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Qualitative Gender End-line Assessment of the Tabora Maternal and Newborn Health Initiative (TAMANI)

CARE Canada

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List of Abbreviations

CHW	Community Health Worker
CSC	Community Score Card
FGD	Focus Group Discussion
GoT	Government of Tanzania
HCP	Health Care Professional
ICF	Informed Consent Form
IDI	In-depth Interview
IGA	Income-Generating Activity
IHI	Ifakara Health Institute
KII	Key Informant Interview
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
PI	Principal Investigator
PO-RALG	Prime Minister's Office for Regional Authorities and Local Government
RMN	Reproductive, Maternal, and Newborn
RMNCH	Reproductive Maternal Newborn and Child health
SAA	Social Analysis and Action
SRHS	Sexual and Reproductive Health Services
STI	Sexually Transmitted Infection
TAMANI	Tabora Maternal and Newborn Health Initiative
Tsh	Tanzanian Shilling
WRA	Women of Reproductive Age

Executive summary

The Tabora Maternal and New-born Health Initiative (TAMANI) is a five-year project, implemented from January 2017 to December 2021 led by CARE in partnership with the Government of Tanzania's Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) and the Prime Minister's Office for Regional and Local Government (PO-RALG). Tthe project aims to improve the quality of Reproductive, Maternal, Newborn and Child Health (RMNCH) services available, and addressing the barriers that rights holders, particularly women and girls, face in accessing care.

This report presents the findings from the qualitative gender endline assessment conducted between April to June 2021. The assessment was led by a team from Ifakara Health Institute and NIRAS International Consulting. The overall objective was to study the potential influence of TAMANI on gender equality and social norms and access to RMNH services in TAMANI target communities. Targeting both the household sphere as well as the Health Facility, the following question guided the work: *What changes in gender and social norms have occurred in the TAMANI project communities and how does this link with access to RMNH services for women, men and adolescent girls and boys?*

The fieldwork was conducted in Kashishi village in Kaliua District (rural) and Tumbi in Tabora Municipality (semi-urban). The key sources of the findings are eight Focus Group Discussion, 28 in-depth interviews and ten Key Informant Interviews with women in reproductive age, male partners, adolescent girls and boys, community health workers, health care providers, community facilitators, youth champions, community leaders and mothers in law.

The report presents findings as per three main sections, Health in the Facility, Health in the Household and Cross-cutting Themes. The three chapters of findings seek to reply to this question according to a number of sub-themes presented in more detail below.

Health at the clinic

TAMANI is well-perceived among both rights holders and duty bearers in Tabora. In general, respondents argue that the quality of health services have improved and mention for example that maternal mortality has gone down, STI levels have decreased, health staff and ambulance services and home visits are available, and that services generally are affordable, of high quality and that waiting times have reduced. Clinic infrastructure, privacy, medical equipment, beds, fresh water, toilets have all increased in standard. Examples of challenges that remain include shortage of drug supplies and you need to bring selected equipment to the facility when giving birth.

Awareness has increased regarding the importance of attending the clinic regularly during pregnancy. Both women and men have learned more on the importance of supporting pregnant women, accompanying them to the clinic etc. Women are to a significantly increased extent giving birth at health facilities, as a result of improved infrastructure and service as well as community dialogue and outreach. Several respondents put forward that bylaws also prohibit home birth and that you are required to go to the clinic, which has also influenced the shift away from home births.

There appears to be consensus around this matter among the respondents – men are accompanying their partner to an increased extent. Many respondents attribute this change to TAMANI and argue that project activities have offered the community a deeper understanding of why this is important.

Generally respondents find the clinic staff welcoming and service minded. A majority found that there has been an improvement while a few claim the staff were always very friendly and others yet say the services are good and HCP generally do their best. Several of the respondents who think there has been an improvement reference Community Score Cards as a forum for dialogue as a trigger for this change

Health in the Household

A majority of the respondents state that men participate more actively in household chores and that TAMANI has sparked conversation and critical thinking in the families regarding division of labour. Several respondents argue this change is small or slow but most agree it's there. The mother still holds the ultimate responsibility for domestic duties but both men and children are increasingly participating – especially when the mother is pregnant or unwell.

There is an increase in joint discussion, participation and decision-making in several private and public spheres between men and women. While it is not fair to say that women have equal status to men in making the final decisions, there appears to be a shift in this dynamic – allowing women more space and agency. Several respondents argue that TAMANI activities have prompted more equal participation in various forms of decision-making and for instance income-generating activities.

There is an increase in dialogue and shared responsibilities between men and women at household level in regards to maternal and child health. However, this is a complex matter where some respondents find it positive that women participate more (becoming more established as decision-maker in the house over for instance expenses) while others emphasise that it is good that men participate more (in matters related to maternal and child health that they previously may not have taken much interest and responsibility for).

The vast majority of respondents say that there is an ongoing discussion between men and women regarding how many children to have and when. Many repeat that previously this decision remained solely with the man, but that there has been a shift towards equal decision making. However, some argue still have the final say, which would explain why some women in Tabora still use contraceptives in secret.

Changing attitudes and reduced stigma around family planning/contraceptives and less use of traditional family planning methods. Several interviews suggest there are more discussions ongoing on household level about family planning options and a large uptake of contraceptive services at the clinic. The main focus evolves around protecting yourself from unwanted pregnancies and less often about STIs/HIV although there appears to have been an increase in demand for condoms. There are still misconceptions around family planning and especially potential side effects which indicates more information is needed, however misinformation appears to be on the decline. In regards to traditional methods, not a single respondent advocated for these methods but generally acknowledged them as obsolete, ineffective and potentially dangerous.

Several respondents speak of stigma around offering young people sexuality education and information and access to family planning but the majority of interviews suggest this is shifting and that people would argue it's very important to target adolescents with this information and services. Some repeated arguments of providing young people with these services and information is that in order to realize your potential in life it is important to avoid contracting HIV or teenage pregnancies.

Many respondents are very positive about how accessible CHW make information and say they wished there were more CHWs, especially on sub-village level. CHW have contributed with ample important RMNCH information including better awareness-raising on the importance of health centre delivery. Considering the many positive reviews of the work of CHWs, some consider them undervalued.

The respondents do not always refer very clearly to the specific "education" initiatives they have partaken in. Sometimes they refer specifically to TAMANI or CARE, but very seldom to SAA or CSC or other project specific activity.

Cross-cutting themes

Respondents offered mixed feedback regarding whether the change induced by TAMANI will last. Many of them argue that results will be sustained. However many also claim that activities should continue in order to guarantee sustainability and avoid setbacks and that "reminders" would be valuable in order to preserve all the information TAMANI has provided. While respondents generally offer positive feedback on TAMANI, some respondent highlighted that it was implemented for quite a short time which has a bearing on the scope of social change obtained, as well as sustainability. Respondents also note that there are still a lot of rights holders that have not been reached by the project activities yet and that if more people were involved, this would have a significant bearing on the sustainability of the project outcomes. Furthermore, the interview questions could also have attempted to tease out more details on how respondents think they could contribute to mechanisms to sustain the change.

Most respondents argue the project has addressed important issues, provided valuable platforms for discussion, facilitated deeper engagement with important health uptake aspects as well as contributed to increased quality service provision. Several persons express that TAMANI has had a positive influence on gender equality and challenging of patriarchal social norms as discussed further in the other subsections of this cross-cutting chapter. The public discussions as an approach were appreciated and found empowering. One of the strengths of CSC that was emphasised was that you can voice a concern and it will be acknowledged and addressed.

There appears to be no reports on backlash or any negative outcomes as a result of TAMANI activities. All respondents are positive regarding the change the project has brought about with the caveat that some speak of very significant change, and others say it's more limited and fairly slow or that some participate in the shift rather grudgingly. However, not a single respondent has argued that no change at all can be identified. Moreover, not all respondents are able to name TAMANI activities as cause for this positive change. However, the key message is that the situation has improved, and it is less important that community members do not always recognise TAMANI or CARE's role in this achievement.

Some respondents argue there has been an increase of adolescent pregnancy rates due to the pandemic and reduced school attendance. COVID-19 and advice on social distancing appears to have brought about fear, stigma and misinformation which had a negative impact on women's attendance at the clinic. At the same time, these circumstances do not appear to have deterred all women from attending their appointments. Social distancing recommendations have also had an impact on the opportunities to meet in larger groups but for some, PPE-equipment has facilitated certain meeting settings to continue business as usual.

Recommendations

Upon presenting these findings, the report presents lessons learned and offers recommendations:

- The holistic approach – a success worth replicating
- Strengthen the institutionalisation through rights holders and duty bearers responsibilities
- Emphasise youth further in future programmes
- Inject light touch boosters to maintain the results
- Follow up on the gender assessment at a later stage
- Dissemination of findings to other ongoing initiative

1. Introduction and Background

The Tabora Maternal and New-born Health Initiative (TAMANI) is a five-year project, implemented from January 2017 to December 2021 led by CARE in partnership with the Government of Tanzania's Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) and the Prime Minister's Office for Regional and Local Government (PO-RALG). TAMANI is financially supported by the Government of Canada and is closely aligned to Government of Tanzania (GoT) health polices, strategies and guidelines.

With a geographical focus of Tabora Region, the project aims to improve the quality of Reproductive, Maternal, Newborn and Child Health (RMNCH) services available, and addressing the barriers that rights holders, particularly women and girls, face in accessing care. With a catchment area of 50 percent of the Healthcare Facilities in the region, TAMANI has supported 56 health planners, 270 health care workers and 1000 community health workers, through whom 298,995 women of reproductive age and 68,695 new-borns have benefitted directly from the programme. In addition, there are more than 300,000 indirect beneficiaries, consisting of women in other age groups than reproductive age, as well as men and boys.

TAMANI has supported improvements to health facilities and the quality of RMNCH services offered. A central part of the programme has also been healthcare outreach in the community through Community Health Workers, providing linkages between households and health facilities[1]. Gender dynamics and social norms have also been addressed, through the encouragement of community dialogue, using the participatory methods Social Analysis and Action (SAA) and Community Score Card (CSC). The issues addressed during these community dialogue sessions include for example division of household tasks and decision making, facility based birth and family planning, and underlying causes for women not to deliver at the health facility[2].

A baseline survey was conducted in 2017 with the support of McGill University's Institute for Health & Social Policy and Ifakara Health Institute (IHI) and a qualitative gender formative assessment was also conducted by IHI. As the TAMANI programme was coming to an end in 2021, a quantitative endline survey was conducted by McGill University and a qualitative gender endline assessment was conducted by IHI and NIRAS. This report compiles findings from the qualitative gender endline assessment. The research was led by Dr. Sally Mtenga and Ms. Irene Mashasi from IHI and Dr. Linda Helgesson Sekei and Ms. Amanda Hammarlund from NIRAS and was conducted between April and June, 2021.

1.1 Overall objective and research questions

The overall objective of the qualitative gender endline assessment was to study the potential influence of TAMANI on gender equality and social norms and access to RMNH services in TAMANI target communities. Targeting both the household sphere as well as the Health Facility, the following question guided the work:

What changes in gender and social norms have occurred in the TAMANI project communities (with specific interest in communities that have implemented gender focused activities such as the Community Score Card and Social Analysis and Action) and how does that link with access to RMNH services for women, men and adolescent girls and boys?

The specific objectives of the research were to:

1. Explore ways in which gender dynamics may have changed which shape men and women' health practices, such as use of contraceptives, child spacing, health facility delivery, health information and dialogue around these health practices.
2. Analyse ways in which gender dynamics may have changed and shaped men and women' social and economic opportunities

[1] See for example TAMANI semi-annual and annual reports.
[2] See CARE (2015): Social Analysis and Action Manual and Annex A and B in this report.

3. Unpack the comparative ability of women and men to exercise autonomy and decision making related to health practices and social and economic advancement
4. Explore ways in which gender dynamics influence adolescent's use of reproductive health services
5. Analyse how Community Health Workers (CHWs) operate within cultural and gender norms, roles and responsibilities and power dynamics which affect their daily working conditions.
6. Explore ways in which the impact of cultural and gender norms have changed from the perspective of other key intermediaries and influencers, notably Health Care Professionals (HCPs), Youth Champions, Community Facilitators (SAA and CSC), Community Leaders and Mothers in law.

2. Methodology

The qualitative gender endline assessment builds on the methodology used during the formative gender research conducted in 2017, which aimed to capture context-specific gender inequality dimensions which indirectly or directly constrain the use of maternal and reproductive health services and other social-economic opportunities among women and girls in Tabora (Mtenga & Shamba 2018). The formative gender research provided the project with a deeper contextual understanding of the more complex dynamics in Tabora that influence RMNCH seeking behaviour, but also more broadly offered insights on the lives of the rights holders in Tabora, - especially women and girls. The formative research specifically looked at the gender dynamics that shape men and women's health practices, the ability of women and men to exercise autonomy and decision making, contraception and social and economic advancement and the ways in which gender dynamics influence adolescent's use of reproductive health services. Findings which emerged were e.g. limited decision making power of women and girls, men's negative attitude towards girls' education, and men's violence in reaction to the use of women's use of family planning. The formative research also found that adolescents were not treated well by Health Providers when accessing reproductive health services, in particular contraceptives. The findings informed the TAMANI project interventions and were also used to create awareness of gender challenges in Tabora among community and district leaders.

The methods, respondent groups and research tools used during the qualitative gender endline assessment, built on the approach applied during the formative gender research. It sought to capture the experiences and perspectives in regards to how TAMANI activities may have contributed to change in their communities, from the perspective of WRA, male partners and adolescents, as well as from Community Health Workers (CHWs), Health Care Professionals (HCPs), community leaders, community facilitators and other influencers (e.g. mothers-in-law). Recognising the complexity of studying the social context of gender, the ambition was to maximize comparability of views and opinions regarding gender dynamics and what changes may have been brought about by TAMANI project.

2.1 Methods and study participants

The following qualitative research methods were deployed:

- A literature review
- Focus group discussions (FGDs)
- Individual semi-structured interviews (IDIs)
- Diaries
- Key Informant Interviews (KIIs)

The following respondent groups participated in the study, largely following the categories during the formative gender research conducted in 2017 and selected due to their important roles during the TAMANI intervention:

- Women of Reproductive Age (WRA) – direct beneficiary group of TAMANI
- Male partners of WRA – indirect beneficiary group
- Adolescent girls and boys (age 15-19) – adolescent girls form part of the direct beneficiary group, adolescent boys were indirect beneficiaries. There were some targeted interventions for adolescents in TAMANI
- Male and Female Community Health Workers (CHWs) – Community members trained to deliver health information

- Health Care Workers (frontline service providers)
- Mothers-in-Laws (influencers and gate-keepers/support)
- Community facilitators (these are e.g. SAA, CSC facilitators and youth champions)
- Community Leaders (influencers in the community, and had been part of CSC sessions)
- TAMANI project staff – had in-depth knowledge and experience of the programme

The research instruments are included as annex C of this report.

Literature review

The research team has consulted a number of relevant documents including the formative gender study undertaken at the beginning of the TAMANI project. The literature review was imperative for the formulation of the Research Protocol and interview tools for the end line research and in that sense have a significant relevance to this report.

The following documents were reviewed[3]:

- Third Annual narrative report of TAMANI
- Year 4 semi-annual report of TAMANI
- TAMANI project brief
- TAMANI formative research report
- TAMANI project Implementation Plan
- CARE guidance Note on gender Equality and Women's Voice
- Presentation of gender formative diarist stories
- TAMANI Household Coverage Survey
- CARE social analysis and action manual
- SAA themes and norms
- District Common Indicators
- TAMANI CSC Tracking Template
- CSC and SAA agreed action plan

Focus Group Discussions (FGDs)

FGDs were used to explore target communities' health seeking behaviour and social norms around decision making and autonomy on social-economic and health aspects. FGDs with WRA, male partners of WRA and adolescent girls and boys were conducted. Six to seven respondents were present per focus group in order to facilitate discussion and to allow sufficient social distancing between the participants due to the risk of COVID-19 infection.

Individual Interviews (IDIs)

Semi-structured IDIs complemented the FGDs by facilitating a space to share individual thoughts, views and experiences. IDIs were deemed important for the research as the sometimes sensitive topics, personal opinions and perceptions may be difficult to share in a group setting, such as experiences of men and women's' decision making processes, personal autonomy and power relations in accessing health services, information and social-economic opportunities etc.. IDIs were conducted with WRA, male partners of WRA, adolescent girls and boys, CHWs, HCPs and mothers-in-law.

[3] See full references in the reference list.

Diaries

During the formative research in 2017, diarists were recruited among literate WRA, male partners of WRA, adolescent boys and girls, and teachers, recorded observed events related to gender inequality happening in their communities over the course of one month. For the endline research, the diarists were recruited among WRA, male partners of WRA, adolescent girls and boys, female and male CHW, and female health care workers, journaled for two to three weeks and took retrospective notes on changes over the past few years of their lives. The recoded observations were instructed to target access to health services, reproductive health services, health practices, opportunities, autonomy, decision making and relationships between men and women. Prior to conducting the observations, the diarists received information regarding the specific objectives of the task at hand, the time frame and compensation for the effort.

Key Informant Interviews (KIIs)

Key Informant Interviews (KIIs) were conducted with community leaders, youth champions, SAA and CMC facilitators and TAMANI project staff. These interviews offered important sources of information, both in terms of the project itself as well as the changes that the KIIs have witnessed as a result of different project interventions. The TAMANI project staff were in fact key informants for the planning of the endline research[4]. They participated in planning sessions and contributed with valuable insights regarding the intervention, which, in addition to the literature review and information from CARE Canada staff, was key to design the research.

2.2 Approach to recruit study participants

SAA and CSC programme activities were used as entry points for the end-line research. This was deemed useful as a number of distinct groups have been engaged in project activities already, and trust has been built within the groups and with the facilitators. By using SAA and CSC as starting points, the ambition was to bring the research closer to the interventions and a context which the respondents were already familiar with. This way the end-line research could also optimise use of the SAA and CSC facilitation trainings that have been undertaken. While mainly women have participated in SAA, the whole community have been invited to the CSC events, where SAA findings/actions are presented.

For the purpose of the study, WRA and adolescent girls were recruited from the SAA participant groups and male partners of WRA and adolescent boys were recruited from the CSC exercises. In order to avoid repetition and not take too much of the respondents' time, the participants in the IDIs were not the same as those in the FGDs and diarists. In the case where there were not sufficient adolescent respondents, the parents who participated in IDIs were asked if their daughter or son would be available to participate in an FGD or IDI.

As mentioned above, TAMANI staff were recruited as Key informants, as well as TAMANI coordinators in the research locations. Key informants were also recruited from the CSC Task Force, which has been established in each community, consisting of trusted community members who had been selected as community facilitators such as youth champions, CSC facilitators and SAA facilitators. Community leaders were selected as KIIs from the village administration, and HCPs as well as CSCs were recruited through the health facilities within the localities where the fieldwork was conducted. In some cases there was a convergence between being a community facilitator and Community Health Worker (CHW) as CHW's often had been trained as community facilitators because they were identified as trusted community members and could link in HCW's for info where needed, and often had the literacy skills required to do the task.

The FGD/interview appointments were arranged in advance in order to avoid interference with routine obligations/work of the participants. Confidentiality of information was assured and informed consent was

[4] Much appreciated contributions by Flavian Lihwa (TAMANI coordinator), Halima Komolanya (TAMANI Gender Manager) and Julian Dalika (TAMANI M&E advisor).

requested prior to interviewing and recording. Throughout the fieldwork, TAMANI staff facilitated introduction in the communities and facilitated the recruitment of respondents, based on the criteria given by the research team.[5]

2.3 Locations and sampling

Two districts were selected for the fieldwork. In order to obtain diversity and a varied lens of the project, one rural district and one municipality with semi-urban characteristics were selected:

1. Kashishi village in Kaliua District (rural)
2. Tumbi in Tabora Municipality (semi-urban)

In both Kashishi and Tumbi, regular livelihoods among the respondents are farming and entrepreneurship, with farming being more prevalent in Kashishi. In terms of education, and the most common level of education is primary education.

An overview of the number of respondents per location is provided in table 1.

Table 1: Overview of data collection exercises

Category	Kashishi village	Tumbi	Total
FGD	4	4	8
IDIs	14	14	28
Diaries	6	7	13
KII	5	5	10
TOTAL	29	30	53

2.4 The research team, training and pilot

The research team had the following composition:

- From IHI: Study Principal Investigator (PI) Dr Sally Mtenga and research scientist and fieldwork supervisor Ms Irene Mashasi
- From NIRAS: Research consultants Ms Amanda Hammarlund and Dr Linda Helgesson Sekei who worked remotely with the team and developed the research instruments and worked on the analysis and report writing
- Four research assistants from IHI (2 female and 2 male): Ms Saada Nkelemi, Ms Irene Njau, Mr Edwin Rubomba and Mr Elibariki Mkumbo
- Two community facilitators from TAMANI (1 female SAA facilitator and 1 male CSC facilitator): Ms Yunia Justace and Mr Mrisho Hussein Mrisho.

[5] Special thanks to Mwanane Shabani Madebo, Daphrosa Leopard Malay, Ruth Giyasi and Rashid Hamad.

Picture 1: Research team and TAMANI staff

The training, pilot and fieldwork was conducted during April and June 2021. Before the fieldwork commenced, a four-day training workshop for the fieldwork team was conducted in Nzega District Council in Tabora, facilitated by Dr Sally Mtenga and Ms Irene Mashasi from IHI.

During the training, an overview of study objectives, study tools, research ethics, data quality, gender concepts, maternal and adolescent health were provided. A key focus area of the training was to capture the approach of TAMANI, in particular the methods aimed at influencing gender norms and behaviours (CSC & SSA) and the themes covered within these methods. The training covered the use of FGDs, IDIs, Diaries and KIIs and simulated FGD and IDI were undertaken to give the team first-hand experience of some possible probes and challenges to be expected. The division of roles within the research team was a key feature of the training as the SSA and CSC team members played a slightly different role than the other team members as they drew on their expertise as SSA and CSC facilitators. The SSA and CSC community facilitators were able to share insights into the programme which contributed to the preparation of the team on how to engage with the participants. It was agreed that the SSA and CSC facilitator would introduce each FGD through SAA and CSC simulation and thereby energizing the participants and making them comfortable and familiar with the situation. The interplay between the research assistants and SAA/CSC facilitators was trialled during the training and pilot.

The research team was briefed on the fieldwork road map, which outlined the sequencing of the data collection process in each location. The training also covered informed consent as well as routine hygiene precautions such as the availability of sanitizer and/or washing hands. This was essential as the fieldwork was conducted during the COVID-19 pandemic. Procedures for community entry, obtaining consent, respect and confidentiality as well as the importance of both audio-recording and note taking during the sessions was covered at length.

Picture 2: Icebreaker during the training, facilitated by Dr Sally Mtenga.

The training included a pilot in Kigusule village in Nzega District Council, not far from where the training was held. The pilot offered an opportunity to practice and further reflect on the research process and methodology, including FGD facilitation, IDI and the best use of tools. The key priority of the pilot exercise was the FGDs with Women of Reproductive Age and Male partners of WRA, and adolescent girls and boys. The IDIs were also piloted. The pilot exercises were reviewed and discussed and informed relevant edits to the research approach and methodology.

Table 2: Overview of training programme for the research team before the fieldwork started.

Day	Activity
Day 1	• Overview: Opening remarks and introduction to TAMANI • Introduction to training & study overview • Research ethics (essentials of informed consent & data quality) • Qualitative research methods • Sampling, respondent selection criteria
Day 2	• Interviewing skills/techniques • Review of the tools • Data handling • Role play - FGD and IDI informant interview • Role play feedback • Debriefing
Day 3	• Appropriate field norms and professionalism • Role Play FGDs • Introduction to Informed Consent Form (ICF) and ICF role play • Debriefing • Logistics for pilot study • Review of IDIs and FGDs • Printing
Day 4	• Team travel to the pilot area • Pilot IDI and FGDs • Debriefing and adoption of field learnings • Arrangement of the fieldwork and role distribution among the team

2.5 Fieldwork road map

The TAMANI staff have established trust within the community and facilitated introductions in the different locations and the research team travelled together for the fieldwork in a vehicle provided by the TAMANI project. While the FGDs and IDIs were conducted, PI Dr Mtenga and fieldwork supervisor Ms Mashasi conducted the KIIs. In collaboration with the TAMANI project team, Dr Mtenga and Ms Mashasi also identified the diarists who received note books and instructions.

The research assistants worked in two teams and took turns having the role of facilitator or note taker/recorder. The plan was to have one female team and one male team. However, this did not always work due to logistical reasons. The SAA/CSC facilitator in each team kick-started the FGD by simulating a CSC/SAA exercise, encouraging the participants to reflect back on the themes which have been covered during the TAMANI interventions. One of the research assistants then continued the session, while the facilitator supported when more energy or probes were needed.

The teams spent 4-5 days in each district, with the female and male sessions going on in parallel in the mornings, followed by IDIs in the afternoon. WhatsApp was used as a platform for the research team to debrief and communicate on challenges, harmonisation, decisions and changes during the fieldwork. The fieldwork supervisor made daily calls to the research teams to find out if there was anything that needed particular attention.

2.6 Transcription, data analysis and reporting

Upon return from the fieldwork, all FGDs, IDIs and KIIs that had been recorded were transcribed in verbatim in Kiswahili and subsequently translated to English, coordinated by IHI. The transcriptions were to the extent possible completed by the respective research assistant who took notes during the session, but due to large volumes of transcripts, additional transcribers were recruited by IHI in order to support the transcript process.

Quality assurance was conducted by the fieldwork supervisor, and IHI relied on their institutionalised procedures to control the quality of the transcripts. The Kiswahili transcription and English translation was incorporated into one document per transcript, which made it possible during analysis to use and compare the Kiswahili and English text. This was useful as it some cases was difficult to understand the meaning in the English translation. The team was then able to cross-check and revise against the original Kiswahili transcript. All in all there were 53 transcripts produced that averaged between 30 and 150 pages and offered generous amounts of details on a vast number of topics. Unfortunately, the 13 diaries were rather generic (see further in the challenges and limitations section below) and did not add value to the rich FGD, IDI and KII transcripts. For this reason, the diaries have not been used as a data source in this report.

The data was analysed thematically with the emerging findings organised as sub-themes within two main categories: 1) Health in the household and 2) Health in the Facility. The thematic analysis explored various themes from different respondent groups' point of view. CARE's Gender Equality framework has been used as reference for the analysis (CARE International 2019). Examples of questions that guided the analysis were:

- What gender dynamics changed and for whom?
- Which actors were influenced?
- Which interventions worked well?
- What did not work so well?

- Were there changes in Knowledge, Attitudes and practices?

On the 16th of June, 2021, the NIRAS-IHI research team presented the initial findings to the TAMANI project team and CARE Tanzania/Canada. This offered an opportunity to validate findings as well as discuss opportunities and challenges of the field work, which was valuable for the continued analysis and finalization of the report.

2.7 Challenges and limitations

In order to avoid risks of COVID-19 infection, the research team wore face masks, offered hand sanitizer to the participants, limited the number of participants in the FGDs to a maximum of seven participants and made sure there was sufficient space between the participants.

During the fieldwork process, Tanzania lost its fifth president, Dr. John Pombe Joseph Magufuli. Intense grief and and mourning shook the country, but the death of the president did not affected the implementation of the field work significantly, because people were encouraged to continue their work and follow Magufuli's spirit of 'hapa kazi tu' ('here it's only work'). Some community members indeed expressed that they felt that the implementation of the research was one way to honour the hard work encouraged by the president.

Although the recruitment of interview respondents went smoothly thanks to the support of TAMANI staff and community facilitators, there were some challenges. It proved challenging to recruit adolescents as many were in school and occupied with school activities. During part of the research, the schools were also closed and some adolescents had gone for holiday to stay with relatives. Some young persons also declined the invite because they felt that they would not have anything to share as a result of limited involvement in TAMANI activities. While some young persons were familiar with the TAMANI project, others had never participated in activities such as SAA and CSC, and just learned or heard about TAMANI from their parents.

Another challenge was posed by delays in starting the FGDs and interviews because some respondents were late to the sessions and others had to be kept waiting. Moreover, there were some worries among the research assistants that there would be confusions about the SAA and CSC terminology, as these were new concepts to them. However, this worked out well with SAA and CSC facilitators part of the research team who could support as needed.

One issue highlighted from Kashishi, which is largely rural, was that not everyone in the older generation speaks Swahili fluently, which caused some issues on terminology used during the research (specifically encountered during the interviews with mothers-in-laws).

Furthermore, the age span per respondent category was not always clear. Some participants of the FGDs were older than the target age category (women having children after the ceiling age of 49) and some of the respondents recruited as adolescents were older than 19 years, related to the above mentioned challenge of recruiting adolescent participants.

A limitation of the data itself is that not all interviews covered the same topics and the interview guides were not always followed. For example, the table with demographics of the respondents was often not filled out (age, education, livelihood, number of children, marital status etc.) which means that this layer of analysis is largely missing. As the guides were not always followed, it was also difficult to conclude if all respondents felt the same way about a certain topic. It is not possible to include all quotes illustrating the findings in the study and the findings are therefore summarised in each of the empirical sections. The interview matrix (annex D) is

a useful tool to refer to in addition to this narrative report where interesting data is inserted that is either relevant to the key areas of the research or else deemed as useful by the research team. Illustrative quotes are inserted in this matrix and subsequently used in this report[6].

Picture 3: Diarist orientation

A challenge experienced during the fieldwork was that the FGD and interview guides, although comprehensive, were long and sometimes had repetitive questions. The guides were therefore revised by the research team after the training and pilot, before the actual fieldwork began. But the tools were still very elaborate and this resulted in long FGD and interview sessions, and long transcripts, which in some cases were difficult to follow. To transcribe verbatim is a challenge as it is very time consuming, both for the Kiswahili transcription and the translation to English. Significant effort was made during the analysis to make sure that the selected quotes in English were correct against the Kiswahili version, as well as making sure that the quotes do not contain grammatical errors due to translation mistakes and that they have a good flow.

While all FGDs, IDIs and KIIs contained rich and highly relevant information, the analysis of the diaries posed a challenge. The research team experienced challenges in collecting completed diaries. While the methodology of using diarists hold a lot of potential for a unique qualitative angle, a learning is that it could have been helpful with interim follow-up and guidance during the timeframe set out for their task. As mentioned above, unfortunately, the diaries did not add value compared to the rich FGD, IDI and KII transcripts and were therefore not used as a data source in this report.

[6] The quotes from Tumbi have been added to the interview matrix in a more elaborate way as this was the first location that was analysed. The Kashishi quotes and analysis was very similar in findings and therefore mainly added when there were differences between the findings or new observations.

3. Findings and analysis

This chapter presents the findings from the Interviews and focus group discussions undertaken. The findings are divided into two main categories:

- Health in the facility
- Health in the household

Under each of these two categories, data is presented according to eight of sub-themes. Each-sub category presents trends in the data and analysis from the research team as well as selected quotes. All text written in italics and accompanied by quotation marks are quotes from respondents while all other text are remarks from the research team.

After the findings are presented for the two main research categories, section 3.3 offers findings on cross-cutting topics, including the impact of the COVID-19 pandemic, and reflections on the sustainability of TAMANI results. Finally, section 3.4 compares the findings to the formative research findings and 3.5 offer a summary of findings as well as recommendations.

3.1 Health in the Facility

This section is structured around eight key themes of health facility service deliveryand uptake and scrutinizes the potential impact of the TAMANi project activities.

3.1.1 Better availability quality of health care provision both in rural and urban areas (pull factor)

In general respondents argue that the quality of health services has improved and mention for example that maternal mortality has gone down, STI levels have decreased, health staff and ambulance services and home visits are available, and that services generally are affordable, of high quality and that waiting times have reduced. Examples of challenges that remain include: lack of drugs (frequently cited) and a few respondents argue there are limited services after 4 PM or weekends *"you should not be sick on Saturday and Sunday" (Adolescent girl IDI, Tumbi)* – meanwhile others say services are always available.

Picture 4: IDI with Healthcare Provider

Not all respondents know who made the ambulance services available or if things have changed for the better pre or post TAMANI (one respondent thanks Magufuli for it); and several respondents argue the health services available at the clinic were good for as long as they can remember.

> "The person in the past had no reason to go to the health facility as the health services were provided poorly. But through CARE it has helped to firstly to educate people to seek health services. Also, the health education that has been provided at scale and CSC, that has educated people and improved the attendance because people are motivated to go" (SAA/CSC facilitator, KII Tumbi)

"The quality of services has increased and the maternal and newborn mortality rate has decreased. In the past, if there were six deaths, now the number has gone down to two or one death, and these also happen rarely and sometimes is due to the distance from where they live to where the health centre is" (Male FGD, Tumbi)

"Now there are improvements because even when you are pregnant they visit you at home and they provide for a transport. In the past, we were just given a seminar and pills, then you leave and come back on the day of delivery" (WRA IDI, Kashishi)

"The service providers were the same, they were charming and they served us well. But if you are a service provider or a leader you can't make everyone happy, you must offend some people. Personally I'm not a liar and to be honest, the services that we have now are the same as the services we had in the past" (WRA, IDI 1 Tumbi)

"Another impact since we started those things [TAMANI activities], we don't have as many complications as abortions, parental deaths and infant deaths. For example, a local Tumbi facility like this, can you imagine that for a whole year I haven't had a single maternal death!" (Male HCP, doctor, KII, Tumbi)

"In terms of reproductive health, it has managed to reduce maternal and child mortality. Something else related to reproductive health is that it has succeeded to reduce even the situation where babies are born in dangerous surroundings, so such things." (Female HCP, nurse, Kashishi)

"We never had a health care centre before, but preliminary reports say that TAMANI has played a huge role in persuading the government to construct a health care centre in our ward and the largest contribution is the availability of an ambulance." (Female CHW, KII, Tumbi)

"Nurses sleep there, so even if you go at four o'clock in the morning, once you arrive at the clinic, they will wake up the nurse and you will get service. If s/he sees this patient can't be treated here s/he calls the ambulance to come and pick you up and take you to the hospital were the patient will get extra service." (Adolescent male youth champion, IDI Tumbi)

"The nurse is just scared and then it is night and you find yourself in a bad situation. You have gone to the health facility for help but you are told that here I cannot do it. S/he receives a salary but s/he is saying I cannot do it, go to town. Even an ambulance is not there so you have to find people to take you to town at night " (Adolescent girl IDI, Tumbi).

3.1.2 Increased awareness of importance of going to the clinic for check-ups during pregnancy

Due to information from dispensaries, from both nurses and midwives (in addition to TAMANI activities and CHWs) awareness has increased regarding the importance of attending the clinic regularly during pregnancy. Both women and men have learned more on the importance of supporting pregnant women, accompanying them to the clinic etc.

> "Because you see that your abdomen/pregnancy hasn't grown that big, and you see yourself capable to do all the domestics duties and experience no pain within your body. It's true that we did spent 7 to 8 months without going to the clinic, but through these discussions I have seen the importance of attending the clinic because after you become pregnant it is good to do a check-up and diagnosis for your healthy situation, probably in the past we lived in dark, you can see yourself healthy while you may be carrying diseases inside you" (WRA IDI, Kashishi)

> "There have been changes during pregnancy. First mothers didn't attend pregnancy clinics, they were not attending at all. So after the arrival of the TAMANI project and after we gave them education in the community, telling them benefits of a pregnant mother attending the clinic, their understanding of the benefits increased and their minds opened. Now they attend the clinic because we were able to tell them the benefits of a pregnant mothers attending the clinic. What is its benefit? They understood how the baby is doing inside the stomach, also that she will get care and medicine if she had anaemia." (Male CHW, Kashishi)

> "And now, it is common that women plan for this, while in the past, she would not go unless her husband would do the planning for her" (WRA, IDI, Kashishi)

The female HCP (nurse) in Kashishi mentioned that the clinic gives out a type of ID card as an incentive to attend and give birth at the clinic. If you try to give birth at home and something goes wrong and you need to go to the hospital, it is more difficult to be admitted if you do not have a card.

The HCP at the clinic often insist that the father-to-be should join the pregnant woman to the clinic, in particular to in order to know what equipment is needed when it is time to give birth, such as gloves, syringes etc:

> "We also put in place to the support for what she will need. If the husband's whereabouts are unknown, there will be a stage where she will not have the energy to carry the child, so we encourage her to come with her husband. We let her know what she should prepare and bring when she comes for delivery."
> (IDI, HCP nurse, Kashishi)

> "They are told to bring three pairs of gloves and money for medicine, and to prepare money in case of emergency" (IDI, HCP nurse, Kashishi).

Several respondents, including a community leader in Kashishi highlight that, although they are very happy with the TAMANI intervention and many more women have started to attend the clinic, this has also had the effect that the number of staff is no longer sufficient. This points to the importance of a responsibility of the government to make sure that the clinics are sufficiently staffed to handle the workload. If not, women may stop going to the clinic again and what has been achieved would be lost.

3.1.3 Clinic infrastructure, privacy, medical equipment, beds, fresh water, toilets have all increased in standard

Fresh water tank, cleanliness, bins, toilets and increased number of beds are frequently cited positives, as well as better equipment, higher standard of services, availability of services, including that of including that of ambulance services. It was put forward that the electricity situation is generally good but sometimes the power cuts cannot be helped, apart from alternative energy sources that some respondents mentioned are being

planned for. These improvements have all contributed to the clinic being a place which is now worth attending, and it is also important to point out that it is not only one aspect that has resulted in the change, it is the systemic approach of the intervention.

> "It's important because before TAMANI, women were restless. We [men] used to give them work until the last day but now women are resting and midwives have been close to pregnant women until the day of delivery. As a father, you get information and you help her to go to the clinic and there at the clinic they are good. When this service came, the referrals decreased because the service was good. After the meetings, there have been better attitudes towards patients and infrastructure improvement. Now we have six-hole toilets, we have an ambulance, we have an increased number of service providers and there is enough space between the kitchen and the bathroom." (FGD Male partners of WRA, Kashishi)

> "In addition to provision of water tanks of about 2000 litres which we didn't have before in our dispensary, I think that TAMANI has accomplished a lot. It was hard for mothers when they gave birth because there was a water challenges in our area. Probably without TAMANI , improved health services and providers visiting our communities and influencing the society to acquire the healthy service, would not have been possible. We live in an area with many from the Sukuma tribe, who have their own beliefs. Bringing them out of their homes and go for treatment in the clinics or for their women to give birth in hospitals is a very difficult thing, but through TAMANI, this has been made possible." (Male FGD, Tumbi)

> "I see a big difference. At that time it was different, before going to the clinic, you first had to find water in a well and take it there, but now there is a tank. So even if I send a pregnant woman I have no problem, and that is the work of TAMANI, so we appreciate it and we would like for it to continue." (Mother in law, IDI 2, Tumbi)

> "For example, they have provided us with support for water service matters, they have brought us big tanks. They have also brought us equipment such as an incubator on the part of infants. It has helped us a lot to prevent infant deaths. [...] The remaining problem is electricity. We said we will use solar power but in our plan we needed one million shillings and the committee is determined to find it anywhere...Every time it cuts off....the whole area" (Male HCP, doctor, Tumbi)

> "We still have the challenge of alternative energy" (Male adolescent youth champion, KII Tumbi)

3.1.4 Availability of drugs, medical equipment and shortage of staff remains a challenge

Shortages of certain contraceptives and various other drugs, as well as other medical equipment is repeated among respondents as a challenge. Respondents have mixed answers. Some find that there is a shortage of staff and lack of privacy, for instance when women are delivering, and others find the opposite. If the service is good, it is of no benefit if you cannot get the right treatment.

> "Drugs are not enough... the problem is on the drugs. Because even if a nurse receives you well, diagnoses you, and there are no drugs what can s/he do?" (Male CHW, IDI, Tumbi)

> "They are so humble. At the reception they are good and they talk with you nicely. The problem is that they don't have drugs and medical supplies, but believe me they are so good " (Male CHW, Tumbi)

"In the past, you might go to the health facility and you might be told that there is no injection available, the implants are finished and there are no condoms. But currently, if we go there and need condoms, we are given". (Male youth champion, Kashishi).

"The challenge is the shortage of medical supplies compared to the number of clients. But in past, the closing hours was between 15 to 16 hours and after that you could not find the nurses. Therefore, it was difficult to see the quality of the services and people opted to find services in other places. However, after they have discovered that there is the quality healthcare services, accessible for 24 hours here, the number of clients increased. People come to get services from long distances, 40 km from here." (Male FGD, Tumbi)

"There is privacy, there are beds, there is a resting room after delivery and there is a special room after the mother has given birth" (Village chair, Tumbi)

"There is no specific room only for delivery. There is a building where women give birth and at the same time other patients are admitted. Here, a woman gives birth and a seriously sick person would be kept in the same place, that's a challenge. And the medicines are not available, drugs are also a challenge" (Female TAMANI facilitator, KII, Tumbi)

You need to bring certain supplies when you are to deliver a child at the clinic, including a bucket, a razor, plastic gloves and a nylon cover for the delivery bed. This comes up in almost all interviews. Some respondents argue that this means that services are not free and that it poses a challenge. However, most respondents argue that services are essentially free and that it is fair for the parents to be to make some preparations and bringing these few supplies. A solution put forward by respondents for people who struggle severely financially is to join savings groups and save up or borrow money for these medical supplies, and that both men and women should be encouraged to save up.

"Money is not a big problem because, for example, when I am eight months pregnant, the father should start preparing savings so that later it doesn't become a problem, so it is about saving up."
(WRA, CSC/SAA attendant, IDI, Tumbi)

"The challenges they face have been mentioned by [another respondent in the FGD]. You may have a husband who is a farmer and who can do casual labour to get 10,000/=. But the preparation may require 20,000/= and this means that the 10,000/= will not cover the cost. Therefore, when you go the dispensary, you may be short of clothes and a basin and the nurse will get angry. S/he will yell that we have told you to prepare yourself, you are aware about this pregnancy, aren't you aware of the day of delivery? She doesn't know that it's just an economic difficulty we have encountered." (Female FGD, Tumbi)

"At present, most people start the preparation much earlier than in the past. Currently when a person has seen that his partner is five months pregnant, we have been advised in those classes that you need to keep things like gloves and nylon sheet at your house." (Male adolescent, IDI, Tumbi)

"You know, sometimes the medical equipment really runs out. But you can't tell someone not to give birth because it is not available, so money is a hindrance. That's why, if I look at one thing there, I would suggest that they would talk about groups, it would be a benefit. You know, if a person is part of a group, also the issue of

safe motherhood would be possible to realise. Through the group, at the end of the day, her savings can also help. Because the life we live, sometimes the challenges comes on the side of the father, that has no money at that particular time, but the mother in the group can borrow money and help to pay for what is demanded to bring, so CARE has been very helpful" (Male TAMANI facilitator, KII, Tumbi)

"She [daughter in law] used to go to the clinic but she didn't say if there was any preparation to be made. When we got there they said 'why did you come without a nylon?' so we had to buy it. Later she was in tears and said we should buy a razor because now there are so many diseases so we can't use scissors." (Mother in law, IDI, Tumbi)

"Then you ask yourself, it is being said that the services for pregnant women and children under five and newborns are free, but is it the statement of leaders or it is reality? Then you realise that it's just a verbal statement, because our health facilities have no equipment and drugs" (Male CHW Tumbi)

If there is a need you may stay longer at the clinic after delivering a baby than what previously was possible. Regarding going into labour at night, some respondents see challenges that are circumstantial, such as living far from the clinic with no means of transport, and others say services at the health facility is not the same during the night compared to during the day.

"In the past, mothers were not staying long. If you give birth at 9 o'clock you are given permission to return almost immediately, but now someone can stay until tomorrow at 9 o'clock before being discharged." (Mother in law, IDI 2, Tumbi)

"If you look at our period, you could give birth at 8am and you would stay until 11am and then you get discharged. But now you stay for 24 hours under supervision after giving birth and then you are discharged. I think that's better because you may be discharged and then anything could happen, so it's good if you stay and they make sure that you and the baby are ok." (Mother in law, IDI 1, Tumbi)

"Labour may start at night and she lives far from the facility and there is no transport, there is no way, but it was not intentional because nowadays we are being told that it is must to deliver at hospital." (Adolescent girl, IDI, Tumbi)

3.1.5 Reported positive attitudes and improved customer care at the health facilities - although waiting times vary and staff is not always sufficient

In general, respondents find the clinic staff welcoming. A majority found that there has been an improvement while a few claimed that the staff were always very friendly. Others say that the services are good and that HCPs are generally doing their best. Several of the respondents who think there has been an improvement reference CSC as the cause for this change. As mentioned in the previous section, some respondents still fear scolding as a result of not having brought the required equipment for delivery. Other reasons for this fear include not having attended your schedules antenatal appointments or teenagers showing up pregnant.

"When you see a nurse on the street you just feel you want to greet her/him just because s/he is the person who you live well with" (Male youth champion)

"Aaah their attitude is good, there is a change through the meetings held by CARE…They have corrected themselves, some didn't have good language with customers, but people complained directly, so they really seemed to have been given a warning" (Male TAMANI facilitator, IDI, Tumbi)

"Previously, the nurses were very strict and not always welcoming, but their attitudes have changed for the better and they are confidential in their work" (Female TAMANI facilitator)

"Services are good but there are few nurses. You may find only one nurse there and two or three women come for maternal services. So a nurse faces a difficult time, but the services are provided well" (WRA IDI, Kashishi).

"Education has helped both the service providers and the community to have appropriate services. That's why mothers before would hesitate to go and get services. They knew that if they would attend the clinic, they would get healed, but insults would be unavoidable from the medical personnel. So both mothers and health providers got educated and now we attend the clinics without fear." (FGD, male partners of WRA, Kashishi)

But there are still certain challenges with customer care among some staff, especially keeping time, and a few have a bad attitude:

"Yes, there are people who haven't changed, especially on the system of time keeping. You may go there at 7am but a staff comes at 9am. That's a problem because when s/he reaches there at that time s/he will attend a few clients and then s/he leaves for tea break and comes back again at 12pm. By doing that you will find that there will be many people waiting for services an at the end they will start insulting people. I have witnessed that. You go there but there is no staff or as a patient you have to go and look for a staff, it's like you don't know your responsibilities" (Male partners of WRA, IDI, Kashishi)

3.1.6 Larger representation of fathers accompanying partners to the clinic, although not always into the actual examination room – and especially not at the time of delivery

There appears to be consensus around this matter among the respondents – men are accompanying their partner to an increased extent. Health workers, women and men all agree. Many respondents attribute this change to TAMANI and argue that project activities have offered the community a deeper understanding of why this is important. However some also argue that it is obliged in different ways, such as the village chairman and clinic staff insisting that the father *has to* accompany the pregnant mother to the clinic. According to the research team, in particular the first Antenatal Care session is compulsory for the men to attend. They check both partners' health status (such as HIV) and if the expecting mother does not go with her partner, they need an approval letter from the village authority explaining the reason why.

"This is because of the awareness given by the professionals in our dispensaries. They have insisted that if a mother comes to the clinic by herself without her husband, she may not get the service. And also through the awareness given by different organisation, and seminars provided by the doctors, has enabled people to be aware." (WRA IDI Kashishi)

"For example, we used to see only mother at the clinic in the past, I didn't see fathers. But now a father carries a child on a motorcycle and brings his baby to the clinic fir testing. A father carries his wife on a motorcycle or a bicycle and brings her to the clinic, but it was not like that in the past." (Female CHW, Kashishi)

"Nowadays, men go to the clinic with their wives, something that they were not doing before." (WRA IDI, Kashishi)

"The way men spend the whole day at the clinic, everyone is surprised. They say 'what happened to men nowadays?' You will hear every woman talking about her husband but in the past, a woman may spend the whole day at the clinic alone and when you go home you get beaten while you are pregnant." (WRA IDI, Kashishi)

"Because I am always at the village and also I go to the dispensary so I observe the situation. In the past you could see a woman coming to the dispensary, carrying two little children while she is pregnant. She would come alone without her husband but nowadays I see husbands going to the facility with their wives." (WRA IDI, Kashishi)

"A certain woman came. She was pregnant but her husband had refused to take her to the clinic. The woman had swollen legs and swollen hands, she said my husband has refused to take me to the dispensary where is he now? I'm going to the executive. I told her to wait and let me speak to her husband to see if he would understand. I went there as a community health worker and I educated him. I told him about dangerous signs to note from pregnant women. The man understood and he brought his wife to the clinic in the morning." (Female CHW, Kashishi)

"Right now, if you go to the clinic, you would find it full of fathers and wives. So there is a big change, as a result of the project, the fathers escort the mothers to the clinic." (Female TAMANI facilitator)

Men often wait outside and can for instance step in if something goes wrong during delivery and the mother has to be rushed to the hospital. But as they accompany their partners to the clinic, they also benefit from various services, such as health advice and health tests. and may be asked to do health tests. In Kashishi, men mentioned services such as condoms. In Tumbi, nutrition advice and height and weight measurement was mentioned among services for accompanying men.

"Before a woman was going to the clinic alone but after this project there is a change and she goes with her partner. The benefit we get from the meeting are awareness on family planning, how to protect ourselves from sexual transmitted diseases and how to protect a baby in the womb. Before we didn't know about this, but now if you look for a service provider, you can even get condoms." (FGD, Male partners of WRA, Kashishi).

"There are some circumstances for which you may be needed, so you must be present at all times when a mother is delivering. Because whatever happens, you have to be there to sort it out." (FGD, male partners of WRA, Kashishi)

"A father must be present. When a referral is needed you have to be there to help. If you are not around, it will be a problem for the delivering mother." (FGD, male partners of WRA, Kashishi).

"To me this is the most success we have had. Fathers have stayed on the benches, and if you ask them 'why are you here?' they will tell you 'I have escorted my partner'." (Male CHW Tumbi)

It was reported by men that they during the first visit at the clinic were informed about the importance to plan the costs ahead. This was in an information meeting/education session. The education seems to be provided

through a series of sessions targeting women. It was not entirely clear how many sessions were offered for men, but it appeared to be a few sessions when the woman had just started to attend the clinic.

> "For the education that has been provided, we are being told that after a mother starts feeling pregnancy symptoms, she has to go to the clinic to confirm if she really is pregnant. Then you are given education and told which things to prepare for delivery, you are supposed to prepare 5 pairs of clothes etc... that education has reached our community. Also they tell us that on the day of delivery you must have some savings in case something happens and you need to be given referral. For example there is a cost of 80,000 Tsh for using an ambulance. We are all aware of that so we make sure we have that money in the house. We are also informed about the transport costs of the nurse who will accompany you there. We are given that education the first time when we go to start the clinic visits." (FGD, male partners of WRA, Kashishi)

> "During pregnancy and with a new born, you must go with your wife to the clinic. There are advantages, they provide education on how to take care of the pregnant woman, services she is supposed to get and that she for example should eat fruits and that there is some food which a pregnant woman is not supposed to eat. At the clinic you will also be educated that when a mother is about to give birth, she should be treated in a certain way." (Male partners of WRA, IDI, Kashishi)

> "First we were given a seminar on how to take care of the pregnancy, how to take care of my wife and my wife was given a mosquito net which protects all of us from getting malaria." (Male partners of WRA, IDI, Kashishi)

3.1.7 Circumstantial factors still sometimes pose a challenge for health service uptake

A majority of the respondents argue that distance to the clinic poses a challenge for health service uptake for persons in remote locations of Tabora. In addition, other barriers listed infrastructure challenges such as poor roads and transportation during the rainy season – especially difficult if you need to get to the clinic during the night. Some respondents mentioned ambulance services as a potential mitigation factor. Over time if you travel far for e.g. a number of ante and postnatal check-ups, transportation costs can become an issue. Being kept busy by household work is a challenge mentioned by some respondents while others argue that this is not an issue anymore.

> "Yes, you know there are some mothers who have no rest. They wake up in the morning and start working. You can find the mother knows her day to go to the clinic but she finds herself working - doing dishes, cooking, washing, fetching water until in the evening. Then you say I will go tomorrow instead, but now it is a problem if you pass even one day you will have problems with them" (WRA, IDI, Tumbi)

> "It may overwhelm her because for example if she is already tired because of the works and at the same time she want to go to the clinic ...She has no transport, she walks a distance by foot from home to go to the clinic until she reaches the clinic she is already lost her energy, but where did she loose her energy? Because she has started her responsibilities while at home" (Female SAA/CSC member, IDI, Tumbi)

> "Previously it was like that but nowadays they have been educated, their responsibilities can't stop them from going for health care services " (Female CHW, IDI, Tumbi)

In addition to being located remotely from a clinic, the Sukuma tribe was in particular mentioned to be difficult to convince to attend clinical visits, referring to both traditional believes and remoteness.

It was reported that in particular Sukuma tribe, in the case a woman has experienced fertility issues and has addressed these through a traditional healer, she would follow through with traditional birth, but attend the clinic for check-ups.

> "These eight trips back and forth, ahaa it's a bit challenge, these Sukuma people are not coming at all, hahaha" (Male adolescent youth champion, IDI, Tumbi)

> "The big problem is that the Sukuma people believe a lot in their traditional beliefs, where they go to their traditional experts to see what to do. But when it comes to others like Tutsi and we Nyamwezi people I can say people are educated because right now when a person feels like s/he is not ok, s/he just goes to the health center to be tested and to get the treatment." (Male adolescent youth champion, IDI, Tumbi)

> "For example a Sukuma tribe girl or an illiterate/uneducated girl, she can attend the clinic throughout her pregnancy period but she can be told that it's a custom and tradition to give birth at home during delivery." (WRA, IDI 1, Kashishi)

3.1.8 Many youth are accessing health care services including family planning and maternal health services, but some challenges remain

There is potentially a risk, or at least a fear, of being scolded if you are a young woman showing up pregnant at the clinic. However, several respondents argue that the stigma towards adolescents seeking information and services is on the decline and the services uptake larger alongside access to information. While it is clear that TAMANI has had a large impact in on RMNCH services in Tabora, this does not seem to the case when it comes to youth services. There is reference to information services in school, but TAMANI is not among the organisations mentioned in this context.

It does not seem to be common to meet adolescents at the health facility: "*when I go I don't find young people aged 18 years and below*" (WRA SAA/CSC member, Tumbi).

> "They have changed recently because health services are now available to larger extent. For example, when you go to the dispensary you will get this service and also students are getting this training in school" (FGD, adolescent girls, Kashishi).

Adolescent boys in Kashishi stated that they were too young to access family planning (they were 14-15 years), but that they get the information in school.

> "It's easy with health sector visits because there are different institutions providing education. For example last year, health experts came to our school to provide information concerning family planning, and they also explained about early pregnancies. So they provided information concerning family planning and I got that information" (FGD, adolescent boys, Kashishi).

3.1.9 Most women give birth at the clinic, there has been a significant increase in this frequency

Several respondents claim bylaws prohibit home birth/traditional midwives and that you are required to go to the clinic. They claim that both the bylaws and the TAMANI activities have influenced the shift away from home births. In a sense, this is an infringement on women's agency to decide for themselves where to give birth,

especially if there are indeed legal or other repercussions for those who for various reasons end up delivering at home. What has been mentioned is a fine of 50,000 for home delivery. In some interviews is that the card given by the clinic gives you access to services, but also that if you do not have the card, you may be denied services, such as referrals in case of complications, at least it will be a more lengthy process.

A female healthcare worker in Kashishi summarises what she thinks has been the benefit of TAMANI, which includes reduced mortality:

> "In terms of reproductive health in regard to the TAMANI project, first of all they have been able to improve for our clients so many more have decided to give birth here. They have also been advising, with the result that many have given birth at the clinics. If we look at the number of people gave birth at home before the TAMANI project, they were many. But since they started, many clients have given birth at the clinic, so we have benefited. Another thing in terms of reproductive health, is that it has managed to reduce maternal and child mortality, and even succeeded to reduce the situation where babies are born in dangerous surroundings, so such things." (Female HCW, Kashishi)

> "Many mothers who were giving birth at home were unknown but after this project they would provide information if a mother died at home. So you can find the number of deaths that occurred and compare with the past. This gives you an assessment that there is improvement" (Female HCW, Kashishi).

A female CHW explains that she is keeping track of the pregnant women in her ward and where they deliver. She argues that all women go for delivery at the clinic as per legal requirement:

> "I have the whole timetable, and I am also aware of all my customers, knowing how many have given birth at the health centre. For the current campaign, all pregnant women are required to give birth at the health centres and not at traditional birth attendants, laws actually regulate this." (Female CHW, IDI, Tumbi)

> "We used to visit to give them advice, and at the clinic we were planning strategies. In case someone gives birth at home, there is a fine of 50,000, so that one also created awareness." (Female CHW, IDI, Kashishi)

> "I don't know who brought those threats but it was said in the streets that if you give birth at home you will pay a 50,000 fine. So when people heard that statement, even people from the village were brought to the dispensary on a motorcycle and when they reached the dispensary they gave birth in five minutes." (WRA, IDI, Tumbi)

> "When we are pregnant we used to prefer to give birth at home but TAMANI has done a good job in educating us to go and give birth at the dispensary." (WRA IDI, Kashishi)

> "We don't continue with that thing [of home births], I mean they talk briefly. But in TAMANI you are told to go and give birth at the hospital because they have seen a lot of mother and child mortality. So you discuss in-depth." (WRA IDI 2, Kashishi)

A shift in roles for traditional birth attendants was mentioned, with a new task to encourage giving birth at the facility instead of at home:

> "Traditional birth attendants are not common any more, they are paid to instead advice pregnant women to give birth at the facility - they are prohibited by the government. In combination with TAMANI activities, this has given good effect for people to embrace clinic birth." (Male CHW, IDI, Tumbi)

> "Previously, people believed in customs and traditions. They trusted traditional birth attendants whom they believed knew everything about delivery, but now it's not allowed." (Adolescent girls, FGD, Kashishi)

> "We are thankful to traditional birth attendants because they are doing a good job in sensitizing people to go give birth at the dispensary. She may even accompany you to the dispensary for deliver and if it happens that you give birth at home accidentally she call the facility to inform them"
> (WRA IDI 2, Kashishi)

Some respondents mentioned that there are pull factors when giving birth at the clinic, such as the right to receive a birth certificate, vaccines etc:

> "There are a lot of benefits when a woman give birth at the health facility, such as a that the baby gets vaccinated. The child also gets a cloth to protect them from the cold. Also parental education is something that you cannot get from home." (FGD, Male partners of WRA, Kashishi)

Some respondents argued that women are often in agreement with the need to deliver at the clinic but that men are sometimes more hesitant, often due to the expenses involved. Expenses associated with delivery is a barrier. Lack of finances for transport and equipment can be a cause for giving birth at home, and if you have a small income, it is a problem:

> "It's lagging behind for the fathers but now I see that a few at least begin to understand. But you may find someone saying 'aaah, when I go to the hospital I need to buy everything!" (WRA FGD, Tumbi)

> "She is supposed to have a clinic card, gloves, maternity clothes, a basin or a bucket for washing clothes, a soap, and a towel for the newborn." (WRA IDI 2, Kashishi)

> "When I go there, they may tell me about the issue of transport but I can't afford that. They may also tell me to buy gloves but I may not have that money, so you may just say that other women are giving birth at home so I will also give birth at home" (WRA, IDI, Kashishi)

The place for delivery is a topic that mothers in laws can influence:

> "Personally I cannot accept my daughter in law to give birth at home even if her husband will delay [taking her to the clinic]. When I notice certain elements of labour pain, I have to tell her to go to the facility, whether she likes it or not" (Mother in law, IDI, Tumbi)

3.2 Health in the Household

This section is divided into eight sub-themes and offers findings and observations on matters from a household or societal perspective, beyond the health care facility.

3.2.1 TAMANI has inspired increase in equal division of HH chores

A majority of the respondents state that men participate more actively in household chores and that TAMANI has sparked conversation and critical thinking in the families regarding division of labour. Several respondents argue that this change is small or slow but most agree that it is there. The mother still holds the ultimate responsibility for domestic duties but both men and children are increasingly participating – especially when the mother is pregnant or unwell. However, all household chores are not considered equal. There is a larger stigma for men to be seen undertaken certain chores and it is a different matter to undertake them inside the house, compared to doing them in public.

Picture 5: FGD with WRA

"I always do things like fetching water. I can even go and look for charcoal, but I won't tell a lie, because I never do washing." (Partner of WRA, Tumbi)

"In the past my father was not doing home chores but now he is doing them because he was given education at the dispensary during meetings. He was give that education so that he can be able to help my mother with home chores" (FGD, adolescent girls, Kashishi)

"Fathers were actually harassing us …they were leaving almost all work to us… Right now, I see that it has decreased, there are a few left but we will continue to educate each other." (WRA, Tumbi)

"We help each other with home chores, but it wasn't like that before. Not all men have changed, but some of them have started to change. They take care of their families, but in the past the woman was the one who was earning the family income. She was supposed to find money for food and clothes. At least now men have been educated." (WRA IDI, Kashishi)

"Responsibilities have existed for a while. They have begun to exist but, not to a large percentage. Always, people don't change abruptly, but the education provided has made people to begin to change." (Male TAMANI facilitator)

"Personally I am glad because I have seen the big changes, from psychological changes to that fathers involve themselves in domestic duties. When you find a man doing laundry, preparing a meal, collecting firewood or preparing the charcoal, it has become a normal practice." (Partner of WRA, Tumbi)

"Equality now has been like globalisation, I know now things have changed. For example, before I came here I did laundry and fetched water and my wife is at work, so it's 50/50." (FGD, male partner of WRA, Kashishi)

"At the very beginning, before we started educating the community, the one who had the biggest responsibilities in the household was the mother. All activities were left to the mother, but now, after educating them, there have been changes. Because our responsibility is to visit the household, and as you visit the household they should all there, both the husband and the wife. So in terms of responsibilities now, they all have responsibilities." (Male CHW, Kashishi)

3.2.2 Increased participation of women in education, income-generating activities and decision-making

Several respondents argue that TAMANI activities have prompted more equal participation in various forms of decision-making and, for instance, income-generating activities (IGA).

"The education helps to reduce patriarchy and to bring about gender equality. Even the mother can sometimes be in a mutual discussion and the father listens to her." (Male TAMANI facilitator)

"The situation is now very good. There is a change because men are now involved with their wives and children as well as in planning important family issues such as budget, food, education and agriculture." (Village chairman, Tumbi)

"There is cooperation and communication, the mothers are happy. They have told TAMANI that this issue has really helped us, we can sit and talk and our husbands will understand us. Differences exist, but in general have diminished. There are some households that are cooperating but some families still need more education. They still have the father as the decision maker when the mother says I should go to the clinic." (Female CHW, Tumbi)

Some respondents say income generating activities are undertaken by men and women almost equally and some say it occurs sporadically when women can balance this with their household chores, which are priority. Many respondents say that the father may consult with his partner/family on certain matters such as how to spend disposable income and that this in itself constitutes a change, bur that the father is the head of the household and the final decision-maker and remains quite unyielding in this position.

"A large percentage of the decisions are made by the father because of the traditions or beliefs we had, that the father is the head of the family... In reality, there are some things that people must communicate, share and cooperate on, for example when you talk about selling a piece of land."(IDI male youth champion, Tumbi)

"In the past, the father was the only decision maker, but when we got a seminar, at least we showed them that even mothers can make decisions." (WRA, IDI, Tumbi)

"The person who had a voice before was a man. Whatever he decides, that was that, but now there is equality. For example, a man cannot sell his plot without involving his wife. If they agree they sell but if not, they don't sell it. Now, as they say, gender equality is 50/50 - the same activities which were done by girls will also be done by boys, like cooking, fetching water or washing dishes. This didn't exist before." (FGD, male partner of WRA, Kashishi)

> "Those things happened long ago. Anything that man can do a woman can also do. That's why we have a female president[7]. It's 50/50 if its business or agriculture, both can do it as far as I know, and where our society is going, all responsibilities will be done by men and women equally, despite their gender difference." (FGD, male partner of WRA, Kashishi)

> "It has had a contribution but it's very small because most of the fathers here are obsessed with tradition, 'that I am the father of the family and if I order this to be done a woman must do it!' So the father can just get up and run to the auction, and give you responsibilities to go to the farm, and do this and that. He wants to find all the tasks accomplished and if you haven't done them, then there will be problems [laughs]. (Female HCP, nurse, Kashishi)

Children are sometimes consulted depending on age but it is difficult to see a clear pattern in this regard. Girls are often attending school up to a certain age – often not as many years as boys, although they still face various challenges, including fear of becoming pregnant.

> "We see even in matters of education, oh so many parents prefer boys. For example, if you are a girl, aah you will end up getting pregnant in Form I if you are not smart. But I crave that thing [education] so that I can achieve my goals, but my parents are holding me back." (Adolescent girl, IDI, Tumbi)

3.2.3 More dialogue and shared responsibilities between men and women on household level in regards to maternal and child health

Dialogue and decision-making concerning maternal and child health are complex matters. Some respondents find it positive that women participate more and are becoming more established as decision-makers in the household over for instance expenses. Others argue that it is good that men participate more in matters related to maternal and child health that they previously when they may not have taken much interest and responsibility for these matters. For example, during an FGD in Tumbi, it was put forward that men sometimes bring their children to the clinic themselves which was not to be expected before.

Fathers tend to bear the cost of clinic visits and they often prepare the necessary equipment for clinic delivery, but sometimes they do not agree that the woman needs all these things for the birth and increasingly, women manage to purchase the required items themselves.

One respondent in Tumbi expresses that it is rewarding to increasingly sit and discuss together. He mentions that relationships become closer between fathers and children and goes on to say "*My partner and I both decide because we already know the right time for a pregnant mother to start attending to the clinic*"
(Male partner of WRA, IDI, Tumbi)

> "At present, most of the youth and men do want to participate in this, accompany his partner to clinic, and to be aware about his child's health." (Male FGD, Tumbi)

[7] After the death of President Dr John Pombe Joseph Magufuli on the 17th of March, 2021, he was succeeded by Samia Suluhu Hassan who had been Vice President.

"The father is also involved in decision-making, because there he is involved in one way or another, as he is afraid of the costs." (Male TAMANI facilitator, Tumbi)

"In the past we were not sharing. When a man says that a woman has no voice, she wouldn't speak, but right now I am grateful that we are sharing." (WRA, IDI, Tumbi)

"Yes, nowadays most of the time we do things together. If it happen that you go to the facility and they tell you that there are no medicines, then we buy medicines. We even have health insurance cards." (Male partner of WRA, IDI, Kashishi)

A female CHW says that fathers are a lot more involved now and can even bathe their children "*For now, both sit down and advice one another and reach a conclusion.This was not the case previously since the father made these decisions on his own.*" (Female CHW, Tumbi)

"After being informed about her condition you organise meetings for the preparations. We cannot start a journey to Tabora without plans and no fare, you must prepare first. We have information and you save something for this as well." (FGD, male partners of WRA, Kashishi)

"I have learned how to share with your partner until you come to a conclusion about which is the right way to take. But otherwise, I know my responsibility. I am a leader but I am also the head of the family. I have learned that the issue of reproductive health is not just for women but for all parents and the whole family." (Village chair, IDI, Tumbi)

3.2.4 Shared decisions on household level regarding child spacing/family planning

The vast majority of the respondents stated that there is a discussion ongoing regarding how many children to have and when. It was also repeated that education is important in order to make informed decisions on family planning and for fruitful discussions. Many reiterate that previously this decision remained solely with the man and some still argue that he has the final say, which would explain why some women in Tabora still use contraceptives in secret.

"She could not plan without me and I could not plan without her because we all agreed that after a certain age of our baby, we can create an environment for having another child." (Partner of WRA IDI, Tumbi)

"But if mother decides to have a child, she can conceive at any time." (Partner of WRA, Tumbi)

"Both of them decide, since it's a decision of whether to get or not to get another child. They then reach an agreement whereas previously, the mother would use family planning methods without involving the father." (Female CHW Tumbi)

"Now that we have received many seminars [about contraceptive methods], we come and we are told about it. Now we decide between the husband and the wife. You sit down you plan, we go for health check-up, it's the job of both the husband and the wife." (Mother in law, IDI, Tumbi)

"It is recent that the issue of family planning is decided by both parents. They agree on how many children they

will have and the methods they will use. There are a lot of methods to plan like syringe, implants, etc." (FGD, male partner of WRA, Kashishi).

"You cannot decide anything alone. She can say something and I can disagree, and I can say something and the mother refuses. That's why we have to sit down and agree whether we should have it or wait a bit." (FGD, male partner of WRA, Kashishi).

Some interviews suggest that men might be less enthusiastic about contraceptives, perhaps as a result of knowing less about the matter. Beyond hesitation to let their partners use contraceptives, there are also reservations among some men regarding using condoms, while others think it's the preferable option (see section 3.2.5).

"The mother often likes the methods, but for the father it's not very easy to go for contraceptives...few fathers go for family planning but she is allowed to go and use the methods." (Male TAMANI facilitator, Tumbi)

"So in making decisions about the issue of contraception, it is largely the father. He is the one who has been making decisions considering when we talk about contraceptive methods... so there may be a time when this is done by force 'No, I don't want to use a condom because I am not enjoying the game'. Now this is where people like us [CHWs] are needed to reach these kinds of people, to educate them." (Male youth champion/CHW, IDI Tumbi)

Regarding mothers-in law, who are influential in MNRCH within the family:

"Contraception was very much a challenge in our community, especially through these mothers-in-law. They often said that contraception is not good, contraception can make a child not give birth again, and you can miss grandchildren. That was very common and many used to say that if you use contraception you may die or you may become infertile." (Female CHW, IDI Tumbi)

Some women still use contraceptives in secret. While most argue that it should be a joint decision, women who are prohibited to use family planning after presenting their partners with this option may opt for proceeding without him knowing.

"That decision should be made by both the husband and the wife but most of the time women are the ones who start the family planning topic. They start investigating which method is better, either syringe, condom or loop but when my husband refuses and I see that my health condition is not well, I will go to get services secretly without informing my him." (WRA IDI 2, Kashishi)

"If a person sees that her husband wants to have more children, she goes in secret and puts the loops in. The husband does not know, they continue living." (Mother in law, IDI, Tumbi)

3.2.5 Changing attitudes and reduced stigma around family planning/contraceptives and less use of traditional family planning methods

Several interviews suggest there are more discussions ongoing at the household level about family planning options, and that there is a large uptake of contraceptive services at the clinic. The main focus evolves around

protecting yourself from unwanted pregnancies and less often about STIs/HIV although there appears to have been an increase in demand for condoms.

> "See there are some changes. One day I went to the clinic I found some young men. I asked them what's wrong? They said 'we came to ask if there are condoms', you see. So, I got a picture that things have changed, in any case they got education on condoms, became aware of it and now they are requesting them for use." (Male TAMANI facilitator, Tumbi)

> "Changes are there but there are some methods that are preferred and some arenot. For example, this method of loop, most people do not like cuttings. Injections are liked and a few like pills. But the leading method is condom. These are liked by everyone. They feel that other methods have got effects and that condoms have no effects, but education on this is continuously being provided." (Female HCP, nurse, Kashishi).

There are still misconceptions around family planning and especially potential side effects which indicates more information is needed. However misinformation appears to be on the decline. In regards to traditional methods, not a single respondent advocated for these methods and generally acknowledged them as obsolete, ineffective and potentially dangerous.

> "They say that if you put implants before you start giving birth, it will move the uterus forward … it will be very difficult to have a baby." (Adolescent girl, IDI, Tumbi)"

> "We have a percentage of about 70% because contraception is not like in the past when people used to spread rumours that once you use it you will give birth to a dead child or a rotten child. But now because of this education they understand and see a person using contraceptive methods and later removes it and gives birth they then have faith and believe that they are good."
> (Female HCP, nurse, Kashishi)

> "You ask them why are you not using family planning and they say it's bad. Why is it bad [you ask]? They tell you that it's bad because it can make you fat, it can destroy your ability to get children etc, they may give you so many reasons."(Male CHW, IDI, Tumbi)

> "That's why we are saying that this education has helped many people because in the past we used to believe that the use of modern family planning methods ruin the reproductive system, that it causes diseases like cancer which ruin the lives of women. But people of this new generation, most of them don't know about traditional methods." (Male partner of WRA, IDI 2, Kashishi)

A CHW argues that modern contraceptives are what all women use now but that the procedure of prescribing these can be done better as to contribute to better health, less side effects and more evidence-based information being spread if they are thoroughly examined by a HCP before being prescribed a certain contraceptive:

> "Access to family planning services is there, but the problem I see is when going for it. We say that everybody has their own body. When she arrives she should be examined to see which method will work for her. But now she could come and say 'I want an injection', she gets in, she gets injected and leaves. In discussions people say

> that family planning methods have side effects but the one who answers always say that there are no side effects as you will find that the providers will examine you to see what method of contraception suits you. But the examination of what contraception suits you is not always done. I can get out of here and go and say I want a syringe method and I just get injected and leave. They can't say no, we can't inject you, maybe you should be examined to see if you should be injected." (CHW, IDI, Tumbi)

TAMANI educaton has helped to get information about modern family planning and myths about effects, and it has also facilitated making informed decisions.

> "She may just go to the pharmacy and buy any contraceptive and pharmacists would just sell to them. Then they start taking those medicines and at the end of the day she get side effects. But for now, they are given education through mother and child services. They give them education first and take some tests so that they are aware." (Male partner of WRA, IDI 2, Kashishi)

> "It has made a great impact, including helping to change my own view on family planning. I used to hate family planning a lot." (Female CHW, Tumbi)

3.2.6 Young people, both boys and girls, are important to target with sexual education/family planning information

Several respondents speak of stigma around offering young people sexuality education and information and access to family planning but the majority of interviews suggest this is shifting and that people would argue it's very important to target adolescents with this information and services. There is a variation in the data in regards to what age each gender should commence receiving sexuality education/access to family planning services and the logic of girls versus boys having this access and information. Some respondents argue that girls are more advanced in knowledge about family planning and that boys are lagging behind in this regard and are more irresponsible. The matter of educating boys appears complex as some respondents state that it is natural for boys to be "irresponsible" up to a certain age, while others think they should act more responsibly based on being informed about the potential risks through CSC dialogue sessions. Yet others say that boys should not receive this information as it will corrupt them into even more irresponsible acts. Some repeated arguments of providing young people with information and services in order to realize your potential in life as it is important to avoid contracting HIV or teenage pregnancies.

There were diverging views on what the appropriate age for starting to receive sexuality education and reproductive health services, ranging from 12 to 18/19 years in the different groups, but distinguished between education and services, with education to be provided at a younger age than services.

> "Personally I think it's good to provide this education early, especially that adolescent girls are educated early about that at a certain stage you will start your menstrual circle. If she is not aware of such changes, she will regard it as a health problem, like how can someone bleed without a wound. She will feel like she's dying, feel isolated and if she's at school she won't understand the teacher because she will only be thinking about this. But if she gets education about these changes early, she will regard it as a normal changes and she will have a confidence, because she won't take it as a strange thing." (Adolescent boy, FGD, Tumbi)

"It can be perceived that you are teaching him/her adultery" says a partner of WRA in Tumbi about the source of this stigma, but he argues that people currently agree that adolescents should still receive this information.

> "Many of the young adults nowadays do go to the dispensary to receive a card and diagnosis of their health status together with their partners. Adolescents are many and the best attendants at health centres nowadays." (Adolescent boy, FGD, Tumbi)

"*Yeah, young people are the nation of tomorrow and need to receive family planning education*" was expressed by a male youth champion in Tumbi. He mentioned avoiding unplanned pregnancies as a big factor and that because of this it is especially important to target girls with family planning information. A girl needs to learn the importance of protecting herself: "*Even if I the father decides to run away, you will still remain with the pregnancy…It is also important for men because we are the perpetrators, that is, we are the reason why a woman is pregnant*."

> "We should all be given that education, father, mother and children from 15 years, even though they are still children but they understand." (WRA IDI 2, Kashishi)

> "It's important because they will be aware and see the importance of family planning as they grow up. It will also help to plan for their children in their future." (FGD, male partner of WRA, Kashishi)

> "Men believe in sharing information through groups, and that it is especially important that youth get information. When the meetings get bigger, more people get informed. When you are many, people get motivated and it is important to also give information in school." (FGD male partner of WRA, Kashishi)

> "As girls we are supposed to be given reproductive health education so that we can have good health and be able to give birth to a healthy baby." (FGD, adolescent girls, Kashishi)

While most respondents speak to the importance of adolescence having access to family planning information and services, it appears this is still not always common for various reasons – one of them being misconceptions of how and when you may access it.

> It's the issue of being given education even though some of them may feel shy even with their mothers… She has the right to go to the facility and ask a midwife some questions, so she must get that service. Most of them they haven't receive that education yet. They still feel shy, they feel shy due to the environment, they feel like maybe people will be surprised when I go there and say things like that, what will they think about me? Maybe they will think that I have started doing bad things, so they get frightened. (Male partner of WRA, IDI, Kashishi)

> "Normally, a hospital cannot provide that service to a person of that age, that is not permitted at all. A hospital cannot give her family planning services because they know that she hasn't reached a right age. The person who gets family planning services is the one who has reached the right age and she is already married. So you cannot take family planning issues simple like that, you must go there with your husband and you can't take contraceptives when you are alone." (FGD, adolescent boys, Kashishi)

Many respondents think that adolescents should consult with their parents about starting with family planning while others say it is entirely the parents' decision. A WRA in Tumbi thinks that adolescents should not involve their parents in sexual habits and family planning decisions but rather keep it private while others state that some parents insist on the daughters using contraceptives so that they will not risk dropping out of school.

> "I have seen that many girls are using family planning method because their parents insist them to do so. They are afraid that their children may fail to complete their studies. Although it may be harmful, you have to rest assured that she will not conceive." (Adolescent boy, IDI, Tumbi)

A male CHW argues that many adolescents only start with contraceptives after they have become accidentally pregnant and thinks that more can be done to target this group with information. A CHW can facilitate uptake of some contraceptives, by bringing them to people's houses.

> "In fact, a large percentage of those who want contraception are young boys. Young girls are only a few percent, because they are afraid. They are in need but they are afraid and those who come forward are the few who use alternatives. She can use a CWH and say that I cannot come to the clinic but when you get to the clinic please bring the condoms and pills to my home. But those who choose injections come on their own." (Female HCP, nurse, Kashishi)

3.2.7 Community Health Workers play a key role in enabling positive results for TAMANI

Many respondents were very positive about how accessible CHWs make information and said that they wished there were more CHWs, especially on sub-village level. Most expressed that the gender of the CHW they are in touch with is irrelevant but it appears that there is sometimes a preference for older/more experienced CHWs. Not all respondents are comfortable to share all aspects of personal health with CHWs/peer educators/youth champions because they are worried about complete confidentiality and would rather save some discussions for the clinic appointment, while others say they willingly share all information. One female CHW respondent in Tumbi explains it sometimes took a few meetings to gain trust: "*They used to say that I am very young and it didn't seem right for me to tell them about good nutrition and to avoid giving birth at home.*"

> "They are good indeed, they educate nicely and in case you haven't understood something you can tell them and they will explain again. They are charming." (Adolescent girl, Tumbi)

CHWs have contributed with ample important RMNCH information, including better awareness-raising on the importance of health centre delivery and sometimes they escort mothers there to give birth. Considering the many positive reviews of the work of CHWs, some consider them undervalued.

> "Before TAMANI we were not aware of the importance of attending the clinic and delivery Women were giving birth at home. But now we have health service providers in our local areas who monitor the homes with expecting mothers and visit them." (FGD Male partners of WRA, Kashishi)

> "They have confidence in me, they believe in the education I provide, they don't doubt me. So even today if I say that I am calling for a meeting, a lot of people will be coming, and I'm so proud of that." (Male CHW, Tumbi)

"The community health workers, these are seen as they have no job and they have no value, but in fact they are doing a lot…community health care workers are not given even a shilling." (Female CHW, Tumbi)

"Now the mother can make the decision if the father refuses. The mother follows the advice she has been given, or she may decide to call the CHW who was visiting her during her pregnancy who will come and get her and bring her to the hospital (dispensary). They often bring a lot of women." (Female HCP, nurse, Kashishi).

"It has contributed because you may find someone in the village who is sick and the CHW has passed through the village. S/he (the sick person) would probably have planned to go to a traditional healer but after consulting a community health worker she decides to come to the hospital, so it also helps." (Female HCP, nurse, Kashishi).

"After the TAMANI project started operating people have been given education. People have benefited from the project because now there are community health workers who were selected by the community. They have received a seminar, so when a woman is pregnant she goes to report to the facility and then after that they keep her record. Those community health workers keep on visiting pregnant women, they sensitize them that if you see labour signs call me, this is my number. So each mother or father have the phone number of community health workers and when you see labour signs as a father you call them and they find a means of transport. If a car is not there, they find a motorcycle, they pay and they take the mother and one family member to help her at the dispensary. So that's how we benefit from TAMANI, people are very happy with that education." (Male partners of WRA, IDI, Kashishi)

It was mentioned by a female HCP that the CHWs have contributed by supporting and education in the communities, but also facilitated the work at the clinic:

"CHWs have helped us here at the clinic. You may be busy but they will help you even in matters of cleaning and you would find that they have also educated mothers and provided support, and this has also helped us." (Female HCP, nurse, Kashishi)

The sensitisation of the fathers starts with the CHW and the work with sensitisation and education offered by CHWs functions in tandem with the HCPs at the clinic. The awareness among fathers does however not always stretch beyond the mothers lactating phase.

"Sometimes we even ask mothers 'how about at home, do the husbands help with the work?' They themselves state that the fathers are helping and when they start the first clinic attendance the husband is there with her. When we provide the education and he is also present, he goes and practises it." (Female HCP, nurse, Kashishi).

"That's why we as CHWs have something called a personal plan. During pregnancy, we educate them and they understand that the personal plan also means to prepare transport. You have planned with the father of the household to prepare transport and you have informed that a relative will accompany the mother during the childbirth." (Male CHW, Kashishi)

"We women, we start at the clinic when we are pregnant. There, we will teach them family planning methods which we explain to them, but also about equality in the family. The husband should not see the wife as a useless person and that he is the only one making decisions. But also about the basic needs of the mother when she is

pregnant and when she gives birth, what should the father do? We tell them that, and also, if it happens that the mother is tested [for HIV] and is found to be infected, then we also educate him not to stigmatise her and stay together but to protect themselves." (Female HCP, nurse, Kashishi).

"You could say that priority is given to pregnant and lactating mothers, but once the child reaches the age of one, then she continues with her routine as usual [laughs]." (Female HCP, nurse, Kashishi).

Child health has also improved as a result of the work of the CHW, by emphasising nutrition of the mother and sensitising the husband of the importance of not too hard labour during pregnancy:

"The topic of maternal and child health is important, many people didn't know the meaning of the child's health, what to do so that she can give birth a healthy child. But after being educated, especially in terms of nutrition, at least mothers try to get at least three meals a day, unlike in the past when a pregnant woman was eating one meal, staying hungry throughout the day and then she would give birth to a baby whose weight is small. But it also helps mothers to prevent abortion because pregnant women used to perform tough chores and were not eating well, so they were also giving birth prematurely. But through this education, it has made husbands to take care of their wives. Even though it is not one hundred percent but many are really trying hard." (Female HCP, nurse, Kashishi).

3.2.8 Stakeholders/initiatives beyond TAMANI offering similar education initiatives on family planning/ RMNCH in Tabora, contributing to positive results

The respondents do not always refer very clearly to the specific "education" initiatives which they have participated in. Sometimes they refer specifically to TAMANI or CARE, but very seldom to SAA or CSC or other specific activities. Some interviewers prompted them about this matter and the respondents then offered a number of different examples of somewhat similar initiatives they had taken part in. In some instances that they simply could not say what trainings/sessions they had sat in on and who organised them, but some argued there are limited initiatives/ opportunities for information beyond TAMANI, apart from sexual and reproductive health information that had been provided to youth in schools.

"That group which I was in was called SITETEREKI. This group was educating girls from 15 to 18 years on how to protect themselves against diseases and also how to protect themselves from unintended pregnancies. The project focused on early pregnancies, contraceptives and STIs" (WRA, IDI 2, Tumbi)

"The reason for this change is education. They have found the community through projects, various projects like TAMANI. There are other projects like TULONGE AFYA, eeeh we are also grateful for the organisations which are helping, so that the right people get education … There are now two organisations that have provided education: TULONGE AFYA and TAMANI, but looking now at TAMANI and TULONGE AFYA, looking at participating and changing people and to what extent TAMANI and TULONGE AFYA have contributed […]Okay, TAMANI, I can say that it has been a major factor, because TAMANI has come up with a better approach than TULONGE AFYA because in TULONGE AFYA, there are only community health workers are working there in the households. But TAMANI has come up with a good approach , that call for meetings." (Female KII, Tumbi)

"I think there is availability of this education but not in excess because there are only two places that you can receive this education. If you go up there to the dispensary, you can get this education." (FGD, adolescent boys, Tumbi)

"After arrival of TAMANI, they set the plan, and asked us if there is any awareness which has been provided regarding sexual and reproductive health, to which we answered them no!" (FGD, adolescent boys, Tumbi)

"For example, when we talk about this TAMANI project, I have been involved in these what we call seminars though they are not formal seminars because we have been called as the group which I mentioned earlier…It's called WORKUP" (Male partner of WRA, IDI 1, Tumbi)

It was mentioned in an interview with an adolescent girl in Tumbi who has not participated in TAMANI group activities that reproductive health information is easily accessed in school through different providers: *"That's easy because such education is available even in schools. There are also groups that call young people like us who give us education, so I think it's easy."* Other adolescents mentioned that they also get information is through the radio and in magazines.

3.3 Cross-cutting themes

3.3.1 Sustainability of TAMANI results

Respondents offered mixed feedback regarding whether the change induced by TAMANI will last. Many of them argued that they think the results will be sustained. However many also insisted that the activities should continue in order to guarantee sustainability and avoid setbacks. For instance during the FGD with WRA in Tumbi, the respondents were in agreement that the project impact will be long-lasting but also said that "reminders" of what they have learned would be helpful – as there was a suspicion that especially men will start to "forget" some learnings over time and re-assume old habits.

"Aaah, I think this thing will live in me all the time" (Male youth champion, IDI, Tumbi)

"It depends, they may be short-term or long-term… We human beings survive because of being reminded over and over. There are people who are used to be reminded so that they can do something, so when I say they might not last long it's because if somebody is used to be reminded, then this depends on the organisation. Will it have a quick system of reminders or will they be slow? If somebody is reminded, it may stick there. But we do remind them a lot, every month you are passing a household and some people might also tell you to come back again tomorrow. So reminding them over and over helps that knowledge to stick. But if it happens today that you are present but tomorrow you are not, then that person may lose." (Male CHW IDI 1, Tumbi)

"The changes will be continuous because people have got this education and they understand and we are still going to the dispensary where they continue to give education, so society will continue to change." (WRA IDI, Tumbi)

"Continue to educate the community, because this project has not gone far, it is not finished beyond the suburbs of this Tumbi ward, so, the community is still uneducated." (Female CHW, IDI, Tumbi)

It was stated that those who have been sensitised through the TAMANI programme will continue to inform their neighbours, and the work in the clinic continues, but there is a concern that the services and equipment may not be like before:

> "As these professionals continue to educate us, and me and my family will take our child to the clinic, and both father and mother attend the clinic together, it is obvious that our neighbours would like to ask us, 'how does this work?' Then I will educate my neighbours and let's continue to educate others." (WRA IDI, Kashishi)

> "Yes but others may step back because they will see that people who used to bring medicines and equipment are not there anymore but we are asking them not to stop so that services continue." (WRA IDI, Kashishi)

Picture 6: Research team after a day of fieldwork

> "We should continue to be given these seminars and fathers will continue to changes and things will continue to be good. Because you understand what to do and fathers understand what to do and our hospitals are good." (Mother in law IDI, Tumbi)

> "It will last because it has already entered people's minds and if you stay, there are people who come and tell you about things, it will be continuous." (WRA, IDI, Tumbi)

> "If we decide to give up on giving influence, it won't last long. If we give up on influencing people to attend health facilities to get services and say 'let's go for counselling with professionals about reproductive issues!'. Even me who has been trained to convince my youth mates that we need to attend, it will not last long [if we stop pushing]." (Adolescent boy, IDI, Tumbi)

Men in Kashishi FGD mentioned that once you have been educated, there is no going back, and the children will learn from them. If possible, it should continue, and if the TAMANI programme stops, the local government should get more involved. If possible also set up a mechanism for complaint and membership groups:

> "The groups you have will continue to provide education but the local government should also put more effort. The district health department should also put more effort towards the villages." (FGD, male partners of WRA, Kashishi).

> "There should be a place where people can go to give their concerns about treatments, that I was treated this way and this way but when I went to report somewhere no action was taken. For example, we used to complain a lot about dispensary toilet pits but no action was taken. So there should be more follow-up, there should be more seminars and even members." (FGD, male partners of WRA, Kashishi)

> "For us who received this education we should come up with strategies of forming groups and keep on lobbying and providing education so that even children who grow up they know for sure that this service is important. When a mother has pregnancy symptoms she should know what her responsibilities are and her husband should also know his responsibilities. These things should be sustainable." (Male partner of WRA, IDI, Kashishi)

A male CSC facilitator says he will continue educating because if you stop, you forget, so you need to keep on reminding about the issues:

> "I will continue addressing community issues because as days go on we keep on educating each other on many things because when you keep quiet sometimes you forget things, so we have to remind each other. If I receive some information I have to share with others that there is this and this, so I won't stop providing education." (Male CSC facilitator, Kashishi)

3.3.2 General feedback on TAMANI activities including SAA and CSC

The public discussions as an approach were appreciated and found empowering. Several respondents highlighted the importance of both discussing health promotional aspects as well as women's and men's responsibilities during SAA, promoting a more fair redistribution of household labour. One of the strengths that was emphasised regarding CSC was that you can voice a concern and it will be addressed. For example, one of the men expressed that the ambulance had been taken away, but that they got another one (through TAMANI) because the concern was raised. Challenges that were mentioned were that some participants did not take the session format seriously in the beginning, or struggled to see the point of some aspects of the gender discussions. One respondent also mentioned that youth could have been targeted more elaborately.

> "It is Tamani because it is not like they conduct discussions in private, all the discussions are conducted in public so many people get that education and even when your husband is not there you will go to give him that education and some of them they understand, they see it as a good thing." (WRA IDI, Kashishi).

> "When I participated in those dialogue [CSC] I was able to learn different things. For example the importance of division of works according to gender equality, the advantage is to do works within a short time, when there is division of work there won't be interruption of works. Another thing which I learn is that the use of family planning make parents healthy, a mother advised to attend to the clinic when she is pregnant for all her child's development stages until a child is born. Another thing is that if there is gender equality there will be division of works." (FGD, adolescent boys, Kashishi)

> "To change that situation you must go to the meetings, you can change your mentality, but if a person has a hard time to understand even if you go to the meetings you will not change, but the intelligent one can change through meetings because they speak." (Female SAA/CSC participant, Kashishi)

> "It's very good to be together and guide each other because the education provided there should not be given to one. When you are together even the issue of patriarchy will go." (FGD, male partners of WRA, Kashishi).

> "It was important because we mostly looked at gender equality. We followed up to look at the responsibility of a mother, and we found a mother has so many responsibilities, while the father has very few responsibilities. So when we met community members they were able to be educated. " [...] They are educated that there are so many responsibilities and you have to reduce the responsibilities for a mother. Because a mother can come from the farm with her husband, she carries the father's hoe and everything, including a child and fire wood. When she gets home she starts cooking while she is pregnant at the same time. So we have met mothers there, we met fathers in internal debates and they were able to open up. Fathers have been saying that it exists in our society and it is done but when we started to get these debates they got educated, and fathers and villagers expressed their ideas." (Female SAA facilitator, Kashishi)

> "I think this format is good and we should continue using this format in the future because we are used to it. We have seen other formats which have been used by other organizations, they just come in with meetings and

every person participates randomly. You raise your hand or you do this or that, but the format which has been brought by the TAMANI project, is the format that brings different people together according to their groups." (Adolescent boys, FGD, Tumbi)

"Not all of them understand that we are given education that benefits us and our families, but still some see it is nuisance to sit and get education." (WRA, IDI, Tumbi)

"At first, youth did not take CARE meetings seriously and they had to put music on to attract youth attention to attend the meeting. But it's different now, there things made us change. Personally, if I have two children, and when I am home, I can take a child to the clinic". (Adolescent boys, FGD, Tumbi)

"In all of them I came to realise that Panga kadi (CSC) is very important. Issues on decision making, gender and other things they are all important. Distribution of roles is also important. So I learnt all these things, and I added something. So whenever you call to visit a household I also talk about those issues."

He thinks it is important to have regular follow-up/evaluations with CHWs:

"Because if you leave me and come back after 6 months, I might have had a problem in the last 3 months, so how will I solve it? So these evaluations need to be done regularly, they strengthen us a lot. You might have told me how to fill the register, and I might forget, but if you come within three months you are not too late, you instruct me and then I improve." (Male CHW, IDI 1, Tumbi)

Adolescent girls have participated in community meetings but say that they have not contributed with ideas. Their involvement seems to have been limited, and they have little awareness of the TAMANI project. "*We participated but we didn't share ideas.*" (FGD, adolescent girls, Kashishi)

One respondent argues that she found the focus of TAMANI to be more on adults and that there should be an attempt to reach more youth:

"I just want to say that my opinion is that this education from the TAMANI project should continue to be provided because we are taking steps from one stage to another [...] Because it has so many benefits and that's why it should continue to be offered to young people." (Adolescent girl, IDI, Kashishi)

It was recognised that the TAMANI interventions has conveyed the same messages, but through different actors:

"The relationship between youth from TAMANI and the CWH is concerning the issue that they all teach, they all teach about health planning. A CWH will teach you the same way in which a youth from TAMANI will teach you. The only difference is that the CWH visits households and youth from TAMANI provide the education in groups." (FGD, adolescent girls, Kashishi)

CHWs attributed changes in the community to the community debates (CSC):

"There have been debates. Fathers, mothers and youth were called, they talked about division of responsibilities, so the men got educated and the women got educated. If it wasn't for TAMANI to bring the debate, I think all this couldn't have happened." (Female CHW, Kashishi)

It was highlighted as important that the session facilitator can communicate in different languages, especially Kisukuma in Tabora:

"We have different tribes here. In order to educate a Sukuma person you will have to use his/her language but if you don't know his/her language it becomes a problem, that's also a challenge." (Male CSC facilitator, Kashishi)

Regarding the discussions on domestic gender issues during CSC, notably, rights holders were encouraged to report abuse, even men who were abused by their wives:

"Yes, it happens in the community and also there was a certain meeting, they said that if you are being abused, don't be scared, go to report. Even if your wife is beating you, you have to speak up. (WRA IDI, Tumbi)

3.3.3 General reflections on changes that have taken place since TAMANI was introduced

There appears to be no reports on backlash or any negative outcomes as a result of TAMANI activities. All respondents are positive regarding the change the project has brought about, with the caveat that some speak of very significant change, and others say it is more limited and fairly slow or that some participate in the shift rather grudgingly. Yet others say that the change has not yet reached more remote locations. However, not a single respondent has argued that no change at all has been brought about. Not all respondents are able to name TAMANI activities as cause for this change. However, since it is clear from the respondents that many aspects relating to gender relations and access to quality care have improved, this is a confirmation that the programme had done a lot of work to strengthen the health system and generated various positive outcomes. Therefore, the key message is that the situation has improved, and it is less important that community members do not always recognise TAMANI or CARE's role in this achievement.

"Most of them [men] will change, they will complain but at the end of the day they have to do it. If you tell him what is needed right now you will hear aah… CARE now they have caused us trouble." (WRA, IDI, Tumbi)

"I am thankful that the TAMANI project has brought big changes in the community. For example in decision making, women were so oppressed in the family but I am thankful that now women have a say, they may tell their husband something and their husbands listen. Also, there are many changes at our dispensary. There were shortage of many things but now we are thankful that we even have a car and this was done by TAMANI through the discussions that we were conducting. Also now, women are not going to traditional birth attendants to give birth anymore, they go to the dispensary, even at 2am you may see a motorcycle taking a pregnant woman to the clinic to give birth. Now there is no other place to go than to the dispensary. But as I said, there is a problem in interior areas where we haven't reached to provide education due to different challenges like transport and all that, so we can't go there to conduct sensitization. But we thank God that now in the street, at the centre and in different places at least people are going to the dispensary to give birth and decisions in the family are made by both, that means they are both at the same level." (Male CSC facilitator, Kashishi)

"The changes I can say have been brought by me by the health worker, ward officials, village chairmen, in fact in this TAMANI project, clinic staff, all have contributed to bringing about that change because were even calling people. You talked and later educated, and the ward executive is also present and s/he insists. Someone you know has a lot of faith in the ward executive and insists until the executive insists that this is true. Someone today calls a nurse, and the nurse insists, and when s/he sees a CHW, he will say that this is what the nurse just told me, but not only the nurse, also my village chairman and my ward executive. I see that the whole chain has greatly helped to bring about change." (Female CHW, IDI, Tumbi)

"For me, the change I have seen, now there are equal rights, for example the right to express oneself. Everyone listens to each other." (Adolescent girl, IDI, Kashishi)

"Another thing that has changed, for example a long time back before TAMANI came, the young people were

afraid to even go to the clinic to ask for condoms to protect themselves from those unintended pregnancies." (Adolescent girl, IDI, Kashishi)

"Fathers were relaxing but since TAMANI came, the father and the mother have equal rights and they are helping each other, and still are until now." (Adolescent girl, IDI, Kashishi)

"Changes are there but they are small." (Female CHW, Tumbi)

"In the past, there were no friendly services but after TAMANI started to be implemented I can say that friendly services are available. Also, there was no health education but now we have. Before TAMANI there was no ambulance but after TAMANi was introduced there is an ambulance. I remember that the kitchen our dispensary was near the bathroom but when people from TAMANI came and held a meeting with us, people reported that the kitchen is too close to the bathroom and that there might be some effects because of this. So they worked on the suggestions and it was built far away. That's how things were before TAMANI." (Male youth champion, Kashishi)

"There are huge changes because in the past people were just sitting and they didn't see the importance of clinics or health centres, but through the TAMANI meetings and us CWHs, they have understood. Changes have been enormous." (Female CHW, Kashishi)

"I have personally seen its significance, for people have begun to be enlightened. They have reached so many women who are going to give birth at the clinic through these debates and external gatherings. In fact, most mothers are comforted and it has reduced mortality, because some ran to witch doctors. But now you find mothers who come from very far places, you will see them at the clinic, they were attending the clinic until they reached the time of delivery." (Female SAA facilitator, Kashishi)

TAMANI has helped also the SAA facilitator in her own family:

"We have changed at home. For example when I went for a test I went with my husband to the clinic, and when we were given that education my husband left there, understanding. So I found that I'm no longer doing most of the works. I remain with household chores and he helps me to fetch water, so those are the activities I do now." (Female SAA facilitator, Kashishi)

There were also specific remarks regarding the overall progress of gender equality:

"The TAMANI project has brought about great changes. Even our sub-village chairperson is a woman, although she was competing for this post with a man, in the end she won." (Adolescent Boys FGD, Tumbi)

"Gender equality… the situation seems to be going well due to the education provided by TAMANI and the CARE people. This education was health related but it seemed to go a long way to groups, so the CARE project has greatly helped, it has helped to a very large percentage." (Male TAMANI facilitator, IDI Tumbi)

"I think from the family level to the community and national level we can see even our President is a woman. Therefore, we can see how far gender equality has reached and personally I think we are doing well in this part. The CARE project has brought great impact, it has emphasized the equality for all, that's how I see it." (Adolescent boys FGD, Tumbi)

"Aah you know mothers have been put far behind. African culture has taken women as if they deserve to be at the back that the father should be at the front. Sometimes the father can take the wrong decision and the mother can make the right decision but most of the time, a father takes the decisions, I feel this is African culture." (Male partner of WRA IDI, Tumbi)

"From my point of view, I as a leader, and as a father, I have seen that there is a big change, through this gender equality there is no negative attitude. First of all, there is no negative perception through equality. I see fathers and mothers participate in the upbringing and development of the child in the womb until birth. They participate only positively, so there is no discrimination of any kind." (Village chairman, IDI, Tumbi)

3.3.4 The impact of COVID-19 on access to health services and project activities

Some respondents argue that there has been an increase of adolescent pregnancy rates due to the pandemic and reduced school attendance. COVID-19 and advice on social distancing appears to have brought about fear and some misinformation which had a negative impact on women's attendance at the clinic and there were respondents who said that home births increased because of fear of delivering in a crowded clinic. At the same time, these circumstances do not appear to have deterred all women from going for their appointments.

"First the Corona disease caused the mothers not attending the clinic, this disease discouraged public gatherings so the mothers were afraid of the crowd because they were now unable to get to the service centre for fear of gathering." (Male CHW, Kashishi)

"You know in last year's Corona pandemic, which I don't know if it still exists or not, there are people who believed that if they go to the hospital they will be infected with Corona, because of a lot of people and interactions, I will get Corona." (Adolescent boy, IDI, Tumbi)

"Sending children to the clinic decreased because the conditions became more and more and even mothers taking them to the clinic decreased." (Female CHW, Tumbi)

"Some were afraid of going to the clinic saying that it is too crowded so I better stay at home. Many didn't go… many gave birth at home" (WRA IDI, Tumbi)

"It affected because there are some people who could not go to the clinic for the fear that if I go I will get Corona. There are also people who say that I can't go to give birth at the clinic because if I go there, there are many people and we share the beds. You may be admitted to a bed and the one who just left the bed may have had Corona so I'm not going, it's better I give birth at home alone." (Female CHW, Tumbi)

"Some failed to go to the health facility saying there are many people and you can get COVID so they are avoiding to go at the facility." (Male TAMANI facilitator, Tumbi)

"It's good because the other day they called us and came to encourage us during this time of Corona. Mothers should not agree to stay at home because of the fear of Corona, they should go and give birth at the clinic." (WRA, IDI, Tumbi)

"Ahhaa, of course the issue of people giving birth at home was there but not on a large scale because although some people were still afraid of Corona they were thinking that If I give birth at home and it happens that I get some problems, maybe over-bleeding, who will help me? Let me just go." (Male youth champion, Tumbi)

"COVID has had many effects, we can see that the effects are there, because you may find a woman who was told to go for childbirth at the health centre but with the fear that if you go you may contract Corona. This is one of the big effects of COVID because at the health centre the infected people are many because the place have different people from different places. You see that high government officers have been affected and therefore one gets fear and decide not to go to the health centre for the service." (Female CHW, Tumbi)

> "Aaah, in one way or another I can say COVID shocked us and affected us because first of all there was people's beliefs that this disease is transmitted through the air, through direct contact or by touching something that the patient has touched. We were advised to avoid unnecessary gatherings, to wear masks, to use sanitisers. So it was hard for us because it was getting to the point where you wanted to meet people but you just feared that these people whom I am going to meet, are they safe?" (Male youth champion, Tumbi)

> "In fact it affected mothers because, especially girls, we got into big loss and shock because many girls got pregnant because of Corona. They stayed home for a long time without going to school, and parents are informed that there are school parents (teachers) and there are home parents (the real parents)". A girl could say that she was home studying but she was actually with her boyfriend." (WRA, IDI, Tumbi)

> "What I learned when schools were closed is that when children are in the street, some of them drop from school, some elders give children too much works to do [...] Another thing is the rapid increase of early pregnancies, I didn't know that when young girls stay at home they may get pregnant, the rate of pregnancies has increased." (Male partner of WRA, IDI, Kashishi)

The COVID-19 pandemic has affected privacy in small clinics as a special COVID room had to be prepared. As the quote below illustrates, in this case it was the room that was dedicated to youth services that was turned into a COVID facility. Combined with the fact that the schools were closed, with increased pregnancies among girls as a result, it is fair to say that it appears that COVID has affected youth significantly, in particular girls.

> "We had prepared a room for youth but when the COVID issue appeared and because we have a very small facility, we turned that room into being a COVID room because we didn't have such a room. So when they come for COVID services, we don't mix them. But first we had prepared this room for adolescent." (HCP, male doctor, Kashishi)

Social distancing recommendations have also had an impact on the opportunities to meet in larger groups but for some, PPE-equipment has facilitated certain meeting settings to continue, but sometimes not without difficulties:

> "Recently, we are unable to meet with the big groups of people. If you call for a meeting, maybe you want to share something, people are not coming. People are not showing up there so you have to visit their households, which is different from providing education in a group at once." (Female TAMANI facilitator, Tumbi)

> "In those classes you are conducting, you provide masks, sanitisers and soap for washing hands. But we saw these challenges personally and we could not solve them. What we should do now is, we are reducing the number of people we will be meeting because we were meeting ten people in each group and it came to a point where we met five people. But with the condition that there must be a bucket of water and soap for washing hands and once you are there you are told to be seated keeping a distance, something which was causing one to wonder why we are seated like this. It builds different beliefs and many people become unable to attend classes." (Male youth champion, Tumbi)

> "We had utensils, we put it there with soap, so we were just getting into the office and doing our job and leave the office safely. We were wearing masks, eee....meetings went on as usual" (WRA IDI, Tumbi)

4 Conclusions and recommendations

4.1 Conclusions

Health at the clinic:

TAMANI is well-perceived among the rights holders of Tabora. In general respondents argue that the quality of health services have improved and mention for example that maternal mortality has gone down, STI levels have decreased, health staff and ambulance services and home visits are available, and that services generally are affordable, of high quality and that waiting times have reduced. Examples of challenges that remain include shortage of drug supplies.

Awareness has increased regarding the importance of attending the clinic regularly during pregnancy. Both women and men have learned more on the importance of supporting pregnant women, accompanying them to the clinic etc.

Clinic infrastructure, privacy, medical equipment, beds, fresh water, toilets have all increased in standard: Fresh water tank, cleanliness, bins, toilets and increased number of beds are frequently cited positives. Better equipment, higher standard of services and availability including as a result of ambulance services. Electricity is generally good but sometimes the power cuts cannot be helped and there is no alternative energy source such as solar.

You need to bring certain supplies when you are to deliver a child at the clinic including a bucket, a razor, plastic gloves and a nylon cover for the delivery bed, this comes up in almost all interviews. Some respondents argue that this means that the services are not free and pose a challenge but most respondents state that services are essentially free and that it is fair for the parents to be to make some preparations and bringing these few supplies. This responsibility is emphasized to be the father's responsibility in the sessions at the facility and that the preparations should start early so that when the time comes, all is prepared. Savings groups was put forward as a mechanism for such savings.

Generally respondents find the clinic staff welcoming. A majority found that there has been an improvement while a few claim that the staff were always very friendly and others yet say the services are good and that HCPs generally do their best. Several of the respondents who think there has been an improvement, reference CSC as the trigger for this change. Some respondents still fear scolding as a result of not having brought required equipment for delivery. Other reasons for this fear include teenagers showing up pregnant or not having attended your schedules antenatal appointments.

Women are to a significantly increased extent giving birth at health facilities. Several respondents state that bylaws prohibit home birth/traditional midwives (traditional midwives are sometimes recruited to promote clinic birth) and that you are required to go to the clinic - they express that this legal requirement, which involves a fine of 50,000 Tsh if you give birth at home, as well as TAMANI activities, have influenced the shift away from home births. In a sense, this is an infringement on women's agency to decide for themselves where to give birth, especially if there are indeed legal repercussions for those who for various reasons end up delivering at home.

If there is a need you may stay longer at the clinic after delivering a child than previously. Regarding going into labour at night, some respondents see challenges that are both circumstantial such as living far from the clinic

with no means of transport, and others say services at the health facility do not offer equal services during the night compared to during the day.

There appears to be consensus among the respondents that men are accompanying their partners to an increased extent. Health workers, women and men all agree. Many respondents attribute this change to TAMANI and argue that project activities have offered the community a deeper understanding of why this is important. However some also argue that it is obliged in different ways (village chairman, clinic staff insist). Men often wait outside, on stand-by in case something goes wrong during delivery and a referral to the hospital will be needed. Men are also able to benefit from information and various services when they accompany their partners to the clinic for check-ups during the pregnancy. The men may be asked to do health tests or offered health advice.

Health in the Household

A majority of the respondents put forward that men participate more actively in household chores and that TAMANI has sparked conversation and critical thinking in the families regarding division of labour. Several respondents argue this change is small or slow but most agree that it's there. The mother still holds the ultimate responsibility for domestic duties but both men and children are increasingly participating – especially when the mother is pregnant or unwell. All household chores are however not considered equal. There is a larger stigma for men to be seen undertaken certain chores compared to others and it is a different matter to undertake them inside the house, compared to doing them in public.

There is an increase in joint discussion, participation and decision-making in several private and public spheres between men and women. While it is not fair to say that women have equal status to men in making the final decisions, there appears to be a shift in this dynamic – allowing women more space and agency. Several respondents argue that TAMANI activities have prompted more equal participation in various forms of decision-making and for instance income-generating activities (IGA).

There is an increase in dialogue and shared responsibilities between men and women on household level in regards to maternal and child health. However, this is a complex matter where some respondents find it positive that women participate more (becoming more established as decision-maker in the house over for instance expenses) while others argue it's good that men participate more (in matters related to maternal and child health that they previously may not have taken much interest and responsibility for). Fathers tend to bear the cost of clinic visits and they often prepare the necessary equipment for clinic delivery but sometimes they don't agree the woman needs all these things and increasingly often, women can manage to purchase the required items themselves.

The vast majority of respondents claim state that there is a discussion ongoing between the partners regarding how many children to have and when. It is also repeated that education is important in order to make informed decisions on family planning and for fruitful discussions. Many repeat that previously this decision remained solely with the man, who some argue still have the final say, which would explain why some women in Tabora still use contraceptives in secret.

There have been changing attitudes and reduced stigma around family planning/contraceptives and less use of traditional family planning methods. Several interviews suggest that there are more discussions ongoing on household level about family planning options and a large uptake of contraceptive services at the clinic. The main focus evolves around protecting yourself from unwanted pregnancies and less often about STIs/HIV although there appears to have been an increase in demand for condoms. There are still misconceptions

around family planning and especially potential side effects, which indicates that more information is needed. However, misinformation appears to be on the decline. In regards to traditional methods, not a single respondent advocated for these methods but generally acknowledged them as obsolete, ineffective and potentially dangerous.

Several respondents speak of stigma around offering young people sexuality education and information and access to family planning but the majority of interviews suggest that this is shifting and that people would argue that it is very important to target adolescents with this information and services. There is a variation in the data in regards to what age each gender should commence receiving sexuality education/access to family planning services and the logic of girls versus boys having this access and information. Some respondents argue that girls are more advanced in knowledge about family planning and that boys are lagging behind in this regard and are more irresponsible. The matter of educating boys appear complex as some respondents argue that it is natural for boys to be "irresponsible" up to a certain age, while others think they should act more responsibly based on being informed and the potential risks, while others yet say boys should not receive this information as it will corrupt them into even more irresponsible acts. Some repeated arguments of providing young people with these services and information is that in order to realise your potential in life it is important to avoid contracting HIV or teenage pregnancies.

Many respondents are very positive about how accessible CHWs make information and say that they wished there were more CHWs, especially on sub-village level. Most express that they do not care about the gender of the CHW who they are in touch with but it appears there is sometimes a preference for older/more experienced CHWs. Not all respondents are comfortable to share all aspects of personal health with CHWs/peer educators/youth champions as they are worried about complete confidentiality but would rather save some discussions for the clinic appointment, while others say they willingly share everything with them. CHWs have contributed with ample important RMNCH information, including better awareness-raising on the important of health centre delivery and sometimes they escort mothers there to give birth. Considering the many positive reviews of the work of CHWs, some consider them undervalued.

The respondents do not always refer very clearly to the specific "education" initiatives they have partaken in. Sometimes they refer specifically to TAMANI or CARE, but very seldom to SAA or CSC or other specific activity. Some interviewers prompt them about this matter and the respondents then offer a number of different examples of similar initiatives they have partaken in – or in some instances that they simply cannot say what trainings/sessions they have sat in on and who organised them. Some argue that there are limited initiatives/ opportunities for information beyond TAMANI.

Cross-cutting themes

Sustainability of TAMANI-outcomes

Respondents offered mixed feedback regarding whether the change induced by TAMANI will last. Many of them argue that results will be sustained. However many also claim that activities should continue in order to guarantee sustainability and avoid setbacks and that "reminders" would be valuable in order to preserve all the information TAMANI has provided. While respondents generally offer positive feedback on TAMANI, some respondents highlighted that it was implemented for quite a short time which has a bearing on the scope of social change obtained, as well as sustainability. Respondents also note that there are still a lot of rights holders that have not been reached by the project activities yet and that if more people were involved, this would also have a significant bearing on the sustainability of the project outcomes.

Furthermore, the interview questions could also have attempted to tease out more details on how respondents think they could contribute to mechanisms to sustain the change. The fieldwork research team also offered their agreement to having witnessed the positive outcomes of TAMANI first hand, which they see stand a risk of being lost unless the project is somehow sustained and some activities are continued. Specific mitigation suggestions include attempts to secure funding for additional years of project activities and/or empowering local leaders to continue peer group meetings.

Moreover, it is important to note that the research team may have received different replies if the questions on sustainability were to be asked in 6 months' time or so and that it is sometimes difficult to know if the change will be sustainable. Therefore it could be worthwhile to continue evaluation exercises in a few months' time and go back to the field and continue mapping change. As well-established, gender and social change takes time and is complex to map.

General feedback on TAMANI activities including SAA and CSC

As previously mentioned, respondents are generally very positive when asked about TAMANI. They think that the project has addressed important issues, provided valuable platforms for discussion, facilitated deeper engagement with important health uptake aspects as well as contributed to increased quality service provision. Most respondents also argue that TAMANI has had a positive influence on gender equality and challenging of patriarchal social norms as discussed further in the other subsections of this cross-cutting chapter.

The public discussions as an approach were appreciated and found empowering. Several respondents highlighted the importance of both discussing health promotional aspects as well as women and men's responsibilities during SAA. One of the strengths of CSC that was emphasised was that you can voice a concern and it will be acknowledged and addressed.

Challenges that were mentioned include that some participants did not take the session format seriously in the beginning or struggled to see the point of some aspects of gender discussions, and it was also mentioned that youth could have been targeted more elaborately.

General feedback on change that has taken place since TAMANI was introduced

There appears to be no reports on backlash or any negative outcomes as a result of TAMANI activities. All respondents are positive regarding the changes which the project has brought about, with the caveat that some speak of very significant change, and others say it is more limited and fairly slow or that some participate in the shift rather grudgingly. However, not a single respondent has argued that no change at all can be identified. Not all respondents are able to name TAMANI activities as cause for this positive change. However, since it is clear from the respondents that many aspects relating to gender relations and access to quality care have improved, this is a confirmation that the programme has done a lot of work to strengthen the health system and generated various positive outcomes. Therefore, the key message is that the situation has improved, and it is less important that community members do not always recognise TAMANI or CARE's role in this achievement.

The impact of COVID-19 on access to health services and project activities

Some respondents argue there has been an increase of adolescent pregnancy rates due to the pandemic and reduced school attendance. COVID-19 and advice on social distancing appears to have brought about fear, stigma and misinformation which had a negative impact on women's attendance at the clinic. At the same time, these circumstances do not appear to have deterred all women from attending their appointments. Social

distancing recommendations have also had an impact on the opportunities to meet in larger groups but for some, PPE-equipment has facilitated certain meeting settings to continue business as usual.

Discussion on findings of formative research in relation to the endline research

Overall, the formative gender research undertaken in 2017 (Mtenga & Shamba 2018) and the qualitative gender end-line research cover slightly different scope of topics but some key findings from 2017 are interesting to highlight for comparative purposes.

The formative research concludes the following: *Women and girls try to exercise agency in an environment that significantly limits their ability to advocate for their own aspirations, desires and rights. Decision-making, especially around sex and reproduction, largely falls to men. When women try to access contraception in secret, this threatens men's status in the community, and sometimes generating cases of GBV. Married women have especially limited agency in making decisions on the use of family planning without their husband's permission.*

The findings from the endline study suggest that women in Tabora exercise increased agency and decision-making power. Women are increasingly part of important discussions on household-level in regards to for instance household expenditure and participate in IGAs. Moreover, there seems to be an increase of discussion regarding child spacing and contraceptives even though some women still feel they need to use them in secret.

The findings of the formative research moreover present that *there is a strong preference for boys over girls in Tabora, resulting in boy's prioritization for education, and decision-making roles within the family. The denial of girls' education is an issue of concern as education is one of the strongest correlations in improving health including the use of maternal health care.*

Several of the interviews from the end-line research confirm that there still is a bias for allowing boys to continue longer in school, ignore household chores in favor of homework or social activities and generally enjoy more freedoms. With this said, most girls in Tabora confirmed they do attend school (at least reaching secondary school) and several respondents argue that boys are increasingly enrolled in household work that previously has been considered chores for women and girls.

In regards to norms around adolescent sexuality, the formative research concludes: *Strong social norms are applied to adolescent girls with respect to sexuality and reproduction. Interactions with health systems reproduce dominant cultural norms in the community. Girls that do try to access contraception are often shamed as "sluts or prostitutes" by their community. Both adolescent and adult respondents validated the dominant view that adolescent girls should not be accessing contraception.*

Several respondents during the endline speak of stigma around offering young people sexuality education and information and access to family planning but the majority of interviews suggest this is shifting and that people would argue it's very important to target adolescents with this information and services. Several respondents argue that for instance shaming young girls is a thing of the past.

Moreover, the baseline study shows that respondents view some health care providers as possessing unfriendly attitudes, which may discourage women, especially girls from accessing reproductive and maternal health services. Both adolescent boys and girls shared that Health Care Workers fear reprisals from parents if they were to provide ASRH services and both adolescent girls and mothers shared that they feared how they or their daughters would be treated if they delivered at the health facility. Both male and female adolescents felt that

health care providers were not comfortable to provide them with ASRH services, especially contraceptives and cited instances where they were denied these commodities.

While there still appears to be some fear among adolescents for showing up pregnant at the health facility, the attitude towards youth appears to have shifted in the health facilities and both adolescent boys and girls confirm that they are accessing contraceptives and family planning information. The FGD with adolescent girls in Tumbi indeed suggest that many girls are relying on family planning methods as almost all girls present for the discussion confirmed they were using them. No health care providers interviewed for the end-line research expressed any discomfort about offering services to young people.

4.2 Recommendations and lessons learned

- The holistic approach – a success worth replicating: The holistic approach of addressing RMNC health from many different angles – through the health facility infrastructure, transport, the HCP services offered, community outreach and dialogue through CWH, SAA and CSC - has been successful and is worth replicating in future programmes.
- Strengthen the institutionalisation through rights holders and duty bearers responsibilities: TAMANI has certainly been successful in strengthening the healthcare system- from gender relations within the household to customer centred quality care and infrastructure. But the linkage to government authorities at different levels could be further emphasised, creating dialogue connecting the rights holders and duty bearers. It is important to connect interventions with government responsibilities as government accountability should be expected as a result of paying taxes and basic services. This is an area which for future interventions could be strengthened, i.e. more clarity to service users/rights holders on who has supported health facilities and why. Moving forward, refurbishment of facilities and inputs such as ambulances through outside funding should be well understood, so that community members know where to escalate challenges, i.e. to be channelled to duty bearers, notably through the village/local authority as entry point.
- Emphasise youth further in future programmes: The inclusion of youth as the youth component did not feature clearly. Best practices from other programmes on how to integrate adolescents should be considered for future endeavours.
- Inject light touch boosters to maintain the results: Many rights holders would like to see TAMANI activities sustained in order to ensure sustainability of the positive outcomes. As this is likely to be difficult at full scale, the CHW's suggestion to provide light touch refresher sessions so that the energy and willingness to continue to contribute to improved MNRC health is maintained.
- Follow up on the gender assessment at a later stage: The research was conducted at the time which the TAMANI programme was phasing out, but still present in Tabora with an operational office and activities ongoing. In order to assess the long-term effects of the programme, another gender assessment could be conducted at a later stage, such as a year or two after the programme phased out.
- Dissemination of findings to other ongoing initiatives: As the programme has been successful and many lessons have been learned, a mapping of ongoing local initiatives in Tabora and share the findings from the qualitative and quantitative endline reports would be a useful way to promote synergies and sustainability.

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Annex A: Social Analysis and Action content in TAMANI

Social Analysis and Action[8]

Themes identified;

1. Facility based birth & family planning
2. Underlying cause for women not to deliver at facility
3. Households task and decision making

Norms and practices that are shared across the region relate to facility based birth and family planning.

Tool: Gender Box

Family planning	*Facility based birth*
○ Male domination on whether women use/not to use FP ○ Man determines family size ○ Use of local ways for family planning ○ Women use FP services secretly ○ Role of women is to give birth only ○ Women who use FP are prostitutes/disobedient ○ Men who allow wives to use FP are dominated by women	○ Women deliver at home/traditional birth attendant (TBA) ○ Use of traditional herbs to fasten labor pain ○ Prepared a person who will remain at home and to escort her for delivery. ○ Prepare delivery supplies such as gloves, making tosh, bucket and razor bladder. ○ To prepare food stock at home on her absence

Community perceptions on underlying causes for women not to deliver at facilities.
Tool: But Why

- Abusive language from HCWs
- No confidentiality i.e labor room not friendly
- Shortage of female nurses/Young age care providers
- Trust/confident to TBAs
- Low male involvement on RCH
- Not allowed to attend ANC
- Comply with social norms
- Fear to undergo C-Section
- High Costs

Households tasks and decision making.
Tool: Pile sorting

Tasks		Decisions
1. Caring for child and sickness		1. Number of children to have
2. House cleanness		2. When to have sex
3. Cash crops cultivation		3. Child spacing

[8] Shared by the TAMANI team in Tabora, December 2020.

4. Food crops cultivation		4. Arrange and receive dowry
5. Preparing children for school		5. When to go hospital
6. Caring cattle's		6. Whether use or not to use family planning
7. Cooking		7. Buying households commodities
8. Washing clothes		8. Selling crops into market
9. Selling food at market		9. Decision whether children enrolled to school
10. Punishing children		10. When to marry for children
11. Participating community event		11. Owning money
12. Fetching firewood		12. Owning land and resources inheritance
13. Fetching water		
14. Feeding and bathing children		

From the discussion of selected tasks and decisions it was observed that, women are overloaded with responsibilities which mostly limit them from accessing RMNCH services. On the other side of decision making; men seen to be final decision makers on most of the issues while women not even to those issues concerned them. Reasons of the inequalities within the societies were; religious training, cultural and norms including dowry payment of bride price, attitudes that women are born to be a mother, taking care of family and perform all household chores/ it is God's plans as well as lack of awareness on the effects of gender inequalities.

TAMANI Project common CSC&SAA agreed actions and action plan.

SAA ACTION PLAN

Common issues went into action plan;

- Low male involvement in MNH services
- Poor preparedness at birth
- Home delivery/traditional birth attendant,
- Use of local herbs as family planning methods and fasten labour pain,
- Inadequate of sexual reproductive health education
- Poor couple communication during pregnancy

CSC Action plans and changes occurred

Indicators agreed into action were;

- Attitude and practice of service users and service providers,
- Availability and accessibility of Emergency transportation services,
- Safety and security at health facility (i.e. fence and hiring of security guard),
- Cleanness and availability of enough latrines,
- Availability of buildings (HFs Staff houses),
- Availability of power and energy,
- Availability and accessibility of drug, medicine and laboratory diagnosis equipment (openness on medical costs)

- Provision of free Health Insurance Cards to the elders whereby both HSPs and community agreed on a role to play to accomplish this.
- Availability and accessibility of safe water at facility
- Finishing of RCH building,
- Recruit ambulance driver.
- Male involvement in MNH,
- Outreach clinic availability of traditional birth attendants,
- Availability of health care workers at facilities
- Environmental sanitation,
- Upgrading dispensary to be health center and availability of reproductive health services

Annex B: Consolidated CSC themes in TAMANI

Consolidated CSC indicators from the districts covered by TAMANI[9]

TAMANI DISTRICTS CONSOLIDATED CSC INDICATORS			
S/N	Common Indicators Raised	Specific Indicators per district	What has changed
1	Availability and accessibility of health care providers	Accessibility and availability of solar power	
2	Availability of drugs and medical equipment	Cleanness of the health facility and surroundings	
3	Availability of infrastructure (staff houses and health facility buildings)	Availability and accessibility of vaccination	
4	Attitude, fairness and practices of service providers to the clients	Male involvement in MNCH	
	Behavior, attitude and practice of service users	Availability of beds	
5	Availability of water supply	Transparency in service fee	
6	Availability of health facility safety and security	Availability of health education	
7	Availability and accessibility of MNH services		
8	Availability and Accessibility of emergency services		
9	Cost share on health services		
10	Availability of laboratory test		
11	Availability and accessibility of youth friendly services		

[9] Shared by the TAMANI team in Tabora, January 2021.

Annex C: Research tools

See separate annex document

Annex D: Interview Matrix

See separate annex document