Tanzania Ministry of Health, Community Development, Gender, Elderly and Children

Tanzania

Child Health and Nutrition Month

Lessons learnt in improving children's lives

November 2017

unicef

Leave no one behind

Child Health and Nutrition Month provides a high-impact package of integrated services delivered at the community level to children under five

Introduction

To reach the most number of children possible, regular events to deliver an integrated package of key nutrition and health interventions to children and mothers, commonly referred to as Child Health Days (CHDs), were introduced in the Eastern and Southern Africa Region (ESAR) over two decades ago. Conducted twice per year, these activities can last one day, a week or a month. Interventions during CHDs vary by country, but core activities include vitamin A supplementation (VAS), deworming, immunisation, and social mobilisation and communication activities to promote immunisation and the uptake of new vaccines. Many countries also include the promotion of key health and nutrition practices, screening for malnutrition, hand washing and sanitation.

This summary brochure documents key components of the Child and Health Nutrition Month (CHNM) programme in Tanzania. Using existing quantitative data and newly gathered primary qualitative data, the documentation exercise addressed seven key themes: the CHNM programme including core interventions and coverage; decentralisation and ownership; coordination, supervision and training; supply and provision of services; community experiences; issues of equity; and sustainability.

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Tanzania

In order to reach the most children possible with key interventions, Tanzania began to implement biannual vitamin A supplementation (VAS) for children aged between six and 59 months in 2001. This built on the Expanded Programme on Immunisation (EPI), which took a vertical approach to health service delivery in the form of campaign-style events. Between 2001 and 2016, the campaign was implemented for one week every June. In 2016 Tanzania changed its approach to CHDs and formalised two month-long interventions in June and December, known as Child Health and Nutrition Month (CHNM).

The programme was scaled across the country to provide a longer-window of opportunity for caregivers to access services and, at the time of the documentation exercise, was organised across all districts to deliver a package of preventative interventions that were integrated with, and in turn, reinforced existing routine services.

The CHNM package focuses on increasing community awareness and utilisation of the following key interventions: VAS; deworming; and screening for acute malnutrition using mid-upper arm circumference (MUAC) and oedema assessment for all children aged six to 59 months. Although immunisation is not a primary CHNM intervention, it is offered to 'mop-up' those children who missed immunisations though the routine vaccination Schedule. When national immunisation campaigns take place, such as the rubella campaign in 2014, they are added to the CHNM primary package to ensure high nationwide coverage.

CHNM services are included in the Tanzania National Nutrition Strategy, and the Tanzania Food and Nutrition Centre provides guidelines and dedicated supervisors to ensure the positive integration of the nutrition component within CHNM.

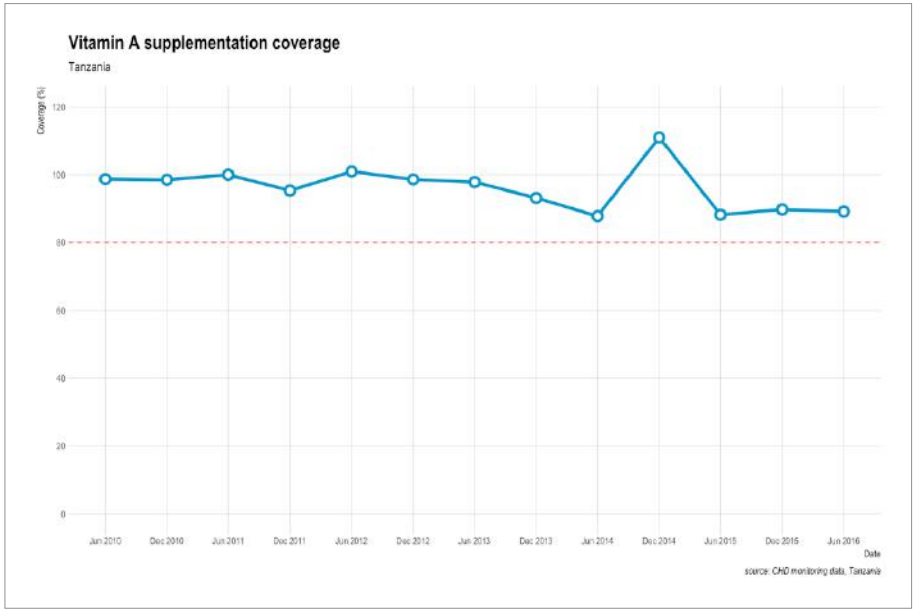
CHNM overview

Interventions

Vitamin A supplementation

VAS was considered by many stakeholders to be the primary intervention and following the shift to biannual administration, VAS was often used as a proxy to refer to the total package of services offered in the CHNM campaign (i.e deworming, MUAC screening and immunisation for missed opportunities).

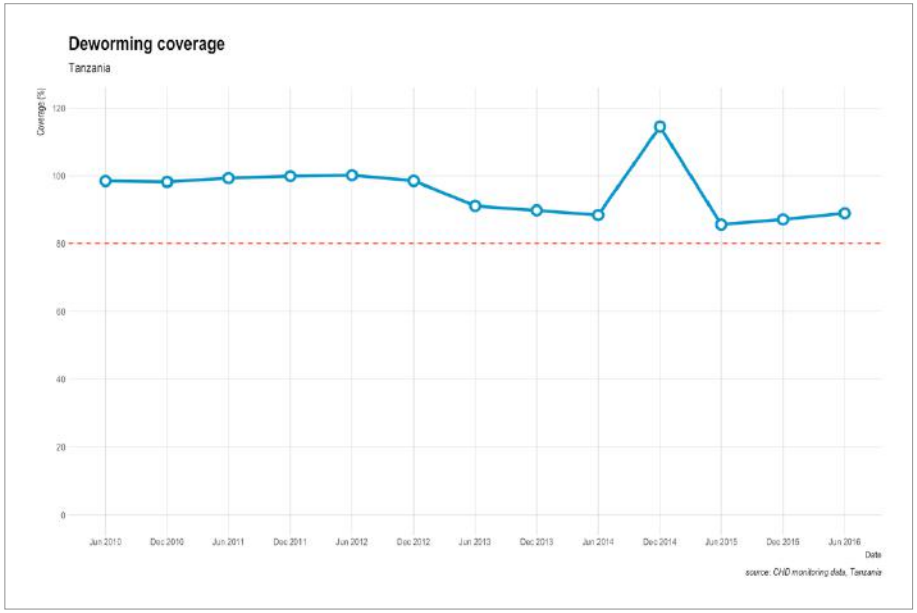
CHNM monitoring data indicated that national VAS coverage rates have remained consistently high over recent years and in the June 2016 round, the national VAS coverage was reported to be 89% (see graph 1). (Please note that CHNM monitoring data reports over 100% coverage due to denominator issues).



Graph 1: CHNM monitoring data indicated that national VAS coverage rates remained consistently high over recent years and in the June 2016 round, the national VAS coverage was reported to be 89%.

Deworming

Deworming was implemented alongside VAS and effectively rolled into the CHNM service package. As with VAS, national coverage levels remain high. According to the monitoring data, all CHNMs between 2010 and 2016 attained over 80% coverage, with a mean of 95%. In the June 2016 CHNM, monitoring data indicated that the national deworming coverage rate was 89% (see graph 2).



Graph 2: CHNM monitoring data indicated that all campaigns between 2010 and 2016 attained over 80% coverage nationally, with a mean of 95%. In the June 2016 round, national coverage was 89%.

Interventions

Malnutrition screening

Screening for acute malnutrition through MUAC and oedema assessment is a core component of the CHNM package, first introduced in December 2015. By integrating this screening service, the government intended to improve coverage and case management and maximise the opportunity offered by CHNMs to identify children in need of outpatient and in-patient case management.

Because of the limited time the intervention has been implemented as part of CHNMs, at the time of the documentation exercise, there was scant administrative data on MUAC screening.

Immunisation

Immunisation is provided as a key component of routine service delivery and during CHNM, vaccination is offered to 'mop up missed opportunities'. The majority of children are vaccinated during routine service delivery and the strong demand for vaccination helped facilitate the integration of immunisation into routine programming rather than delivering it through vertical campaigns. Despite the high rate of uptake of immunisations through the routine system, the CHNM provides a safety net to ensure no children miss vaccinations, and when there have been specific disease outbreaks, immunisation campaigns have been integrated with CHNM to ensure high coverage.

Social mobilisation

Social mobilisation is a core component of CHNM used to raise awareness about key interventions and mobilise communities to seek services. In remote and hard-to-reach areas mobilisation efforts remain critical and multiple strategies have been employed including interpersonal communication, radio broadcasts, and the distribution of information education communication materials. Community health workers are the primary drivers of social mobilisation because they are 'close to' and trusted by the communities they serve, but social mobilisation activities are most successful when community and religious leaders are also engaged and actively encourage caregivers to attend CHNMs.

'I visited the facility when I was sick. When I was admitted, the doctor told me about the vitamin A campaign and said I should bring my baby. This is my first time here. I was told by the doctor that I should go and tell other women in my area so I told them. Many women were receptive to my message but not everyone. The best way to inform our communities about this campaign is though the use of leaders who can do the announcements'.

Caregiver, Duthumi health facility, Morogoro

Decentralisation and ownership

The health system in Tanzania is decentralised with a strong infrastructure that provides high quality routine services through primary health care facilities. The success of CHNM is largely dependent on the strength of the district health system. The decentralised system facilitates greater planning and ownership of CHNM at a district level, and government funds are allocated directly to districts according to their microplans that tailor CHNM activities according to the needs of their target population.

In turn, CHNMs strengthen the primary healthcare system, and facilite the supportive supervision of frontline health workers during campaign-style interventions. Representatives from Council Health Management Teams (CHMTs) highlighted district-level budgeting through CHNM microplans as one of the key successes of decentralisation. They emphasised that it had increased the sense of ownership and made CHNMs more sustainable as a dedicated budget was included in the Comprehensive Council Health Plan.

Increased ownership at the community level is also evident through local planning by health facilities and dispensaries. Governing committees have been established in each facility to ensure that community and religious leaders, representatives from private facilities and influential members of the community are involved and engaged in planning and problem solving for CHNMs. Such community engagement has made a positive contribution to the programme's sustainability and reinforced local capacity building.

'The CHMTs get the facility committees involved in planning for the next financial year. They come with plans according to their problems. They identify the total number of medicines needed, Mebendazole, vitamin A, and the rest. They work out the total number of outreach sites, how many mobile clinics they are going to do. We take their plan and combine it with our CHMT plan. This is much more sustainable, because previously we were just waiting for the donors to fund us, to come to educate and supervise us during the campaign. But now we do planning and budgeting in the district, and we start from the community level'.

CHMT representative

Coordination, supervision and training

Strong links have been forged between the Ministry of Health Community Development, Gender, Elderly and Children, the President's Office Regional Administration and Local Governments, the Tanzania Food and Nutrition Centre (TFNC), and regional and district councils.

The government developed its first National Multi-Sectorial Nutritional Action Plan (NMNAP) in 2016. This was an action-oriented strategy that clearly defined the responsibilities of each agency and how they should be organised in relation to nutrition activities, including those aligned with the CHNM. In addition to the release of the NMNAP, the government also issued new guidelines and training manuals for CHNM in 2016, which were delivered along with additional training to all CHMTs across the 26 regions of mainland Tanzania. The training was due to be cascaded from the district level to health facility staff and community health workers, but activities were restricted due to human resource, logistical and financial constraints. Although most health workers and Community Health Workers (CHWs) received some form of training and orientation on CHNM implementation, interventions and social mobilisation, many lower level health staff engaged in the documentation exercise requested further training, particularly on the health benefits of core interventions.

Regional-level stakeholders confirmed they had frequent upward contact and communication with national-level stakeholders, and in turn monitored and supervised the activities of the CHMTs in their catchment area. Similarly, the CHMTs were responsible for overseeing CHNM outreach in their district. They supervised community-level activities and provided on-the-job training to health workers and CHWs as necessary, in addition to assisting with supply, data and logistical issues.

CHNM data on VAS, deworming and MUAC screening was collected by CHWs during CHNM activities. Each facility collated its static site, mobile and outreach data before submitting it to the district. Coverage rates were then calculated and submitted to the regional level with a supportive narrative report outlining challenges, good practices and lessons learned throughout the district. From the regional level, data was channelled upwards to be centrally compiled by TFNC and then shared across the government and partners. TFNC played an active role in analysing the data to assess how well the CHNM was functioning at multiple levels.

'I am thankful that we have the nurses and they know everything so they can instruct us… Through their instruction, we have come to know how to provide vitamin A… But I want training about the importance of vitamin A and its health benefits. When I know things like this, I will provide vitamin A well and more confidently'.

CHW in Morogoro

Supply and provision of services

The government is responsible for the clearance of supplies through customs and their management from the central level, ensuring stocks reach every district CHMT who then roll supplies out to their various service delivery points. UNICEF supports the government to procure both vitamin A and Mebendazole for CHNM and Nutrition International support VAC procurement, providing in-kind donations of capsules.

Human resource shortages persist across the Tanzanian primary health care system, and lower-level facilities only employ one or two professional health workers. Many participants emphasised the challenge that health facilities faced in providing routine services, immunisations and outreach during CHNMs. The campaigns limited the number of other activities that professional health workers could undertake, and 'non-technical' tasks were therefore allocated to CHWs during CHNMs. District-level officials and health staff confirmed that CHW were trained to perform many CHNM activities including the administration of VAS, deworming and MUAC screening, and to update the tally sheets of services provided.

In the documentation exercise, stakeholders emphasised the role of CHWs and the commitment they invested to ensure communities accessed CHNMs. CHWs themselves suggested that they worked for the campaign because of the positive impact they had seen it brought their communities, but noted that the lack of resources made available to them can have a negative impact on their motivation.

Community perceptions

The social norm was for mothers to be responsible for their child's health. A mother was more likely to identify symptoms in a child, and if care was needed, was responsible for presenting the child at a health facility. In terms of preventative care, mothers were also responsible for attending routine services for vaccination and presenting at CHNMs and it was clear that many had absorbed the key health and nutrition messages they had learnt at CHNMs and through routine health education.

Misconceptions and rumours about CHNMs were widespread and may have prevented some caregivers from attending, but many community members highlighted that the provision of effective treatment and education by community health workers helped to dispel rumours and build community trust in interventions. As one participant concluded *'When they speak about the importance* [of CHNM interventions] *it helps with the rumours and encourages more people to come*'.

Community-level stakeholders emphasised that health education that targeted men was having a positive role on care-seeking behaviour, with many men now 'allowing' and in some cases 'supporting' mothers to attend health services. A significant number of caregivers emphasised the importance of regular attendance at CHNMs and community-level respondents frequently reported the positive health impacts they perceived CHNM services to be having on children in their community.

'This service is good because it helps the children to have good health. I like the campaign because it costs me nothing. I walked by foot, it only takes few minutes. When you get here, the staff explain to you, then they start providing the service. I am happy, it is a good service and it helps us. If they tell us to come again we will come because it helps our children.

I feel good because they have given my child all the services at the same time. I like that they do everything together because you know us, if you take a child for the vitamin A service then when you come to think that you must go again for deworming tablets or vaccination, we might think there is no need. A mother might think why should I go twice for something that can be done once? I think it is helpful they have combined services.

For other mothers, I can advise them using an example of my own child. I have gone and they gave my child vaccines, vitamin A drops and deworming tablets as well as checked her nutrition status. And now I know the nutrition status of my child, I know if nutrition has increased or not. If my child is in a bad situation, then I should increase nutrition so I have already been educated through this vitamin A and nutrition month for children'.

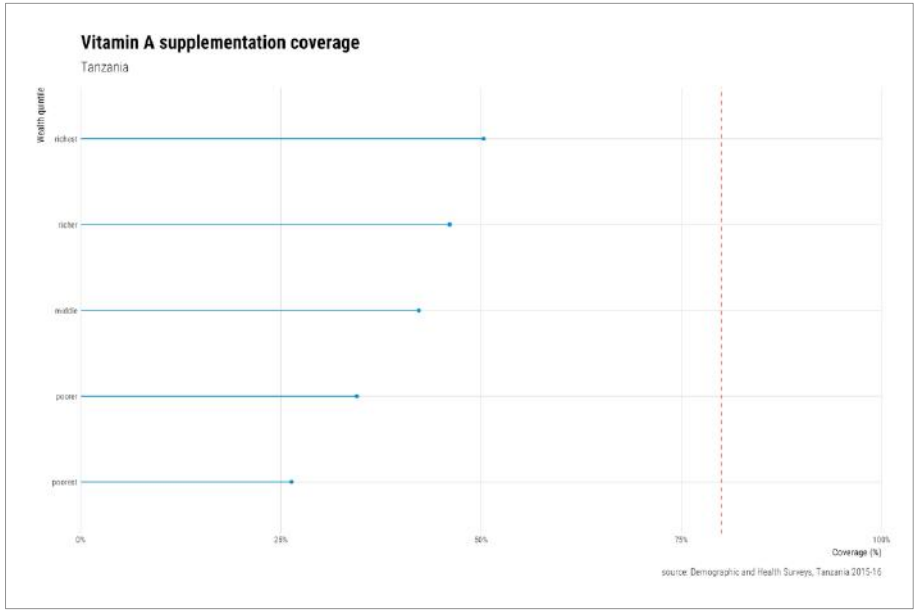
Caregiver attending CHNM, December 2016

Equity

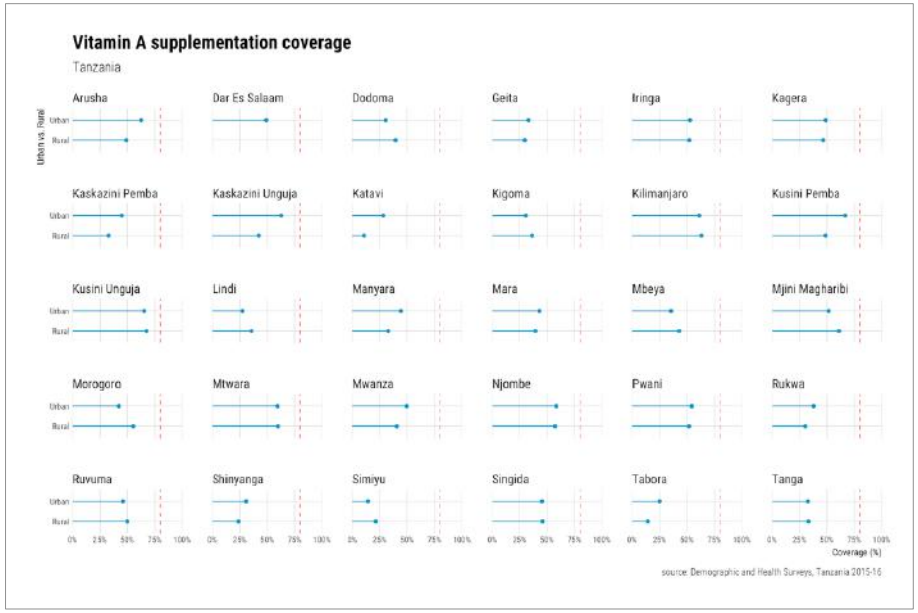
In order to explore the issue of equitable delivery of and access to services, an analysis of wealth quintile at the household level was undertaken using the DHS dataset (2015-2016) that includes five categories from poorest to richest. Nationally, the overall pattern was one in which the richest three quintiles had marginally better access to VAS than the poorer two quintiles (see graph 3).

Across all stakeholder groups, no association was made between a child's gender and access to CHNM. This finding was triangulated with the quantitative analysis of coverage data from the DHS where no difference between male and female uptake of VAS services was observed. Similarly, in the DHS data, there was no great observable difference between the coverage of VAS in urban and rural settings (see graph 4), although the qualitative narratives suggested VAS administration was more challenging in rural areas.

National-level respondents stressed that equity was a priority issue. District-level CHNM microplans were a fundamental tool for tackling coverage and equity at the local level. Working with regional councils and district CHMTs was critical to understanding the underlying causes of low coverage amongst certain groups and in specific geographical areas, and for the development of plans and strategies to overcome challenges in future CHNMs.



Graph 3: According to the DHS data (2015-2016), the overall pattern of VAS by wealth quintile showed that the richest three quintiles had marginally better access to VAS than the poorer two quintiles.



Graph 4: According to the DHS data (2015-2016), there was no great observable difference between the coverage of VAS in urban and rural settings.

Sustainability

National-level stakeholders noted that campaign style interventions could effectively target populations in need, and provide care to those who did not engage in routine services. The campaign was also a valuable mechanism to provide care to children who had missed opportunities as part of routine services, and the campaign could act as an effective safety net for the health system.

It was suggested that increased government ownership and financial commitment to CHNMs would eventually lead to a shift from campaign interventions to routine delivery. It was well recognised, however, that this shift would have to be implemented slowly and in parallel to broader health system strengthening. The transition of immunisation from an intervention provided during dedicated campaigns to one integrated into routine service delivery was seen by some stakeholders as good practice, but whilst lessons could be learned from this experience, it was widely acknowledged that a campaign-style approach would have to be maintained for other interventions (VAS, deworming and MUAC) in the short- to medium-term.

Political will for the ownership of the CHNM and the development of the NMNAP had secured strong coordination across government and partners for the campaign and sustainability for the future.

Conclusion

The Child Health Day programme has been successfully implemented in Tanzania for over fifteen years. In 2016, several positive achievements were documented: the programme shifted its approach to be a month-long campaign providing a package of key interventions across the whole country including screening for malnutrition using MUAC measurements; national guidelines and training on CHNM were developed and rolled out; and high coverage rates were maintained overall with coverage of 91% reported for VAS in December 2016. Several key components have contributed to the success of CHNM in Tanzania.

Decentralised health system. The development of district-level microplans, and the inclusion of a budget line in the Comprehensive Council Health Plans, have facilitated greater local planning and enabled interventions to be better tailored to the immediate context and receptive to the needs of the target population. This has fostered a greater sense of ownership and accountability at sub-national levels. The national coverage rates for CHNM interventions are consistently high, but to address disparities in coverage at regional and district levels, Tanzania has prioritised an equity-focused approach to CHNM that aims to ensure services reach the most vulnerable children in the hardest-to-reach areas.

Good coordination and collaboration. Coordination and collaboration across government agencies has raised the profile of nutrition and contributed to CHNM being accepted as a nutrition-sensitive campaign. The development of the first National Multi-Sectorial Nutritional Action Plan in 2016 helped to define roles and responsibilities related to nutrition interventions, and governmental review and feedback on regional- and district-level reporting has increased accountability and ownership.

Effective social mobilisation. In Tanzania, social mobilisation and community engagement has been key to raising awareness of CHNMs and encouraging utilisation of services offered. Multiple methods of social mobilisation have been used, but actively engaging community and religious leaders in social mobilisation has been highly beneficial as they are able to foster trust, help dispel negative rumours, and encourage attendance at CHNMs. Expanded health education for male caregivers and incentivising their attendance at CHNMs was improving men's knowledge of and involvement with the health of their families. To sustain these advances, it is critical that targeted social mobilisation be continued and adequately resourced.

"The vision for CHNM is to make sure that we reach those unreached children…"

	Lessons learnt and good practices
CHNM programme	• The key interventions offered during CHNM are focused and mutually supportive. The recent introduction of MUAC screening maximises the opportunity presented by CHNM to identify children with acute malnutrition. • Extending the timeframe of the campaign from one week to a month in 2016 provided caregivers with a longer opportunity to access campaign services. Health workers were able to stagger services across the month. This helped with targeted planning at the district level. • Engaging community and religious leaders and CHWs in social mobilisation activities is important and has proved effective as they are perceived to be 'close' to and trusted by the communities they served.
Decentralisation and ownership	• Decentralisation is a strength. The development of microplans at the district level has harnessed a strong sense of ownership. The increased role of CHMTs in CHNMs and the inclusion of a budget line for CHNM in the CCHP, have also facilitated greater planning at the district level and enabled interventions to be better tailored to the local context and receptive to the needs of the target population. • Engagement with governing committees at health facilities and with dispensaries that include community representation has developed and reinforced the sense of local ownership and was perceived to have made CHNMs more sustainable due to enhanced local capacity.
Coordination, supervision and training	• The presence of nutrition units across government structures has successfully raised the profile of nutrition. Their advocacy and positioning efforts have contributed to CHNM being accepted as a nutrition-sensitive campaign and has helped foster commitment for the biannual event. • The first National Multi-Sectorial Nutritional Action Plan in 2016 helped to define responsibilities related to nutrition interventions, including CHNM, and given the increased number of actors working in the nutrition sphere, has facilitated improved collaboration across agencies. • Deployment of nutritionists to the regional and district councils, development of new guidelines and strengthened national and regional support mechanisms for data collection have contributed to significant improvements in reporting structures, with an average feedback time of one month post-CHNM. • Governmental review and feedback on regional- and district-level reporting has increased accountability and ownership at the lower levels and generated positive motivation.
Supply and provision of services	• There has been recognition of the need to improve supply chain management. Mechanisms for the clearance of commodities have improved ensuring the government has access to adequate supplies of VAC and Mebendazole for CHNMs.
Community perceptions	• Social mobilisation and community engagement is key in raising awareness of CHNMs and encouraging utilisation of services offered. Using multiple methods of social mobilisation to target difficult-to-reach communities is particularly effective. • Engaging and involving community and religious leaders in the social mobilisation process is highly beneficial as they are perceived to be 'close to' and trusted by the communities they served. • Expanded health education for male caregivers and incentivisation is reported to be positively improving men's knowledge of and involvement with the health of their families, and is beginning to increase male engagement in care seeking behaviour, and their active support for CHNM attendance.
Issues of equity	• An equity-focused approach to CHNM that aims to ensure services reach the most vulnerable children in the hardest-to-reach areas has been prioritised in Tanzania. With the development of district microplans, interventions and resources can be tailored towards engaging those most in need. • Training on data management and supportive supervision at the district level sought to help CHMT members collect and analyse quality data for evidence-based decision making regarding the identification and targeting of children at risk of missing out on CHNM services.

Recommendations

Despite the successes, a number of challenges remain and must be addressed to ensure the success and sustainability of the programme.

Data management. The use of census data or NBS projection data to estimate commodity needs for CHNM and for calculating coverage at local levels is problematic. NBS data is considered *'misrepresentative',* and has complicated planning and reporting procedures, the underestimation of commodities, and the overestimation of coverage. Although NBS data is used for national level reporting, local head count data enables a more accurate estimation of CHNM coverage at the district level, yet issues with denominators persist and contribute to data management challenges. Addressing issues associated with the denominator is important for ensuring the quality and accuracy of planning and reporting. In parallel with the continuing development of data management capacity at sub-national levels, advocacy at the national level should support the reconciliation of denominators used during analyses.

Dedicated funding. Specific funding for CHNM remains limited, and insufficient resources have lead to less interventions and activities being implemented than outlined in the district microplans. Delays in the release of funds from the central level to the districts have compounded these issues and have resulted in important components being scaled back or removed. There is substantial political will for CHNM, and external partners should support the government to increase their commitment and dedicate sufficient resources.

Human resources. The management of human resources for CHNMs remains challenging and there is a shortage of adequately trained staff to implement CHNM at the lower levels. Due to human resource, logistical and financial constraints, training has not been fully aligned to the new guidelines and it did not cascade to down to community-level actors. Whilst it is clear that capacity has been enhanced over recent years, it remains imperative that support for coordination, supervision and training is reaffirmed. Sub-national actors must be empowered to assume responsibility and be accountable for the CHNM at their operational level.

Supplies. Although mechanisms for the clearance of commodities have improved, there is recognition that supply chain management needs ongoing strengthening as bottlenecks in the timely distribution of commodities to regional and district levels risk additional pressure being put on already strained resources.

Transition. The health infrastructure in Tanzania lends itself to the expansion of routine services with the eventual integration of key interventions that are currently delivered through CHNMs. To ensure the equitable provision of services, and maintain high coverage levels whilst reaching the most vulnerable children, transition needs to happen gradually and in the context of broader health system strengthening.

"…and the future plan is therefore to have universal coverage of VAS, deworming and MUAC screening."

	Recommendations
CHNM programme	• Data management systems across CHNM and routine services, particularly in relation to referrals for malnutrition management and immunisation should be strengthened. • Addressing issues associated with the denominator used for the analysis of data is important for ensuring the quality and accuracy of reporting. In parallel with the continuing development of data management capacity at sub-national levels, advocacy at the national level should support the reconciliation of denominators used during analyses.
Decentralisation and ownership	• Building on the political will for CHNM, the government should be encouraged to increase their commitment, allocate sufficient resources and ensure that funds are disbursed to districts on time. • Capacity needs to be strengthened at multiple levels, particularly in relation to planning, budgeting and human resource management, and a greater level of accountability built into the programme.
Coordination, supervision and training	• Capacity has been enhanced over recent years, but it is critical that support for coordination, supervision and training is reaffirmed. • Sub-national actors must be empowered to assume responsibility and be accountable for the CHNM at their operational level. Training is essential for the provision of quality service. • Frontline providers should have the competency to deliver all necessary interventions (e.g MUAC screening) and to communicate key information about the health benefits of the interventions to caregivers and the broader community.
Supply and provision of services	• It is imperative that mechanisms for the clearance and distribution of commodities continue to be strengthened to safeguard the timely release of commodities and ensure that the effectiveness of the CHNM programme is not jeopardised. • In parallel, capacity for human resource management at sub-national levels needs to be strengthened. Clear staffing strategies, training and consistent incentives for CHWs need to be put in place to ensure the provision of quality services during the campaign.
Community perceptions	• It is critical that targeted social mobilisation be continued and adequately resourced to build community trust, overcome rumours and misconceptions, and encourage the positive utilisation of CHNM services. • Sustained efforts should be made to involve male caregivers and ensure they support attendance at CHNMs. Community and religious leaders should continue to be recognised as central to effective community engagement, particularly in rural areas.
Issues of equity	• Further support should be given to strengthen capacity and competencies for the collection, interpretation and use of data at local levels and regional and district levels. • Using equity focused evidence-based decision making can help ensure CHNM strategies effectively target children at risk of missing essential services.

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