Innovating for Maternal and Child Health in Africa (IMCHA)

Annual Technical Report

10 September 2015 – 09 September 2016

Prepared by: Institute of Development Studies, University of Dar es Salaam
& HealthBridge

For: International Development Research Centre (IDRC)

Innovating for Maternal and Child Health in Africa (IMCHA)
Annual Technical Report

Project number and name	**108023-001: Improving access to health services and quality of care for Mothers and Children in Tanzania**
Recipient institutions	Institute of Development Studies, University of Dar es Salaam & HealthBridge
Location - country(ies)	Tanzania
Project start date	10 September 2015
Project completion date	09 March 2020
Period of report:	10 September 2015 to 09 September 2016

Section 1: Synthesis

During this reporting period, the project has achieved its objectives. First, we managed to write and complete revision of the project Implementation Plan. The Implementation Plan was submitted and approved by the IDRC.

Secondly, the project was successfully launched at the region, district and local levels on 20th and 21st November 2015. Key Regional and District level stakeholders attended the meeting. These included Regional Administrative Secretary of Iringa region; District Executive Directors of Kilolo and Mufindi Districts; District Commissioners of Kilolo and Mufindi Districts; Council Health Management Team (CHMT) members; Chairpersons of the Council Health Services Board (CHSB); In-charges of health facilities; Chairpersons of the health committees; and councillors from the selected study wards.

Third, we managed to finalize study design and baseline data collection tools. Likewise, we managed to collect qualitative data through in-depth interviews and focus group discussion in 18 villages. Qualitative data were collected in January and March 2016 in Kilolo and Mufindi Districts respectively. The qualitative data are largely used in the design of specific interventions to improve access to health services and quality of care for mothers and children. In addition, quantitative data through household surveys, exist interviews and health facility assessments were collected in 38 villages. Quantitative data were collected from May to July 2016 in both study districts. To a large extent, quantitative data will be used to compare before and after implementation of the project in the study districts. We have started data analysis and the findings are expected to help in the design of the community and health facility interventions.

Fourth, we have managed to recruit 2 PhD students. The PhD students have already been registered at the University of Dar es Salam. They have been exposed to various capacity strengthening trainings particularly on research methodology. The PhD students were also actively involved in the design of the study tools, data collection, coding as well as data analysis.

Section 2: Progress of Project Objectives

a) **Status of Project Objectives and Milestones in Year 1.**

Project objective	*Measurement (indicator)*	*Progress (completed, on-track, delayed, not started, new, removed/deleted).*	*Comments on status*
Launching of the project at the district and local levels		*Completed*	
Finalizing study design and		*Completed*	

tools			
Training of research teams on data collection		*Completed*	
Baseline data collection		*Completed*	
Design of the interventions		*On-track*	*Preliminary data analysis to inform interventions completed*

b) **Revised or Delayed Project Objectives or Milestones.**

No delays or revisions of objectives and milestones to report.

c) **Governance and Coordination of Project.**

Figure 2 indicates governance and coordination structures at the operational level. It also indicates how the project team members will link with stakeholders at the local and national level as well as with HPRO and other IMCHA teams.

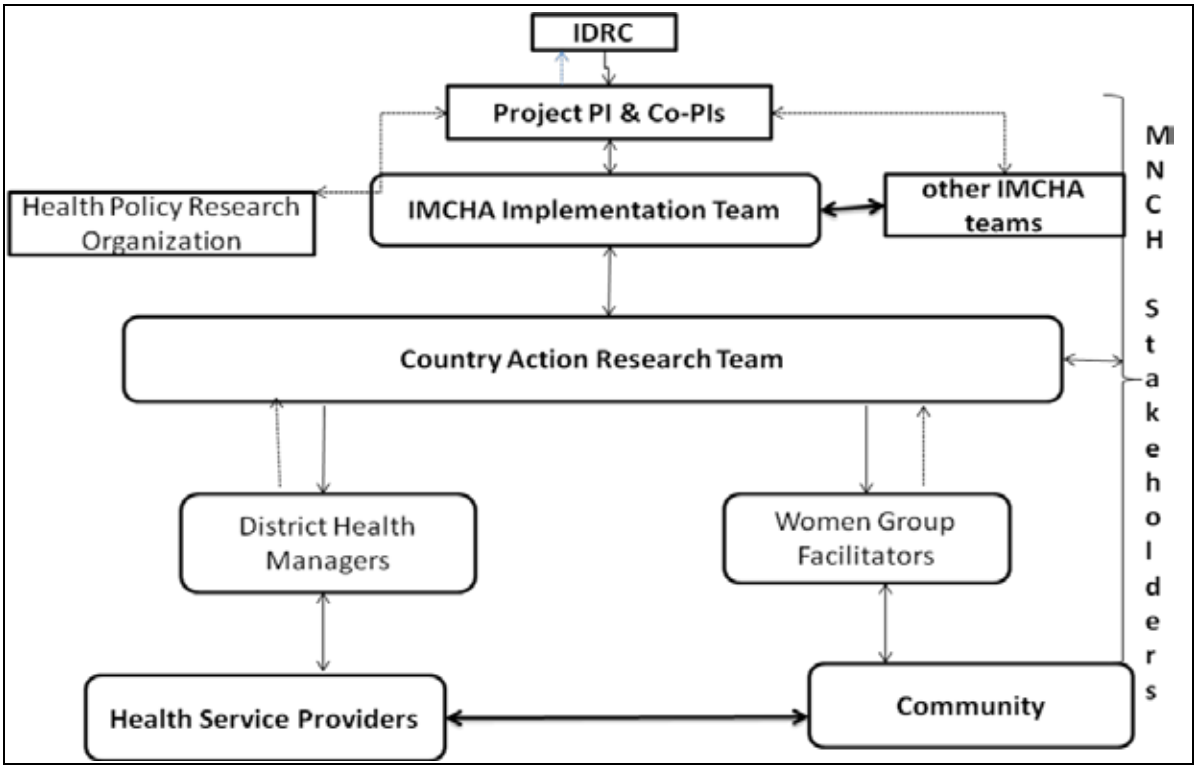

Figure 2: Governance and Coordination Structures for IMCHA Project

Country Action Research Team - The Action Research Team (ART) is comprised of the key researchers, regional and district health management team members. This team coordinates the entire research process, from situation analysis to endline evaluation. The ART facilitates the design and implementation of the interventions at the community and health facility level. The team will also monitor the implementation of the interventions. Furthermore, the ART will facilitate the project review meetings scheduled after every six months.

District Health Managers – The district health managers will be trained to facilitate sessions at every workshop with health facility committee strengthening. The district health managers will also facilitate quality improvement interventions in the health facilities.

Women Group Facilitators - To promote buy-in and facilitate sustainability of the community based interventions, community's group facilitators will be identified and recruited from the local communities. Women group facilitators will facilitate monthly meetings of the women. They will also facilitate community meetings.

Health Service Providers – through health facility quality improvement intervention, health providers will be actively engaged in addressing health facility (supply side) barriers that affect access to health services and quality of care for mothers and children.

Community, including women - through women's participatory action group interventions, community members will be actively engaged in addressing community (demand side) barriers that affect access to health services and quality of care for mothers and children.

Governance or coordination structure	*Number of meetings planned for reporting period*	*Number of meetings conducted for reporting period (with dates)*	*Name of core research team attending meeting (please * beside name if they are a PI, co-PI or focal decision maker on research team*	*Additional persons attending meeting (name, title and organization)*
Project PI & Co-PIs	*12*	*We conducted 3 Skype meetings and 2 physical meetings as follows:* *-26/03/2015 Skype meeting* *-07/01/2016 Skype meeting* *-18/01/2016 Skype* *-* *-30th Nov – 04th Dec 2015 Face –to- face meeting in Dar es Salaam at Double View Hotel*	*1. Dr. Stephen Maluka (PI)* *2. Dr. Robert Salim (co-PI)* *3. Dr. Rachelle Desrochers*	
Implementation Research Team (IRT)		*We conducted 2 Skype meeting and 1 physical meeting as follows:* *-* *-30th Nov – 04th Dec 2015 Face to face meeting at Double View Hotel in Dar es Salaam*	*1. Dr. Stephen Maluka (PI)* *2. Dr. Robert Salim (co-PI)* *3. Dr. Rachelle Desrochers* *4. Ms. Lisa MacDonald* *5.Prof. Peter Kamuzora* *6. Dr. Dereck Chitama* *7. Dr. May Alexander* *8. Prof. Esther Dungumaro*	*1. Mr. Japhet Paul (PhD student)* *2. Mr. Chakupewa (PhD student)*
Country Action Research Team	*12 meetings*	*We conducted 10 physical meetings as follows:* *- 28th -30th October 2015: Face to face meeting at Double View Hotel in Dar es Salaam.* *-*	*1. Dr. Stephen Maluka (PI)* *2. Dr. Robert Salim (co-PI)* *3.Prof. Peter Kamuzora* *4. Dr. Dereck Chitama* *5. Dr. May Alexander* *6. Prof. Esther Dungumaro*	*1. Mr. Japhet Paul (PhD student)* *2. Mr. Chakupewa (PhD student)*

		-14th January 2016: face to face meeting at Primary Health Care Institute, Iringa. *-25th January 2016: face to face meeting at Primary Health Care Institute, Iringa.* *-01st March 2016: face to face meeting at Primary Health Care Institute, Iringa.* *-21st -24th March 2016-Face to face meeting at Kibaha Conference Centre* *-06th – 12th June 2016: face to face meeting at Kibaha Conference Centre* *-01st – 07th August 2016: Face to face meeting at Kibaha conference centre*		

However, there has been changes in the leadership on the part of Canadian partner. In June, 2016, Dr. Rachelle Desrochers accepted a position at the Canadian Institute of Health Research and resigned her position at HealthBridge Foundation of Canada. Dr. Peter Berti took over her role as Co-PI on the project.

d) **Health Policy and Research Organization (HPRO) Collaboration.**

Description of focus or purpose of communication	*Date (D/M/Y) and type of communication (email, skype/phone, meeting)*	*Focal staff and organizations/institutions involved*	*Key ideas and actions resulting from meeting*
Planning meeting	*Face to face Meeting 0n 28th May 2015 at Kibo Hotel Arusha, Tanzania*	*PI, Co –PI; other IRTs and HPRO*	*Development of engagement plans*
Capacity building on mixed methods	*Face to face Meeting was held in September 2015 in Dar es Salam, Tanzania*	*PI, Co –PI; other IRTs and HPRO*	*Capacity building*
Capacity building on costing and mixed methods	*Face to face Meeting was held in Nairobi, Kenya.*	*PhD student; other IRTs and HPRO*	*Capacity building*
Strategic planning for policy engagement	*Face to face Meeting was held on 11-15 April 2016 at Mount Meru Hotel in Arusha, Tanzania*	*PI, Senior Member of the project; other IRTs and HPRO*	*Development of strategic communication plans*

Section 3: Methodology and Measurement

a) **Data/Methodology.**

Research methodology planned for reporting period	*Actual progress during reporting period*	*Comments and/or rationale for variation*
Qualitative data collection using in-depth interviews (IDIs) and Focus Groups Discussions (FGDs). 40 FGDs were planned; 20 in each district. In addition, 90 IDIs were planned to be conducted- 50 for each district.	*Completed 38 FGDs and 80 IDIs in the two intervention districts*	*2 (5%) of FGDs and 10 (11%) of IDS were not conducted because respondents were not available. In addition, for IDIs saturation point was reached as no any new information/data was coming out of the interviews.*
Quantitative data collection using Household Surverys, Exit Interviews and Health Facility Assessment. 570 HH surveys and 285 Exit interviews were planned.	*Completed facility assessment in 19 health facilities; 467 HH surverys; and 217 Exit Interviews*	*All health facility assessments were carried out. 103(18%) HHS and 68 (23%) were not conducted because respondents were not available within the time available to carry out the interviews.*

With regards to gender analysis and integration in the project, Lisa MacDonald, HealthBridge's gender advisor, conducted gender training during the research team's implementation workshop in December 2015. In addition to this, Prof. Esther Dungumaro, a demographer with extensive experience in gender studies, participated actively in the design of the data collection tools and will have a field presence to gauge and ensure the comfort level and active participation of female participants in the women's groups, HFCs, HFQICs and Collaborative Learning Sessions.

During data collection, attention was given to recruit women from poor households as well as women living with HIV/AIDS. This was aimed at ensuring that the voices of the marginalized women are taken into account. Similarly, focus group discussions (FGDs) were conducted separately for men and women. This aimed to ensure that women expressed their views freely without being dominated by men. Concerted efforts were also done to include women from marginalized groups in the FGDs.

In addition, the project will provide gender equity and social inclusion (GESI) sensitization training to all staff and partners engaged in the project, as well as to the health facility staff and local health management committees.

Section 4: Completed Activities and Outputs

a) Health Systems Analysis and Synthesis

i) Number of health system analyses and syntheses that are gender and/or equity focused.

During situation analysis, we conducted stakeholder analysis in the study region to identify key actors and stakeholders involved in the improving maternal and child health. Stakeholders identified will be engaged from an early stage of the project implementation. In addition, during review meetings (collaborating learning sessions) scheduled after every six month the key stakeholders from the regional and national level, including MNCHTWG will be invited and actively engaged.

In addition, the HPRO has conducted stakeholder mapping at the national level. Again, these stakeholders will be actively engaged in the implementation of innovations to improve MNCH.

Further, we conducted a review of existing literature on quality of antenatal and childbirth care and implementation or associated bottlenecks in Tanzania to help narrow initial ideas regarding the possible types of interventions and activities that the team will engage in to address the barriers revealed in the analysis described above.

ii) Number of networking and exchange opportunities supported through IMCHA.

None to report.

iii) Number of synergistic research opportunities

None to report

b) Partnerships and Collaboration

i) Number of new partnerships or collaborations between decision-makers and researchers

None to report.

ii) Number of connections established between IRTs and organizations outside of IMCHA.

None to report

c) Integration of Research into Policy and Practice

i) Decision makers' follow up on recommendations from research into health systems planning forum(s)

None to report

ii) Number and description of evidence-based policy and practice promoted by IRTs.

None to report

ii) Number and type of knowledge translation activities.

Details of knowledge translation activities	*Description of publication or description of meeting*	*Link to online reference*	*Comments or contribution to policy or practice*	*Follow up actions or recommendations*
Improving access to health services and quality of care for mothers and children in Tanzania	*Exhibition at the University of Dar es Salaam Research Week (28^{th} – 30^{th} April 2016)*			
Improving access to health services and quality of care for mothers and children in Tanzania	*Exhibition at the 40^{th} Dar es Salaam International Trade Fair (01^{st} – 10^{th} July 2016)*			

Section 5: Capacity Building

i) Number of emerging researchers involved in the IRT research

Name of student or emerging researcher (defined as new to the health systems field < 5 years).	*Current level of study (i.e. masters, PHD, Post docs, new investigator).*	*Current role or tasks undertaken for reporting period*	*Outputs or description of how this is being used for the research process of the project*
Japhet Paul	*PhD*	*Supporting quantitative data collection and analysis*	*Peer reviewed articles and PhD thesis*
Chakupewa Joseph	*PhD*	*Supporting qualitative data collection and analysis*	*Peer reviewed articles and PhD thesis*

ii) Number of individuals who received training, networking and exchange opportunities

Title of training/networking or exchange	*Dates and location*	*Name/title of persons attending (please describe their role in the implementation research team)*	*Comments or contribution to area policy or practice*
Japhet Paul		*PhD candidate*	*Enhanced capacity in costing and mixed methods*
Chakupewa Joseph		*PhD candidate*	*Enhanced capacity in undertaking mixed method studies*

Section 6: Research Findings

The project has been able to complete baseline data collection which is expected to inform the design of the

specific community and health facility interventions to improve access to health services and quality of care for mothers and children in Tanzania. Data collection and analysis were focused on what barriers exist to seeking care, reaching a health facility, and obtaining quality care and the ways in which these are conditioned by local social, cultural and gender-related factors. The factors examined included household-level decision-making regarding health care and household expenditures, local attitudes towards and cultural barriers to men's involvement in MNCH services, local cultural practices surrounding pregnancy and childbirth, fear of judgment in the community, and religious influences. The open-endedness of the questions in the qualitative component of the data collection allowed the research team to explore other factors raised by participants.

A preliminary analysis of the data gathered during focus group discussions and in-depth interviews in the intervention areas suggests that the primary barriers to seeking care are that: 1) though women do not perceive that receiving permission to seek care is not a problem, men tend to be responsible for household decision-making and women perceived themselves as having narrow decision-making space; 2) women delay seeking antenatal care due to fear of judgment by health care providers and/or their community (due to their wealth, marital status, age, failure to abide by child spacing recommendations, fear of being screened for HIV); 3) men are not engaged or involved in their partner's health and health decision-making during pregnancy, delivery and post-natal care due to many social barriers to their involvement (Men lack education; Entrenched belief that men are not responsible for pregnancy issues; Men are afraid of seeing a pregnant woman giving birth; Men feel shy because it is uncommon to accompany their partners).

The primary barrier to reaching a health facility is that transportation to a health facility is costly, which may also act as a deterrent to seeking care. And the primary barriers to obtaining quality care are that: 1) health care providers, particularly nurses, often have poor attitudes toward patients (which may also act as a deterrent to care seeking); 2) health facilities experience frequent drug stock outs and equipment shortages.

With regard to community involvement and participation, it was evident that in both study districts, communities are represented through health facility committees and boards. Health facility governing committees were in place in almost all health facilities. However, despite their existence, the actual influence of local communities on the planning process remains limited. Local influence over priority-setting was very limited, participatory planning at the village level was not reflected at higher levels of authority and voices from the communities were often not heard. To a large extent, district health plans and budgets reflected the voices of the district health managers. It was evident from the findings that if these committees are strengthened through training and provision of little incentives, they can constitute an important resource that can be used to mobilize community resources and create demand for MNCH services.

The findings revealed that while Community Health workers (CHWs) were perceived as community-based resource persons in facilitation of the process of community mobilisation on health issues, they face significant challenges which undermined their performance. In areas where they worked well CHWs helped to identify pregnant women in the community and follow them up in order to ensure that they delivered with assistance from trained health workers and they further ensured that the child received all the vaccinations.

The main interventions, the community-level women's group and health facility committee (HFC) strengthening, and the health facility-level health quality improvement committee (HFQIC), are geared to address the socio-cultural barriers to women seeking care and men being engaged in their partner's pregnancies and deliveries. The HFQICs will be key in addressing the issue of health care provider attitudes toward patients. Strengthening Health Committees and Community Based Health Insurance (CHF) would contribute to addressing the issue of

drug stock outs and equipment shortages. In addition, the Collaborative Learning Sessions to take place every 6 months, which will include stakeholders and decision-makers at the district and regional levels and will provide an opportunity to discuss issues which cannot be addressed by the health facility and advocate for solutions.

However, the health facility quality assessments revealed that quality and use of data in the study districts is also poor, which hampers many well-planned efforts that rely on the health management information system (HMIS) for feedback. Health facility staffs place more emphasis on reporting than interpretation and utilization of data, a weakness that needs to be addressed. Furthermore, there is a problem of insufficient managerial capacity of health managers in managing resources, planning, implementation and monitoring, especially at the district level, mainly due to insufficient capacity and lack of awareness concerning new management techniques.

However, these findings suggest that any investment in improving quality and accessibility of maternal, newborn and child health services will have wider impact only if the issues of health system governance, leadership capacity, health financing, health information management, and supply chain management are addressed.

Section 7: Key Challenges

During the team inception workshop in November 30th to December 4th 2015, we decided to reduce the scope of the project to focus only on the period of care from pregnancy, labour and immediate postnatal care (within 6 weeks of delivery), excluding pre-pregnancy (e.g. family planning) and child health (e.g. prevention and treatment of childhood illness).

The main capacity needs for the researchers include capacity building on doing costing studies and re-packaging research evidence for different audiences, including policy makers and the media. We have started working with Health Policy Research Organization (HPRO) and other implementation research team members to address these needs. One project team member and a PhD candidate attended training on costing in Nairobi Kenya in 2016 organized by the HPRO. In addition, the project will provide gender equity and social inclusion (GESI) sensitization training to all staff and partners engaged in the project, as well as to the health facility staff and local health management committees.

Administratively, we did not encounter significant challenges during this reporting period. Most of the planned project activities were implemented successfully without major challenge except the procurement of the project vehicle. The United Republic of Tanzania has so far not granted exemption for the project vehicle on the grounds that the process of signing of the Grant Agreement did not involve a representative from the Ministry of Finance. While, the University of Dar es Salaam is still making follow up to the Ministry of Finance, we are worried that if this problem is not sorted out, it might affect the implementation of the project activities.

Section 8: Recommendations to IDRC

No recommendations to make