Tanzania Service Provision Assessment Survey 2006 (TSPA)

Key Findings on
Family Planning,
Maternal Health,
Child Health,
and Malaria

This report summarizes the reproductive and maternal and child health findings of the 2006 Tanzania Service Provision Assessment Survey (TSPA), carried out by the National Bureau of Statistics of the United Republic of Tanzania and the Ministry of Health and Social Welfare of the United Republic of Tanzania. Macro International Inc. provided technical assistance. The 2006 TSPA is part of the worldwide Measure DHS project which assists countries in the collection of data to monitor and evaluate population, health, and nutrition programmes. Funding for technical assistance was provided by the United States Agency for International Development (USAID) through the President's Emergency Plan for AIDS Relief (PEPFAR). Local costs of the survey were financed entirely by the pooled fund of the Poverty Eradication Division (PED) in the Ministry of Planning, Economy and Empowerment.

Additional information about the 2006 TSPA may be obtained from the headquarters of the National Bureau of Statistics, Kivukoni Front, P.O. Box 796, Dar es Salaam, Tanzania; Telephone: (255) 22 212-2722/3, Fax: (255) 22 213-0852, E-mail: dg@nbs.go.tz. Information may also be obtained from www.nbs.go.tz.

Additional information about the DHS project may be obtained from Macro International Inc., 11785 Beltsville Drive, Calverton, MD 20705 USA; Telephone: 301-572-0200, Fax: 301-572-0999, E-mail: reports@measuredhs.com, Internet: http://www.measuredhs.com.

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Tanzania: Zones and Regions

Introduction

The 2006 Tanzania Service Provision Assessment survey (TSPA) describes how the formal health sector in Tanzania provides services for family planning, maternal health, child health, malaria, HIV/AIDS, and other communicable diseases.

The TSPA was carried out by the National Bureau of Statistics and the Ministry of Health and Social Welfare (MOHSW). Local costs of the survey were financed entirely by the pooled fund of the Poverty Eradication Division (PED) in the Ministry of Planning, Economy and Empowerment. Macro International Inc. provided technical assistance through the MEASURE DHS project, which is funded by the U.S. Agency for International Development (USAID) and the President's Emergency Plan for AIDS Relief (PEPFAR).

The major objectives of the 2006 TSPA are to:

- determine the level of preparedness of health facilities for providing quality services;
- provide a comprehensive body of information on the performance of the full range of public and private health care facilities that provide reproductive, child health, and HIV/AIDS services;
- identify gaps in support services, resources, and processes used in providing quality services;
- describe the processes used in providing child, maternal, and reproductive health services and the extent to which accepted standards for quality service provision are followed;
- provide information for periodically monitoring progress in improving the delivery of services at Tanzanian health facilities;
- provide input into the evolution of a system of accreditation of health facilities in Tanzania; and
- provide baseline information on the capacity of health facilities to provide basic and advanced level HIV/AIDS care and support services.

The TSPA involved a nationally representative sample of 611 facilities, including: 1) all national referral hospitals, regional hospitals, specialised hospitals, district hospitals, and district-designated hospitals throughout Tanzania; 2) a sample of other hospitals, health centres, dispensaries, and stand-alone VCT facilities. Facilities are also identified by managing authority, that is, facilities run by the Government of Tanzania, private for-profit groups, parastatal organisations, and faith-based organisations (FBO). Trained interviewers collected the data between April and August 2006.

This report summarizes the major TSPA findings on family planning, maternal health, child health, and malaria based on interviews and observations at 611 health care facilities. To put the results of the 2006 TSPA into context, this report also includes data from the 2004-05 Tanzania Demographic and Health Survey (TDHS) based on data collected from over 13,000 Tanzanians. Data from the 2004-05 TDHS are presented in yellow boxes in each section.

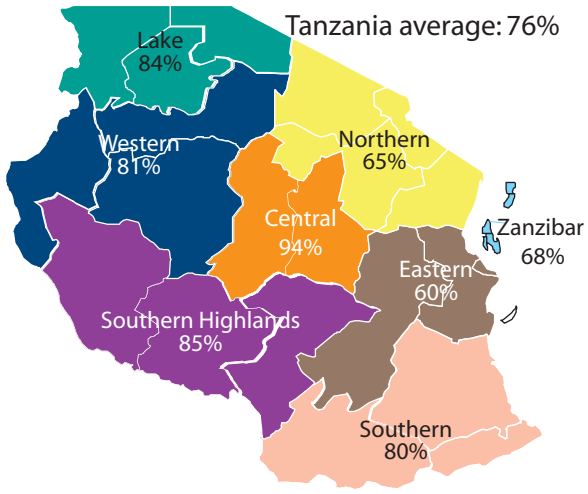
2006 TSPA Results: Family Planning Services

Modern family planning services are available in 76 percent of all health care facilities. In most facilities services are available five days per week. Almost all government facilities offer family planning compared to 32 percent of private for-profit facilities, 50 percent of parastatal and 39 percent of faith-based organisations. Family planning services are available in 76 percent of dispensaries. This is especially important to note, as most Tanzanians use dispensaries as their primary source of health care services.

Availability of family planning services varies by zone. Only about two-thirds of facilities in Northern, Eastern, and Zanzibar zones offer any modern methods, compared to more than nine in ten facilities in Central Zone. Availability of modern methods in health facilities does not necessarily correspond to use, as women in Dodoma and Singida (in Central Zone, where the majority of facilities offer FP) are less likely to use family planning than women in Arusha and Kilimanjaro (in Northern Zone, where only two-thirds of facilities offer FP)(from the DHS, see map on page 2).

Availability of Modern Family Planning Methods

Percent of facilities offering any modern method of family planning (N=608)*



*contraceptive pills, injectables, implants, IUD, male condoms, spermicides or diaphragm

There is less support for long-term methods and traditional family planning. Less than 10 percent of facilities offer male or female sterilisation. Sterilisation is most available at hospitals (see figure on page 2). Only about one-third of facilities provide counselling on the rhythm method.

Photo by Paul Ametepi, Macro International

Putting the TSPA into Context: Family Planning in Tanzania

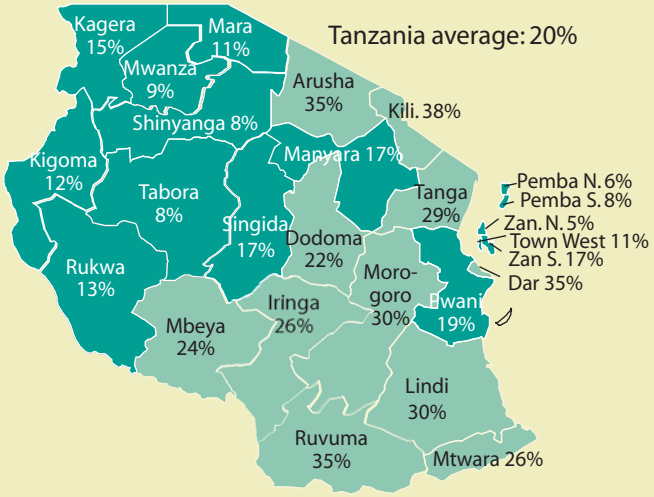
According to the 2004-05 TDHS, Tanzanian women have an average of 5.7 children. Fertility has not changed substantially since 1991. Almost all men and women know of at least one modern method of family planning, but only 20 percent of married women are currently using a modern method. This is a slight increase from 17 percent in 1999.

Pills and injectables are the most commonly used methods. The TDHS reported that two-thirds of modern method users obtained their method from a public source, such as a government hospital or health centre.

Almost one-quarter of married women have an unmet need for family planning — that is, they do not want any more children or want to wait at least two years before having their next child but are not using any family planning. Four out of five non-users of family planning have not recently discussed contraception with a health worker.

Use of Modern Methods of Family Planning by Region

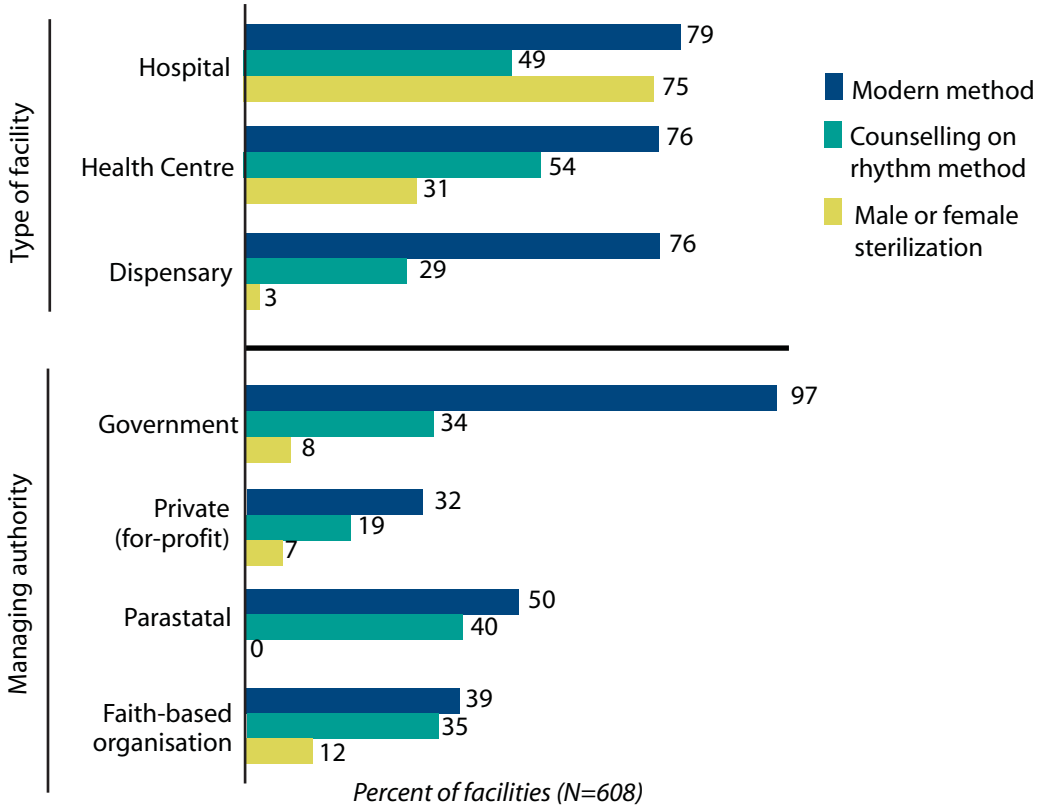
Percent of currently married women currently using any modern method of family planning



Discontinuation of family planning use is a problem in Tanzania— 37 percent of users discontinue use of their method after one year.

A quick comparison of SPA and DHS data suggest that lack of services is not the cause of the low use of modern methods. In fact, availability of modern methods in facilities does not correlate to use among married women.

Availability of Family Planning Services by Facility Type and Managing Authority



Percent of facilities (N=608)

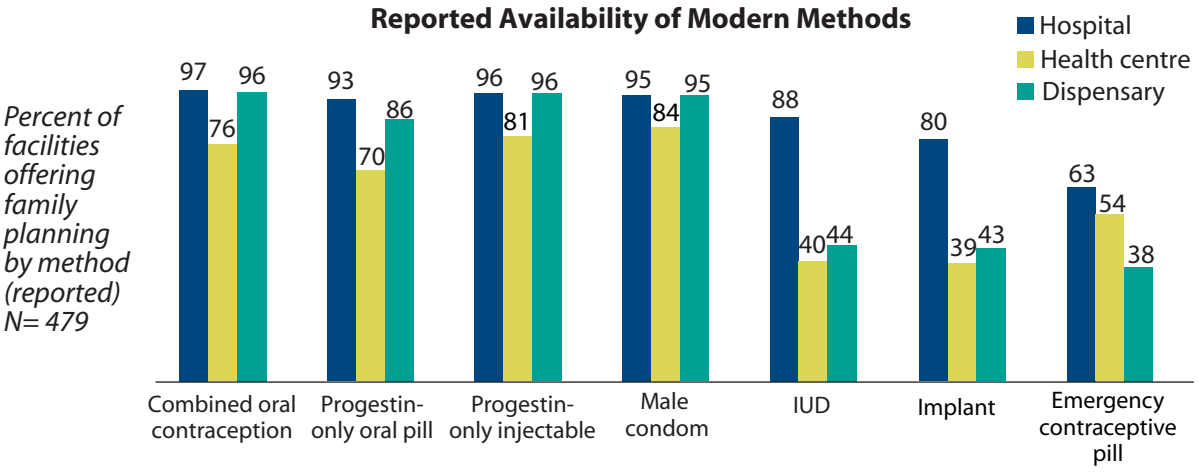
Method Availability

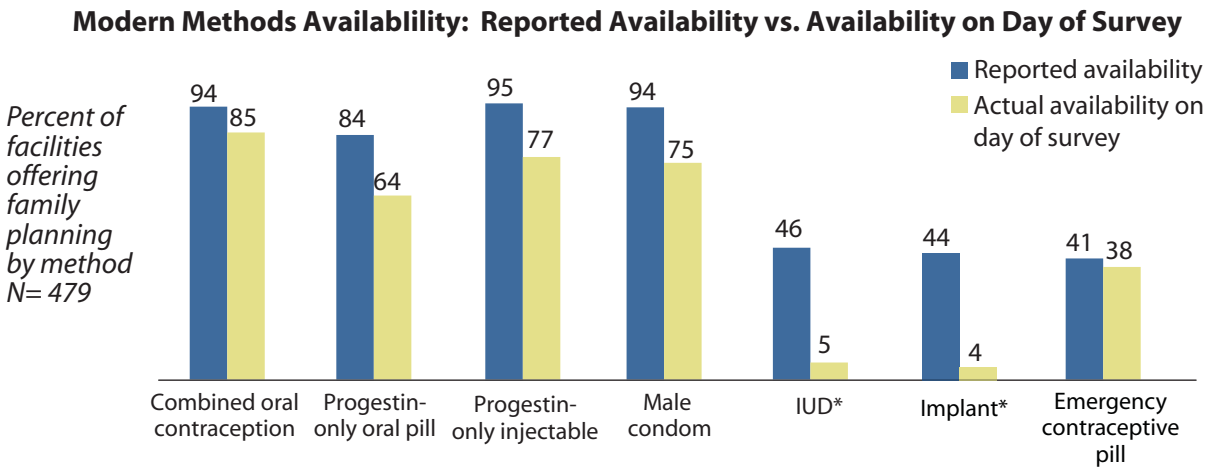
Family planning services that offer many different contraceptive methods are best able to meet the needs of their clients. Nationwide, 84 percent of facilities providing any family planning services reported that they offer at least four different reversible family planning methods. Ninety-six percent of facilities offer at least two methods. Fewer facilities actually had these methods available on the day of the survey (see figures below).

According to the DHS, pills and injectables are the most widely used methods. They are also the most available methods, with more than 95 percent of hospitals and about three-quarters of health centres reporting availability. Most facilities stock male condoms (94 percent) which provide dual protection against pregnancy and HIV/AIDS. Three-quarters of facilities that offer FP actually had male condoms on the day of the survey.

Long-term and permanent methods are less available. Less than half of facilities offer the IUD, meaning that they prescribe it or can actually perform insertion. Therefore, real access to IUDs is even lower, since only 39 percent of facilities offering IUDs have the method and the basic equipment (e.g. gloves, speculum, tenaculum, forceps, etc.) needed for insertion. Forty-four percent of facilities report that they provide implants; however 4 percent of these facilities actually had implants available on the day of the survey.

Emergency contraception is not a family planning method but instead is used just after unprotected intercourse to prevent unplanned pregnancy. Only 41 percent of facilities report that they offer emergency contraception. The progestin-only pill, which also can be used as emergency contraception, and which is recommended during breastfeeding, is available in 84 percent of the facilities.





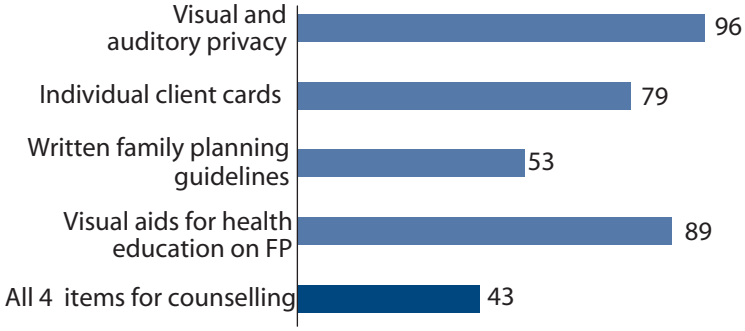
**Facilities that prescribe or counsel on these methods can report that they have these methods available. Therefore it is not expected that all of these facilities would actually have an IUD or implant in-stock on the day of the survey.*

Components Supporting Quality Family Planning Services

High quality family planning services may reduce discontinuation and contraceptive failures and help attract new users. Findings from the TSPA present a mixed picture of family planning services in Tanzania. On the plus side, 96 percent of facilities providing family planning have privacy for client counselling. In addition, over three-fourths of facilities have individual client cards and visual aids for counselling. Surprisingly, however, only half have family planning guidelines on site.

There are wide variations among zones in terms of basic resources for family planning services. More than half of all facilities that offer FP in Northern, Southern, and Zanzibar have all four items for quality counselling (visual and auditory privacy, client cards, written FP guidelines, and visual aids), compared to only 28 percent of facilities in Eastern Zone. There is also variation by managing authority. Three in five parastatal facilities have all items for quality FP counselling, compared to 45 percent of government facilities and only 27 percent of private-for-profit facilities.

Items to Support Quality Counselling for Family Planning



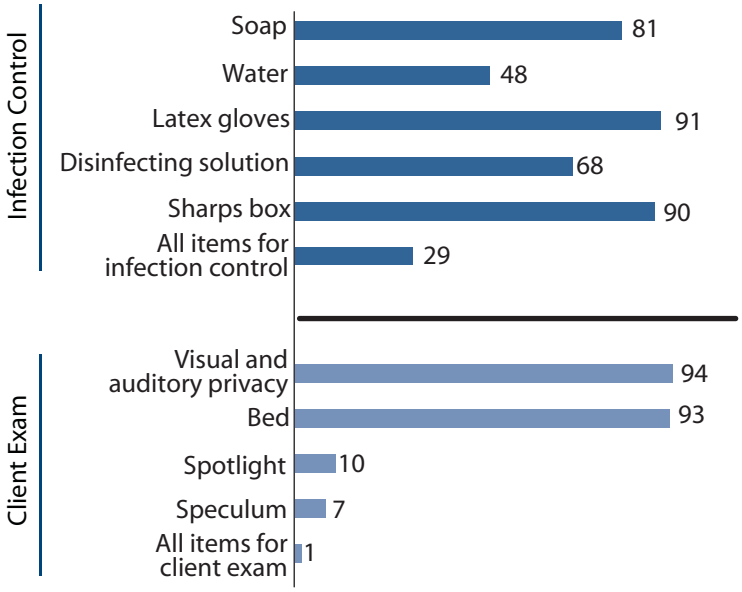
Percent of facilities offering family planning services (N=476)

Infection Control

Photo by Paul Ametepi, Macro International

Most family planning service sites do not have all the items needed for infection control. Infection control is less important during provision of oral contraceptives, condoms, and other methods that pose no risk of viral or bacterial infection to the client. There are very few facilities, however, that offer only these methods. Less than one-third of all facilities offering family planning have all items for infection control including soap, running water, latex gloves, disinfecting solution, and sharps box (for safe disposal for needles and blades) at the service site. While most facilities have soap, latex gloves, and sharps boxes, about half do not have running water. Facilities in Southern Highlands and Zanzibar were most likely to have all the items for infection control (54 percent and 49 percent, respectively) while only 9 percent of facilities in Western Zone had the necessary items.

Conditions for Quality Examination of Family Planning Clients



Percentage of facilities offering family planning services (N=476)

Sterilisation and Disinfection

More than half of facilities that offer FP have the equipment necessary for high level disinfection through dry heat or autoclave, boiling/steaming or chemical disinfection. However, the full package of equipment, knowledge of temperature and time for method used, and automatic timer is rarely available because few facilities have automatic timers. Hospitals are most likely to be able to carry out high-level disinfection.

Equipment and Supplies for Specific Methods

Photo by Paul Ametepi, Macro International

A large proportion of facilities that offer FP do not have the basic equipment for a pelvic examination. For example, only 7 percent of facilities have a speculum at the service site. Some experts advocate that clients receiving oestrogen-containing methods should have their blood pressure checked; however, only 76 percent of facilities offering these methods had blood pressure equipment available. Only 39 percent of facilities providing IUDs had all the basic items necessary for IUD insertion and/or removal. In all, only 8 percent of facilities have IUDs, all basic items for insertion, and are able to provide quality conditions including infection control, privacy, an examination bed, and examination light (see figure on page 4).

Sexually Transmitted Infections (STI) Services

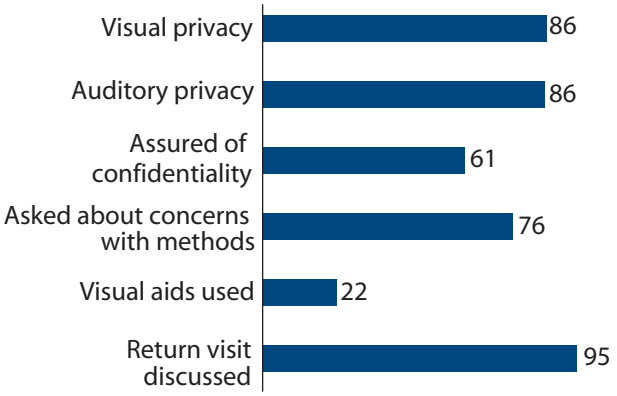
Women in need of family planning are, by definition, sexually active, and therefore also at risk of contracting STIs. Family planning services are key opportunities for providing STI services. As seen on page 3, more than 90 percent of facilities stock condoms, which, in addition to preventing pregnancy, protect against HIV/AIDS and other STIs. Routine treatment of STIs in FP service areas, however, is not common. According to the TSPA, FP providers in 27 percent of facilities that offer FP routinely treat STIs. FP providers in dispensaries are most likely to treat STIs (29 percent), and STI treatment is most common in government and faith-based facilities. More than half (57 percent) of FP facilities have visual aids about STIs or HIV/AIDS. Only about one in five have information about STIs or HIV/AIDS for clients to take home. While more than half of FP facilities have family planning guidelines, only 40 percent have guidelines for diagnosis and treatment of STIs.

Of the facilities providing FP and STI services, 99 percent have at least one medication to treat syphilis, and over 85 percent have medication to treat chlamydia or trichomoniasis. Only 46 percent, however, have medication to treat gonorrhea.

Observation of Client Visits

The TSPA observed family planning client visits to assess how closely providers adhere to internationally recognised standards for quality service provision. Trained interviewers observed 704 clients of family planning services; 23 percent of these clients were visiting the family planning facility for the first time, and 77 percent of the clients came for a follow-up visit. Almost all of the clients left the facility with a family planning method. Three in five clients received the progestin-only injectable and almost three in ten received combined oral contraceptive pills.

Observed Conditions and Content for Family Planning Counseling

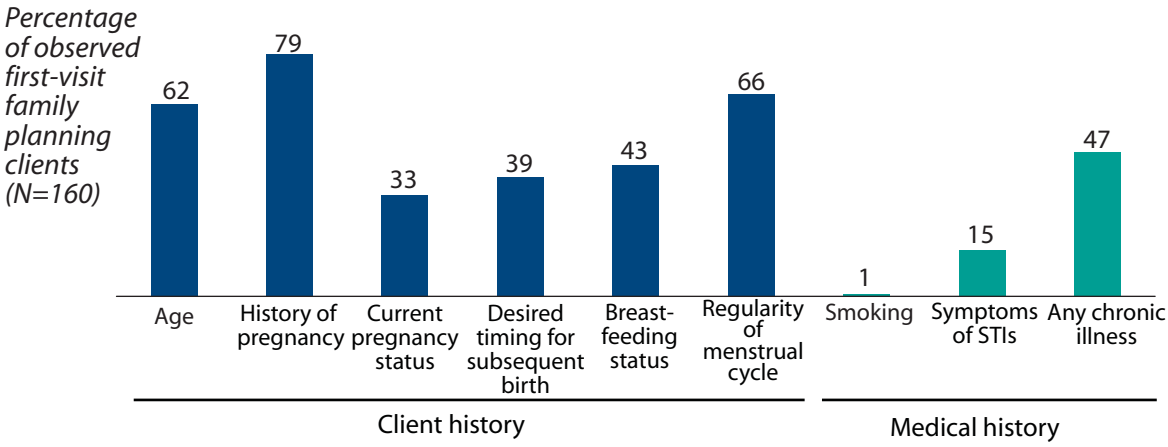


Percent of observed family planning clients (N=704)

Over 85 percent of the family planning consultations took place under appropriately private conditions. Three in four clients were asked by providers if they had any concerns about their methods. This is a fairly large percentage considering that many of the clients were repeat visitors to the facilities. Return/follow-up visits were discussed with almost all clients (95 percent). It is interesting to note that visual aids were used in only 22 percent of the consultations, even though these aids are available in 89 percent of family planning facilities.

Observations of consultations with first-time family planning clients indicate some major gaps in counselling. For example, only about one-third of providers talked with clients about if and when they want another child and only 15 percent asked clients about STI symptoms. These findings also suggest that providers are not doing a careful screening of first-time clients or using the visit as an opportunity to provide preventive HIV and STI counselling.

Observed Elements of Client History for First-Visit Family Planning Clients



Management Practices and Training

The 2006 TSPA collected data about several aspects of management: up-to-date client registers, user fees, and routine staff training and supervision. Results varied widely by facility type and zone.

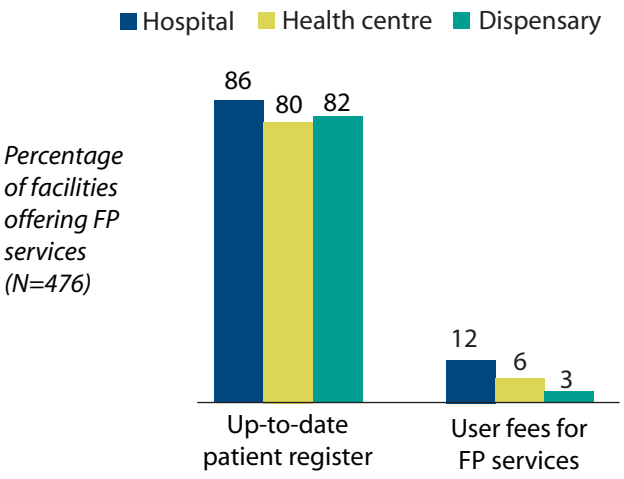
More than four out of five (82 percent) facilities offering family planning have up-to-date client registers, essential tools for management information systems.

In Tanzania, government and parastatal facilities do not charge for family planning services. Private-for-profit and faith-based facilities, however, often have a consultation fee and charge for the FP method and for tests. Overall, 12 percent of hospitals, 6 percent of health centres, and 3 percent of dispensaries charge some user fees.

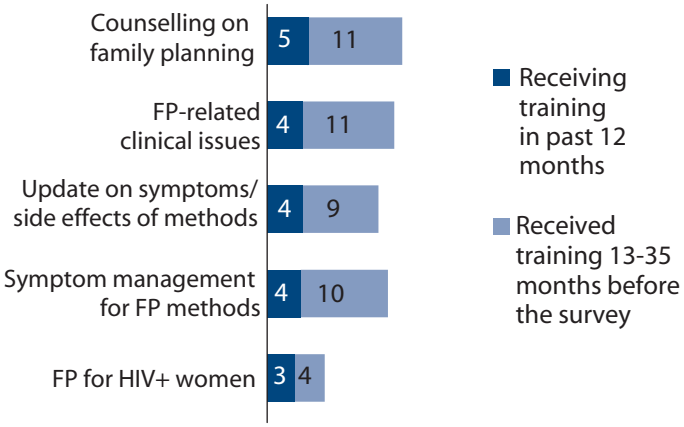
The TSPA describes a family planning facility as having routine supervision if at least half of the interviewed providers were personally supervised during the six months preceding the survey. According to this definition, 89 percent of family planning facilities provide routine supervision.

The TSPA interviewed 1,368 family planning providers. Only 6 percent of interviewed service providers received any pre- or in-service training during the 12 months preceding the survey, while another 12 percent received this training 13-35 months prior to the survey. Private and faith-based facilities are most likely to provide routine training for their staff, while parastatal facilities are least likely to provide training. The training provided covered a range of topics including family planning counselling, update on contraceptive methods, and diagnosis and treatment of STIs.

Management Practices for Family Planning Services: Patient Register and User Fees



In-Service Training Received by Interviewed Family Planning Service Providers



Percent of interviewed family planning service providers (N=1,368)

2006 TSPA Results: Maternal Health Services

Maternal health services are not consistently available throughout Tanzania. Nationwide, 82 percent of health care facilities provide antenatal care (ANC) services, usually five days per week. Not surprisingly, hospitals (95 percent) and health centres (93 percent), are most likely to offer ANC. Only 80 percent of dispensaries, the most common source of health care for Tanzanians, provide ANC. Four of out five facilities offering antenatal care also provide tetanus toxoid vaccines. Normal delivery services are available in 74 percent of facilities, while almost two-thirds of facilities offer postnatal (or postpartum) care. Emergency transportation support, however, is far less available. Only 40 percent of facilities provide transport to a referral site for maternal emergencies, and only 5 percent can perform a Caesarean section.

Overall hospitals are more likely than dispensaries to provide maternal health services and to have the appropriate infrastructure and equipment. Availability of maternal health services varies widely among the zones (see table on page 9). Facilities in Zanzibar are least likely to offer services in all areas; only 8 percent of Zanzibari facilities offer normal delivery services, and only 15 percent can provide emergency transport to a referral site.

Emergency maternal care is available in very few facilities. Fewer than 10 percent of all facilities have the necessary equipment to handle complications of labour and delivery, such as a vacuum extractor, blood transfusion services, a D&C kit, or equipment for newborn respiratory support.

Malaria during pregnancy can have serious adverse effects on both the mother and the foetus. For more malaria findings, see the Malaria section, page 22.

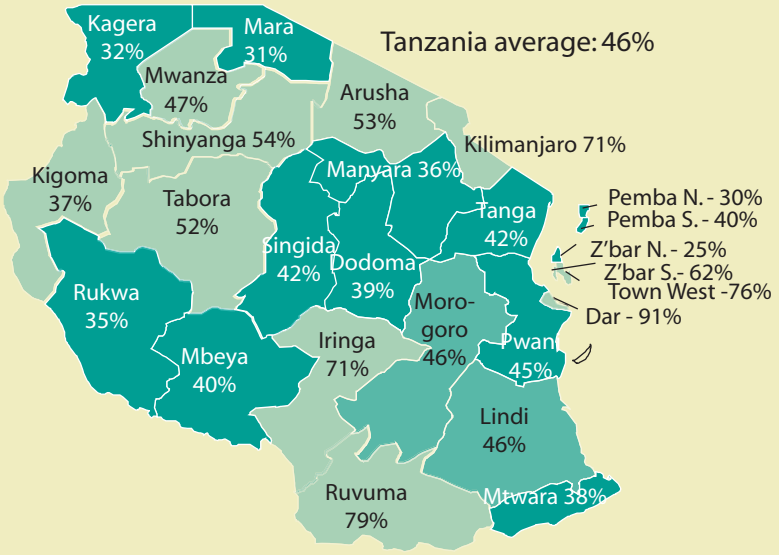
Putting the TSPA into Context: Maternal Health in the TDHS

According to the 2004-05 TDHS, 94 percent of pregnant women make at least one antenatal care visit; 33 percent make 2 or 3 visits, and over 62 percent make 4 or more. However, most women seek care well after the first trimester of pregnancy.

Far fewer women go to health care facilities to give birth. Nationwide, only 47 percent of women give birth in a health care facility. Women staying at home are more likely to be assisted by a traditional birth attendant or a friend or relative than by a trained provider. Delivery at home is more than twice as common in rural as in urban areas. Among all births, the proportion assisted by a skilled attendant ranges from only 31 percent in Mara to 91 percent in Dar es Salaam. Among women who did not deliver in a health care facility, only 17 percent received any postnatal care.

Delivery by Medical Personnel by Region

Percent of women with a birth in the past 5 years who were assisted at delivery by a health professional



There are approximately 578 maternal deaths per 100,000 live births. Many of these deaths are related to complications of unsafe abortions. Others are due to complications during and after term deliveries, particularly infection, haemorrhage, and high blood pressure.

Availability of Maternal Health Services

Percentage of facilities offering specific services, by zone (N=608)

Zone	ANC	Normal delivery	C-section	Maternal emergency transport	Postnatal care
Northern	76	66	5	38	57
Central	97	94	2	54	78
So. Highlands	91	87	4	54	71
Western	81	85	2	40	55
Lake	84	83	6	42	70
Southern	94	87	8	35	80
Eastern	70	55	8	33	53
Zanzibar	67	8	2	15	56
TOTAL	**82**	**74**	**5**	**40**	**64**

Antenatal Care and Postnatal Care

Nationwide, 82 percent of facilities offer antenatal care services. Antenatal care services vary from only 67 percent of facilities in Zanzibar to 97 percent of facilities in Central Zone. Most hospitals provide ANC services five days a week, while about a quarter of health centres and dispensaries only offer ANC services one or two days a week. Similarly, tetanus toxoid vaccines are available five days a week at most hospitals, but less often at other facilities. However, tetanus toxoid vaccination is not always offered on the same days that antenatal care is offered.

Postnatal care is available at 64 percent of facilities, most commonly hospitals and health centres.

Items to Support Quality ANC Services

The availability of basic items for ANC varies throughout Tanzania. Only 45 percent of facilities that offer ANC have all the essential supplies for basic ANC—iron and folic acid tablets, tetanus toxoid vaccine, blood pressure apparatus, and fetoscope. Other items needed for exams are less available. For example, while almost all facilities offering FP have visual and auditory privacy, only 31 percent of ANC sites have visual aids for counselling clients, and only 8 percent have an examination light. Generally hospitals are better equipped.

Photo by Paul Ametepi, Macro International

Testing capacity for anaemia, high blood pressure, urine glucose, and syphilis vary in availability. Fewer than 20 percent of all facilities that offer ANC can provide any of these four tests, while the majority of hospitals can provide all tests.

Availability of Diagnostic Tests

Percentage of facilities providing ANC with capacity for conducting the indicated diagnostic test (N=499)

Zone	Anaemia	Urine protein	Urine glucose	Syphilis
Northern	30	27	24	29
Central	1	9	8	5
So. Highlands	18	18	16	23
Western	14	10	8	12
Lake	12	16	16	18
Southern	16	21	14	16
Eastern	35	35	35	35
Zanzibar	5	9	12	7
TOTAL	**19**	**20**	**18**	**20**

Photo by Paul Ametepi, Macro International

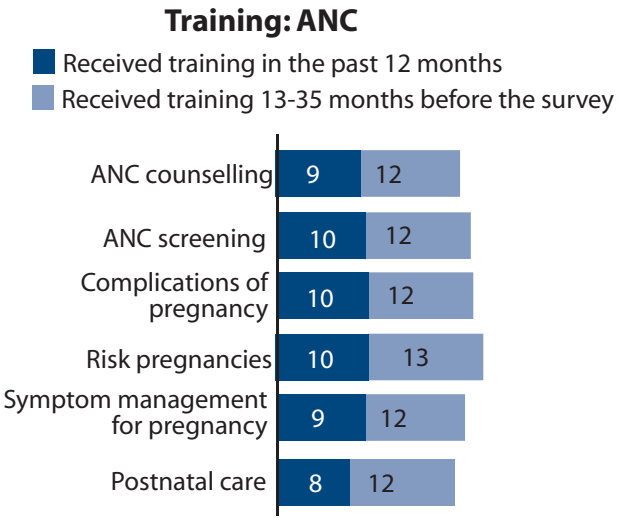
Availability of Medications

ANC facilities also vary in their capacity to treat common problems of pregnancy. Almost 9 in 10 facilities have an antibiotic and almost all facilities have an antimalarial drug. Only 12 percent of facilities have methyldopa (aldomet), used for treating high blood pressure, a common complication of pregnancy. Most facilities have at least one medication for treating the sexually transmitted diseases trichomoniasis (87%), chlamydia (90%) and syphilis (97%) but only 52 percent have medication to treat gonorrhea. Overall, only 8 percent of all facilities providing ANC have medications on hand for treating all of these common complications and infections.

Management Support for ANC and PNC

Over 80 percent of facilities have up-to-date client registers for ANC. Far fewer, only 19 percent, have registers for postnatal care.

The TSPA concludes that a facility has routine staff training if half of interviewed providers in that facility report that they received structured pre- or in-service training within the year preceding the survey. Approximately one-third of facilities providing ANC offer their staff routine training. Facilities were more likely to provide personal supervision: in 89 percent of facilities, at least half of interviewed providers had received personal supervision once or more in the six months preceding the survey.



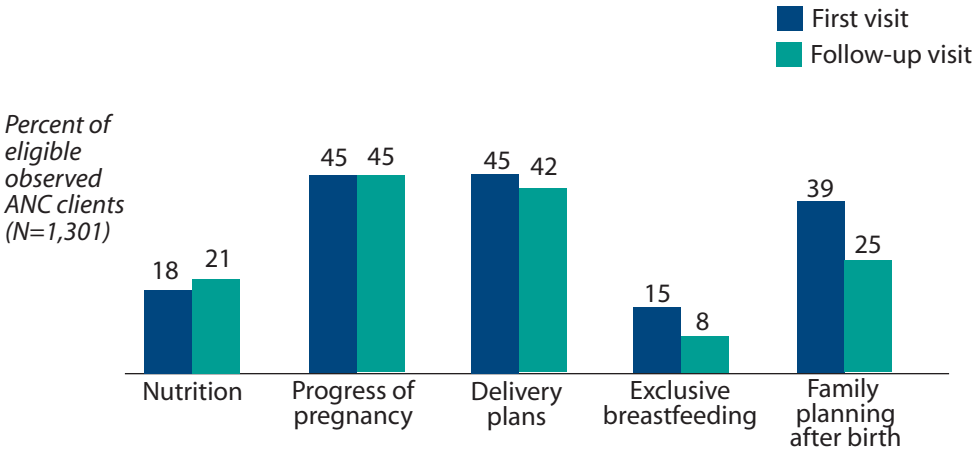
Percent of interviewed ANC providers with training in specified topics (N=1,601)

Adherence to Standards in ANC

TSPA interviewers observed the client-provider interaction of over 1,300 ANC clients. About half of the clients observed were visiting for the first time in their pregnancy, while the other half were coming for a follow-up visit. This was the first pregnancy for 21 percent of the clients.

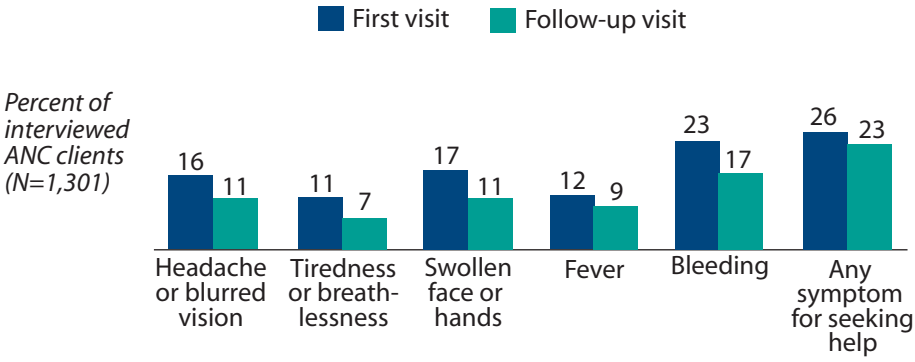
The findings suggest that health care providers do well with routine activities for monitoring pregnancies but are less alert to complications of pregnancy or to related health concerns. For example, over 80 percent of eligible pregnant clients were weighed and had their blood pressure checked, but only 27 percent had their urine tested for protein. About half of observed clients were given iron tablets and 36 percent received the tetanus toxoid vaccine. Taking client histories was inconsistent. Few clients were asked about any medications they were currently taking, and only 59 percent of first clients with previous births were asked about complications of previous pregnancies. Delivery plans were discussed with only about half of late term (i.e. at least 8 months pregnant) clients. Very few clients were counselled about postpartum family planning and breastfeeding. This is cause for concern for both women's and newborns' health.

Counselling Topics Discussed During First and Follow-Up Visits



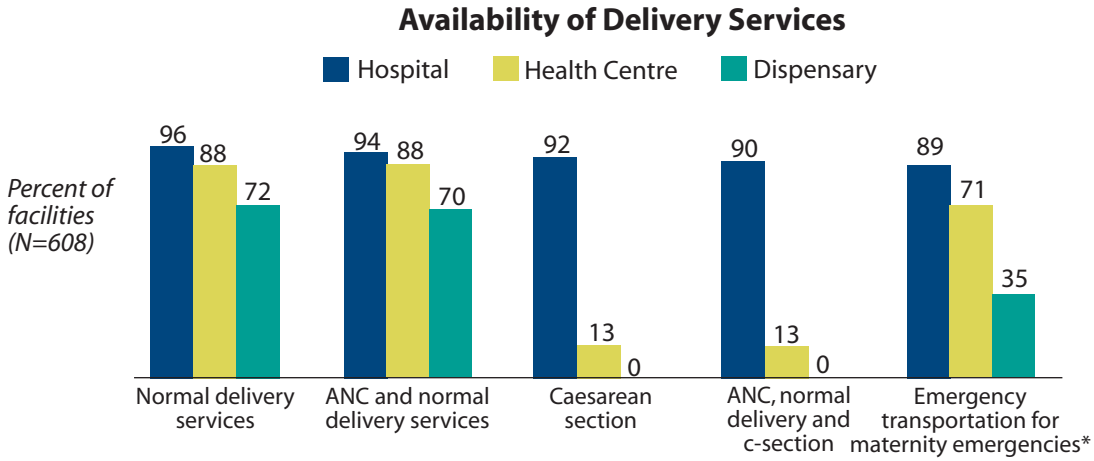
Also of concern is the absence of counselling and education on specific warning signs of pregnancy. Among clients who were interviewed as they left the facility after receiving services, only 24 percent said that their providers had talked with them about any warning sign of pregnancy during the current visit or any prior visits. Results from the TDHS were more encouraging—almost half (47 percent) of women who received ANC reported that their provider had told them about signs of pregnancy complications.

Warning Signs Discussed During First and Follow-up ANC Visit



Delivery Services

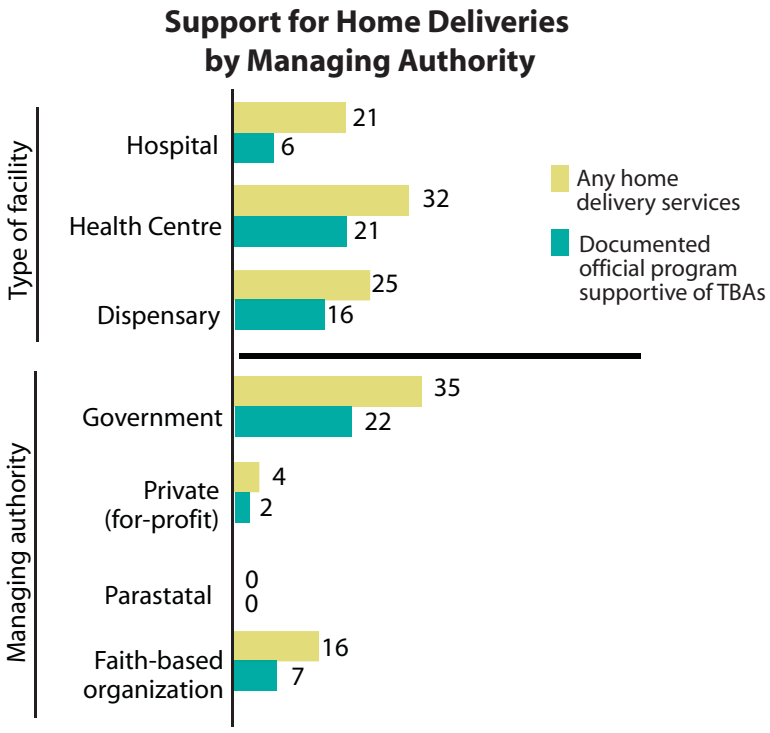
As noted on page 9, only 74 percent of all facilities provide normal delivery services. Availability of these services ranges from only 8 percent of facilities in Zanzibar to 94 percent of facilities in Central Zone. Half of hospitals had more than 76 vaginal deliveries in the month before the survey, while half of health centres had 16 or more deliveries in the past month and half of dispensaries had 6 or more. Hospitals are also most likely to provide emergency delivery services. Almost all hospitals provide Caesarean sections, compared to very few other facilities. Overall, 40 percent of facilities can provide emergency transportation or are the referral site for maternal emergencies. All hospitals should be able to provide emergency transportation services, and yet 11 percent of hospitals do not have this capability.



*Facility provides support for emergency transport to referral site or the facility is the referral site

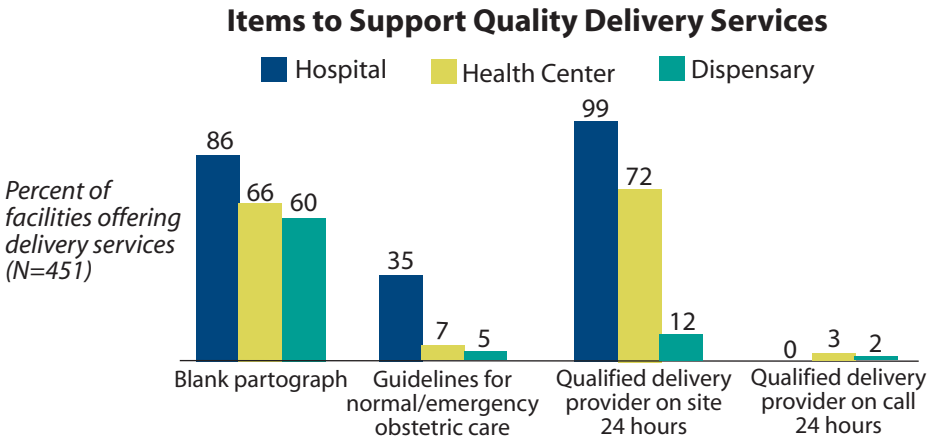
Domiciliary Care Practices

According to the DHS, slightly more than half of pregnant women in Tanzania deliver at home, most without assistance from a trained provider. Health care facilities can support home deliveries in various ways, for example, by training traditional birth attendants or by sending trained midwives to attend deliveries at home. The TSPA findings show that only 26 percent of all facilities have services supporting home delivery, either for routine cases or emergencies. Sixteen percent of facilities have programmes with traditional birth assistants. Government facilities are most likely to provide support for home deliveries.



Elements and Practices to Support Normal Deliveries

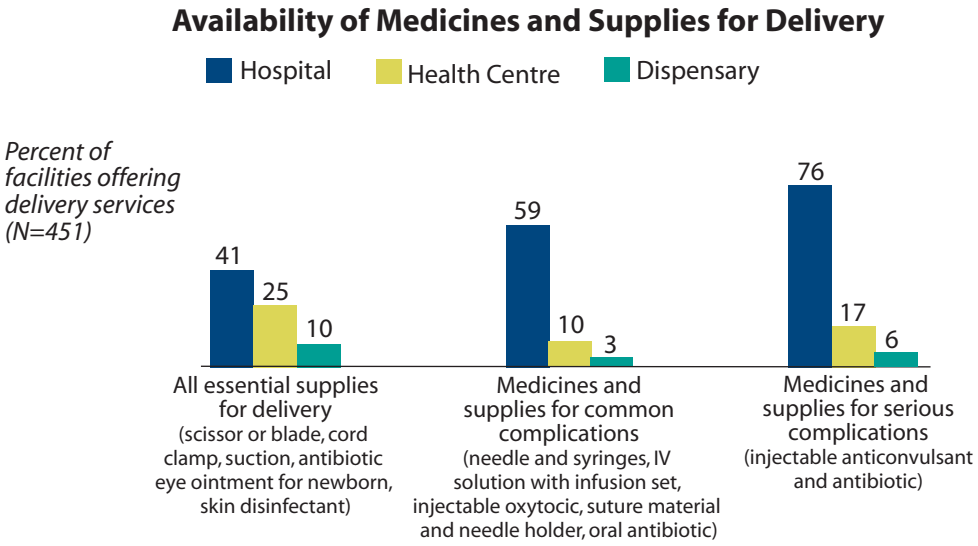
Most facilities providing delivery services have delivery beds and private delivery rooms. Only 12 percent of facilities have an examination light, however. Fewer facilities have other necessary items, especially guidelines for both normal and emergency deliveries. The partograph, a standard tool used for monitoring the progress of labour, is available in two-thirds of facilities.



A total of 23 percent of facilities offering deliveries have a trained provider on site 24 hours a day, while another 2 percent have a provider on call 24 hours a day.

Supplies for Normal and Complicated Deliveries

Only 13 percent of facilities have the necessary supplies for normal deliveries in the delivery area: scissors or a blade, cord clamp or tie, suction apparatus, and skin disinfectant. Antibiotic eye ointment for newborns is available in 44 percent of delivery sites. Very few facilities (6 percent) have all the supplies needed to handle common complications (see list in figure at right). Interestingly, more facilities (11 percent) have the medicines needed to treat serious complications. In both cases, hospitals and faith-based institutions are most likely to have all the necessary items.



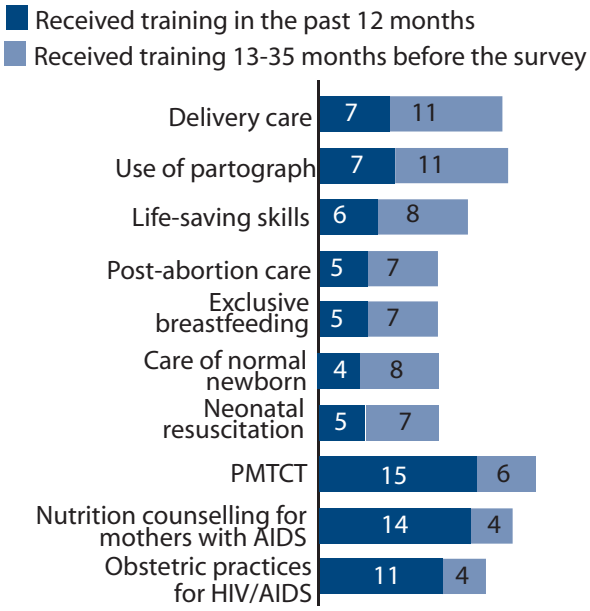
Of most concern, however, is that equipment for life-threatening emergencies is in such short supply. Nationwide, only 5 percent of facilities have a vacuum extractor (used for assisted vaginal delivery), and only 8 percent have a D&C kit (needed to remove retained placenta). Injectable oxytocics to prevent haemorrhage are available in the delivery area in only 11 percent of facilities that offer delivery services. Only 7 percent have blood transfusion services (although almost all hospitals have this ability) and 16 percent have newborn respiratory support services. Overall, only 7 percent of facilities can perform a caesarean section. Hospitals are most able to provide c-sections (96 percent).

Management Practices and Training

The TSPA interviewed over 1,400 delivery service providers. Only 23 percent of these providers reported receiving any training (pre- or in-service) during the year preceding the survey. Only 5 to 15 percent had been trained in any specific topic, including delivery care, life-saving skills, post-abortion care, prevention of maternal to child transmission of HIV (PMTCT), or exclusive breastfeeding. Almost 80 percent, however, were personally supervised at least once within the six months preceding the survey.

Photo by Paul Ametepi, Macro International

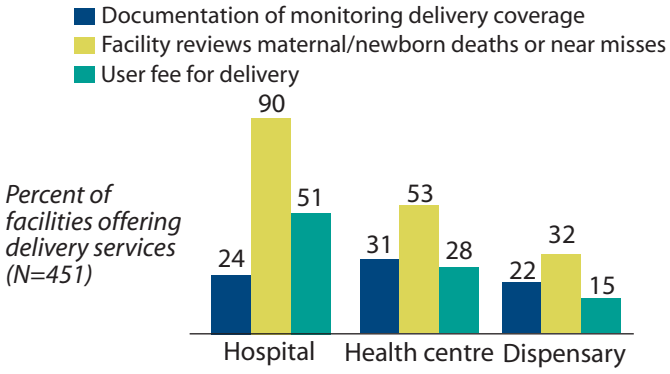
In-Service Training: Delivery



Percent of interviewed delivery-service providers with training in specified topics (N=1,454)

Only about one in four facilities document monitoring of delivery coverage in their catchment area. Monitoring of delivery coverage is highest in health centres (31 percent) and parastatal facilities (50 percent). No facilities in Zanzibar monitor delivery coverage, while 45 percent of facilities in Southern Zone monitor coverage.

Management Practices



Careful reviews of maternal or newborn deaths or near-misses help providers recognize problems and prevent future deaths. Nationwide, only 37 percent of facilities providing delivery services conduct these reviews. Hospitals are most likely to conduct record reviews (90 percent) compared to only half of health centres that offer delivery services.

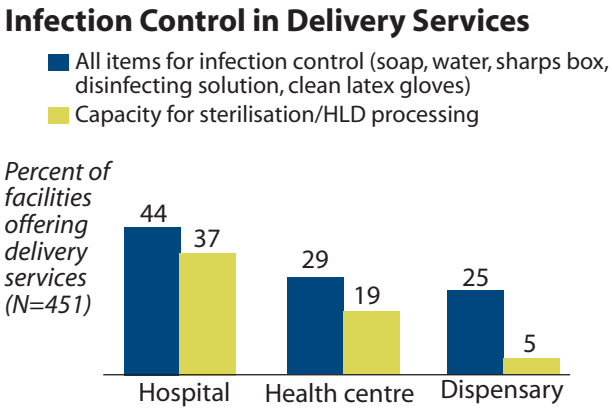
Almost no (1 percent) government facilities charge user fees for delivery, while the majority of private and faith-based facilities charge fees. Nationally, 18 percent of facilities charge delivery fees.

Infection Control

Only 30 percent of all facilities offering ANC and 26 percent of facilities offering delivery services are fully equipped with soap and running water, clean latex gloves, disinfecting solution, and a sharps box. Running water is available in only 48 percent of ANC sites and 47 percent of delivery sites.

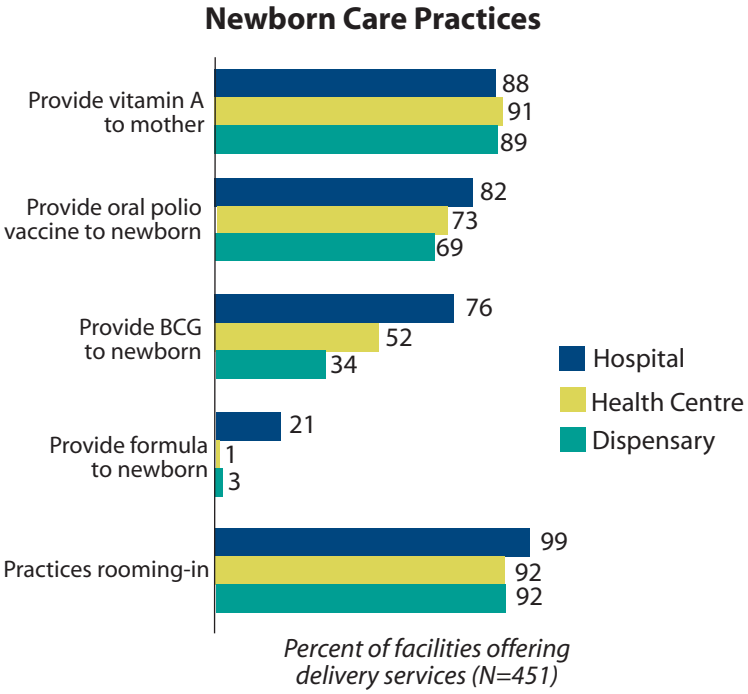
Photo by Paul Ametepi, Macro International

Only 8 percent of facilities offering delivery services have the capacity for sterilisation or HLD processing, again, usually because the facility is missing an automatic timer. In most facilities, delivery service equipment is sterilised at the central processing site of the facility, not in the delivery service area itself.



Newborn Care

Several routine practices can increase newborn and infant survival. Vitamin A supplementation to breastfeeding mothers, for example, decreases risk of infections and death among newborns. Nine in ten facilities that offer delivery services routinely provide vitamin A to new mothers, and 80 percent of facilities have vitamin A either in the delivery room or in the pharmacy. Other recommended practices, such as rooming in, where the baby stays in the mother's room, are almost universal. However, 4 percent of facilities still provide formula or other liquids to newborns before breastfeeding is established.



2006 TSPA Results: Child Health Services


Photo by Paul Ametepi, Macro International

The TSPA assessed the availability of three basic child health services: curative care for sick children, immunisations, and growth monitoring, The TSPA also evaluates Tanzania's adherence to the World Health Organization's Integrated Management of Childhood Illness (IMCI) strategy as adopted by the Ministry of Health and Social Welfare (MOHSW) in 1996 and the MOHSW's Expanded Programme of Immunisations (EPI).

All facilities provide curative care for sick children, 79 percent provide childhood immunisations and 81 percent provide growth monitoring. Over 90 percent of hospitals and government facilities provide all three services. Dispensaries are least likely to provide all three services (77 percent). Availability of these services also varies by zone, from only 64 percent in Zanzibar and Eastern zones to 97 percent of all facilities in Central Zone.

Immunisation services are least available in private facilities (24 percent) and parastatal facilities (40 percent) as well as in Eastern Zone and Zanzibar (64 percent each).

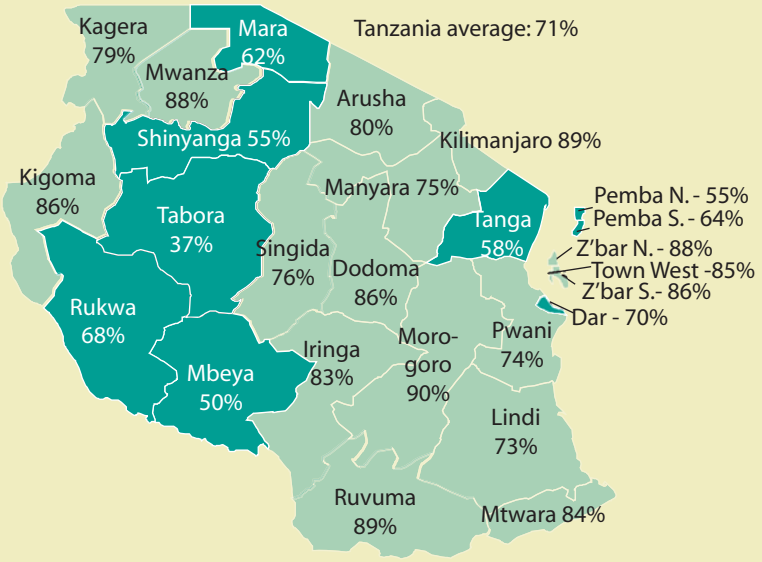
Putting the TSPA into Context: Child Health in Tanzania

Child mortality has declined dramatically since 1999. As of the 2004-05 TDHS, the infant mortality rate was 68 per 1,000 live births, down from 99 deaths per 1,000 in 1999. The under-five mortality rate was 112 deaths per 1,000 live births compared to 147 in 1999. Still, one in every nine children in Tanzania dies before his or her fifth birthday.

In 2004-05, 71 percent of Tanzanian children had received all of the recommended EPI vaccines (BCG, three doses each of DPT/THB and polio, and one dose of measles). Over 80 percent of urban children are fully immunised compared to 69 percent of rural children.

Vaccination Coverage

Percent of children 12-23 months who have received all recommended vaccinations



Among children with acute respiratory infection (ARI) or fever in the two weeks before the DHS, 57 percent were taken to a health facility for treatment. Only about half (54 percent) of children with diarrhoea were treated with oral rehydration salts (ORS), although almost all mothers know about ORS packets. Only one-third of children with diarrhoea were given increased fluids, a critical intervention to prevent dehydration. About half were taken to a health provider.

Malnutrition is a serious problem in Tanzania. More than one-third of children under age five are stunted, or too short for their age. Stunting is a sign of chronic malnutrition. Almost one in four children are underweight, or too thin for their age. Both stunting and underweight have decreased substantially in recent years.

Availability of Child Health Services

Percentage of facilities providing the indicated services at the facility, by type of facility

Facility type	Outpatient care for sick children	Growth monitoring	Immunisation	All 3 basic child health services
Hospital	100	91	91	91
Health centre	100	90	85	85
Dispensary	99	80	78	77
Total	**100**	**81**	**79**	**78**

Immunisations

The Expanded Programme for Immunisations (EPI) aims for all children to be fully immunised by age one. The basic EPI vaccines for the seven major childhood diseases (BCG, polio, DPT-HB, measles) are available in three out of four facilities that provide childhood immunisation services. No vaccine is universally available.

According to the EPI, vitamin A should be stored with vaccines in order to increase provision of vitamin A. Almost all facilities that offer child immunisation in Tanzania follow this recommendation.

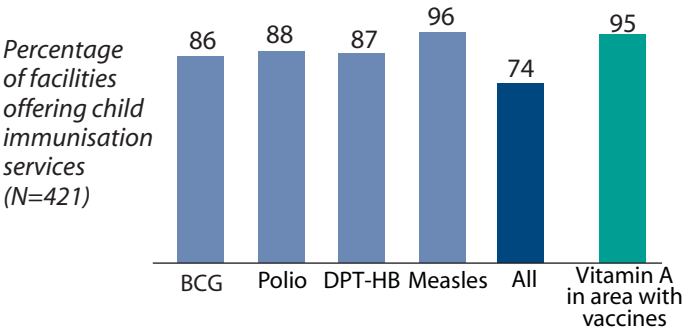
Several supplies are needed to provide the best vaccine services. Among the facilities providing child immunisation services, four in five have blank immunisation cards, 85 percent have syringes and needles, and 97 percent have vaccine carriers.

According to the TSPA, quality child immunisation includes:

- *Availability of all EPI vaccines (74%) and vitamin A (95%)*
- *Equipment: immunisation cards, syringes and needles and vaccine carriers (68%)*
- *All items for infection control (37%)*
- *Client register and tally sheet, documentation of DPT dropout rate or measles coverage (18%)*

Only 16% of facilities have all these components

Availability of Vaccines and Vitamin A for EPI



Certain administrative components are also needed. While about nine in ten facilities have a client register and tally sheet, only about two-thirds monitor measles coverage or DPT dropout rates in their catchment areas. Government facilities are most likely to monitor community coverage of measles and DPT dropout rates.

Overall, only 16 percent of facilities have all the components necessary for providing quality child immunisation available on the day of the survey.

Growth Monitoring

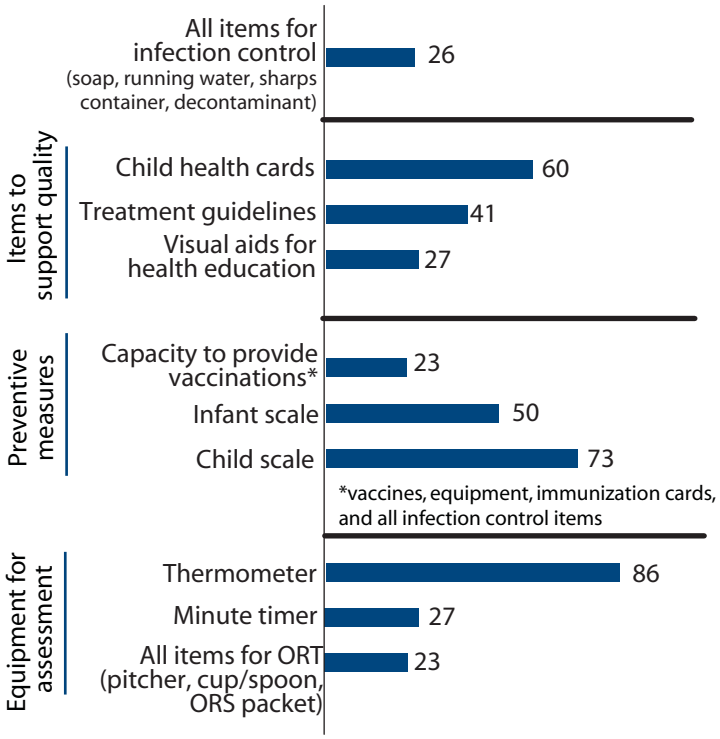
Four in five facilities provide growth monitoring for children. However, these services are not always offered the same day as the other child health services. Furthermore, only half of facilities have a scale to weigh infants, and three-quarters have a scale to weigh older children (see page 18).

Photo by Paul Ametepi, Macro International

Care for the Sick Child

All facilities provide curative care for sick children. However, only 11% of facilities offering sick child care have all of the items needed to provide quality services including infection control items, individual health cards, treatment guidelines and visual aids. Many essential items needed for treating sick children are available inconsistently. For example, only 41 percent of facilities have treatment guidelines, only 27 percent have visual aids, and 16 percent have IMCI counselling cards for providers. Only about one in four facilities have the items necessary to provide oral rehydration therapy. Thermometers are widely available (86 percent), but only 27 of facilities provide timers for counting respiration.

Availability of Equipment and Supplies for Quality Assessment of Sick Child



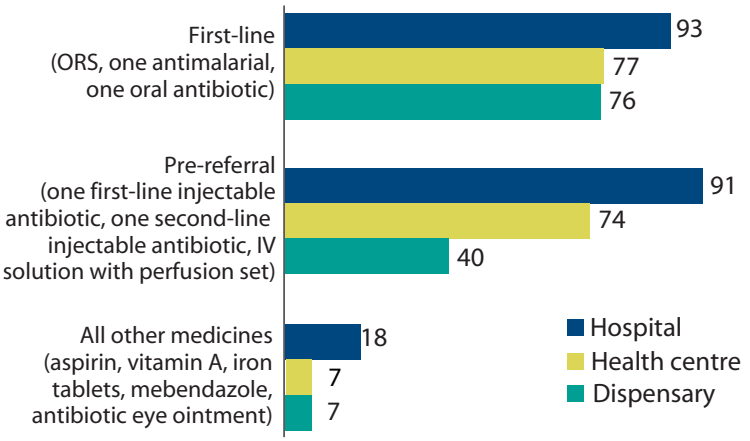
Percentage of facilities offering outpatient care for sick children (N=605)

The IMCI guidelines were created to improve quality of care for sick children, as well as to improve preventive care. Integration of services is key to the IMCI strategy— that is, sick children should not only be treated according to their symptoms, but providers should take the opportunity to provide preventive services such as immunisations, growth monitoring, and other assessments. It is crucial that these services be offered in the same sites on the same days. In Tanzania, only half of facilities offer EPI services on every day that sick child services are available, and only 23 percent of facilities offering sick child care can offer all items needed for immunisations. This is a missed opportunity, as parents may not bring their children back to the facility at a later date for immunisations.

Essential Medicines for Treating Sick Children

Three in four facilities have all three first-line medicines identified by the IMCI guidelines— ORS, at least one antimalarial, and at least one antibiotic. Hospitals are most likely to have these three items. Pre-referral medications—one first-line injectable antibiotic, one second-line injectable antibiotic, and IV solution with perfusion set and sterile syringes— are available in less than half of facilities. Dispensaries are least likely to have pre-referral or other medicines. Government-run facilities are least likely to have pre-referral medications, because the majority of government facilities are dispensaries.

Availability of Essential Medicines



Percent of facilities offering each item (N= 605)

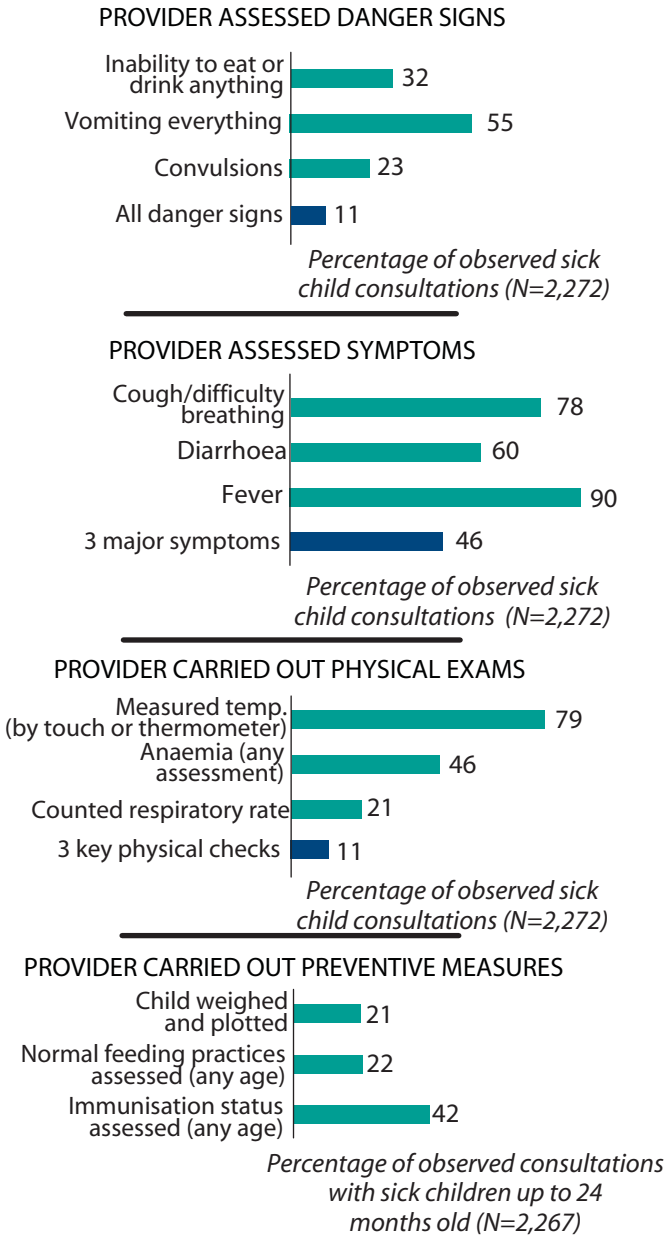
Observation of Sick Child Consultations

TSPA interviewers observed sick child consultations to check for a variety of standard practices based on IMCI guidelines. Only during one in ten consultations did providers check for all three major danger signs: ability to eat or drink anything (32 percent), vomiting (55 percent) and convulsions (23 percent). Various aspects of the physical examination were also missing; 21 percent did not check temperature, more than half did not assess for anaemia, and only one-fifth assessed dehydration or counted respiratory rates. Providers should also check sick children's weight, feeding practices and immunisation status, regardless of diagnosis. These basic preventive measures are not regularly carried out.

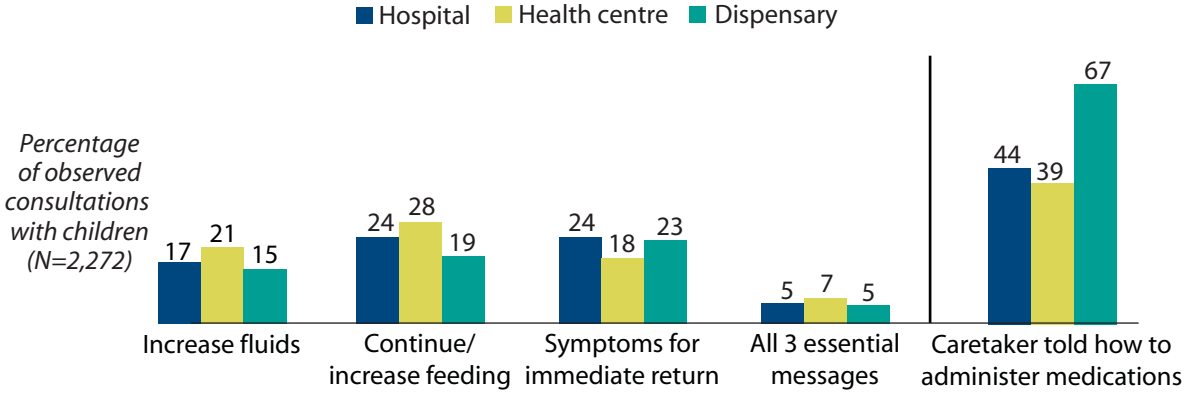
IMCI guidelines state that sick child services should also be able to provide vaccines and growth monitoring. However, children's weights were plotted in only 21 percent of observed sick child consultations, and immunisation status was assessed less than half of the time. These are clear missed opportunities for prevention.

Providers should tell caregivers how to care for their sick child. While about two-thirds of caregivers were told what illness their child had, far fewer received specific instructions on how to treat it. Only 16 percent of caregivers were told to increase fluids to the child, and one in five were told to continue or increase feeding or what symptoms required a return visit. In all, these three essential messages were given in only 6 percent of observed visits. Among observed sick children who were prescribed or provided oral medications, almost two in three caregivers were told how to administer medications, but the caretaker was asked to repeat back the instructions in only 14 percent of observed consultations.

Observed Assessments and Examinations



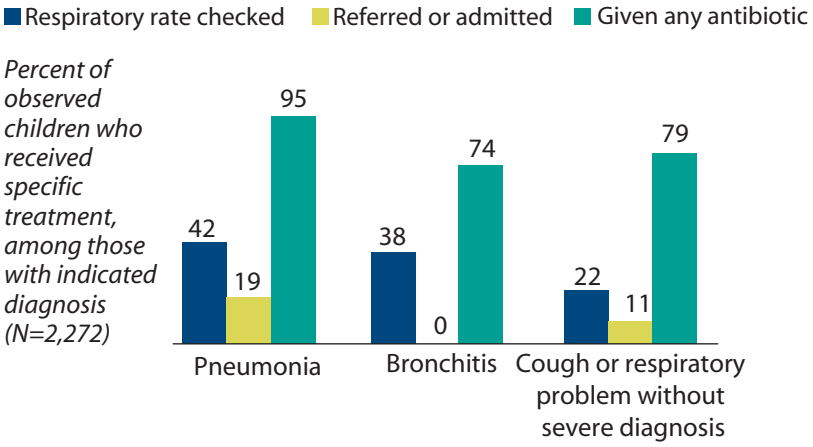
Essential Advice Given to Caregivers



Treatment by Diagnosis

Specific illnesses call for certain recommended treatments according to the IMCI guidelines. Among observed children with pneumonia or severe respiratory illnesses, 19 percent were referred or hospitalised. Among these children, respiratory rate was checked in less than half of cases, while temperature was assessed for almost nine in ten. Almost all children with pneumonia or severe respiratory illnesses were given antibiotics. Three in four children with bronchitis and four in five children with non-severe respiratory problems were also given antibiotics.

Treatment of Children with Respiratory Illnesses

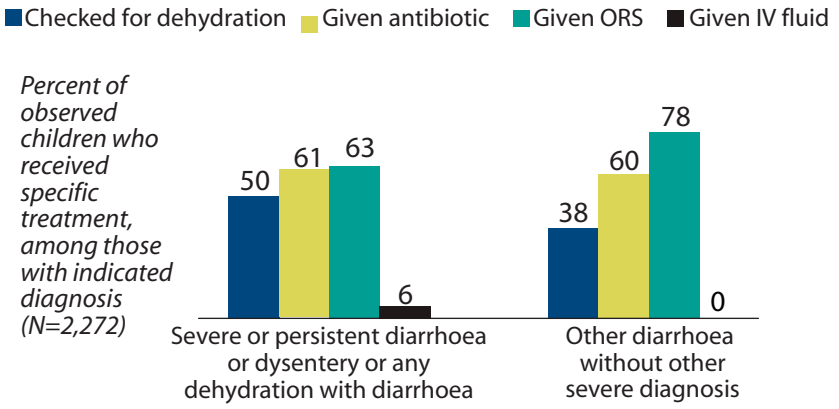


**Diagnoses of children made by the providers*

According to the IMCI, children with fever should receive an antimalarial and a fever-reducing medication such as aspirin. One in five children diagnosed with severe fever was referred or admitted, and almost two in five received an antibiotic. About nine in ten of these children received medication for symptoms, such as aspirin or cough medicine. Ninety-six percent of children who were diagnosed with malaria received an antimalarial drug. Almost half also received an antibiotic.

Two in ten children diagnosed with severe diarrhoea were referred or admitted compared to about one in ten children with the less severe diagnosis. Antibiotics should not be prescribed for non-dysentery related diarrhoea; however 60 percent of children with any type of diarrhoea were given antibiotics. ORS was prescribed for 63 percent of those with severe diarrhoea and 78 percent of those with less severe cases.

Treatment of Children with Diarrhoeal Diseases



**Diagnoses of children made by the providers*

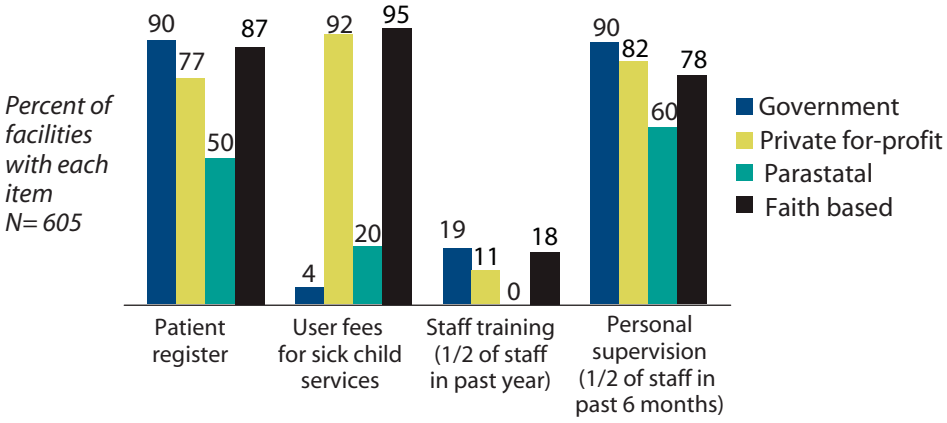
For all diagnoses, providers failed to assess for many of the major symptoms and danger signs, and did not consistently provide the basic physical exams. Antibiotics were prescribed for a wide range of diagnoses, signalling a possible overuse.

Management Practices Supporting Sick Child Care

IMCI guidelines recommend various administrative and management practices to support the provision of quality services for the sick child. Most facilities (86 percent) have an up-to-date client register. Seventeen percent of facilities provide routine staff training, meaning that half of staff interviewed in that facility have been trained in the year before the survey, and 16 percent of individually interviewed providers had received training within the 12 months before the survey. Less than 10 percent of providers received training in most topics, including EPI/cold chain, ARI and diarrhoea treatment, IMCI, and malaria treatment, in the year before the survey. Only 2 percent of providers received any training in paediatric AIDS management in the three years prior to the survey.

In almost nine in ten facilities half of staff were supervised in the six months before the survey. Three-quarters of child health providers interviewed for the TSPA reported that they had been supervised in the six months before the survey. During this supervision, supervisors usually checked records, observed work, and discussed problems.

Management Practices Supportive of Quality Child Health Services by Managing Authority



According to MOHSW policy, child health services should be free to all children under age five. However, one-third of facilities that offer sick child services charge at least some fees for sick child services. This is most common in faith-based (95 percent) and private for-profit (92 percent) facilities and in hospitals (50 percent). Also troubling is that among the facilities that charge fees, only 19 percent post their fees.

Caretakers' opinions

Caretakers had some complaints about the health care services their children received. Twelve percent of caretakers complained about the waiting time to see the provider, while another 12 percent reported that medicines were unavailable. Six percent said the cost of services is a big problem.

Photo by Paul Ametepi, ORC Macro

2006 TSPA Results: Malaria

Almost all facilities offer malaria treatment services and have first-line antimalarial medicines in stock. In fact, only 8 percent of facilities had a stock-out of first-line antimalarials any time during the six months preceding the survey. Treatment protocols are less readily available. Only one-third of all facilities have treatment protocols in all relevant service sites in the facility. Hospitals, for example, have an average of almost four service sites, and yet no hospitals have protocols for treating malaria at all sites.

Laboratory capacity for diagnosing malaria is also missing from two-thirds of facilities. Almost all hospitals can test for malaria with a blood smear, compared to only two-thirds of health centres and one-quarter of dispensaries. Only 1 percent of all facilities have the rapid test for malaria.

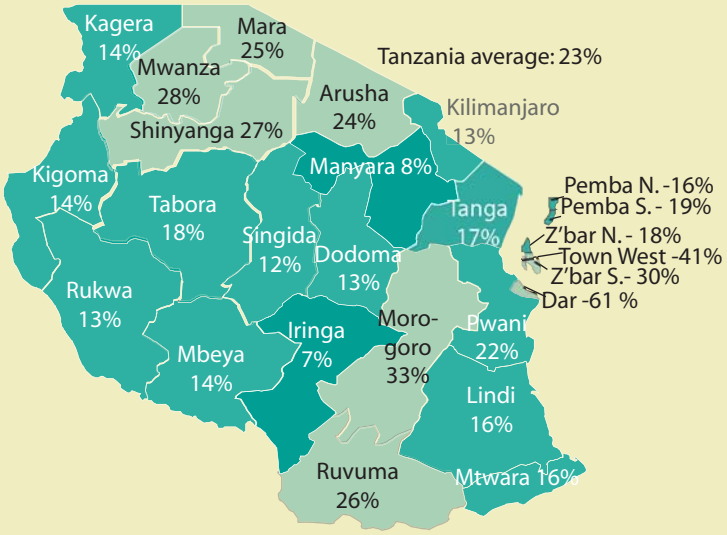
Putting the TSPA into Context: Malaria in Tanzania

Malaria is the number one cause of morbidity and mortality in Tanzania. Approximately 16 million cases occur every year, resulting in about 100,000 deaths.

The National Malaria Policy and Strategy aims to increase use of insecticide-treated bednets (ITNs) and improve treatment. In 2005, the Government of Tanzania introduced artemisin-based combination therapy (ACT) as the recommended malaria treatment. According to the 2004-05 TDHS, 46 percent of households had at least one bednet, but only 23 percent had an ITN. Young children and pregnant women are most vulnerable to malaria, but only 16 percent of children under five and pregnant women slept under an ITN the night before the survey.

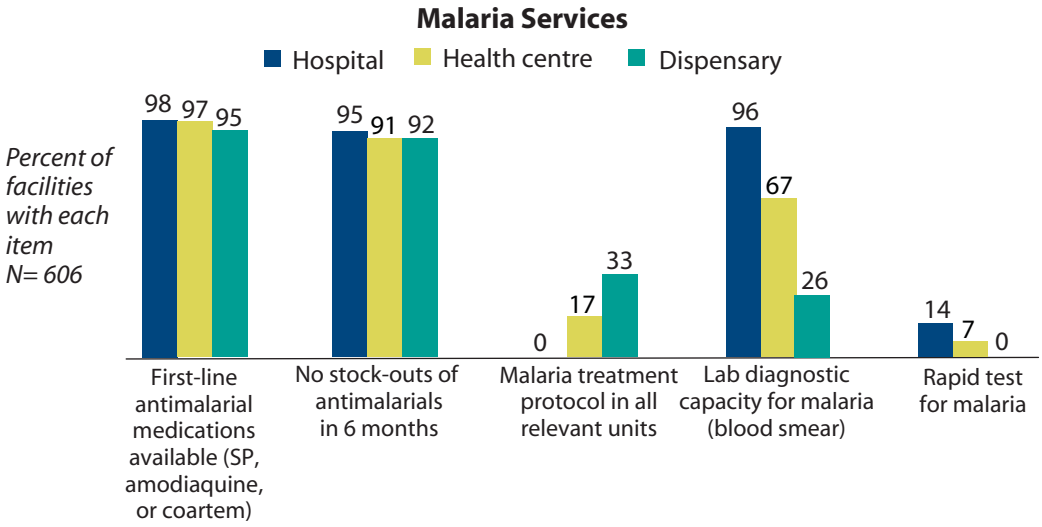
Ownership of Bednets

Percent of households with an insecticide treated net (ITN)



Malaria during pregnancy contributes to infant mortality, and thus, pregnant women are recommended to take two doses of the antimalarial drug SP/Fansidar as intermittent preventive treatment (IPT). Fifty-two percent of women received IPT during an ANC visit according to the DHS, but only 22 percent of pregnant women took the two recommended doses of SP during their last pregnancy.

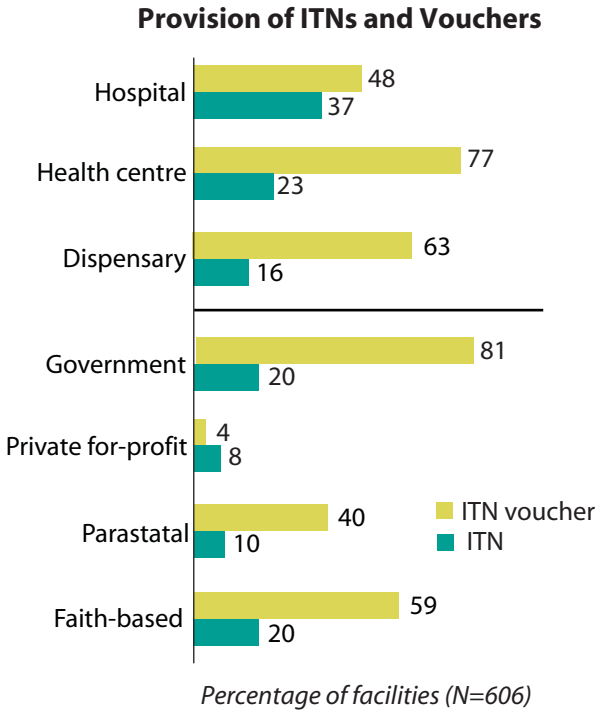
Fever is the primary symptom of malaria in children. Among children under five with a fever, 58 percent took an antimalarial drug. Anaemia is also a major sign of malaria in children. Almost three in four children have some form of anaemia, while 47 percent have moderate or severe anaemia.



Provision of Insecticide-Treated Nets (ITNs)

All government health facilities should be providing vouchers for mosquito nets to all pregnant women. According to the TSPA, eight in ten government facilities are providing vouchers.

Overall, two-thirds of facilities that offer malaria treatment services provide vouchers for ITNs. Provision of vouchers varies dramatically by zone, from 1 percent in Zanzibar (where the voucher program has only just begun) and 46 percent in Eastern to 92 percent in Central Zone. According to the national voucher scheme, facilities should not be providing nets - pregnant women should use their vouchers to purchase them in the private sector. Currently 18 percent of all facilities and 20 percent of government facilities provide nets.



Percentage of facilities (N=606)

Training

One-fifth of facilities have clinician providers of malaria services trained within the 12 months preceding the survey. Only 8 percent of facilities have nurse-providers of malaria services trained in the year preceding the survey. An additional 13 percent and 8 percent, respectively, received this training one to three years prior to the survey.

Antenatal Care and Malaria

Pregnant women should receive malaria prevention information during antenatal care visits. Almost half of observed first-visit ANC clients were told of the importance of using an ITN, and half received a voucher for an ITN. Almost all women who received a voucher were also told how and where to use the voucher. Women who came for follow-up visits were less likely to be given information about ITNs, and only 14 percent received a voucher for an ITN, possibly because they received this information at an earlier visit.

The Tanzania Reproductive Health and Child Policy calls for intermittent preventive treatment (IPT) of malaria by using SP twice during the pregnancy. Almost all (95 percent) facilities have a first-line antimalarial for treating malaria during pregnancy. Fewer women actually receive these medications.

Six in ten first-visit ANC clients and four in ten follow-up clients were given IPT or provided information on IPT. Half of first-visit clients were given information on how to take the IPT medicine. Fewer than a third took their first dose in the facility under the supervision of a provider. The importance of the second dose was explained to only 10 percent of first-visit clients.

Conclusions and Recommendations

Tanzania has experienced some significant health improvements in recent years. According to the 2004-5 TDHS, use of family planning has increased, childhood mortality has decreased, and stunting and underweight in children have become less common. Still, Tanzania faces significant challenges. Only three in four children are fully immunised, and many sick children do not receive the appropriate treatments. Many children still face malnutrition, and three-quarters are anaemic. Women, also, are not receiving the best level of health care. Half of births occur at home, without the assistance of a trained provider, and few women receive postnatal care. Most women and children still do not use insecticide-treated bednets to prevent malaria, and many pregnant women do not receive intermittent preventive treatment. Will Tanzania be able to continue the progress already made? What role do health facilities, policies, and personnel play in the health situation in Tanzania?

The TSPA findings provide information to help answer some of these questions. The results are very mixed. Key conclusions and recommendations are noted below:

General Patterns:

- Most of the observed clients attending family planning, maternal health, child health or malaria services have only a primary education. And yet most service sites do not have or use educational materials, visuals, or even guidelines. Furthermore, providers are not giving caregivers and patients necessary information. Most pregnant women are not told what warning signs to look out for, and many caretakers are not told how to continue feeding their sick child. Providers must be trained to improve this essential communication, and, in addition, appropriate visual aids and take-home materials should be created to make sure that patients and caretakers understand the diagnosis, their options, and their treatment regimens.
- Infection control is inadequate in all service areas, most often because of a lack of running water, which is available in only about half of facilities. Without running water, facilities will never be able to fully manage infection and provide top quality care.
- Integration of services is stressed by the IMCI and other policies adopted by Tanzania. And yet there are many missed opportunities in all service areas. Facilities providing care for sick children do not always provide immunisations or growth monitoring, and only one quarter of family planning facilities treat STIs. And yet, when a facility is faced with long lines of patients waiting to be seen by too few providers, it may not be possible to provide such integrated care. Tanzania must find ways to recruit and retain trained health professionals in order to meet the growing health care needs of the population.
- User fees are rare for family planning and maternal and child health services, primarily because government-run facilities offer these services for free. However, facilities that do charge for services rarely post their user fees. Facilities that charge fees must be up front about the fees they charge to ensure that clients know the cost of services.
- Recent training of providers (within one year of the survey) ranges from only 6 percent in family planning service areas to about one-third in ANC service areas. Information and skills on critical and current issues such as PMTCT, malaria treatment, and exclusive breastfeeding are not being transmitted to providers. Regular in-service and pre-service training must become normalised practice in order to keep providers up-to-date in their knowledge.

Family Planning:

- Three-quarters of facilities offer family planning services, but coverage is inconsistent. Only about two-thirds of facilities in Zanzibar, Northern, and Eastern zones offer family planning services, while 94 percent of facilities in Central Zone offer these services.
- Most facilities can provide contraceptive pills, injectables, and condoms, although even these most popular methods are not always in stock. Far fewer provide long-term methods like IUDs. Even among those facilities that offer the IUD, only 39 percent have the equipment necessary for insertion and/or removal. Increasing availability of long-term methods will help to reduce discontinuation and unmet need. Worldwide, the most successful FP programmes include a mix of both short and long term methods.
- TSPA findings suggest that family planning providers are not consistently screening new clients or gathering the appropriate information on the clients history. Few clients were asked their desired timing for their next birth, their breastfeeding status, or if they had any STI symptoms. This information is crucial for providing a safe, effective, appropriate method, and yet, providers may not have the time to collect a full history. Family planning providers need support in handling their time and client load so that many clients can be seen without sacrificing the quality of care provided. Appropriate protocols should also be made available and followed.

Maternal Health

- When serious health problems occur during pregnancy and childbirth, a few minutes can mean the difference between life and death. Health care facilities and health care providers must be able to respond rapidly. In Tanzania, the tools needed for emergency obstetric services are not available in most facilities. Although 74 percent of facilities provide childbirth services, only 7 percent can transfuse blood, 5 percent can perform a Caesarean section, and only 40 percent provide maternal emergency transport service. Dispensaries, the first stop for care for most Tanzanians, are not able to provide C-sections, and only one third provide emergency transport services.
- Currently more than half of births occur at home. Yet only one in four facilities have services supporting home delivery, and only 16 percent have programmes with traditional birth attendants. Why are there still so few services for such a common event as childbirth? Making safer delivery services more available should be a national priority in Tanzania, demanding immediate attention from all levels of government.
- Antenatal care (ANC) is widely available in Tanzania, and most women seek care at least once during pregnancy. It is widely recognized that good ANC can improve both maternal and foetal outcomes. According to the TSPA and the TDHS, however, the quality of ANC services varies throughout Tanzania. Less than half of facilities providing ANC have the basic recommended equipment and supplies, and only about half of first-visit ANC clients were given iron tablets or the tetanus toxoid vaccine. Furthermore, less than 20 percent of facilities providing ANC have the capacity to test for common problems during pregnancy such as anaemia and gestational diabetes (through a urine glucose test) . These tests, which can prevent costly and life-threatening conditions, are inexpensive and easy to procure. Making them widely available depends less on money and more on good management and organizational systems. District health management teams need to focus on ensuring that ANC and delivery services have the basic supplies for preventive care.
- Basic supplies for delivery are lacking from most service areas. Only two in five hospitals have the most basic supplies, such as a scissor, cord clamp, suction apparatus, skin disinfectant and antibiotic eye ointment for newborns. While many facilities may never have the ability to carry out complicated deliveries, all facilities should have the supplies necessary for an event as common as a routine delivery.

Child Health

- Almost four-fifths of facilities provide immunisation services. However, all vaccines are not available in all facilities, and facilities providing sick child care do not always provide immunisation services everyday. Vaccinations for all basic childhood diseases should be available in all facilities in order to ensure full coverage. Children should not have to visit multiple facilities or return for multiple visits in order to obtain all needed vaccines.
- Only three-quarters of facilities treating sick children have the three first-line treatments. Oral rehydration salts, antimalarials, and oral antibiotics are simple, inexpensive, and essential drugs that should be available in all facilities. Facilities are also lacking pre-referral medications and other basic medicines, including aspiring, vitamin A, and iron tablets. Administration of these medications requires no specialised equipment or training, and yet could greatly reduce morbidity and mortality. Stocking all facilities with the recommended first-line and pre-referral medications should be a priority.
- Providers are not assessing danger signs or performing the expected basic exams on sick children. This may lead to incorrect diagnoses, and could potentially endanger sick children. Written guidelines or protocols are needed to improve the quality of care for sick children. Again, this may not be because providers are not properly trained or knowledgeable, but because they are stretched too thin, trying to see as many children as possible, and therefore skipping over some elements of the exam in the interest of time.
- As in other countries, providers in Tanzania appear to be overprescribing antibiotics for sick children. While an antibiotic may be warranted in pneumonia or dysentery cases, it is not necessary for children with minor respiratory or diarrhoeal illnesses. Unnecessary use of antibiotics should be limited, as antibiotic resistance is growing world-wide.

Malaria

- Antimalarial medications are available in almost all facilities, and stock-outs are rare. While this is good news, the focus should be on prevention of malaria rather than just treatment. Although Tanzanian policy encourages the use of insecticide-treated nets, only two-thirds of facilities provide vouchers. Very few private for-profit facilities provide either nets or vouchers. Increasing availability of free nets, both in facilities and in other non-medical locations could reduce the number of malaria cases.
- Only half of first-visit ANC clients were told of the importance of using an ITN. While half received a voucher for an ITN, fewer were told how and where to use the voucher. And although almost all facilities have preventive anti-malarial medications, only about 60 percent of first-visit ANC clients were given IPT, and even fewer were instructed on how to take it. This gap is not acceptable. Appropriate visual aids and written instructions for clients should also be created to help pregnant women understand the importance of IPT.

Key Indicators

	Type of Facility		
	Hospital	Health center	Dispen-sary
Family Planning Services			
Family planning services available 5 days a week (% of facilities)	98	80	92
Availability of any modern method (% of facilities)	79	76	76
All items for quality counselling[1] (% of facilities)	69	51	41
All items for infection control[2] (% of facilities)	49	33	28
Conditions for quality pelvic exam[3] (% of facilities)	24	2	0
STI treatment provided by FP providers (% of facilities)	19	19	29
User fees for FP services (% of facilities)	12	6	3
Maternal Health Services			
Facilities offering antenatal care (%)	95	93	80
Facilities offering postnatal care (%)	77	73	63
Facilities offering tetanus toxoid vaccine (%)	93	88	79
ANC facilities with all items for quality counselling[4] (%)	28	14	12
ANC facilities with all items for infection control[2] (%)	49	35	28
ANC facilities with all essential supplies for basic ANC[5] (%)	71	50	43
ANC facilities where STI treatment is provided by ANC providers (%)	31	22	41
ANC facilities with all medicines for treating pregnancy complications[6](%)	75	18	4
Facilities with user fee for ANC (%)	30	16	8
Facilities offering normal delivery services (%)	96	88	72
Facilities offering caesarean section (%)	92	13	0
Facilities offering emergency transportation support for maternity emergencies (%)	89	71	35
Facilities offering any home delivery services (%)	21	32	25
Delivery facilities with all items for infection control[2] (%)	44	29	25
Facilities offering delivery services with all essential supplies for delivery[7] (%)	41	25	10
Facilities offering delivery services with user fee for delivery (%)	51	28	15
Child Health Services			
Facilities offering curative outpatient care for sick children (%)	100	100	99
Facilities offering growth monitoring (%)	91	90	80
Facilities offering childhood immunisation (%)	91	85	78
Immunisation facilities with all equipment for immunisations[8] (%)	82	61	68
Immunisation facilities with all basic child vaccines (BCG, DPT-HB, polio, measles) (%)	87	74	73
Facilities with all first line[9] /pre-referral medicines[10] (%)	93/91	77/74	76/40
Facilities with user fees for sick child services (%)	50	43	31
Malaria Services			
Facilities offering malaria services providing ITN vouchers/ITNs (%)	48/37	77/23	63/16
Facilities offering malaria treatment with 1st line anti-malaria medicines in the facility (SP/Fansidar, Amodiaquine or Coartem) (%)	98	97	95
Facilities with lab diagnostic capacity for malaria (blood smear) (%)	96	67	26

1-Visual privacy, client cards, written guidelines, visual aids
2-Soap, running water, clean gloves, disinfecting solution, sharps box
3-Private room, exam bed, exam light, vaginal speculum
4-Visual aids for health education, guidelines, client card/record
5-Iron and folic acid, tetanus toxoid vaccine, blood pressure apparatus, fetoscope
6-Antibiotic, antimalarial, 4 STIs, and anti hypertensive
7-Scissor/blade, cord clamp, suction apparatus, antibiotic eye ointment, skin disinfectant
8-Blank immunisation cards, syringes and needles, cold box with ice packs
9-ORS, one antimalarial, one oral antibiotic
10-One 1st line injectable antibiotic, one 2nd line injectable antibiotic, and IV solution with perfusion set

Managing Authority				
Govern-ment	Private	Parastatal	FBO	TOTAL
94	82	100	73	91
97	32	50	39	76
45	27	60	37	43
30	22	20	32	29
1	0	0	2	1
29	17	0	24	27
0	37	0	11	4
96	30	50	83	82
79	15	50	59	64
95	27	40	80	80
14	9	20	7	13
30	17	20	36	30
50	23	40	31	45
43	14	0	31	39
2	43	0	28	8
2	60	0	33	10
91	18	20	73	74
3	4	0	15	5
44	16	40	50	40
35	4	0	16	26
25	35	0	30	26
11	0	0	29	13
1	86	50	91	18
100	100	100	99	100
95	30	50	81	81
94	24	40	78	79
69	64	50	69	68
76	91	75	62	74
78/32	76/77	40/30	78/67	77/45
4	92	20	95	33
81/20	4/8	40/10	59/20	63/18
95	96	90	94	95
12	79	50	69	33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