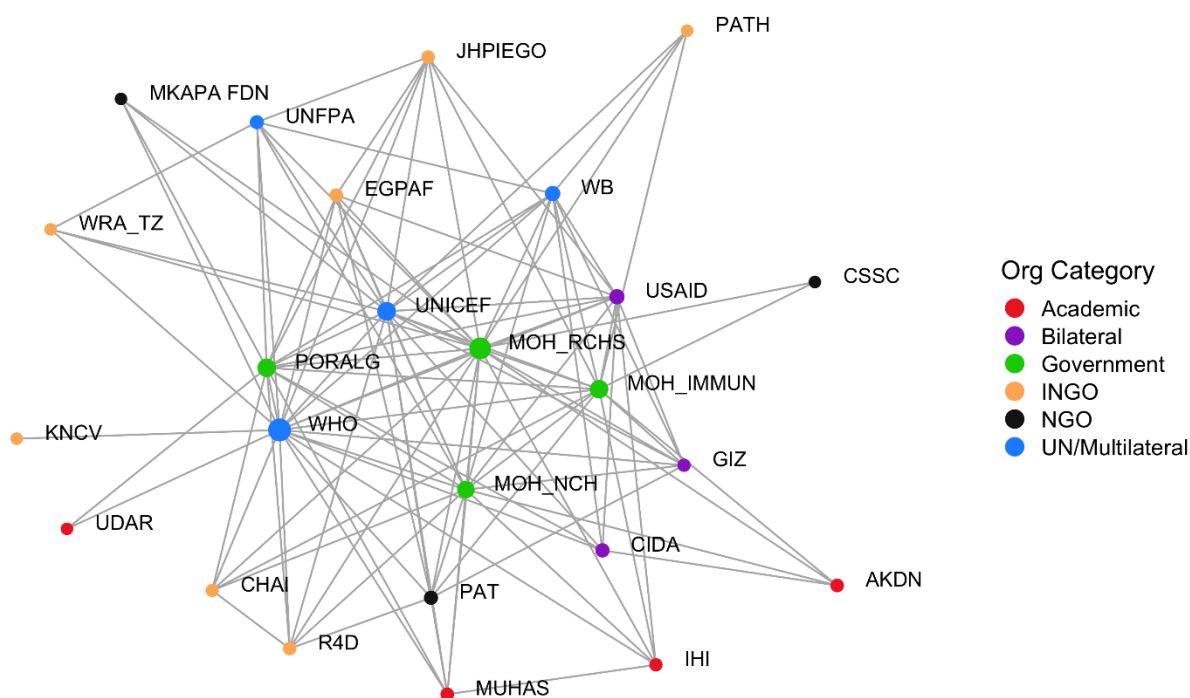
The implementation of strategy requires a well-performing structure with adequate resources for delivering services. During this time period, the government in Tanzania shifted health care financing approaches that decentralized some funds to local administrative levels and to facilities, along with decision making on how to spend them. This was reported to improve local problem resolution for some constraints such as medicine stockouts.

The decade prior to the MDGs was also a time of expansion of public-private partnerships. The private sector is wide ranging and includes faith-based organization (FBO) providers, NGO providers, for-profit private clinics and hospitals, pharmacies, and laboratories. It was the impression of respondents that as the private sector expanded, accessibility to child health interventions, especially curative services, increased. In particular, FBO facilities, private clinics, and accredited drug dispensing outlets offered IMCI, diagnostic testing, and PMTCT. This is important because people are increasingly seeking care in the private sector because they believe services to be of higher quality, medicines are available, and there is better customer service.

"Number two [success] was allowing of private public partnerships, so you find there are many dispensaries and clinics owned privately that provide services. This is a good type of change with downside effects. We shall talk to you about the good side which is that now you can access private health facilities and it is competitive." [Academic]

Approaches within immunization, IMCI, and newborn health programs illustrate how strategic prioritizing and resource provision can support progress in child health. Documentation of the cost effectiveness of immunization and the absence of disease were identified as the major contribution to the achievement of MDG 4. The country leadership of the immunization program was reported to be excellent and effective. The building of personal networks and trust enhanced Tanzania's ability to

attract Gavi support and to proceed rapidly through multiple introductions of new vaccines while maintaining high levels of coverage of existing vaccines. Long-term country commitment has been demonstrated by increasing country financing of vaccines and delivery systems.

For IMCI, Tanzania was an early adopter. This garnered global attention and reinforced a sense of local pride and leadership as it was initially scaled, although this interest has not continued to grow. Newborn health interventions emerged later after global awareness was raised through the WHO World Health Report and the first newborn Lancet series in 2004. This was followed by the development of local evidence including estimates of higher mortality rates than expected and the first newborn situational analysis. With the support of committed local leaders, a newborn desk was created in the MOH and a budget line was assigned. Ultimately, experts facilitated the design and promulgation of targeted interventions and services adapted to Tanzania's service packages. The successful rollout of some of these (HBB and KMC) added further momentum.

> *"We were able to come up with the newborn situation analysis that was activated by the 2005 DHS. There was no consensus, and then through this we were able to raise funds and work on the aspect of asphyxia and low birth weight, which are among the major killers of newborns. So, having that situational analysis and then getting a focal person in the Ministry and then having the road map … also helped to raise the profile for newborn health."* [Government]

HEALTH SYSTEMS ENABLERS

The integration of interventions into service packages was reported to increase efficiency and convenience for clients and providers, and ultimately, utilization.

> *"Number one is the use of IMCI guidelines. It is the basic ground level management of childhood illnesses. IMCI, the integrated management of childhood illnesses, which has incorporated now the newborn and maternal as well. And now it has incorporated TB and HIV… which I think is a fantastic thing to do. It actually contributed to lot of knowledge base at the basic primary health care level."* [Academic]

Certain resources were essential for implementing interventions successfully. Ensuring that trained human resources and medicines were available when and where needed pushed performance and built trust in service delivery. The most important of these resources for IMCI and immunization were adequately trained providers and the availability of medicines and potent vaccines at local levels.

For some programs, the availability of data, efforts to improve the quality of that data, and the continuous use of information to refine programs were essential. More recently, some of these systems have added technology that has streamlined and expanded the availability of information. The strongest systems were reported to be in immunization and at various points in time for IMCI and malaria.

> *"Another system that was important was data collection, because at that time we were not monitoring data. It wasn't used for action…We started in 2008 using the DVDMT [District Vaccine Data Management Tool] and then as time was going on, a new invention came in. For vaccine information now, we are using new technology, the BID initiative [better immunization data initiative]. Now they've got every facility so it has a tablet so data can be put in quickly. What is important is getting the data and taking action."* [Multilateral Agency]

Systematic, supportive supervision was identified as critical for all programs, but it had to be implemented well to support performance. At the outset, the IMCI program emphasized supervision similar to that of the immunization program. Both programs had the staffing, guidelines, and resources for mobility needed to carry out supportive supervision routinely. Leadership ensured it was a priority. Emphasis on strong supervision resulted in more reliable delivery of services and improved quality. However, quality remains a challenge for many other services offered today.

> *"IMCI started in 1996. There was one statement – if you can't supervise it, don't do it. They developed strong supervision. Go right to where you are doing it – it takes time to work on these mechanisms. To have supportive supervision and actually look at the skills."* [NGO]

The immunization program illustrates the importance of health systems strengthening phased in sequentially over time. This has resulted in more robust systems that have been sustained.

> *"Number one was we looked at the cold chain…. At the national, regional, and district levels, there needed to be good cold chain for vaccines storage for three months; this way it assured kids were getting potent vaccines. The second system was to ensure distribution of vaccines – the availability of vehicles was important, so we needed to reach the lower level on time. Every district had a vehicle to distribute vaccine. Then, we built capacity of health workers. There were different trainings done in facilities. In higher-risk districts, we got MCHIP [USAID's Maternal and Child Health Integrated Program] support so that officers were deployed in those regions…. There was supervision, mentoring, and normal training on the ground."* [Multilateral Agency]

Stronger health system components provided a foundation for Tanzania's successful scale up of child health interventions. Systems strengthening activities were successful in part because of the characteristics of the network of organizations implementing them (see Figure 13). This network is fairly dense with the highest level of centralization of all the networks studied. The network is organized around the MOH_RCHS (most central point) followed closely by UNICEF and then the MOH_NCH, PORALG, and WHO. USAID leads off the next tier of organizations. The MOH_RCHS has by far the highest betweenness centrality in any of the networks, reflecting their important leadership role in coordinating nationwide program implementation efforts and orchestrating linkages between organizations that do not have direct connectivity with each other.

Figure 13. Confirmed implementation relationships with nodes sized by betweenness centrality
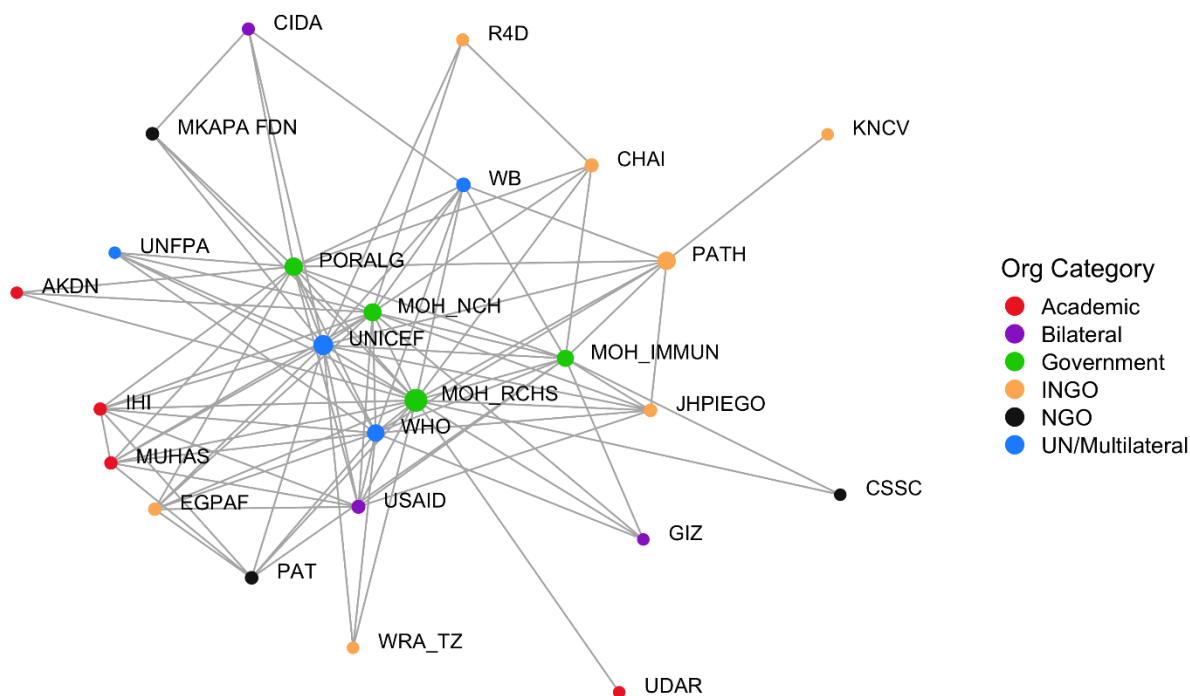
COMMUNITY ENGAGEMENT ENABLERS

Greater community participation in health and the delivery of health services has also contributed to progress in improving child health. As new services were introduced or revised, public education campaigns informed and mobilized people to seek care. These campaigns have successfully raised general awareness, as well as awareness of immunization, HIV/AIDS, ITNs, and IMCI. They have been less successful for maternal, newborn, and nutrition interventions related to stunting.

> *"Public health campaigns are useful. So, pneumonia, malaria, diarrhea - these are the major killers and a lot of campaigns have been done to raise public awareness on them."* [Academic]

Other small scale mechanisms for community engagement in health aimed for active ownership such as the use of Village Health Days for IMCI in a few districts. Some respondents felt these were crucial to progress, but others perceived them to be costly and not sufficiently effective. As the IMCI program was scaled, the priorities shifted to ensuring the availability of field workers, training, and supplies. Intensive community participation beyond local government processes did not become part of the package, and if it was done, activities were small scale and related to the presence of NGOs.

> *"One thing which we contributed a lot to was that the village government people owned the process … and when they owned these processes of monitoring the child health condition, really they would say, 'I have 100 children under five… And I have seven severely malnourished, and we will do something….'"* [NGO]

More recently, Tanzania has begun to deploy and activate community health workers (CHWs) and community mobilization to extend service and change household practices to reach the SDGs. The system in Zanzibar enjoys high-level political commitment and has begun to see results, but the system requires close supervision and incentives to be sustainable. For mainland Tanzania, it will take more time to complete roll out and measure effectiveness.

"So now we are seeing that we are describing their roles and articulating that there are supervisors and how they are attached to the system, and how they are going to be incentivized. You know those things have been coming stronger and we have never had that previously." [Government]

STRATEGIES AND FACTORS AT THE COUNTRY LEVEL THAT CONSTRAINED PROGRESS

In contrast to factors that enabled progress, another set of strategies and factors ultimately functioned as barriers, bottlenecks, or constraints to momentum for child health. These are described below using the same categories.

"In our health system we find there are gaps, gaps in terms of accessibility, second in terms of human resource, third in terms of the equipment and medicine availability, and all this is the financial component." [Government]

Table 2. Summary of Factors that Constrained Progress

Category	Factors that Constrained Progress
National Priorities and Resources	• Lack of long-term projections to help anticipate need (population growth, financing commitments, urbanization) • Frequent turnover of leaders at all levels • Shifts in politically supported signature issues • Amounts, allocation, and volatility of financing • Hidden costs of "free care"
Health Systems	• Shortages of human resources • Lack of adequate training, mentoring and supervision of human resources • Capacity building network of organizations limited • Inadequate performance and quality in programs • Shortages of medicines • Hard to establish reliable estimates of some important data • Weak data systems • Declining performance as programs scaled up (e.g., IMCI)
Community Engagement	• Rapid social change (urbanization) limits bridging with health system • Lack of timely care-seeking, especially for newborns in communities

NATIONAL PRIORITY AND RESOURCE CONSTRAINTS

As the government works toward achieving the SDGs and long-term goals, it has not been adequately anticipating changes that will affect the fit and execution of health programs in the future; ensuring the most effective health programs down the road may require making systems changes now. For example, population growth remains high in Tanzania, and projected human resource needs may be too low. Population is growing rapidly in urban areas without managed development of health services. Significant,

impending financing requirements, such as for vaccines when Tanzania graduates from Gavi support, have not been built into long-term budget plans.

As new government administrations come into power, major turnover of leaders usually occurs. For effective transitions, stakeholders with experience and institutional memory spend considerable time advocating and orienting new people to issues, strategies, and plans. However, this is done individually and not as a coordinated effort of the network of child health organizations. Often new administrations seek signature issues that differ from their predecessors, and this has sometimes shifted commitment and resources before legacy programs are stable and institutionalized. All of child health was highly prioritized during the Kikwete administration, contributing to Tanzania's success in achieving MDG 4. Current leaders have emphasized the more general buildout of infrastructure, ensuring the accountability of human resources for health and increasing access to medicines.

"Based on the changing of leadership at all levels, from the national level to district level, you have to keep on re-orienting the teams on child survival and importance. When it comes to the planning, it has been changing in the priority setting so people think that since we have meet the MDG targets, we don't have to continue planning for these interventions which is not a good sign." [Multilateral Agency]

"We have the strategies, we have the guidelines, we have policies and interventions in our strategic plans…and stakeholders are decided [that] this intervention works…[W]e all know for intervention to work the coverage should not be less than 80 percent and the challenge remains that the coverage of most of our interventions is not beyond the 50 percent." [Government]

Several health care financing issues were identified as constraints. These include the amount of national funding available for specific activities such as supervision of community-based programs or for the effective scaling up of programs or interventions, and the allocation of funding with respect to geographic and economic equity. Programs such as IMCI, HIV/AIDS, and the expansion of CHWs all require support for supervision and quality of care at national scale. Allocation of resources to rural versus urban and weak versus strong performing zones may not sufficiently address the costs of ensuring reliable access to health workers and quality care.

By policy, the government provides most MNCH interventions free through public facilities. However, even with this support clients often face costs that exceed their means. Addressing this issue will be critical to achieving the government's Universal Health Coverage aims.

"We have a policy that says all under-fives and pregnant women, those HIV-infected and those with cancer should have free treatment. But it doesn't translate in reality. In two ways, one is the indirect costs. We have to pay as parents of a child under 5. I have to pay for a malaria test, I have to pay for the complete blood count. I have to pay to open the file and because I have an under 5. I am told you have to pay half. But I still have to pay and the indirect costs for accessibility to the health facility that is so far that I also have to pay the cost of going there. So, treatment of under-5s is not free." [Academic]

SYSTEMS CONSTRAINTS

By far, the most significant systems constraint reported by respondents was human resource shortages. This includes shortages in overall availability, the uneven distribution of staff by facility or geography, and shortages of some categories of health providers. Even when staff are available, they may not be sufficiently confident, motivated, or capable of providing services. Maternal and newborn health

interventions are particularly affected. For example, dispensaries that are closest to people may be understaffed, and the providers that are there may not have the confidence or skills to care for small newborns or delivery. This is especially true in more remote areas where the need is greater and staff have limited mentoring. Even neonatal units in facilities need more specialized nurses and doctors.

"In the rural areas, we are having acute shortage of human workforce. You can't really run the program; you can't really run the services, and this is one of the challenges we are facing. A universal challenge, I may say because ... people are coming from rural to urban settings, so the quality of rural services is compromised." [Government]

"There is the challenge of human resources. You look for somebody today and they are not there tomorrow." [Multilateral agency]

In this context, capacity building efforts and their coordination are critical for supporting managerial and technical skill development. Yet, the capacity building network has fewer connections between organizations and likely lower levels of information exchange (less centralized, more dispersed).

Government departments, especially MOH_RCHS, together with UNICEF and WHO, dominate the capacity development network (Figure 14). After them, USAID is the most connected with others. The MOH_RCHS and UNICEF are at the control center but NGOs and academic institutions are more dispersed, with each group having limited numbers of connections. The WRA_TZ is isolated in the network.

These findings might reflect organizational priorities. Thirty-two percent of organizations listed capacity building as one of their three top priorities but 88% identified it as an activity they engage in. The reduced connectivity of the NGOs poses a possible missed opportunity to develop a capacity development program that is not duplicative and engages the varied skills of all partners.

Figure 14. Confirmed capacity building relationships with nodes sized by betweenness centrality
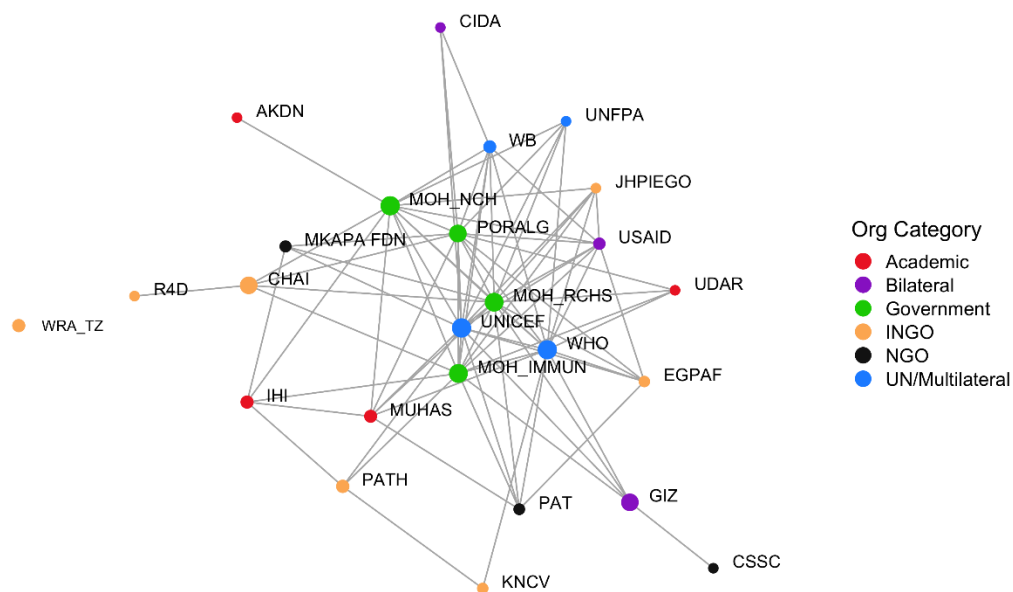
The second most important systems constraint that affects all child health interventions involves performance and quality. Quality problems are most visible for maternal and newborn care around the time of delivery and for premature newborns. Complications requiring a higher level of care are more common, and the consequences of poor quality can be severe. Large patient volumes in facilities and inadequate staffing or supplies contribute to the problem. Efforts to improve quality of care are underway but may not have been in place long enough to change behaviors and have a system-wide effect. Quality improvement is a long-term strategy, and it is unclear how much more time it will take to institutionalize processes or to achieve culture change. One further issue involves the provision of private sector services. Respondents noted that oversight in the private sector is likely insufficient to assure standards are met and maintained.

Lack of appropriate medicines when and where they are needed is a persistent systems issue. Without antimicrobials, rapid diagnostic tests, and antimalarials, IMCI cannot be carried out effectively. More remote, low performing areas have more shortages. Recently, there have been improvements in supply of medicines although in the longer term this may be difficult to sustain.

> *"So appropriate things are being done, more of essential drugs and commodities are there. But those are not matched with procurement and financing."* [NGO]

For some measures of health system performance, particularly for births, deaths, nutritional status (stunting), and rare but significant events, estimates are difficult to establish and subject to the quality of collection processes. Reporting of these data have political and social consequences as well as technical implications.

The quality of routinely reported data varies widely. While the immunization program has invested heavily and succeeded in establishing a more robust system, other technical areas rely on integrated reporting systems which may lack completeness and accuracy. Reporting for newborn health and IMCI could be better. Limited data have led to inadequate planning and implementation. High quality, accurate data and transparent ways to assess them are essential to understanding what is and is not working in the health sector. At this time, more trusted data for maternal and newborn mortality and morbidity would be helpful.

As noted earlier, a number of changes made to the IMCI program after 2006 were reported to have diminished its performance and potential. While the program was championed when it was first adopted, there has been less promotion since. With the shift in focus from child health to newborn health, IMCI and other services have been more fragmented, driven by differences in target populations.

> *"That is fine, now IMCI is useless. Zero. We are not providing more in-service training for IMCI. We don't train our students anymore because there is no funding."* [Academic]

COMMUNITY ENGAGEMENT CONSTRAINTS

Underlying social determinants of health shape community engagement and ownership of health. Poverty, lack of economic opportunity and education, and gender roles set the stage for inclusion in or exclusion from the health system. With rapid urbanization, communities are bigger and less cohesive, and the ways children are cared for and raised has changed. This has made bridging households with the health system more challenging.

Respondents reported that health system priorities in the last few years have shifted the locus of care from households and communities to facilities. This has come about with the addition of interventions that include referral and higher levels of care with more specialized providers. For interventions that can be delivered in the community (e.g. IMCI) and with a lack of investment in empowering communities, families appear to be more passive about managing their health. In particular, lack of timely care-seeking by families for newborn health problems and danger signs remains a major constraint to reducing newborn mortality.

"Right now, people are waiting for their children to be sick and to be taken to the health facility, you see? Now it means they are passive to the health of their children." [NGO]

GLOBAL INFLUENCES ON MOMENTUM

Table 3. Summary of Global Factors that Enabled and Constrained Progress

Enablers	Constraints
• Highly visible and resourced global commitment to a specific health issue • Creation of expectation for Tanzania to consolidate strategies • Learning and innovation from cross-country exchange	• Changing priorities • Volatility of resources based on changing priorities • Fragmentation of approaches to child health problems and interventions

ENABLING FACTORS AND CONSTRAINTS FROM THE GLOBAL LEVEL

Global commitments to child health, particularly those with high political visibility and resources behind them, have enhanced country-level prioritizing and action. For Tanzania, the most important of these were Every Women Every Child and the Global Reproductive Maternal, Newborn, and Child Health (RMNCH) strategies. The President's Emergency Plan for AIDS Relief (PEPFAR) and Global Fund resources for preventing and managing HIV/AIDS had major influence on country priorities. This helped PMTCT programs, but also shifted attention away from other child health problems in some time periods.

"I can only say that it [HIV/AIDS funding] was really a problem around 2008. Now it is not like this anymore, now we have very big global commitment for maternal and newborn health." [NGO]

Global commitments created expectations for countries to develop and consolidate strategies for the initiatives involved. At different points in time, Universal Child Immunization helped focus immunization, the WHO launch of IMCI led to early adoption, and the Every Newborn Action Plan helped structure the strategic actions designed to address newborn mortality. The WHO and UN agency facilitation of the process of developing costed roadmaps for MNCH has spurred country commitment to implementation of programs at scale.

"I think the roadmaps play the big part in terms of providing impetus for increasing the scale and visibility of child health programming." [Government]

Global engagement around strategies and roadmaps through convening of countries also encouraged sharing of learning and innovations. This has accelerated the adaptation and introduction of new

technical strategies and new diagnostics or treatments. This has been seen more recently in efforts to strengthen community-based newborn care and care for small and sick newborns.

Global commitments can also be a double-edged sword. Ultimately, priorities change and external resources for a particular strategy will diminish, leaving country programs struggling to maintain progress as was experienced with IMCI. As HIV/AIDS and newborn health received greater global attention and resources, other elements of child health slipped into the background. Sometimes these shifts were driven by donors and their agendas, not by the countries targeted for these strategies and interventions.

> *"We know that for some time a lot of funding was shifted to HIV, and other programs especially maternal and newborn health or maternal and child health were receiving less funds."* [NGO]

Child health is a broad technical area with multiple diseases and conditions to prevent and manage, as well as multiple sub-populations to serve. For some time, global approaches to working with countries have been fragmented due to a failure to coordinate efforts. For example, different working groups and agency divisions worked with Tanzania on different aspects of child health. These included the Global Action Plan for Pneumonia and Diarrhea plans, an Integrated Community Case Management (iCCM) alliance that offered technical guidance on scaling community-based care of pneumonia, diarrhea, and malaria, HBB to address birth asphyxia, and so on. These siloed approaches originating from the global level sometimes created parallel workstreams and piecemeal interventions.

A PROMISE RENEWED, CALL TO ACTION, AND ENDING PREVENTABLE CHILD AND MATERNAL DEATHS

USAID has engaged in multiple child survival or child health initiatives that were intended to raise interest and attention to ending preventable deaths. These were introduced to Tanzanian counterparts with varying effects, described below.

A PROMISE RENEWED

This initiative, with a goal of improving newborn and child survival, called for commitment to ending preventable child deaths by expanding the use of existing interventions known to be effective. Respondents from multilateral agencies and USAID were the most familiar with the details of the initiative and stated that it helped to bring together countries to reflect and re-commit priority and resources for child health promises. MNCH strategies were consolidated and aligned, although this may have been accomplished through the Global RMNCH Strategy anyway.

CALL TO ACTION

The Call to Action was not recognized as frequently by respondents. They saw it more as an event to put child survival at the center to re-establish commitment. Innovations and best practices from other countries were shared (as with A Promise Renewed), and both had positive impacts on prioritization. While media events were employed to raise awareness for the Call to Action, respondents felt that there was less practical information sharing compared to other activities such as regional WHO AFRO meetings.

This initiative is perceived as being more of an internal strategy driven by USAID. It has provided an umbrella for several strategic activities related to maternal and newborn health. This included rolling out Maternal and Perinatal Death Surveillance and Response to accumulate information on mortality for accountability. Current activity in Tanzania is really focused on the measurement and analysis of mortality data.

FINDINGS: LEADERSHIP

COUNTRY-BASED ORGANIZATIONS AS LEADERS

The word cloud below illustrates how often respondents identified child health-related organizations as important leaders that moved child health forward. Over the past 15 years, UNICEF has stood out because it has a clear mandate for child health. The organization provided considerable resources for child health programs at national and local levels, and it has been a long-term, stable partner of the government. The Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDEC) is the owner and decision maker regarding child health from a public sector perspective, and it provides official oversight for programs. It legitimizes the work of other organizations.

Figure 15. Word Cloud of Child Health-Related Organizations Identified as Leaders

USAID is also an important stakeholder providing resources for reproductive and child health work and access to a network of contracted technical partners. While respondents recognized USAID and contracted stakeholders as important contributors to progress, they felt that organizational working relationships with government have been challenged at times. Sometimes donors do not include the government in procurement processes and in others there has been less than transparent information sharing. WHO is viewed as an agency that continually introduces innovations and technical guidelines that benefit children through improved services or programs. It has been active in immunization, IMCI, malaria control, and nutrition.

> *"UNICEF had the resources – especially for immunization – UNICEF bought everything in those days. Now it is the government. There must be commitment from the government. There are other partners and USAID was a big help with the process."* [NGO]

Organizational network analysis provides another lens on the child health network as a whole and further reinforces most of the qualitative findings noted above (see Figure 16). In Tanzania, there is a high level of connectivity among all organizations engaged in child health, and the lead organizations (MoHCDEC, PORALG, WHO, UNICEF, World Bank) effectively link almost everyone together. These links can ensure the flow of information and provide for good coordination. Conversely, too many links can sometimes create inefficiency in that coordination.

Figure 16. All confirmed relationships sized by betweenness centrality

More than half of the possible relationships in the network have been actualized. A major question for the network moving forward is whether it would function more effectively if organizations on the periphery had stronger connections with others. Respondents also ranked organizations by some leadership qualities and identified UNICEF and the MOH_RCHS as the best coordinators, and UNICEF, WHO, and the MOH_RCHS as the most influential and best sources for evidence on child health. As recognized leaders by their peers, these three organizations are best positioned to secure effort from other network members.

INDIVIDUALS AS COUNTRY LEADERS

Respondents identified a number of individuals as strong child health leaders or champions. Most had worked previously with government in the MoHCDEC or PORALG, while some still do. In addition to government staff, respondents identified academics and elected leaders.

Top national leadership significantly contributed to raising commitment and ensuring action on child health in Tanzania. As noted earlier, former President Kikwete was widely recognized as a champion for MNCH. His leadership was effective because he was well versed politically and technically, continuously learned about child health, and he remained focused on outcomes, not just inputs and processes. He

received frequent and direct reporting on programs and monitored the scorecard he put in place. His commitment was reinforced in public through media coverage of speeches and events. In addition, his role at the global level for child health elevated the importance of Tanzania's performance and raised further support.

National technical leadership has also been important, and respondents identified several people frequently. Dr. Neema Rusibamayila, former Director of Preventive Services, was especially effective at coordinating MNCH stakeholders to harmonize and align support with MoHCDEC priorities. She helped guide allocation of support to regions, zones, or districts with equity in mind and led reviews of performance and plans for improvement. Dr. Georgina Msemo, currently the Liaison Officer at the Global Financing Facility (GFF) in Tanzania, was the first focal person for newborn and child health in MoHCDEC. Later she also managed reproductive and child health services and efforts to strengthen primary health care. She helped launch the government's newborn health program and served as a role model for applying interventions such as HBB by participating in training at local levels. Respondents also listed other individuals in MoHCDEC positions as leaders, describing most of them as effectively carrying out the functions of their particular office.

The PORALG office is a high-level focal point for leading activities in health and other sectors nationally and can also effectively support uptake and implementation of programs in districts. The PORALG leaders responsible for health at various points in time have used their ability to convene across multiple sectors at the national level, to set expectations for local government action, and to monitor impact. Their activities have lent considerable momentum to child health intervention programs earlier. At this time, the office is particularly active in child nutrition.

> "PORALG is responsible for overseeing the implementation of services and making sure they are done according to standards and monitoring that." [NGO]

As noted earlier, leadership changes in country-based or global organizations have had important repercussions on child health activity. Loss of knowledge, experience, and memory of longer-term efforts to improve child health have stymied child health progress while new working relationships are built. Respondents also mentioned periods of weak leadership in key government positions. Weak leaders were characterized as being generally less available or willing to listen. Frequent travel and attention to a limited set of priorities without delegation have meant slow decision making.

GLOBAL OR REGIONAL ORGANIZATION LEADERS

Gavi, the Global Fund, and the GFF have all exercised leadership for child health in Tanzania. Gavi has provided funding for new vaccines and health systems strengthening and its requirements have helped structure and improve immunization programming. The Global Fund has provided resources for malaria, TB, and HIV, although at one point the transition of resources from bilateral organizations to the Global Fund (GF) mechanism created gaps. The GF process has helped improve coordination of stakeholders in-country. The GFF is relatively new and respondents were uncertain about its leadership, even though its mandate clearly contains child health. Respondents reported that funding for child health has appeared to have declined under the GFF investment case and plans, although this may reflect that it is in early stages.

FINDINGS: POLITICAL COMMITMENT

POLITICAL COMMITMENT

Levels of political commitment to child health have shifted over the past 15 years. Child survival outcomes, most clearly communicated through the MDGs, drove commitment early on. There was the highest level of political commitment from the president's office during this time period, which contributed to increased resources, activity, and accountability. Child mortality rapidly declined.

> *"I think during this period we are all aware it was the era of MDGs and for Tanzania, child health was one of the priority, among all the MDG goals…. During this period, we had very strong political will and support, and this really reflected downwards to the programs. We were able to protect child health interventions."* [Multilateral Agency]

However, after 2008 more attention was focused on neonatal and by extension maternal health, and lower priority was accorded to the health of children up to five years of age. The focus on neonates was important for further reduction in child mortality but led to less attention on improving the equity of and sustaining programs that served older children.

> *"The UN report of 2014 said that Tanzania had already met the MDGs. So, by the end of MDGs, there was the impression that the child health is doing well but maternal health is not. And I think to some extent that was put rightly - so there needed to be focus on maternal health. But I think there was an over-focus to the extent that you find that people talk more of maternal and newborn health and newborn health is the new way to reach the additional progress in child health. So, I think in a way this has affected the level of attention to child health and I think not only in-country, but I think [among] the partners and others."* [Government]

In the last few years, investment in facility services and higher-level care for mothers and sick newborns has become more important. This reflects the more recent commitment of government to expand the scope of services available. While this is intended to reduce mortality from complications and serious illness, too high a proportion of children under five years continue to die of preventable causes that can be managed in the community. This is Tanzania's 'unfinished agenda' persisting from the MDGs.

> *"We focus now say on construction of health facilities, putting the human resources, okay. But we need also to see that all those preventive services are highly sustained. Because they must now depend on partners support when we need also the government to take it and buy it."* [Government]

While respondents, mostly from multilateral agencies, mentioned examples of broader interventions aimed at children thriving, they generally did not perceive Tanzania to have a commonly held, expanded vision for child health under the SDGs or that such a vision drives current decisions.

> *"I don't know how these were prioritized among all health topics because there are others that are equally important. So, I guess the difficult decision to make in Tanzania is, are we committed to these sustainable development goals? It will be a quite a long way for newborn health and also for maternal health. For the children, I think under-5s there has been something done but we need to sustain it."* [NGO]

LACK OF POLITICAL COMMITMENT AND ACCOUNTABILITY

While there is stated political commitment to child health, resources are not always allocated accordingly. This may be due to a scarcity of resources or competing priorities. With Tanzania's rapid development, resources are being diverted to other sectors for work that supports progress overall, particularly for major infrastructure to support economic development (roads, electricity, etc.). Competing priorities can also occur within the health sector, such as when large-scale HIV/AIDS programs were introduced, or focus turned to maternal health, resulting in less attention to child health.

"I think you know the political will is there. But I think the finances are not there or maybe people are not putting the money on the essential goal, you prioritize but you don't put the money." [NGO]

Some respondents felt that in earlier years, some child health priorities were donor-driven rather than government-led, reflecting a lack of ownership and commitment. This has changed more recently as government leadership has strengthened and demonstrated ownership of plans and programs.

*"The problem we have with the interventions is that they are donor-driven.*" [Academic]

Respondents questioned the level of actual commitment to child health beyond government plans and pointed out that accountability requires attention.

"I would say that commitment is 50-50. No one is outspoken in policy that we should prioritize child health issues. There are no slogans for child health improvement, and it is business as usual. Even though the government has coined a new name for the Ministry of Health which includes elderly, gender and children, it is just a name. It indicates that the government was interested to address issues of the elderly, children and gender, but that is not actually happening. This is now the third year, but I can't see any changes in the ministry that are addressing children like the words they are saying." [Academic]

The most effective accountability mechanisms for health concern national government delivering on political promises made in elections or described in party manifestos. These guide and help prioritize work within the sector, with PORALG playing a leading role.

The accountability network identified through the ONA is the least well connected of all networks studied (lowest density). Confirming responses from IDIs, PORALG has the highest betweenness centrality, validating its key role and power as an information bridge among organizations. Even though 68 percent of organizations listed accountability and governance as an activity, only one organization confirmed it was a priority.

Figure 17. Confirmed accountability relationships with nodes sized by betweenness centrality
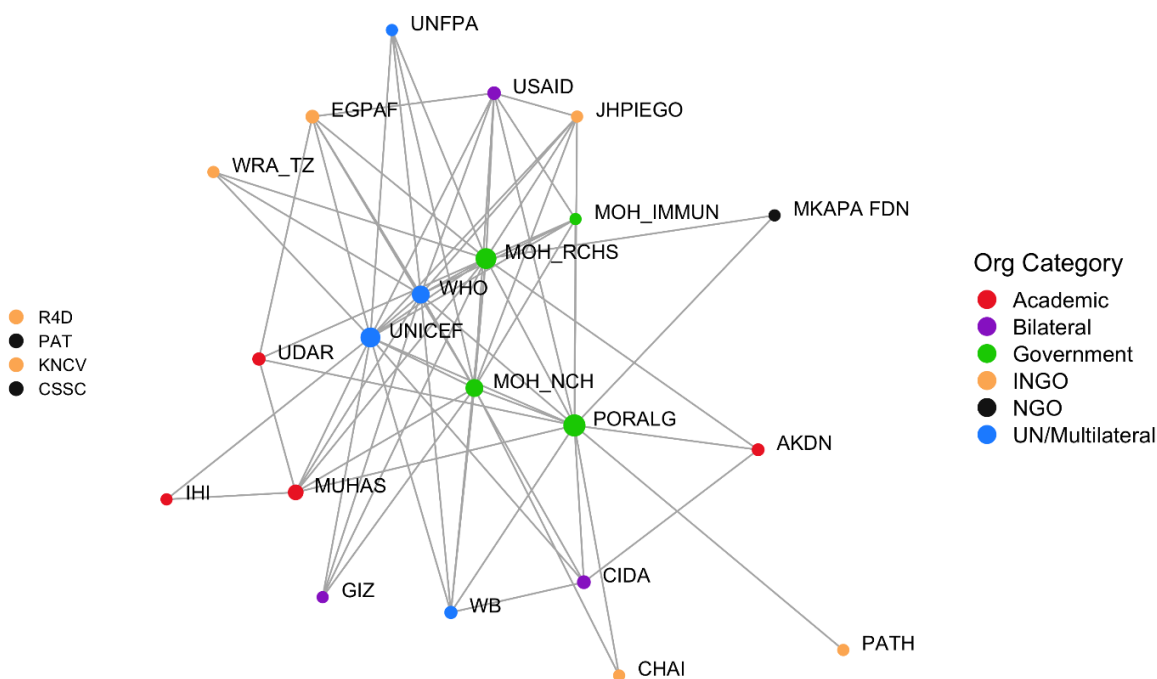
BUILDING POLITICAL COMMITMENT

Respondents were asked to describe what was done to build political commitment to child health and by extension, what could be done to build it going forward. Child health stakeholders routinely advocate and orient new people during times of transition. In Tanzania, well-presented evidence can be influential, especially if it has been generated by credible local experts and communicated well. Commitment to newborn health was initially built through a situation analysis, a process that has just been repeated as efforts broaden to include the prevention of stillbirths and better management of prematurity.

> *"We need to continue advocating. We need to continue [sharing] evidence that this is where we are going and this is where we are. So, if we do that it could help us to navigate through and renew the political commitment."* [Multilateral Agency]

It is important to build political commitment not only at the national level but at regional and district levels because Tanzania has decentralized management and decision making. This entails engaging council leadership, as well as health staff, so that resources are raised and allocated well, and that local government is held accountable.

> *"The sub national leaders [need] to commit to the national agenda. For two or three campaigns there was the national strategic plans being shared. The regional commissioners they were committed to really implement the plan and to go back to make sure the DCs and executive directors are also committed to the agreed priorities for the country and their local areas. …. So, I think it is very important to sensitize and make sure the local government is participating in giving out resources in the interventions."* [Multilateral Agency]

FUNDING PROCESS

Funding is an important aspect of the policy environment, as resources can constrain or enable the implementation of programs and services. Tanzania allocates only seven percent of its domestic budget to the health sector (2017/18) and is one of the highest recipients of Development Assistance for Health (DAH) globally (30-48 percent of budget, 2015). During the years of investment in child health, new funding mechanisms were developed at the global level that led to significant shifts in process for Tanzania. These included Gavi that centralized vaccines and associated systems funding from multilaterals and bilaterals, the Global Fund that shifted previously bilateral funding for malaria, TB, and HIV, the RMNCH Trust Fund/United Nations Commission for Lifesaving Commodities for Women and Children that addressed specific commodities, and the GFF that applies results-based financing but has only recently been introduced into the country system. With the high level of Tanzania's reliance on external funding, these shifts sometimes disrupted program progress.
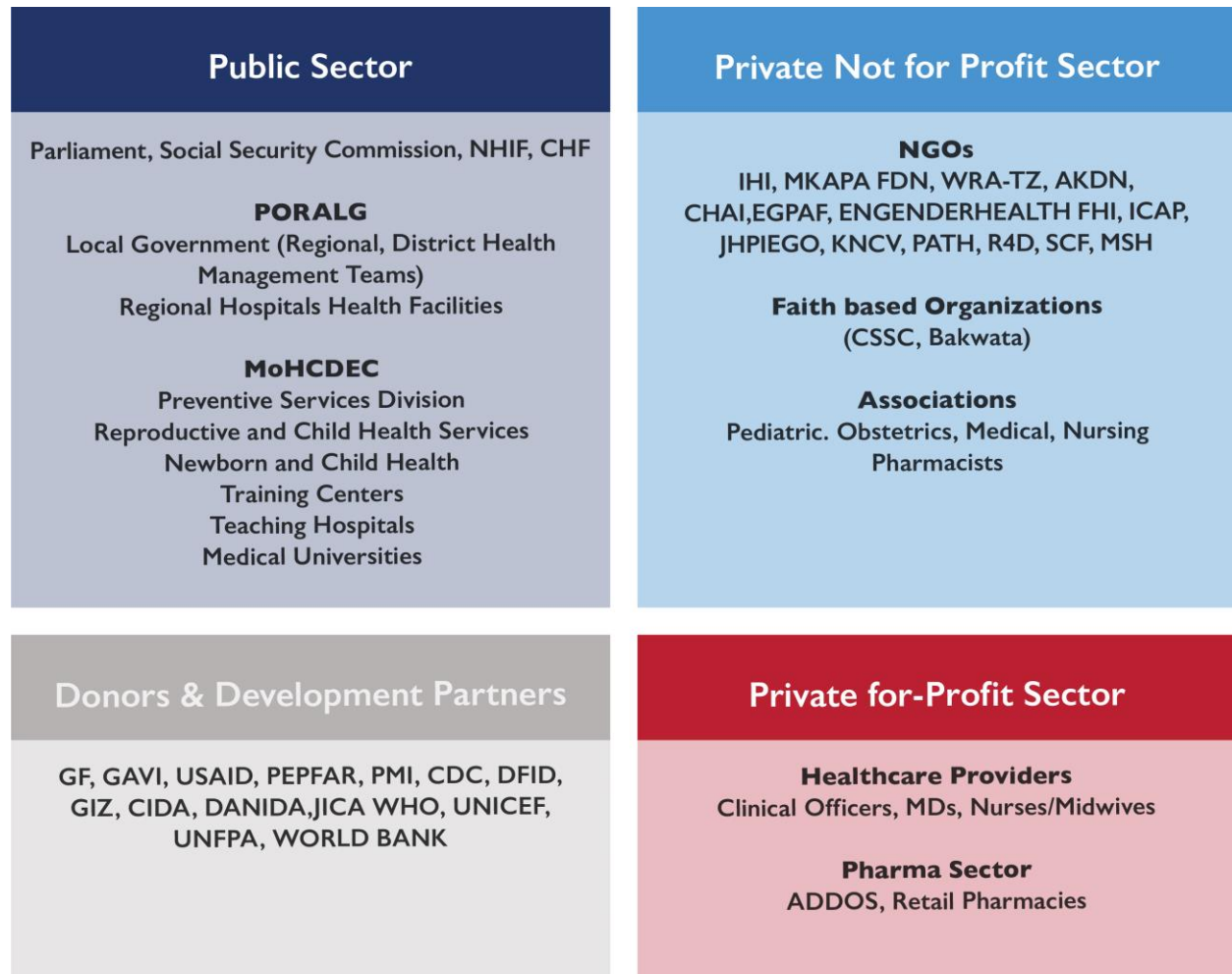
While this study did not explore health financing information for child health over the past 15 years, the IDIs provided some insight on child health funding. Respondents noted that funding is closely related to and interacts with political commitment. Global funding for MNCH increased after 2008 with intensified interest in meeting MDG goals. New funding partners such as the Bill & Melinda Gates Foundation moved into Tanzania, and this helped diversify sources. However, after the latest change in administration and the shift of DAH funding priorities in the context of SDGs, respondents felt that resources have become less available for MNCH.

FINDINGS: STAKEHOLDERS, GOVERNANCE, AND COORDINATION

STAKEHOLDER LANDSCAPE

WHO ARE THEY?

Figure 18. Health Sector Stakeholders

Public Sector	Private Not for Profit Sector
Parliament, Social Security Commission, NHIF, CHF	**NGOs** IHI, MKAPA FDN, WRA-TZ, AKDN, CHAI,EGPAF, ENGENDERHEALTH FHI, ICAP, JHPIEGO, KNCV, PATH, R4D, SCF, MSH
PORALG Local Government (Regional, District Health Management Teams) Regional Hospitals Health Facilities	**Faith based Organizations** (CSSC, Bakwata)
MoHCDEC Preventive Services Division Reproductive and Child Health Services Newborn and Child Health Training Centers Teaching Hospitals Medical Universities	**Associations** Pediatric. Obstetrics, Medical, Nursing Pharmacists

| Donors & Development Partners	Private for-Profit Sector
GF, GAVI, USAID, PEPFAR, PMI, CDC, DFID, GIZ, CIDA, DANIDA,JICA WHO, UNICEF, UNFPA, WORLD BANK	**Healthcare Providers** Clinical Officers, MDs, Nurses/Midwives **Pharma Sector** ADDOS, Retail Pharmacies

Compared to other countries, there are many stakeholders in the health sector in Tanzania. As illustrated above, these include the multiple levels of government (Ministry of Finance, PORALG, MoHCDEC, regional and council health management teams), development partners (bilaterals, multilaterals, foundations), NGOs including INGOs, civil society organizations, and faith-based organizations, and the private sector.

The ONA provided data on the frequency of interaction and quality of relationships of the organizations in the child health network. These network characteristics are the levers for creating stronger trust and better alignment around goals and results.

In Tanzania, most organizations interact on a monthly or quarterly basis. The MOH_RCHS is the most active, followed by other government agencies. The high frequency of interactions creates a dynamic environment for working together but also poses a risk for inefficiency if meetings are not well utilized.

Figure 19. Confirmed overall frequency of interaction with nodes sized by betweenness centrality
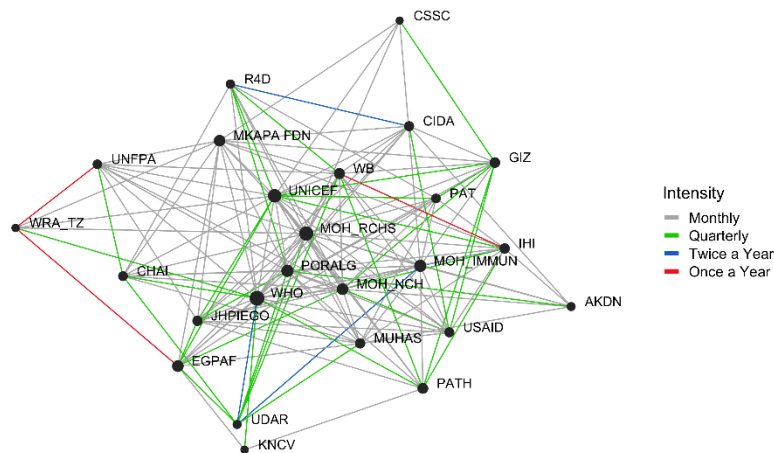
Most working relationships were reported to be "good" and "very good." The MOH_RCHS has the most "very good" relationships, while organizations on the periphery tend to have "fair" relationships between each other (NGOs, bilaterals). USAID is the exception, having all "good" and "very good" relationships (Figure 20).

Figure 20. Confirmed overall quality of relationships with nodes sized by betweenness centrality
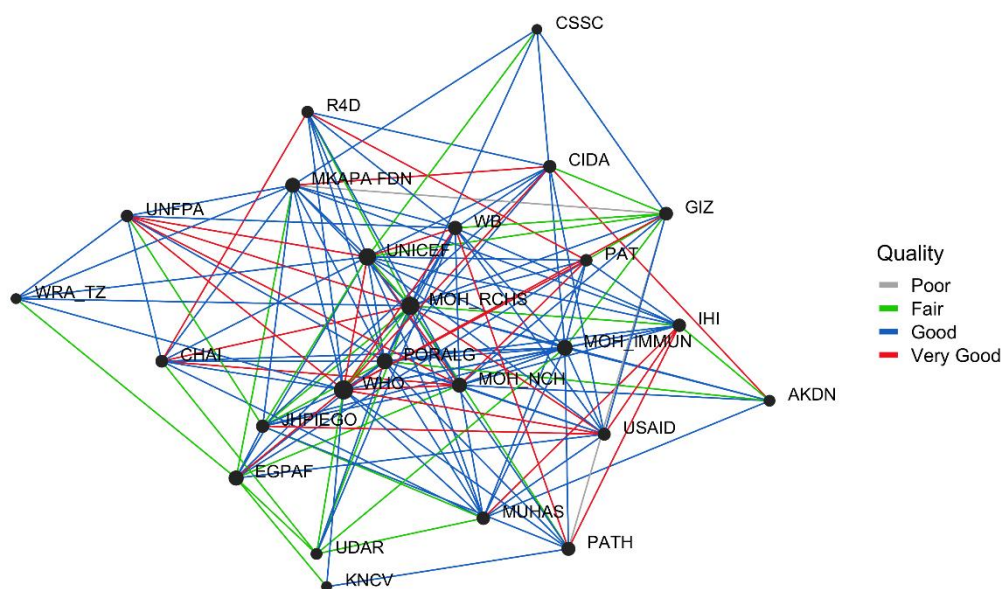
EFFECTIVENESS OF GOVERNANCE

Child health organizations use different modalities to work together to achieve goals, usually under the leadership of government. These include several coordination groups including the RMNCH TWG, the Development Partners Group (DPG)-Health, the Interagency Coordinating Committee (immunization), the HLSCN TWG, and multiple subgroups defined by technical topics. Stakeholders also work together in ad hoc technical meetings built around specific subjects or tasks. The tasks have included reviewing evidence and formulating guidelines for interventions, assessing program effectiveness and developing new strategies or plans, or designing interventions and developing training manuals. Any of the stakeholders can lead these meetings or workshops, depending on the purpose.

The RMNCH TWG is the key coordination mechanism for child health stakeholders. It is chaired by the RCHS Section of the Preventive Services Division, which makes decisions about and communicates policies, guidelines, and strategic plans. Together, the representatives of the organizational members review program plans, progress, and outcomes, and agree on actions for improvement. While the effectiveness of the group process has varied over the years, it has successfully standardized and harmonized program implementation guidelines, worked to ensure equitable coverage (minimized duplication and overlap), mobilized resources, and learned to improve impact. The group has afforded credibility to the efforts of partners and has held its members accountable for progress.

DPG-Health was established to support the government in its implementation of the National Health Policy, the current Health Sector Strategic Plan, and the health-related objectives in the broader poverty reduction strategy (Mkukuta II). DPG-Health has provided a venue for development partners to map

activities in detail, harmonize plans, mobilize resources, and align funding with the objective of increasing aid effectiveness.

The Interagency Coordinating Committee was established in the mid-1990s to coordinate and support immunization and related activities in Tanzania. Chaired by the Director of Preventive Services, it led efforts to harmonize stakeholders and mobilize resources, to plan, assess, and agree on actions to improve immunization programs, and to work on the introduction of new vaccines. As a requirement of Gavi, it has played an important role in seeking funding for new vaccines and health system strengthening.

"I think these groups have been very effective and very important. They have been active in driving some of these agendas, yes, the interventions and mobilization of resources and coordination of partners." [Multilateral Agency]

Respondents felt that the multisectoral HLSCN meetings chaired by PORALG were the most effective for facilitating multisectoral work (e.g. nutrition), for activating local government at region and council levels, and for formal recognition of plans and performance.

"When it is under the prime minister's office, it means the power to call all the sectors is much easier and done in a coordinated way." [Academic]

EFFECTIVENESS OF COORDINATION

The effectiveness of coordination has varied over time and technical area. For child health, effectiveness has varied with the strength of leadership of the Preventive Services Division and the priority and time accorded to coordination efforts. During the Kikwete administration, coordination was active, timely, and consistent. Effectiveness has also varied with the willingness of donors and technical agencies to work transparently with government counterparts, particularly around what resources are available and how they are applied through multiple organizations. This has varied by development agency, agency rules, and how decisions are delegated within them.

"Also, with the government commitment itself - that has increased ..[the]..level of accountability and because the government is actually guiding the process. So, ownership is within the government and is a key thing in terms of sustainability. So, we are seeing that engagement is also increasing over time which we think is the most important part." [Academic]

The ONA provides additional information on how intensely organizations worked together over the last five years. These levels range from basic communication to coordination to more intensive collaboration. In Tanzania, relationships were characterized by a mix of coordination and collaboration. The few communication-only relationships were among the more peripheral organizations in the NGO category. UNICEF has the most intensive relationships that have been confirmed as collaboration. (See Annex D).

IDI respondents identified contributors to effective coordination including having clear, common, and realistic goals for interventions and outcomes. For newer interventions such as those for newborn health, the process of developing a situation analysis helped, and planning large-scale campaigns for any health purpose (ITNs, maternal health, introduction of IMCI) tended to pull organizations together.

Interventions or programs that came with more resources, such as HIV/AIDS, were more likely to receive coordination attention. The planning process for the Sharpened Plan and Plan II were effective at building buy-in to priorities and aligning stakeholder activities, especially when the underlying strategic frameworks were strong (e.g. HBB, nutrition). Coordination is most effective with strong MOH leadership that convenes stakeholders frequently and holds everyone accountable to commitments.

"Well, it could be better, but I think it was successful, the outcomes show that there has been good coordination but always still have areas where people are running parallel programs. So, there is room for improvement but there was good coordination, and this is why we have successes that we talked about." (Academic)

There have also been constraints or barriers to coordination. These include structural issues such as the gap between national offices and more operational districts, where the regional level exists but does not seem to strengthen communications or alignment; or the parallel structures of local government and the public health system that function better together when guidance comes from the higher level of PORALG. Also, some coordinating structures are used more for "rubber stamping" approvals rather than useful exchange and participation. Finally, the Dodoma and Dar es Salaam separation of offices and staff of government agencies and stakeholder agencies contributes to inefficiency and less frequent interactions that might otherwise ensure good sharing of information and rapid decision making.

The intentions and behaviors of stakeholders have also interfered with coordination. Donors and implementing partners sometimes act on their own agendas, leading to higher transaction costs and fragmentation of child health work. Organizations may also angle for credit for activities (and ensuing funding) rather than functioning as part of a broader stakeholder team in which attribution may not be feasible. Respondents sometimes complained of a lack of transparency and sincerity within the network.

"It is difficult because international organizations have their own agendas yah, and you can't coordinate this if people are not true to their word." [NGO]

"So, the more transparency there is the better and the more monitoring in terms of how much is going into doing what, and resulting in what, then our country can really move to impact. Otherwise you could have 100 partners and end of the day nothing much to say for it." [Government]

SYNTHESIS: WHAT HAVE WE LEARNED ABOUT CHILD HEALTH COORDINATION?

Respondents were clear about the value of good coordination. Tanzania's early achievement of MDG 4 was due in part to effective government leadership and coordinated action of multiple types of stakeholders. Respondents reported that inclusive and participatory coordination drives the child health agenda and enhances the execution of those plans. The system has high levels of coordination throughout, building the confidence of staff and their willingness to improve. Stakeholders are held accountable to each other and to their common goals as part of the working group process.

However, respondents also acknowledged that effectiveness of coordination varied over time and by technical area, depending on the strength of convening leadership, willingness of external partners to engage transparently, and the type of activity at the center of coordination. For example, higher levels coordinate around policy, guidelines, and resources while more operational levels coordinate around geographical footprint, activities, and intervention issues. Respondents reported better coordination at

operational levels or within technical areas, at least partly because the tasks are more concrete and practical.

The ONA validated that strong networks with well-linked organizations at the center have been established in Tanzania. These organizations serve as platforms for expanding the network's collective effectiveness. Working engagement is frequent and intense with most relationships at coordination and collaboration levels. The inclusion of public and private sector organizations in the network provides the opportunity for more efficient use of resources and increased capacity to address complex problems.

RESPONDENT RECOMMENDATIONS FOR IMPROVED COORDINATION

Respondents were asked to recommend actions for increasing the effectiveness and efficiency of coordination with respect to improving child health outcomes. The following table summarizes the most frequently reported responses.

Table 4. Recommendations to Improve Coordination for Child Health

Category	Action
Restructuring participation and the expected type of working relationship	Add to or strengthen regional and council-level mechanisms of coordination. Must be well connected and bridge the national with the district
	Establish more formal connections between the government academic institutions and the MOH to address barriers stemming from being in different ministries
Adjusting the roles of stakeholders	Be more mindful and leverage the comparative advantage of different types of organizations around activities
	Work to support and ensure continuity of government leadership in coordination mechanisms to facilitate consistently strong leadership
Process improvements	Review and address management challenges using process improvement (e.g. Dar and Dodoma locations, anticipated personnel changes)
	Be individually (as an organization) accountable for consistent participation and commitment
	Streamline funding channels
Try new strategies, monitor what differences they make, and institutionalize what works	Build on the example of multisectoral engagement for nutrition
	Leverage communication technologies, starting with the stakeholder portal or platform
	Conduct an annual health forum sponsored by the highest levels of government
	Focus on addressing underlying risk factors of child disease or health to help cross technical and sector boundaries

CONCLUSIONS: TANZANIA'S CHILD HEALTH NETWORK

VISION

Respondents were asked to describe their 10-year vision for child health in Tanzania. The most commonly reported vision statements included a mix of impacts, outcomes, and priorities.

Table 5. Respondent Vision Statements

• Decreased under-5 mortality rate (decrease NMR more quickly)
• Decreased prevalence of stunting
• Optimal early child development
• Child health is a high priority on the national government agenda
• System focused on newborns and the perinatal period
• Sustained coverage of immunization
• Access to adequate numbers of skilled human resources (especially nurse midwives, neonatal specialists, and pediatricians)
• Adequate numbers of newborn care units in hospitals (staffed and supplied)
• Universal access to community health workers

Some of these statements reflect the goals of current national health plans while others speak to health systems components that are perceived to be needed to maintain and enhance progress in child health. However, most respondents did not speak passionately about the future or communicate a shared vision likely to motivate people to drive child health forward. This is in keeping with the limited discussion of SDGs in contrast to descriptions of what was done to achieve MDG 4.

Nevertheless, Tanzania has a robust child health network with the potential to contribute to improved child health outcomes in pursuit of the country's broader development aspirations for its people.

EFFECTIVENESS OF TANZANIA'S CHILD HEALTH NETWORK

LEADERSHIP

Child health in Tanzania has benefited greatly from high-level political champions' interest and actions. At the present time those in leadership are focused on broader economic priorities and general health infrastructure. This raises the question: how might their interests and passions be engaged in support of more specific child health needs for the near term?

Turnover of leaders in the government health sector is common and results in changing priorities, need for more reorientation and advocacy, and delays in decision making. The challenge is perhaps most acute for MOH directorates that are crucial to programs. It may be possible to better leverage the child health network as a whole to accelerate leadership transition rather than relying on individual organizations to advocate for issues or population groups specific to their particular focus. Using the comparative advantage of network members in a coordinated and deliberate way can engage leaders more holistically and quickly. For example, a new leader could be educated about MNCH goals and programs using a continuum of care approach despite network organization's varied individual priorities (e.g., technical/clinical interventions, maternal health or neonatal health, supply chains, quality

improvement, etc.) However, for this to happen key organizational stakeholders would have to actively pursue a network-positioned approach.

COMPOSITION

There are many organizational stakeholders with a wide range of interests in child health. This diversity has contributed to broader, more innovative approaches in areas such as information system development and accredited drug dispensing outlets. For most areas of work (except accountability), stakeholder organizations are closely linked and coordinating or collaborating together. Government and the major UN agencies are usually at the center of these networks while NGOs and academic organizations are more on the periphery.

Given the nature of Tanzania's health system structure, this is not unexpected. Nonetheless, there may be opportunity to more closely engage peripheral organizations around relevant work streams. For example, academic organizations conduct research with increasing numbers of studies done as "implementation science." These are of most use to implementing organizations such as council health management teams or NGO service providers; yet the linkages with them are less intensive or inefficiently mediated through national groups in the center of the network. By intentionally aiming to increase either the number, intensity, or frequency of connections, more peripheral organizations may be better incorporated and therefore better positioned to contribute to national progress.

Looking forward, the relative lack of non-NGO private sector health providers in the network may be a missed opportunity.[17] As urbanization and development increases, it is likely that the private sector will grow. At this time, however, they are outside or tangentially connected with the prevailing national child health network.

GOVERNANCE

Respondents clearly articulated the gains achieved through working in coordination with others. There is consonance around policies, guidelines, and standards; overlap and duplication have improved, resources are mobilized and allocated more efficiently and equitably, and common goals more readily achieved. Of the four key coordinating groups identified, the RMNCH TWG has been most central to child health, although the DPG-Health, the Interagency Coordinating Committee, and PORALG's cross sector nutrition group HLSCN have played important roles for specific functions or technical areas. Among the organizational network agencies, the MOH_RCHS, UNICEF, and WHO have been the most central and have exercised the most "management" of network activity. While USAID's location in the network is one tier out from the core, this position is important for leading the closer participation of other bilaterals and NGO partners.

However, how well these and other structures have governed and therefore acted in concert at the national level has varied over time. Factors include - strength and credibility of coordination leadership

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[17] The lack of private sector organizations, especially those who work for profit, partly reflects study methodology in that the broader market was not included because there were limits to the number of organizations that could be considered overall.

at the time, consistency in convening, stakeholders accountability for commitments made, or transparency and respectfulness of interaction. At particular times, government leaders have had stronger convening power and corresponding levels of engagement of partners. Because leaders will change throughout the relatively long period of time needed to demonstrate child health improvements, it is important that the national child health network commit to becoming more collaborative and stronger as a group.

While the government leads child health in Tanzania, the interests and network participation behaviors of development partner organizations have also varied over time. Variation arose from differing technical or political mandates, organization agendas and expectation of responsibility, and individual leader styles. The weakness in the accountability network may reflect low expectations and organization-centric rather than network-centric identity. Coordination and accountability may be improved by consciously trying to advance the quality of common network engagement to agreed goals. This means improving processes (communication, planning, working jointly, follow through on commitments) and building greater trust among members (reliability, transparency). This suggests a greater focus by donors and technical agencies on working together, especially in times of transition or competing priorities.

In trying to understand governance and coordination at the national level, it became clear that the full value of collaboration to child health outcomes would not be realized unless there are better child health networks and collaboration at regional and district levels. This is because health care is administered at these levels; they are the locus of active management, service delivery, and community engagement. National organizations and the national network have their own important roles, but also an obligation to build and help ensure collaboration at more operational levels. This will need considerably more attention and resources to be successful.

FRAMING OF CHILD HEALTH

Prior to 2005, child health was framed as "child survival" and was addressed by a few critical interventions that managed illness (oral rehydration solution, pneumonia case management, IMCI) or prevented illness (vaccination, vitamin A supplementation). By 2005 to 2008, mortality had come down and child health was reframed to focus on newborn mortality, which was declining more slowly and accounted for the highest proportion of deaths under 5 years. Tanzania continued to work toward MDG 4 but shifted along with global initiatives to the language of "ending preventable child deaths." Since 2015, reducing newborn mortality (and improving maternal health) continues to be the priority and basis for child health framing. More recently, Tanzania launched a multisectoral nutrition strategy that, along with emerging commitment to equity and the SDGs, may be a harbinger of a broader framing.

Figure 21: Evolution of the Framing of Child Health

It is clear that over the past 10 years, child health framing has become more specific to the population drivers of mortality and subgroups such as newborns or the "preventably" ill. This was partly driven by Tanzania's success with MDG 4 and has inadvertently excluded or lowered the priority of addressing some aspects of child health, occasionally causing competition for attention and resources. Ultimately, the prevailing global framing of Survive-Thrive-Transform and its numeric goals will require a more inclusive framing.

IS CHILD HEALTH A MOTIVATING ISSUE IN TANZANIA?

PERCEPTIONS OF THE SEVERITY OF CHILD HEALTH PROBLEMS

The majority of respondents reported that mortality was severe for under-5 children but had improved with the MDG 4 achievement, and they now feel a less pressing need to address it. This is reflected in their limited reference to preventable child deaths due to pneumonia, malaria, and diarrhea. Their concern focused more on the status of newborns, for which high mortality persists despite a shift of attention after 2008.

> *"We have not registered good progress as we have seen in the child mortality. As we know that the newborn mortality is mostly related to maternal health, and… the maternal health, the maternal mortality did not do well. There was some progress but not to the extent which was expected."* [Multilateral agency]

Stunting is viewed as a major, intractable problem in Tanzania and rates have not moved significantly for some time. Respondents noted that low rates of exclusive breastfeeding probably contribute as well as those factors that contribute to inadequate nutrition overall. They expressed frustration at not having a specific understanding of transformative actions that could be taken rapidly.

PERCEPTIONS OF THE EFFECTIVENESS OF INTERVENTIONS

The majority of respondents believe that immunization interventions were very effective and seemed to have "won the game." Likewise, IMCI has been effective although a number of significant systems shortcomings continue to limit its effectiveness and other interventions dependent on case management. Much of the access to such services is in public facilities, which can be under-resourced and overwhelmed with patient volume and consequently unable to provide a reliably high quality of care.

> *"As I have shown in term of leadership and governance, we have been working with high-impact interventions to ensure these high-impact interventions are scaled up throughout the country. One of them which we cannot*

talk a lot about as I mentioned earlier was the huge coverage of immunization and vaccination.”
[Government]

“This is a public facility and he was so overwhelmed, the doctor was so overwhelmed that he actually just looked at the child and he said the child is breathing fast, he has a cough, so treat and go. By the rules and regulations computerizing everything he now has to enter the details, so he has to spend time to [do] it. He does not have the time to listen to the history or to spend time with the baby. He has the time just to put the information in the computer and let them go.” [Academic]

CHILDREN AS AN AFFECTED GROUP

While awareness and sympathy for the health needs of children was high in the early 2000s, this view has ebbed and been replaced with concern for newborns, especially around the time of delivery. The majority of respondents reported newborn mortality as pressing with insufficient work to address it. A related concern was expressed for the health of women during delivery.

“I don't know how these were prioritized among all health topics because others there are equally important. So, I guess the difficult decision to make - Tanzania is committed to these sustainable development goals - but it will be a quite a long way for newborn health and also for maternal health. [NGO]

POLICY ENVIRONMENT, POLITICAL COMMITMENT, AND ACCOUNTABILITY

The level of political commitment for child health and its components has varied over time but nonetheless remains central to the Tanzanian government as illustrated by plans and budgets, and by early adoption of interventions and approaches. At the national level there are a handful of key processes for confirming political priority, the most important of which is the documentation and approval of the party manifesto. If child health programs are confirmed in this process, then they will much more likely receive attention and resources and be publicly monitored and improved. This may be an area in which the child health network could focus its attention.

This study looked at child health only through the lens of the health sector; groups and networks outside health could conceivably be engaged to increase commitment and resources. Given the multisectoral approach to nutrition, it is a test case for this hypothesis and could be studied to identify potential political and other resources to advance child health moving forward.

The study did not assess political commitment and accountability at district and facility levels. If these levels are increasingly autonomous and administratively accountable to their populations, then it will be important to build a better understanding of how they work.

RECOMMENDATIONS

Children are valued and their health is of critical importance to Tanzania's future. Tanzania's citizens, government, and development partners share these norms. These recommendations are offered in the spirit of achieving demonstrable improvements in children's lives.

The recommendations are presented in two sections. The first documents priority recommendations for improving leadership, governance, commitment, and ultimately collective action to achieve a bright future. The second presents programmatic recommendations most frequently reported by respondents in this study.

PRIORITY RECOMMENDATIONS

What should Tanzania do to make sure that the full range of child health issues are at the forefront of its health aspirations?

An Inspirational Vision and Reframing Child Health Inclusively

What vision will actively motivate Tanzanians and partners to heighten action and how should child health be framed to drive progress?

Recommendation 1: Based on Tanzania's aspirations for development and commitments made to the principles of the SDGs, clarify the national vision for child health overall, reframe how it will be approached to be more inclusive of all children under five years and operationalize both in the Sharpened Plan III.

During the MDGs era, Tanzania mobilized commitment, resources, and people to reach the motivating common goal of child mortality reduction and more recently has signed on to SDGs. While current plans document technical goals and indicators, they do not rise to the level of a new vision that inspires people to innovate and reach for the more complex set of SDGs related to children. To galvanize greater government and public commitment, and to better align partner participation in the child health network, government and partners should undertake a rapid adaptation of their 10 year child health vision that will also help guide decisions on the new Sharpened Plan III. It may be possible to integrate such an activity into the Sharpened Plan III development process as it involves government leadership and partner stakeholders.

This longer-term vision should provide space for actions to address the unfinished agenda of newborn and child mortality, the emerging agenda of children thriving and reaching their full potential, and ensuring that no Tanzanian child is left behind. While there is a process beginning for devolving SDGs, it might be more effective to lead with the aspirations of Tanzania's child health stakeholders, especially those of PORALG and the MOH, and work subsequently to align them. To support communication of this clarified vision (or SDG 3), child health is likely to need to be reframed in-country. There are multiple ways to reframe it, but the new framing will be more effective if it is more inclusive – of newborns and children under five; and of health (e.g. illness) and well-being (e.g. nutrition, early child development).

One example to reframe child health more holistically yet be able to prioritize activities is to focus on vulnerability in childhood. From the perspective of mortality, newborns, especially premature newborns, are perhaps the most vulnerable. From the perspective of undernutrition, repeated infections, and

stunting, children in poverty or remote, underserved areas may be more vulnerable. From the perspective of the MDGs unfinished agenda, children 1 to 59 months without access to care and medicines or from families that cannot or will not seek care are vulnerable. If the health of all children regardless of age or risk group is not addressed, then the ultimate goal of all children reaching their full potential is unlikely to be met. Experience has shown that success – Tanzania's achievement of MDG4 – can sometimes lead to complacency and children may be left behind.

In addition to adapting the vision and reframing how child health is presented, it is equally important to effectively communicate both, including throughout government and to regions, districts, and communities. Donors have a crucial role here. A practical and inclusive vision and framing will be easier to align with the SDGs so they are understood more widely.

Effective Collective Action through Collaboration

How may the current coordination among child health stakeholders be improved to collaborate on a few priorities that result in effective action and result in a more robust, sustained child health network overall?

Recommendation 2: Starting with the RMNCH TWG as the core child health network:

a) **Choose one or two priorities that the national child health network will work on together, and plan, implement, and monitor a more collaborative process that demonstrates tangible results and strengthens network capacity.**
b) **Help build or strengthen child health networks at regional and district levels so that they are capable of more effective collaboration for child health.**

At the national level, the child health network is well interconnected and *coordinates* most work. This is a good foundation on which to build a stronger, *collaborative* network more capable of enhancing child health.[18,19]

One way to build understanding of collaboration is to try it out. The RMNCH TWG could agree to go beyond coordination for a specific activity that is on their agenda – one or two priority areas of work that matter for the national network and for regional or council health management teams. This might be addressing lack of utilization of community-based services by unreached families (equity) or improving the quality of care provided to children in facilities or expanding the use of better quality data and information. In addition to the technical plans for these activities, the national network organizations would have to work to strengthen how they interact, work together, monitor process and make improvements such that they are also enhancing each other's capacity and actions. This effort

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[18] Himmelman, A.T. (2001), On Coalitions and the Transformation of Power Relations: Collaborative Betterment and Collaborative Empowerment. American Journal of Community Psychology, 29: 277-284. doi:10.1023/A:1010334831330
[19] Coordination is defined as exchanging information and arranging activities for a common purpose. In contrast, collaboration is defined as coordination plus enhancing the capacity of each other and achieving a common purpose by sharing risks, resources, responsibilities, and rewards.

would demonstrate the concrete benefits of collaboration, empower government leadership and illuminate the advantages of more effective partnership.

While focusing on the national level child health network will be more manageable at the outset, respondents made it clear that there is a pressing need to enhance coordination and collaboration at implementation levels (regions, districts, facilities). Local level management teams need to be expected to coordinate operationally and to build nascent networks into collaborative bodies. Governance and management structures and policies already exist.

Organizations in the national child health network often support activities at local levels – through staff or other groups – so they are in a position to set expectations for how people will work together and to support leadership of the local network. Again, it may be easier to focus on specific activities to model working more effectively together and to clarify what is needed from the national level to empower the local level. In the end, it will likely be faster to move into collaboration at local levels because the work is closer to the ultimate customers (children and their caregivers) and more concrete (services vs policy). However, the capacity of existing child health networks or management teams at these local levels may not be clear. In this case, it can be useful to start with a network assessment and to explicitly build their capacity because remote national-level networking alone will likely be insufficient.

Recommendation 3: Bring the private sector more directly into the vision and plans for child health now, as it is very likely to provide a higher proportion of services and influence health-related choices and behaviors as the economy grows and urbanization increases.

Respondents noted that plans and projections for the future of child health (and health in general) need to better account for likely changes in the environment and country context. Two changes that were noted were rapid urbanization and a somewhat reactive stance to addressing related health problems, and the growth of supply and demand for private sector health care. Tanzania has multiple approaches and programs related to the private sector ranging from regulation and standards setting to public-private partnerships. This study was not designed to include an in-depth exploration of the status of the private sector nor these approaches, and thus recommendations are best left to other activities. However, the study did identify a pressing need to incorporate an understanding of child health and the private sector in the future. This should be included in the vision, plans, and child health network strengthening already proposed.

Building and Leveraging Political Commitment

How should child health stakeholders enhance the participation of high-level leaders and ensure long-term follow through on political commitments?

Recommendation 4: Take action to raise national political attention to the health of children and actively collaborate for accountability in pursuit of country health goals.

- Prioritize embedding the most important bundle of child health programs, via the appropriate channels (PORALG, MoHCDEC), into the national statement of priorities (party manifesto).
- Highlight and publicize information from existing accountability mechanisms (such as scorecards and reporting to PORALG) at district and national levels to rebuild a sense of urgency for progress in child health.

- As part of strengthening district child health networks, build capacity and support stronger accountability activities.

Because child health has not been as high on the national political agenda as it was during the previous decade, it is critical to identify and bundle the most important child health priorities, and to engage advocates to embed them in the most effective processes of political prioritization and resource allocation. The health ministry and regional administration/local government leaders drive these processes, but other partners in the child health network need to work more cooperatively to forward the same agenda.

While the child health network is less engaged in accountability work (compared to strategy, capacity building, and implementation), there are accountability systems in place in Tanzania that could be more effectively used to raise support with the government and the public. This includes scorecards and other required reporting but will need more active communication and advocacy at national and district levels on the part of more members of the network. The results-based financing of the GFF presents another opportunity to apply accountability processes by highlighting pressing needs as well as successes.

ADDITIONAL RECOMMENDATIONS

The following recommendations are more programmatic in nature and emerged as key themes from the respondents. They are presented in summary form. Other evaluations, studies, and performance reviews document the problems and recommended solutions in more detail. This list is intended to reinforce the importance of these topics.

Recommendation 5: Ensure that evidence and research is applied to improve health programs and services.
- Measures to coordinate and collate research have been put in place but they lack linkages to those who can apply them in regions and districts. Set up and activate these linkages, such as those between PORALG and the MoHCDEC.
- Set up spaces to bring together implementers and researchers to adapt evidence into practice.

Recommendation 6: Double down on improving neonatal health.

- Target more resources explicitly to neonatal interventions, especially postnatal visits in the first week and the introduction of chlorhexidine to first-line services.
- Ensure CHWs and community health programs are providing effective newborn-related interventions for the "last mile."
- Strengthen human resources for neonatal health including revision of midwifery curriculum and adding specialist nurses.
- Expand neonatal centers in facilities.

Recommendation 7: Improve the quality of child health programs and services.

- Make improving quality the key agenda for child health.
- Aim for long-term system change, not just training of personnel.
- Use performance-based contracts to incentivize better quality.
- Strengthen data and information to improve health services. Build on promising systems in key programs such as immunization and projects such as the Better Data Initiative.

Tanzania has made remarkable progress in child health over the past 30 years and has much to be proud of. However, the task is far from complete, and broader societal and economic changes could endanger the progress that has been made. Thanks to the active engagement and deep commitment of a broad range of actors, the country has a strong and dedicated foundation to build further meaningful progress over the next decade. Selecting and agreeing on a limited set of clear actions and deliverables that will be the focus of joint coordinated efforts will be the key to a successful transformation and healthy prospects for Tanzania's children.

FOR MORE INFORMATION