Innovating for Maternal and Child Health in Africa (IMCHA)

Annual Technical Report

10 September 2016 – 09 September 2017

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 Reporting Format and Guidelines for Implementation Research Teams (IRTs)

Purpose: The annual progress report provides feedback on project milestones, particularly against the objectives set in the grant for this project. The report provides the opportunity to share lessons and information on the impact of interventions that improve the lives of women and children. The information you will provide will feed into the overall monitoring and evaluation of the IMCHA initiative.

Overview: The log-model and performance measurement framework included in the **Annex 1** outlines the expected results of the IMCHA initiative.

Please outline general project information in the table below:

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 Foundation of Canada
Location - country(ies)	Tanzania
Project start date	10 September 2015
Project completion date	09 March 2020
Period of report:	10 March 2017 to 09 September 2017

Section 1: Synthesis

Please provide a synthesis of the project's key achievements and challenges encountered during this reporting period (i.e. the last year). Describe any changes to the project strategy and identified solutions/ways forward (max. 1 page).

During this reporting period, the project has largely achieved planned objectives. We conducted the first Women Group meetings as part of our community-based Women's Participatory Learning and Action Group (WPLAG) intervention in all 20 villages involved in the implementation of the project. The meetings were conducted in two phases. In first phase, we conducted four meetings, covering four villages from 3 wards (Lugalo and Mazombe village in Kilolo district and Ikimilinzowo and Kibengu village in Mufundi district) during 05th to 09th May, 2017. This period coincided with HealthBridge's site visit in Iringa, and the meetings were also attended by the HealthBridge team namely Dr. Khadija Begum (Co-PI) and Dr. Sian Fitzgerald (Executive Director). The meetings were facilitated by IMCHA research Team members namely: Dr Stephen Maluka (PI), Dr Robert Salimu (Co-PI), Dr Alexander May (team member) and Mr Chakupewa Joseph (PhD student). In second phase, the remaining 16 of the first Women Group meetings took place from 07th to 16th June, 2017. These meetings were conducted in 16 villages and were facilitated by Dr. Alexander May (team member), Mr Chakupewa Joseph (PhD student), and Mr. Paul Japhet (PhD student).

The main objective of these first Women Group meetings was to enable women group members identify and prioritize problems, and identify root causes of the problems that affect demand for and utilization of maternal and child health (MCH) in their villages. Through participatory activities women were able to identify several problems that affect demand and utilization of MCH services in their villages/communities. In addition, women group members were facilitated to prioritize 5 problems which affect demand and utilization of MCH services in their villages. Overall, the following steps were adopted in achieving objectives:

Step I: Identifying problems affecting MCH by Women Group through sticky note

The facilitator led women groups to identify problems affecting MCH in their respective village. At this step, women groups were supplied with sticky note to identify one problem that each participant considered the most important. All written cards were placed on the flip chart for each member to see. In circumstances where some women were unable to read they were assisted by Community Interventions Supervisors (CIS) and Women Group Facilitators. On average, 10 problems were identified at this step.

Figure 1. Showing sticky note in the process of identifying MCH problems

Step II: Identifying additional problems affecting MCH by Women Groups through group discussion
The facilitator formed small groups and requested women to identify additional two problems that were not identified during the first step. On average 4 groups were formed composed of 4 to 6 members in each group. The identified problems were written on the flip chart to proceed with the next step.

Step III: Prioritizing five (5) major problems affecting MCH from the identified problems in step I & II
During this step, participants selected the 5 most important problems from the list of the problems which were identified in step 1 & 2. In order to prioritize 5 problems, the following procedures were followed. The facilitators supplied sticky notes to each member so that she may select only one problem from among the identified problems. Sticky notes with all identified problems were placed on the flip chart on the wall and were read loudly by the facilitator. In order to get five problems tallying was done. The problems that attained higher frequencies (problems that were mentioned by more women) were selected. In each village, five problems were considered as priority problems with exception of a few villages where 4 or 6 problems were considered as priority.

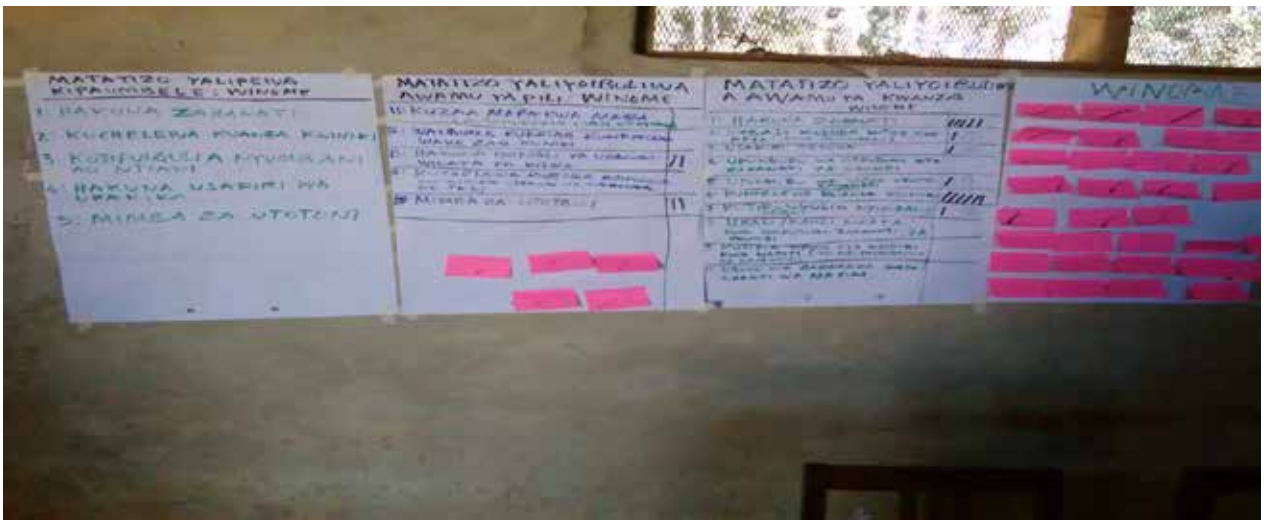

Figure 2. Showing three steps that were used to identify and prioritize problems affecting MCH at Winome Village, Ukumbi Ward

Step IV: Discussion on root causes of each prioritized MCH problems in each village
Through small groups, Women Group members were requested to discuss root causes for all prioritized problems. Each group was given opportunity to present each problem and its root causes. In order to reach a consensus tallying was done to identify the most frequently cited root causes.

During this reporting period, the project also conducted the second Women Group meetings of the first round of the community-based WPLAG intervention. The second women group meetings were conducted in Kilolo and Mufindi Districts from 10th to 15th July and 17th to 21st July, 2017 respectively. The objective of these meetings was to identify strategies to address the root causes identified in the first Women Group meetings. The meetings were attended by women group members and 10 men representatives from each village. The rationale of including men in the meetings was to give men an opportunity to share their views as key stakeholders and decision makers in maternal and child health matters. On average 30 participants attended the meeting in each village. In each intervention village, the meeting covered three major areas:

(i) Presenting to men the identified problems and their root causes that affect demand for and utilization of maternal and child health services. These problems and root causes had already been identified and prioritized by women during the first meeting;
(ii) Discussing together all the prioritized problems and root causes. Men were given opportunity to critically reflect on these problems and provide their opinion;
(iii) Setting feasible strategies on how to address all agreed prioritized problems.

Table 1 below provides an example of problems and strategies which were identified and discussed during the second Women Group meetings at Ihomasa Village in Mufindi District. These strategies will be finalized during the third and fourth Women Group Meetings.

S/N	PRIORITIZED PROBLEM	SUGGESTED STRATEGIES
1	**Home delivery**	1. The village government to enact by-laws that will impose penalty (monetary) to male and female partners who deliver at home
		2. The Women Group to cooperate with community health workers to provide education at the community level on the importance of giving birth at the health centre
		3. Women group to cooperate with community health workers to make follow up for each pregnant mothers at the village level so that they may give birth at the health facility
		4. The women Group to sensitize the village government to prepare action plan of constructing health centre so that pregnant mother may seek delivery service close to their residency
2	**Poor participation of men on matters relating to ANC service**	1. To form a small group of men who will educate their fellow men on the importance of participating fully in matters related to maternal and child health. Such education to be given at different gatherings like in bar, football match and other social gatherings.
		2. The Women Group to cooperate with other stakeholders to plan and strategize provision of education for men on the importance of accompanying their partners for ANC service especially first visit.

		3. The village government to enact bylaws that will impose heavy penalty (monetary) to male partners who for any reason does not accompany their partners for ANC service, during the first visit.
3	**Late ANC Booking/ Not attending ANC at all**	1. The Women Group to cooperate with the Community Health Workers to provide education to the community on the importance of early ANC visit
		2. The Women Groups to cooperate with village government to plan and strategize for the construction of health centre at the village so that ANC service could be made available close to their residency.
4	**Giving birth without observing child spacing**	1. The Women Group to cooperate with other stakeholders to provide education on the importance of using family planning methods so that they may observe child spacing
		2. To form a small group of men who will educate their fellow men on the importance of making use of using family planning methods. Such education to be given at different gatherings like in bar, football match, and other social gatherings.
		2. The Women Group to cooperate with other stakeholders to provide education to primary and secondary school students on sexual reproductive health education
		3. The village government to enact bylaws that will impose heavy penalty (monetary) of about 500,000 together with 12 strokes publicly for those who will impregnate young girls

Health facility Quality Improvement Intervention

During our meeting held in May 2017 between Tanzania researchers and HealthBridge team, we agreed to drop this intervention. It was evident that it was not possible to form Quality Improvement Teams (QITs) in the health facilities to address delay 3 - receiving adequate and appropriate care at the health facilities. Initially, a Quality Improvement Team was planned to comprise of representatives from the various provider roles within the facilities for example, a Matron, Nurse Midwife, Clinical Officer, Laboratory Technician and Data Clerk. The health facility assessment which was conducted in all intervention health facilities involved in the project revealed that most of the health facilities, particularly dispensaries have two or three staff which makes it difficult to form a QIT. We agreed that QITs intervention should be replaced with health workers' sensitization and training another which can help address health systems (Supply side) problems, particularly Delay-3 which affects utilization of MCH services. The most important factor is bad attitudes and disrespectful language of the health service providers, and delay in providing services. This intervention will be designed and implemented during the next reporting period.

Strengthening health facility governing committees (HFGCs).

This **intervention will be completed during the next reporting period. During this reporting period, we identified facilitators who will be providing training to the HFGC. There are 10 health facility governing committees in our intervention villages. Each committee is composed of 11 members. Therefore, a total of 110 committee members will receive the training. In addition, we have started developing training materials for the HFGCs.**

Section 2: Progress of Project Objectives

a) **Status of Project Objectives and Milestones.** Please indicate the progress against the objectives set in the project grant for this reporting period (i.e. last year).

Project objective	*Measurement (indicator)*	*Progress (completed, on-track, delayed, not started, new, removed/deleted).*	*Comments on status*
To understand the processes and contexts at the community and facility level that can affect acceptability, quality, equity and utilization of MCH services within the project area	*-Number of Women's Participatory Learning and Action Groups meetings* *-List of problems and root causes identified by Women's Participatory Learning and Action Groups*	*Completed*	*Completed*
Conducted the Second round of Women Group meetings	*- Number of Women's Participatory Learning and Action Groups meetings* *-List of problems and strategies causes identified by Women's Participatory Learning and Action Groups*	*Completed*	*Completed*
Formation of Quality Improvement Teams (QITs) in the health facilities	*Number of health facility QITs formed and trained*	*This component of intervention would be replaced with health workers' sensitization and training to ensure ouality of care at the health facility*	*Formation of QITs within each facility is not feasible within the given staffing pattern of the facilities. Only a few health staff are available in the health facilities which isnot enough to form a QIT team.*
Strengthen health facility governing committees (HFGCs)	*Number of meetings and information sharing sessions conducted with the HFGCs* *- Number of HFGCs revitalized and trained*	*Delayed*	***Will be completed during the next reporting period. During this reporting period, we identified facilitators who will be providing training to the HFGC, and have started developing training materials for the HFGCs***

b) **Revised or Delayed Project Objectives or Milestones.** If applicable, explain how and why a project objective or milestone was revised or changed from the original stated in the grant during this reporting period. If

applicable, please detail the reasons for revision (please note that revisions in objectives need to be discussed with your lead project officer at IDRC).

As indicated above, we faced challenges in terms of forming Quality Improvement Teams (QITs) in the health facilities to address delay 3 - receiving adequate and appropriate care at the health facilities. Initially, a Quality Improvement Team was planned to comprise of representatives from the various provider roles within the facilities for example, a Matron, Nurse Midwife, Clinical Officer, Laboratory Technician and Data Clerk. The health facility assessment which was conducted in all health facilities involved in the project revealed that most of the health facilities, particularly dispensaries have two or three staff which makes it difficult to form a QIT. Therefore, we jointly decided to replace this intervention component with health workers' sensitization and training to address delay 3 and to change providers' attitudes and practices towards women and related service provisions, but our overall objectives of health facility strengthening remained the same. This intervention will be designed and implemented during the next reporting period.

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c) **Governance and Coordination of Project.** Describe the coordination and governance of the implementation research team for managing the research project (as per the approaches detailed in the project proposal and implementation plan). Detail the frequency and type of communication supporting this project during this reporting period. If applicable, please note any changes to the governance structure or challenges encountered.

Figure 1 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 Health Policy and Research Organization (HPRO) and other IMCHA implementation research teams (IRTs).

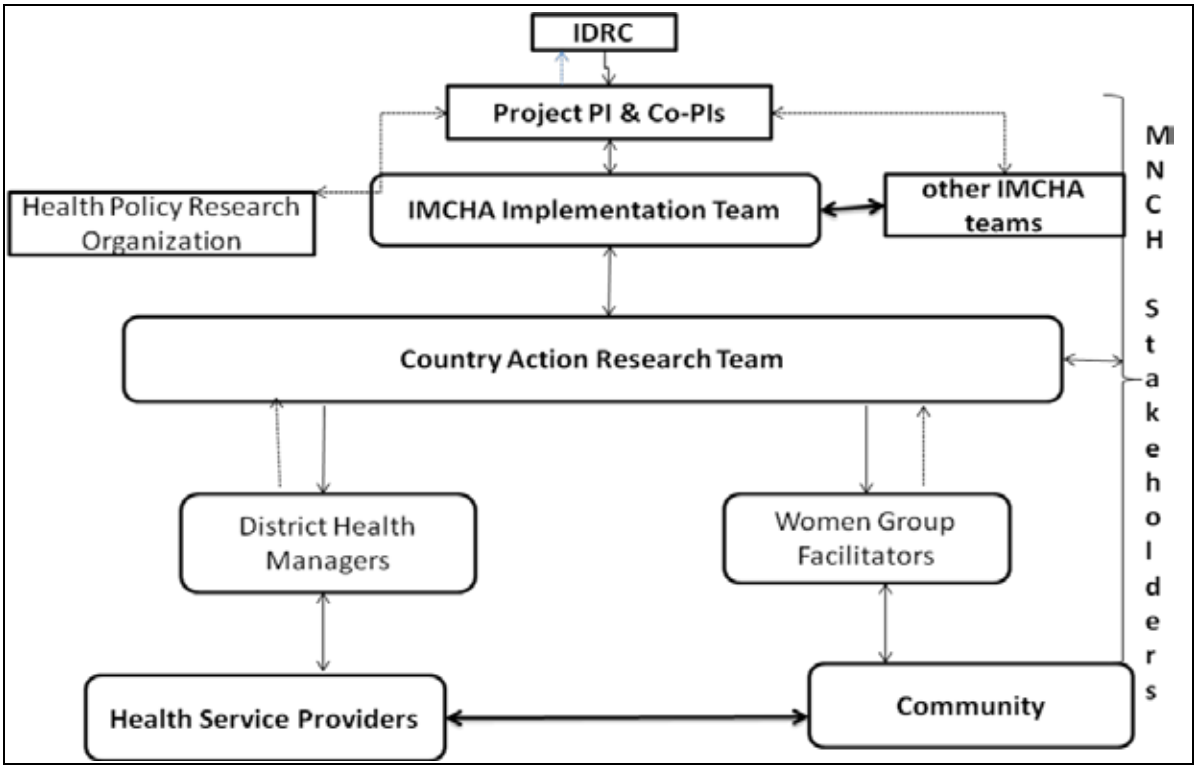

Figure 1: Governance and Coordination Structures for IMCHA Project

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 facilitate 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 governing committees (HFGCs) aimed at strengthening their capacity and creating accountability in quality service provisions.

Women Group Facilitators (Community Health Workers) - To promote buy-in and facilitate sustainability of the community based interventions, Women group facilitators have been recruited from the local communities and have been provided training. Women group facilitators will facilitate monthly meetings of the women groups. They will also facilitate community meetings in which women groups will share their planned strategies to address maternal and child health.

Health Service Providers – through sensitization and training, 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.

Women Participatory Learning and Action Groups (WPLAGs)
Twenty WPLAGs have been formed in all intervention villages through village level orientation meetings. The WPLAGs have also been trained on participatory learning and action group process. The process goes through a four phase participatory learning and action cycle to develop interventions: the first and second phase involves a series of meetings to identify and prioritize the problems in the community, and the root causes of these problems. This is followed by development of strategies to address these problems in third phase, and in the final phase actual implementation/action takes place. Each cycle consists of eight WPLAGs meetings in each village, and the project will complete two cycles during its lifetime. The WPLAGs meet monthly to identify and prioritize MNCH problems in their area with focus on delays 1&2; select and implement interventions to address these; and evaluate the entire process. The WPLAGs have already completed Phase I of problem identification and prioritization. They are now in the Second Phase of designing strategies to address MNCH problems in their area. The Third phase will involve implementation of the strategies and the last phase will be evaluation of the strategies.

Community, including women - through women's participatory learning and 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)*

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	*6*	*We had several email exchanges between the PI and Co-PIs.- We had face to face meetings between Tanzania and HealthBridge team on 1st May and 11th May 2017 during HealthBridge's site visit in Tanzania.*	*1. Dr. Stephen Maluka (PI)* *2. Dr. Robert Salim (co-PI)* *3. Dr. Khadija Begum (Co-PI, HealthBridge)* *1. Dr. Stephen Maluka (PI)* *2. Dr. Robert Salim (co-PI)* *3. Dr. Khadija Begum(Co-PI, HealthBridge)4. Dr. Sian FitzGerald (Executive Director, HealthBridge)* *5.Prof. Peter Kamuzora* *6. Dr. Dereck Chitama* *7. Dr. May Alexander* *8. Prof. Esther Dungumaro*	*PhD student Mr. Japhet Paul and Mr. Joseph Chakupewa*
Country Action Research Team	*6 meetings*	*We conducted 3 physical meetings as follows:* *- 01st May 2017 at Double View Hotel in Dar es Salaam during HealthBridge's site visit in Tanzania* *- 11th May 2017 at the University of Dar es Salaam during HealthBridge's site*	*1. Dr. Stephen Maluka (PI)* *2. Dr. Robert Salim (co-PI)* *3. Dr. Khadija Begum(Co-PI, HealthBridge)* *4. Sian FitzGerald (Executive Director, HealthBridge)* *5.Prof. Peter*	*1. Mr. Japhet Paul (PhD student)*

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)*
		visit in Tanzania *-7th June 2017 at Primary Health Care Institute in Iringa.* *-08th-09th March 2017 at Royal Hotel in Mufindi District, Iringa region.*	*Kamuzora* *6. Dr. Dereck Chitama* *7. Dr. May Alexander* *8. Prof. Esther Dungumaro* *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)*

During this reporting period, HeathBridge Foundation of Canada visited the project site in Iringa, Tanzania. The objectives of this visit were to observe and understand the project implementation activities on-site, review the intervention design and determine if any modifications needed in the design/plans, review the status of baseline analyses, and discuss next steps, and types of support needed from HealthBridge.

The agenda of the site visit is attached as **Annex 2**. On the first day of the visit the country research team provided an overall update of the project implementation status (please see **Annex 3** for the power point presentation by IDS). The HealthBridge team accompanied by IDS team, had the opportunity to meet key regional and district level health officials, visit some lower level health facilities, and observe Women Group meetings in four villages of both intervention districts. On the last day of the visit, the team met at the University of Dar es Salaam to discuss on key reflections from the field visit, determine next steps, and decide if there are any recommendations to IDRC. The Power point presentation by HealthBridge is attached as **Annex 4**. Briefly, the following suggestions were made by HealthBridge and jointly agreed:

- § There is need for additional field (District) level staff for better coordination of project implementation activities. HeallthBridge proposed a revised project organogram (Figure 2);
- § Simultaneous implementation of both demand and supply side interventions is needed to have the balance between demand creation and service provisions;

- § Interventions should focus on delivery of key messages through harmonization of multiple channels
- § Interventions engaging and targeting men are necessary to increase access and utilization of MNCH services;
- § There is need to capture the baseline socio-demographic information of Women Group participants. Additinally, village level contextual data should be collected both at baseline and endline for impact evaluation; HealthBridge agreed to develop the questionnaire to capture these data;
- · At least one 6-monthly collaborative learning sessions to be attended jointly by IDRC and HB representatives;

A report of the site visit prepared by HealthBridge is attached as **Annex 5**.

d) **Health Policy and Research Organization (HPRO) Collaboration.** Please describe the number and type of communication between the IRT and HPRO.

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*
	Several email exchange	*HPRO led by Lynette Kamau*	*Discussed about the project implementation*
	Several email exchange	*HPRO led by Lynette Kamau*	*Discussed about joint meeting between HPRO, PIs and Policy makers in Dodoma*
Questionnaire for PI	*Tanzania National Meeting of Implementation Research Teams (IRTs), organized by EA-HPRO 28th -30th June 2017,*	*Implementation Research Teams and EA- HPRO*	Six Implementation Research Teams of Tanzania met to discuss the national engagement strategy. The specific objectives of the meeting were: -Agree on Key messages that align with national priorities as per 3 themes of the IMCHA program: high impact, community-based interventions; quality of care at the facility level, and human resources for health; -plan the next steps for future National engagement -Identify areas for collaboration and outline possible roles and responsibilities. On June 30th, presentations were made

			to the Tanzania's deputy permanent secretary (DPS) of the President's Office Regional Administration and Local Government (PORALG)
	Several email exchanges during Sep 05-07, 2017	*EA-HPRO led by Lynette Kamau*	*To discuss on developing a proposal for requesting additional funding opportunities from EA-HPRO*

Section 3: Methodology and Measurement

a) **Data/Methodology.** Please give details on the data collection methods implemented during this reporting period.

Research methodology planned for reporting period	*Actual progress during reporting period*	*Comments and/or rationale for variation*
Conduct the first Women Group meetings in all 20 intervention villages as part of first cycle of WPLAGs intervention.	*Conducted 20 Women Group meetings in 20 villages; 10 villages of Kilolo District and 10 villages of Mufindi District. The objective was to enable women group members identify and prioritize MNCH problems and the root causes of these problems in their community/villages* *We also collected basic data on composition and socio-demographic characteristsics of the WPLAGs.* *We also collected village level contexual data from all intervention and comparison villages*	*As per discussion during HealthBridge's site visit in May, we decided to collect socio-demographic data of Women group participants and village level information from all 20 intervention villages. Accordingly, HealthBridge developed two questionnaires to capture basic data on villages and Women Group participants. Although data collection was conducted during June, 2017, we considered this as baseline since no remarkable/measurable interventions took place at that point*
Conduct the Second Women Group meetings in all 20 intervention villages as part of first cycle of WPLAGs intervention	*Conducted 20 Women Group meetings in 20 villages; 10 villages of Kilolo District and 10 villages of Mufindi District. A report was written covering each meeting* *During these meetings 10 men from each village were also engaged to discuss prolems which were identified*	*There were no variations*

	and prioritized by women group members during the first Women Group meetings. *The objective was to enable women group members and men to identify and pioritize strategies to address MNCH problems identified in their areas.* *We collected basic data on composition and demographic characteristsics of the men who participated in the meetings in July 2017.* *-We collected data on the participations and understanding of men on male involvment in MCH issues.*	

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.
Nothing to report during this reporting period.

ii) Number of networking and exchange opportunities supported through IMCHA.
Nothing to report during this reporting period.

iii) Number of synergistic research opportunities

Title of concept note or proposal	*Details of person or group submitting*	*Date of submission*	*Outcome of submission or comments*
A Health Systems Approach to Improving Maternal, New-born and Child Health at the District level in Tanzania	*Institute of Development Studies, University of Dar es Salaam led by Dr. Stephen Maluka in collaboration with University of Leeds, UK.*	*Submitted to the Medical Research Council of the United Kingdom (UK) in May 2017*	*The proposal was not successful*

Please detail and additional related preparatory activities or actions taken: _____

_____

b) Partnerships and Collaboration

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

- Tanzania National Meeting of Implementation Research Teams (IRTs), organized by EA-HPRO 28th -30th June 2017. Six Implementation Research Teams of Tanzania met to discuss the national engagement strategy.

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

Nothing to report during this reporting period.

c) Integration of Research into Policy and Practice

i) Decision makers' follow up on recommendations from research into health systems planning forum(s)
Nothing to report during this reporting period.
Please detail any additional related preparatory activities or actions taken: _____

_____

ii) Number and description of evidence-based policy and practice promoted by IRTs.
Nothing to report during this reporting period.
ii) Number and type of knowledge translation activities. The activities may include information sharing and dissemination (reports, journal articles, policy briefs, practitioner tools, workshops, conferences, seminars, radio programs, films, interviews, websites, CD-ROMs, etc.) and creation of new knowledge in forms other than publications or reports (new technologies, new methodologies, new curricula, new policies, etc.).

- Participated in abstract submission for a symposium entitled "Gendered and social analysis in baseline surveys – reflections for intervention design" to present at the Canadian Conference on Global Health 2017.

Section 5: Capacity Building

This section gathers collective as well as project specific data on capacity building efforts within IMCHA.
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*	*PhD Research proposal which has been submitted to the Institute of Development Studies, University of Dar es Salaam*
Chakupewa Joseph	*PhD*	*Supporting qualitative data collection and analysis*	*PhD Research proposal which has been submitted to the Institute of Development Studies, University of Dar es Salaam*

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

- Nothing to report

Section 6: Research Findings

Please describe any preliminary findings from your research project. Highlight the significance of these findings in relation to the existing knowledge-base and/or policy environment

It was evident that the vast majority of community members supported the project and were willing to support the implementation of the project in order to address maternal and child health problems facing their communities. The most identified problems through first set of Women Group meetings were: late booking for antenatal services, lack of male involvement in maternal and child health services, home delivery and limited utilisation of family planning services, as well as malnutrition of under-five children. As discussed above, in each village women Group members together with men have suggested a number of strategies which would be further evaluated for their implementation feasibility through the remaining WPLAG meetings.

The supply side problems mentioned by the women group members were: bad language of the health providers, delay in receiving appropriate care, and lack of facilities and equipment in the health facilities. Further, it was also evident from the women group meetings, interviews and focus group discussion that within the health care sector, the supply chain for drugs and commodities is inefficient and often leaves health facilities with stock-outs. These bottlenecks in the health systems are likely to undermine the success of the community and health facility interventions to improve health services and quality of care for mothers and children in Tanzania implemented under Innovating for Maternal and Child Health in Africa (IMCHA) programme.

In terms of the implementation of the project, the following were suggested by Healthbridge, and jointly agreed by HealthBridge and IDS through a meeting on May 11, 2017 at the University of Dar es Salaam

- In order to make the Women Group meetings more participatory, interactive and informative, there is a need to have some designated members of the Women Groups to conduct the meetings.
- Community health workers may need further training and support to develop skills and expertise to maximize their involvement as women group facilitators.
- Documentation and analyses of Women Group meetings is needed using some semi-structured tools; information should be entered into the database for each village and each meeting to generate summary reports.
- For effective implementation of the project in the district and village levels, there is need for field level (District) project staff for ongoing coordination, monitoring and supervision of field activities and organizing community events. This will also reduce PI's workload.

Section 7: Key Challenges

Discuss any challenges encountered during this reporting period. These may include administrative or financial challenges, changes in political/policy space, unexpected delays, or staff changes. Describe how you have responded to them (solutions/way forward) and identify any specific support you require from IDRC.

Administratively, we have faced challenges in terms of project coordination and management at the field level. It was acknowledged by Healthbridge during site visit that most of the activities are done by the PIs and the senior project staff. In order to reduce the workload of the PIs and senior project staff HealthBridge suggested a revised project organogram (Figure 2) and proposed to include field coordinators who will be responsible for

ongoing field coordination, monitoring and supervision of field activities and organizing community events. Figure 2 below shows the revised project governance structure.

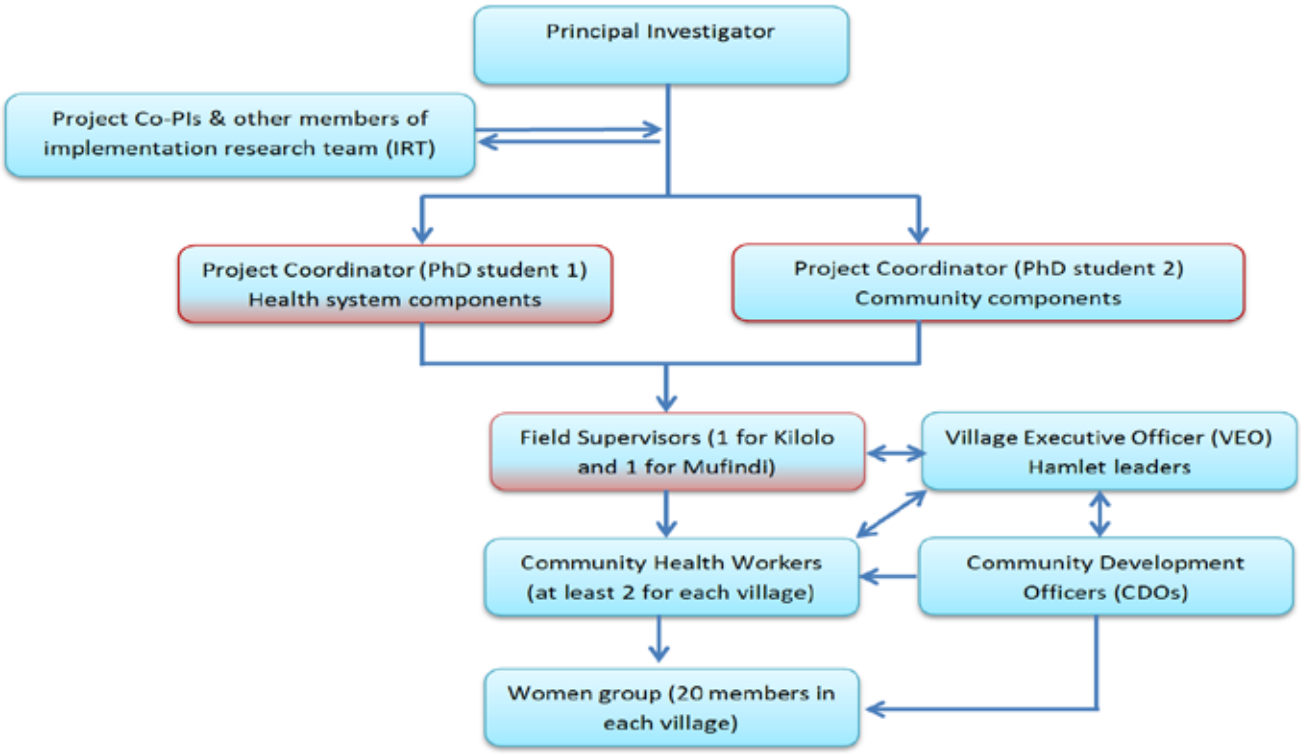

Figure 2: New Governance and Coordination Structures for IMCHA Project

Further, we faced challenges in terms of forming Quality Improvement Teams (QITs) in the health facilities to address delay 3 - receiving adequate and appropriate care at the health facilities. Initially, a Quality Improvement Team was planned to comprise of representatives from the various provider roles within the facilities for example, a Matron, Nurse Midwife, Clinical Officer, Laboratory Technician and Data Clerk. However, most of the health facilities, particularly dispensaries have two or three staff which makes it difficult to form a QIT. IDS proposed to drop this intervention and it was jointly agreed by HealhBridge and IDS.

Section 8: Recommendations to IDRC

Summarize any recommendations for IDRC with regard to the administration of the project, its scope, duration or budget.

After HealthBridge's site visit, on May 11, 2017, HealthBridge and IDS had a wrap-up meeting to discuss on key reflections from the field visit, determine next steps, and decide if there are any recommendations to IDRC. The Power point presentation by HealthBridge with key recommendations to IDRC is attached as **Annex 5**. Briefly, the following key recommendations were jointly agreed by IDS and HealthBridge:

- Need for additional field level staff (District) with justification for additional budget allocation (IDS will draft and HealthBridge will review)
- Rationale for supply and demand side integration of interventions through delivery of key messages via multiple channels
- Support from HPROs required for refining key messages as suggested by PI

- At least one 6-monthly collaborative learning session be attended jointly by IDRC and HB representatives
- PI is willing to visit Canada along with country Co-PI to update field activities and disseminate findings