

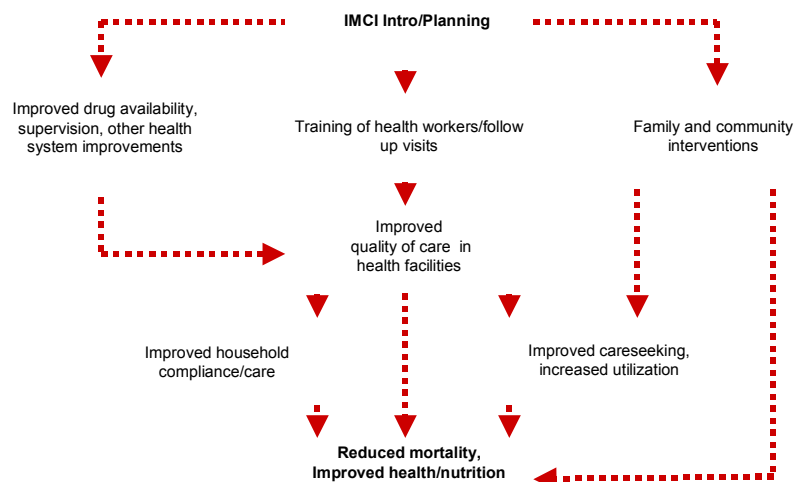
# INITIAL KEY MESSAGES FROM TANZANIA MCE

## Feedback for policy makers

24 September 2003

### 1. What were the expectations for the MCE?

- a. The IMCI strategy would be delivered in an integrated way including its 3 components:
  - i. Improving health worker performance
  - ii. Improving health systems support
  - iii. Improving family and community behaviors
- b. According to the proposed IMCI impact model (Figure), a reduction in mortality of at least 20% would be obtained in a two year period by the joint effect of the 3 components
- c. The design of the evaluation would not allow the assessment of the separate effects of the three components of IMCI
- d. The evaluation would be carried out under real-life circumstances



## 2. What was the actual comparison?

- a. Four districts in rural Tanzania that, over the study period from 1999 to 2002, had:
  - i. Reasonably well-functioning health services
  - ii. Comparable levels of per-capita health expenditure
  - iii. High utilization rates of government health facilities
  - iv. High coverage of selected key interventions (e.g. EPI)
  - v. Large numbers of governmental and non-governmental health actors active in the districts, including health worker training and community activities, mostly with patchy coverage
- b. Two of these districts (Morogoro and Rufiji) also had:
  - i. Strengthened district management skills (priority setting and resource allocation tools)
  - ii. Decentralized control of the health budget
  - iii. High training coverage of IMCI for health workers
  - iv. No increase in provision of IMCI-specific community level activities

## 3. What did we find? Relative to the comparison districts, Morogoro and Rufiji districts presented:

- a. Substantial improvements in quality of care in health facilities as assessed through a health facility survey
- b. Important weaknesses in health systems support for child health care
- c. No marked changes in utilization rates
- d. Lack of differential change in IMCI-related key family behaviors measurable through a household survey
- e. No increase in overall economic costs of providing care to under-five children
- f. A likely reduction of 13% (confidence interval -4 , 26%) in under-five mortality over a two-year period
- g. The above differences were unlikely to be due to changes in external (or contextual) factors

#### **4. Summing up:**

- a. IMCI implementation at health facility level was associated with improved quality of care, no increase in costs, and a possible reduction in mortality, suggesting that IMCI is good value for money;
- b. These improvements were observed in the presence of strengthened district health management skills, decentralized planning and budget control, and tools for resource allocation and priority setting;
- c. Improvements in health systems support for IMCI, including supervision and referral, are still needed;
- d. The lack of a community component may have limited the potential impact of IMCI on mortality and on observed behaviour change;
- e. Given the implementation realities in Tanzania, the design of the evaluation does not allow the assessment of the separate effects of the three components of IMCI;
- f. IMCI implementation in Tanzania should continue to be supported with special attention to reaching a high coverage with the community component.