Improving Maternal and Reproductive Health in Six Districts in Tabora, Tanzania

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Final Report

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Acronyms

ASRH	Adolescent Sexual and Reproductive Health
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
CHMT	Council Health Management Team
CHW	Community Health Worker
CSC	Community Scorecard
DCDO	District Community Development Officer
DRCHCo	District Reproductive and Child Health Coordinator
DED	District Executive Director
DHS	Demographic and Health Survey
DMO	District Medical Officer
EmOC	Emergency Obstetric Care
GoT	Government of Tanzania
HF	Health Facility
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HMT	Health Management Team
HSSP III	Health Sector Strategic Plan III
IEC	Information, Education and Communication
LFA	Logical Framework Analysis
MNCH	Maternal, Neonatal and Child Health
MoHSW	Ministry of Health and Social Welfare
MRH	Maternal and Reproductive Health
PMO-RALG	Prime Minister's Office–Regional Administration and Local Government
PRC	Program Review Committee
PSC	Program Steering Committee
RBM	Results Based Management
RCDO	Regional Community Development Officer
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
SAA	Social Analysis and Action
SRH	Sexual and Reproductive Health
TABASAM	Tabora Adolescent and Safe Motherhood
TCCP	Tanzanian Communication and Capacity Program

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1 Executive Summary

The is the final report for the Tabora Adolescent and Safe Motherhood (TABASAM), a 3-year project implemented by CARE, Tanzania Ministry of Health and Social Welfare (MOHSW), the Prime Minister's Office, Regional and Local Government (PMO-RALG) and Jhpiego. The project was financially supported by the Government of Canada Department of Foreign Affairs Trade and Development (DFATD), CARE and Jhpeigo with a total budget of CAD $10,971,139. The Tabasam project was part of the Government of Canada's Muskoka Initiative to improve maternal, newborn and child health and was closely aligned to Government of Tanzania (GoT) health policies, strategies and guidelines. Tabasam was implemented between April 2012 and June 2015. The goal of project was to **improve maternal and reproductive health in six rural districts in Tabora, Tanzania**. The project had three intermediate outcomes:

1. Increased utilization of Maternal and Reproductive Health (MRH) services by women and adolescent girls in target communities.
2. Improved quality of Maternal and Reproductive Health services at government health facilities in target districts.
3. Strengthened management and accountability for Maternal and Reproductive Health services in Tabora region.

The main strategies under the first outcome focused on strengthening of community-based delivery of maternal reproductive health information and services through the development of a community health worker (CHW) program. Women's empowerment approaches using Village Savings and Loans (VSL) groups supported improved women's autonomy and decision making around access to health care services. The strategy for the second outcome involved health care worker training, mentoring, the community score card process and the provision of obstetric and neonatal equipment. Finally, for the third outcome, the project supported Health Management Teams (HMT) through capacity building on a range of skill areas including planning, budgeting, supportive supervision, as well as data collection and analysis for decision making and logistics forecasting strategy.

In two and half years of implementation the Tabasam project was ***highly successful*** in bringing a program to scale that that not only reached but in many cases exceeded project expectations for improving maternal and reproductive health in Tabora, Tanzania. Key project results include:

- 375 health workers in basic emergency obstetric and neonatal care
- 983 community health workers provided regular counseling and home visits to their communities
- 80% of women delivered with a skilled birth attendant in a health facility setting, which representing a ***34% increase***
- 57% of women received at least 4 antenatal care services during their pregnancy representing a ***40% increase***

- More than 80% of maternal and reproductive health care clients in Tabora were satisfied with health services and the attitude of the health workforce during their visits. The level of satisfaction ***improved by more than 38%*** from baseline.
- Council Health Management Teams in each district now conduct regular standardized supervisory visits to health facilities

2 Introduction

This report follows the final reporting templates found on page 77 of the Contribution Agreement signed on March 2012.The Logic Model that the project followed has been approved in September 2014 and is part of Amendment 1 signed on June 29, 2015. In order for this to be a stand-alone project document, project implementation according to output has also been included. Section 3 Project Summary and Section 4 Project Context provide the background, key stakeholders and beneficiaries, along with the different contexts influencing project outcomes in the Tabora region in Tanzania. Section 5 contains the description of project implementation and assessment of immediate, intermediate and ultimate outcomes based on monitoring and endline data. The final sections include a risk management assessment, a gender equality assessment as a crosscutting theme, successes and lessons learned.

Rational and Justification

In 2010, Tanzania was one of eleven countries which contribute 65% of all maternal deaths globally.[1] Nationally in Tanzania, funding for MRH programmes has been disproportionately underfunded compared to competing health issues such as HIV/AIDS. Maternal mortality, estimated at 454 per 100,000 live births, remains high in Tanzania[2] and maternal deaths represent 17% of all deaths to women age 15-49. Over 8,000 maternal deaths occur annually with maternal deaths higher in rural districts where 82% of annual births occur. In response, Tanzania developed a National Roadmap for Maternal, Neonatal and Child Health (MNCH), the primary purpose of which is to align resources and improve coordination of interventions and the delivery of services across the continuum of care for women.[3] It recognized pregnancy (both in terms of frequency and timing), child birth and poor quality of health services as factors which perpetuate high maternal mortality in Tanzania. These factors have also had a detrimental 'knock-on' effect for neo-natal and child survival, growth and development and family well-being more generally. Family planning (FP) in particular is one of the most cost effective ways to reduce maternal, infant and child mortality.[4] Yet its provision is absent or lacking for many women in Tanzania while myths and misconceptions prevail without clear information and communication to counter them.

[1] According to statistics provided in the national roadmap, there are an estimated 13,000 maternal deaths, 157,000 under five deaths and 45,000 new born deaths annually.
[2] National Bureau of Statistics, 2011, Demographic and Health Survey.
[3] Government of the United Republic of Tanzania, Ministry of Health and Social Welfare (April 2008). National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008-2015.
[4] Vlassoff, M, S Singh, JE Darroch, E Carbone and S Bernstein, 2004, Assessing costs and benefits of SRH interventions, Occasional Report, New York: The Allan Guttemacher Institute, No 11..

Tabora region is the largest of the 26 regions in Tanzania and is located in the central-western part of the country. The area of Tabora is 76,151 km² (approximately 9% of Tanzania) of which almost 70% is forest and game reserve. It is one of the most isolated and under-resourced areas of the country. Most economic activity in the region is agriculture, notably subsistence farming. Tabora forms part of the Western Zone (along with Kigoma region) and ranks at the bottom for most health and education measures. The region exhibits high levels of structural inequality which have a direct bearing on MRH outcomes with sixty-six per cent of the population in the region is in the lowest two wealth quintiles compared to the national average of 40%.[5] Polygamy is most prevalent in the Western zone with approximately one third of marriages polygamous.[6] This contributes to high levels of fertility; the Tabora region has the highest fertility rate in Tanzania at 7.1, well above the national average of 5.4 and 6.1 for rural areas.[7] Educational attainment in the region is the lowest in the country with 42% of women and 34% of men having never been to school.[8] In 2010 in Tabora region, only 18% of married women use modern contraception, 54% of women delivered at home and only 46% of women are attended by a skilled provider.[9] Adolescent pregnancy was also high in the region; approximately 29.5% of girls aged 15-19 in Tabora region had a live birth or were pregnant at the time of the last TDHS in 2011.[10]

The TABASAM project has addressed health system weaknesses, at community, facility and management levels, and fostered linkages between formal facility-based health services and communities through the achievement of the following intermediate outcomes between 2012 and 2015:

- Increased utilization of Maternal and Reproductive Health (MRH) services by women and adolescent girls in target communities.
- Improved quality of Maternal and Reproductive Health services at government health facilities in target districts.
- Strengthened management and accountability for Maternal and Reproductive Health services in Tabora region.

Identification of stakeholders

Government of Tanzania

The Government of Tanzania, specifically the Ministry of Health and Social Welfare (MoHSW), was the main project partner. At the regional level, this partner facilitated the implementation of the project and aligned activities with government workplans; mobilized local community and volunteer groups; and, provided local health information data as needed. The local government authorities in Tabora region promoted awareness of and cooperation with TABASAM activities amongst health workers.

[5] Ibid.
[6] National Bureau of Statistics,, 2011, Tanzania Demographic and Health Survey.
[7] Ibid.
[8] Ibid.
[9] Ibid.
[10] Ibid.

Tabora Regional Health Management Team (RHMT) and Council Health Management Teams (CHMT)

RHMT and CHMT were the key partners in Tabora through which Tabasam implemented interventions associated with improving quality of health services and governance and accountability of maternal and reproductive health services. Tabora has one RHMT that coordinates and guides the provision of health services in the Tabora region, which is located in the town of Tabora, the largest city in the region. CHMTs manage and deliver health services at the district level. There were six districts in Tabora at the beginning of the project (Igunga, Nzega, Uyui, Tabora Urban, Sikonge and Urambo) with Urambo being split into two adding Kaliua for a total of seven districts. Tabasam staff were embedded in each of the district medical offices and worked closely with District Medical Officers.

Non-governmental organizations (NGOs)

Three NGOs were contracted to conduct community score card activities in the selected 30 communities. These NGOs are Tabora Development Foundation Trust (TDFT) implemented CSC in Uyui, Tabora Centre for Advocacy Development (TACEDE) in Igunga and Women's Economic Group Coordinating Council (WEGCC) in Nzega district from December 2013 to February 2015.

Project beneficiaries

The project had a positively impact on 1,766,649 women, adolescent girls and newborns, their families and communities in the Tabora Region; 6 Council Health Management Teams (CHMTs) the Tabora Regional Health Management Team (RHMT), 375 health workers and 983 Community Health Workers.

DIRECT BENEFICIARIES	**BENEFICIARIES**
Women and adolescent girls of reproductive age (15-49 yrs)*	511,399
Newborns *	81,844
RHMT/CHMTs members	70
Health workers	375
Community Health Workers (CHWs)	983
CHW Supervisors	178
VSLA members	2839
Community-based Trainers	150
CSO partners (organizations)	3
SUBTOTAL	**597,841**
INDIRECT BENEFICIARIES	**NUMBER**
Families (including men and boys)	1,057,213
Children under 5	111,595
SUBTOTAL	1,168,808
TOTAL	1,766,649

(*from 2012 Tanzanian Population and Housing Census)

Total amount of CIDA and other investments (CDN)

Please see financial report.

Governance Structure

CARE Canada bore the overall legal responsibility for the project, and was responsible for abiding by all contract terms and conditions. In addition, CARE Canada bore the overall responsibility for project management, administration, implementation, and quality assurance – including narrative and financial reporting to CIDA and other stakeholders. It served as the primary liaison with CIDA, and participated in the Project Steering Committee (PSC). CARE Canada brought specialized technical assistance to the project, particularly in maternal and reproductive health, gender equality and results-based management. CARE Canada also facilitated the sharing of best practices and lessons-learned generated by the project with other Canadian NGOs and partners implementing projects through the CAN-MNCH network of which it is a member.

CARE Tanzania had responsibility for implementation of the Tabasam project. The project utilized the expertise of the monitoring and evaluation team, human resources unit and the finance unit within CARE Tanzania (in Dar es Salaam). The key staff (e.g., Country Director, Assistant County Director-Program, Maternal /SRH Technical Unit Director, Program Quality and Learning Coordinator, Gender Advisor, and Accounts Manager) based in CARE's Country Office in Dar Es Salaam played key roles in project implementation and oversight.

In Tanzania, a project team based at the CARE Office in Tabora region managed the overall project. This team was comprised of a Program Coordinator, who was directly responsible for overall project management and implementation. The Program Coordinator was supported by a Deputy Program Coordinator, Program Accountant, Program Administrator, M&E Officer, Administrative Assistant and Office Assistant. Nine Program Officers and six Program Managers were based in each of the six district health offices in Tabora. The project also engaged seven drivers, one for each district plus one for the central office in Tabora. A total of 29 CARE Tanzania field staff were responsible for implementing and supporting TABASAM project strategies in the six districts of Tabora region.

The CARE team worked closely with Jhpiego personnel assigned to support health worker capacity building in the 178 TABASAM supported health facilities. Jhpiego engaged a Program Manager and Program Officer based in Tabora were the primary focal points for the TABASAM project. The Program Manager participated on the Project Review Committee (PRC). The Senior Technical Manager, M&E Officer and Midwifery Advisor also provided support from Dar es Salaam. Jhpiego's Country Director was the primary focal point at national level for the project and also participated in the PSC.

Project structure using WBS

WP 1000: Improved access to and utilization of MRH services	**WP 2000:** Improved quality of MRH services	**WP 3000:** Improved management and accountability for MRH services	**WP 4000:** Project and knowledge management
1110 Support communities to develop gender-sensitive emergency transportation, communication and blood donation plans (output 1.1.1) 1120 Train selected communities to conduct maternal death reviews and report to facility (output 1.1.2) 1130 Train identified community health workers on MRH (output 1.1.3) 1210 Train community facilitators on community dialogue methodologies (SAA) (output 1.2.1) 1220 Facilitate the participation of women, men, female and male adolescents in community dialogues (output 1.2.2 – no activity associated. Measured at baseline/endline) 1230 Sensitize (through knowledge and skills building) women and girls to participate in community decision making (output 1.2.3) 1240 Develop and adapt MRH IEC/BCC messages (ensure gender and youth friendly) 1310 Train male and female adult and youth community based trainers in Village Savings and Loans (VSL) methodology (output 1.3.1) 1320 Form new and strengthen existing VSLA groups in communities (output 1.3.1)	2110 Train Health workers on FP, ASRH, and BEmOC, including communications skills (output 2.1.1) 2120 Train health workers in communication skills for FP/SRH services appropriate to women, men and male and female adolescents (Added to achieve output 2.1.2) 2130 Train staff in selected facilities to conduct maternal deaths reviews (output 2.1.3) 2140 Print and distribute current obstetric emergency guidelines to health facilities and supply equipment selected health facilities (output 2.1.4) 2150 Strengthen emergency referral system (output 2.1.5) 2160 Train health workers in primary data collection, reporting and utilization of data for analysis and planning (output 2.1.6) 2210 Establish mechanism for accountability dialogues between the community and health workers (output 2.2.1)	3110 Facilitate and support planning and review meetings with CHMT, RHMT and implementing partners (output 3.1.1) 3120 Support CHMT, RHMT and R/DCDO to address gender issues in district planning and review meetings (output 3.1.1) 3210 Facilitate supervisors to prepare written feedback during (or post) supervision visits (output 3.2.1) 3220 Train RHMT and CHMT personnel in RBM methodology, evidence based, gender-sensitive planning, budgeting and management as informed by district HMIS and community data (output 3.2.2) 3230 Provide logistic forecasting and management training to CHMTs (MOH Integrated Logistic Systems) 3240 Train RHMT and CHMT members in primary data collection, reporting and utilization of data for analysis and planning (output 3.2.4) 3250 Strain CHMT members on supply and commodity chain management (output 3.2.5) 3310 Facilitate interface meetings between communities, health workers and local government (output 3.3.1) 3320 Support CHMT, RHMT and others to address gender issues in CSC and community interface meetings 3330 Monitor follow up of joint action plans developed during CSC interface meetings	4110 Project inception (completed) 4120 Project baseline and endline surveys (including health facility assessments) 4130 Financial and administrative management and reporting 4140 Performance monitoring and reporting 4210 Assemble tools and technical materials (ensure gender, governance and environment incorporated) 4220 Strengthen technical capacity on project components (implementing partners and CARE personnel) 4310 Foster regional sharing between other health projects under the Muskoka umbrella 4320 Inform national maternal and reproductive health policy and guidance 4330 Conduct annual partner review meetings

3 Project Context

Recognizing that reduction of maternal, newborn and child deaths is a high priority for Tanzania, the government has put in place a number of enabling policies to strengthen health services with a special focus on MNCH and MRH interventions. The Tanzania Development Vision 2025 strives for high quality livelihood for all Tanzanians. Its objectives include ensuring access to quality reproductive health services for all individuals of appropriate ages, reducing infant and maternal mortality rates by three quarters of current levels, providing access to quality primary health care for all, enabling food sufficiency and food security, and promoting gender quality and empowerment of women in all health parameters.

The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015 (The One Plan) was launched in April 2008 and aimed to reduce maternal mortality by three-quarters from 578 to 193 deaths/100,000 live births and neonatal mortality to 19 deaths/1,000 live births by 2015. The One Plan addressed the issue of human resource shortage for health through the improvement of employment, deployment and retention of workers at all levels of care as well as capacity building to health workers (both supervisors and service providers) on maternal, newborn and child care including family planning and nutrition. Furthermore, issues of essential equipment and supplies, infrastructure and referral system at all levels were given priority.

In an effort to improve maternal health situation and reaching the MDG5 targets, in May 2014 President Jakaya Kikwete launched the 'Sharpened One Plan' (2014-2015) to accelerate progress on reduction of maternal, newborn and child deaths. The emphasis of The Sharpened One Plan is on access to and quality of family planning services, care at birth and commodity security to maximize health outcomes for women and children. It also underscores the critical need to strengthen accountability and monitoring mechanisms as well as reinforcing partnerships for social mobilization, funding and technical assistance. The president also launched the Reproductive, Maternal, New born and Child (RMNCH) Score Card, that has been developed to track progress of key RMNCH indicators at both national and sub national levels. The score card focuses on a number of MRH indicators with clear targets for each. The aim is to motivate officials to identify areas of weaknesses and take action to ensure mothers and children don't die due to causes that can be prevented.

There are two types of primary health facilities in Tanzania: dispensaries providing a basic range of curative and maternal and child health care, and health centers, offering inpatient and a higher level of delivery care and staffed by a wider range of more qualified health workers. A dispensary is expected to provide services a population of 6,000 people while a health center covers for 50,000 people which is approximately the population of one administrative division. The district hospital is a very important level in the provision of health services in the country, in fact each district is supposed to have a district hospital. Regional Hospitals offer similar services like those agreed at district level, but they have specialists in various fields and offer additional services which are not provided at district hospitals. The

health sector is a priority area of the 'Big Results Now' initiative in a bid to fast track national development improvement for 2015-2018. The four priorities for health system strengthening component of the Strategy are consistent with the TABASAM Project's priorities: 1) equal distribution of skilled health workers from the lower level of primary health care, 2) quality delivery of services, 3) availability of important drugs and health equipment, 4) strengthening reproductive health of mother and child by reducing at least 60 % of mortality rate by the year 2018. All these goals require great effort from the community, the MOHSW, local government, development partners and the private sector and merge closely with the TABASAM's program and activities.

4 Project Implementation

This section describes the project implementation from September 2012 until April 2015. As a final report, it provided the cumulative achievement of the project activities but also highlights some of the results and activities accomplished during year 3 of implementation.

Outcome 1: Increased access to, and utilization of Maternal and Reproductive Health services by women and adolescent girls in six districts

Output 1.1.1 Obstetric and emergency transportation and communication plans are organized by communities (year 3 activity)

Indicators	Target	Endline	% Achieved
# of communities with functioning EmOC plans	101 villages	101 villages	100%
# of women who use EmOC transportation	12/vehicule/month	0	0

In 2013 the MoHSW of Tanzania placed a moratorium on the purchase of new motorized tricycles for emergency transportation until a design flaw from the previous procurement could be fully examined. This meant that Tabasam was not approved to purchase the 101 tricycles originally planned for and cause some delay in implementing the emergency transportation and communication plans. The issue was discussed at the Project Steering Committee (PSC) in November 2013 and it was agreed that procurement of tricycles would need to start in early 2014 or an alternative would need to be identified. The alternative plan was initiated in early 2014 and Tabasam consulted extensively with the CHMTs and RHMT who recommended the purchase of 16 modified Suzuki Maluti vehicles. The project had to then undertake another approval process with the MoHSW and development a procurement process. The vehicles were finally purchased and distributed in early 2015. Each vehicle cost approximately US$ 13,000. These vehicles were distributed to 16 dispensaries servicing a total of 44 dispensaries and 102 villages. Two vehicles in Tabora Municipal will serve all 24 dispensaries and 29 wards in the district. The facilities selected had to satisfy the following criteria: remoteness, high maternal mortality, high birth rates, poor communication and distance from referral facilities.

The Regional Administrative Secretary (RAS) is the contractual responsible officer and responsible for their operation and maintenance including, fuel, insurance and the driver's salaries. However, each village developed an emergency transportation plan that includes a community contribution thru the construction of a garage, the creation of a Social Fund for emergency fuel allocations and the provision of the driver. Community drivers received one day of training on the medical equipment within the vehicle as well as how to complete the logbooks.

District	# Emergency Vehicles	# Facilities Served	# Villages/Wards Served
Tabora Municipal	2	24	29 wards
Sikonge	2	2	9 village
Urambo/Kaliua	3	4	13 villages
Uyui	3	8	26 villages
Nzega	3	3	8 villages
Igunga	3	3	17 villages
Total	**16**	**44**	**102**

Because of the delay in procurement and dispensing of emergency vehicles, the project did not have time to start logging the number of emergency transports conducted by each vehicle. Log books have been created and are in each of the vehicles and they report to the CHMTs on a regular basis.

Output 1.1.2 Selected communities trained on conducting maternal death reviews (MDR)

Indicator	Target	Endline	% Achieved
# of CHWs trained on reporting maternal deaths (Maternal Death Notifications)	438 CHWs trained	983 CHWs trained (443 men, 540 women)	214%

Training on reporting of maternal deaths was incorporated into the training of all CHWs (output 1.1.3). CHWs have been trained to report on maternal deaths in the community to the health facility where maternal death reviews are conducted by health workers.

Output 1.1.3 Community Health Workers (CHWs) conducting focused MRH education to women, adolescent girls, and other household members

Indicator	Target	Endline	% Achieved
# of home visits conducted by CHWs	4/month/CHW = 70,776	263,079	371%
# of community education sessions conducted on MRH issues	4/community/month	122	100%

The Community Health Worker (CHW) program was one of the key community interventions introduced by the project beginning in September 2012 with the recruitment of CHWs. CHW were selected based on specific criteria such as being a role model for the community members, able to read and write. Tabasam organized a CHW Strategy Intervention Meeting in February 2013 and invited a range of participants including the Regional and Community Management Team (R/CHMT) members and CHW district coordinators to plan the CHW program in four key areas: family planning and adolescent health, antenatal care (ANC), child birth at facility and post-natal care. During this meeting the roles and responsibilities of CHWs were discussed and operational issues around rolling out the program were determined. At this meeting the number of CHWs and their associated coverage was determined based on information from the districts and included considerations such as population size and proximity to services. It was deemed important to have a linkage between the health facility and the community health worker, provide supervision support to CHWs and incentives to support the work of CHW. Following this meeting, the CHW strategy was refined and put into action with training of CHW taking

place over a six month period and conducted by Jhpeigo. The CHW program was set up using the 2012 MoHSW *National Integrated Community Maternal, Newborn and Child Health Guidelines* developed in collaboration with Jhpeigo.

In October 2013, the Tabasam project selected and trained 60 Training of Trainers (TOTs) for four weeks based on the national curriculum and the *Integrated Community MNCH Trainers' Guide*. Those trained to be TOTs were qualified medical practitioners (nurses or clinical officers) from Tabora and had some experience on maternal and reproductive health. The selected CHW participants attended a three week government-accredited CHW training program according to the *National Integrated Community MNCH Training Package* (includes manual for CHW and job aides and IEC materials) including two weeks of classroom training and one week of practical training at the community level at the end of 2013. The training covered antenatal, postpartum and newborn care, family planning, how to plan community based MNCH activities, referral system, maternal death reporting (output 1.1.2), reporting and monitoring of community MNCH services. At the end of the training the CHWs received a certificate of attendance signed by the Tabasam project representative and a government official. In addition 178 supervisors, medical professionals from health facilities, were also to support the 987 CHWs.

The CHWs began operating in October 2013. Tabasam provided CHWs with tools including gum boots, an umbrella, t-shirt, a backpack, bicycle, referral forms, report forms, registers and a job aid. The CHWs also received markers and flip-charts for their community mapping exercise. In addition each CHW received a monthly allowance of TSHS 15,000 (US $8) to cover communication and transport costs.

Each health facility was taken as a reference point upon which selected villages within the facility's catchment area would have affiliated CHWs. Initially 889 CHWs were selected which was later increased to 983 covering 473 villages in the 6 districts. The CHWs are linked to the health facilities in which the 178 CHW supervisors are based. CHWs began their volunteer work which consisted primarily of conducting household visits, issuing referrals participating in community meeting at the village or sub-village level, completing their registers and submitting end of month reports directly to the supervisors. Because of the shortage of staff at the health facilities to which they are attached, CHWs also began to spend more and more time assisting at the facility itself as well as supporting government sponsored vaccination and other campaigns.

CHWs did not work in all villages and wards served by each of the Tabasam-supported facilities. In some instances, CHWs may be working in 60% of the villages covered by the health facility catchment area, in other instances it might only be 20%.The initial project design focused on the selection of approximately 1,000 CHWs to support 180 health facilities - or approximately 5 CHWs/facility. In total the CHWs covered 483 villages in the region.

Number of Health Facilities and CHWs/district

	Nzega	Igunga	Tabora Urban	Uyui	Sikonge	Urambo	Total
# Facilities	36	35	24	38	19	26	**178**
# CHWs	190	168	179	174	108	110	**929**
Average CHW/facility	5	5	7	5	6	4	5

CHW Supervision

The supervision of the CHWs was a quarterly activity. Depending on the size of the district and the number of CHWs, the activity last from 1 to 4 weeks. It took place at the health facility and lasted for minimum with of 3 hours. The TABASAM staff were accompanied always by the District Reproductive and Child Health Coordinator (DRCHCo) and frequently by other members of the District Health Management Team (DHMT) including the MTUHA Coordinator, the District Nursing Officer and the CHF Coordinator. The visits serve several purposes, to:

- validate the data collected by the CHWs;
- discuss experiences and challenges faced by the CHWs and identify areas where CHWs needed ongoing support (i.e. completing registers);
- verify CHW receipt of monthly payments; and,
- conduct supportive supervision of home visits to assess quality of CHW counselling.

Payments for CHW were somewhat dependent on performance. Therefore, if a CHW was performing poorly or not truthfully filling out monthly reporting forms, monthly allowances could be withheld.

Refresher Training (Year 3 Activity)

Approximately a year after the initial CHW training, a refresher training for CHWs was conducted in all six districts in October 2014. CHWs were divided into groups of 30-35 with 2 trainers for each. Training took place over two full days. Tabora Urban included CHW Supervisors as participants. The refresher training focused on data collection and review of core responsibilities. Each district emphasized particular topics depending on the district needs (identified thru the quarterly CHW monitoring visits, discussions with CHMT members, Supervisors and other health personnel). In Uyui, for example, the emphasis was clearly on data collection. CHWs received training on filling in the registers, the monthly summary and census forms and the importance of an ongoing "mapping exercise" of their catchment areas. They were also reminded of the danger signs for pregnant and post-delivery women as well as those for infants and the children under-five. There was also a session on strengthening communication and counselling skills aimed at encouraging behavioural change. All districts identified "developing Action Plans" as a primary deliverable.

Output 1.2.1 Community members and leaders mobilized to participate in community dialogues

Activity cancelled.

Output 1.2.2 Women and adolescent girls enabled to make decisions about their MRH needs

Indicator	Target	Endline	% Achieved
% of women and girls reporting autonomy to make decisions on family planning	10% increase	85% (>30% increase from baseline)	100%

During the household survey, 85% of women responded that they have the autonomy in the use of the family planning and are able to tell their husband/partners that they want to use family planning. This proportion is high in all districts and demonstrates how women acquired agency on the choice of the FP method in comparison with the baseline which was reported at 53%. In addition about two third of the women reported that they will be able to use family planning methods despite the disapproval from their husbands. The focus group discussions with women and men revealed mixed feelings about the level of autonomy and decision making that women can regarding maternal and reproductive health. While on the one hand, men and women seem to decide together on maternal and reproductive health issues, the continued dominance of men in the decision making and control over household matters including the maternal and reproductive health issues is still present. What this means is that women creatively find space to decide on their maternal and reproductive health issues in a ways that does not conflict with their position in the society. It explains why there are cases where women use family planning secretly without involving their husbands.

"We have the power to decide, I can decide to go for checking my health status…Yes I can make my own decisions, I can go for the checks up even if he [partner] does not want and I come back home to give the feedback." (FGD Female, Igunga, 2015)

It's not possible, we have to discuss together, for example the number of children, the women cannot decide on that like to have two children without discussing with the husband, you all have to decide" …."She can't decide, it's a must to discuss the budget on food, clothes and everything… In our tribe a woman cannot make decision because she is under a man…So women from our society do not have any say." (FGD Male, Igunga, 2015)

Interestingly, men are increasingly accompanying their partners for ANC services mostly during the first visit because of the obligatory HIV test, and few in subsequent visits. However the same men are still reluctant to allow women to engage in maternal and reproductive health and household decision making. Addressing maternal and reproductive health issues that are embedded in the social and cultural norms often entails a complex process which demands for long term programming, while short-term interventions only touch on the most superficial issues of gender equality. CHWs have played an important role in promoting increased access by women and adolescent girls to health facilities and encouraging family planning.

Output 1.3.1 Existing VSLA groups strengthened and new VLSA groups formed

Indicator	Project Target	Achievement to March 2015	% Achievement end of project
# of new VSL groups formed	95	84 new groups	88%
# of VSLAs groups that are trained on MRH issues	122	124	100%

Under TABASAM, Village Savings and Loan Associations (VSLAs) are primarily a means for improving access to MRH services through empowering vulnerable women and adolescent girls to overcome the financial barriers to accessing such services. VSLAs are also platforms for delivering MRH health education on various aspects including family planning, childbirth preparedness, male involvement and emergency obstetric care. During the April 2012 and March 2013, the project identified 58 new VSLA in Igunga, Nzega and Uyui and 37 existing groups were mapped in Igunga and Nzega districts. Formation of VSLA groups involves the processes of conducting preliminary meetings from districts to village level.
This stage of formation has been finalized. It involved Community Development Officers, DRCHCOs, Ward leaders and community leaders of respective villages. The mail role of these partners was to mobilize and sensitize the community to form Village savings and loan association through community meetings. By the end of the project, Tabasam established 84 new VSLA groups and enhanced the capacity of 37 already formed VSLAs. The project supported 124 VSL groups with a total membership of 2,839 of which 930 (33%) are men and 1,909 (67%) are women. Integrating MRH activities into the VSL groups was a major activity for the project. There has been a total of 455 MRH education and awareness sessions conducted with the VSLA groups. The sessions were conducted by CHWs and by CHMT members and health facility personnel. The major topics were: family planning, the purpose and importance of ANC visits and danger signs.

Outcome 2: Improved quality of maternal and reproductive health services at government health

Output 2.1.2 Health workers trained in FP/ASRH and BEmOC

Indicator	Target	Endline	% Achieved
# of health workers trained in BEmONC disaggregated by sex and cadre	364	375 (138m, 237 f)	103%
# of health facilities receiving one post BEmONC training visit (mentoring/ coaching) during the project	180	192	106%

Health workers Disaggregated by Sex and district

District	Male	Female	Total
Igunga	24	28	52
Nzega	37	47	84
Sikonge	7	33	40
Tabora Urban MC	16	57	73
Urambo	19	27	46
Uyui	28	38	66
Kaliua	7	7	14
Total	**138**	**237**	**375**

Using the National Learning Resource Package for BEmONC, Tabasam (Jhpeigo) conducted Basic Emergency Neonatal and Obstetric Care (BEmONC) clinical skills training to health care providers and supervisors as well as provision of post-training follow up, mentoring and coaching. The first BEmONC trainings were held in 2013 where a total of 268 health care workers from the 178 health facilities supported by Tabasam were trained. The project anticipated training 364 health care workers but many health facilities were only staffed by Medical Attendants who are not sufficiently qualified for the BEmONC training according to the MoHSW. Tabasam made several requests to train Medical Attendants on BEmONC but were denied until the results of a pilot training were assessed. Therefore, the training was extended to skilled personnel in non- TABASAM facilities. Training for 96 health workers from Tabasam and non-Tabasam supported facilities took place in April and May 2014. Of the 107 trained, 20 were CHMT members and 41 from non-TABASAM supported facilities.

Mentoring was conducted following the BEmONC training in order to provide on-site coaching and mentoring and to encourage adherence to the national standards for quality BemONC service delivery. Specifically the mentoring focused on clinical decision making, infection prevention control, partograph use, active management of third stage labour, essential newborn care and postpartum care and management of various obstetric complications. All facilities received at least one visit after the equipment was distributed in September 2014.

Through June to September 2014 Tabasam staff also conducted training and mentoring on BEmONC with CHMT members in all districts. In cases where health facilities lacked supplies, these would be

distributed. In addition a two meeting was held at the Kitete Hospital with R/CHMT members from all seven districts in attendance.

District	CHMT Mentors	Facilities Visited	Health Workers Trained	Supplies distributed
Igunga	DRCHCo, DNO,	35	62	500
Nzega	DRCHCo, DNO	36	56	1,600
Sikonge	DNO, District Lab Coordinator, MTUHA Coordinator, DRCHCo	19	45	380
Tabora Urban	DRCHCo, DNO	22	27	-

The mentoring covered the following areas:

a. distribution an orientation on partographs to plot contractions and monitor labour progress;
b. ensuring the availability of an emergency tray in each facility
c. promoting hygiene, infection prevention and ensuring the existence of a placenta pit
d. reviewing how to manage eclampsia, malaria, anemia and folic acid deficiency
e. ensuring the existence of a referral action plan (medical criteria, contact list, transportation options, fuel availability)
f. reviewing national MDR guidelines

Finding from mentoring showed that facilities continued not to use partographs to monitor labour and a general lack of emergency trays. Every facility was required to develop and action plan during/following the training. Although they differed slightly by district, the main components were as follows:

- Preparation of the emergency tray (and a commitment to monitor its contents and resupply it frequently).
- Review and updating of emergency contact list – including numbers and contacts for the district (and regional) hospital. This also included an emergency transportation list of taxis, hired vehicles from community members.
- Emergency drug list and the identification of staff member tasked with the responsibility of ensuring a constant supply.
- Ordering process for partographs and other materials.

Output 2.1.3 Health workers trained to provide family planning services appropriate for women, men and male and female adolescents

Indicator:	Target	Endline	% Achieved
# of health workers trained on short-term, long-term or permanent family planning methods	270	290 (87 m, 203 f)	108%

Tabasam trained health care providers on short-term as well as long-term/permanent methods of family planning including SRH and communication skills appropriate to women, men and adolescents. Following Tabasam project staff consultative meetings with Tabora regional and district HMTs, it was agreed that family planning trainings on short-term methods were no longer a priority for the project as training were already supported by multiple donors. Consequently, the RHMT/CHMTs requested Tabasam to focus on long-term and permanent family planning methods. This request was approved at the PSC meeting in November 2013 and the family planning target was reduced from 364 to 270 due to the increased cost of conducting training on long-term methods. By April 2014, a total of 117 health workers trained on short-term methodologies, 155 on long-term methodologies and 18 on permanent methods (total trained = 290). The permanent training was provided to 9 pairs of surgeons and assistant surgeons trained on vasectomy and mini-laparotomy. As part of the in service training for long-term and permanent methods, 455 women have been inserted with Intra uterine devices and 1,082 women with implants. Some of these implants can be kept for many months until the woman decide to change her family planning decisions.

Distribution of FP training by sex

Training	Female	Male	Total
Short-term	85	32	117
Long-term	110	45	155
Permanent	8	10	18
Total	**203**	**87**	**290**

Output 2.1.4 Selected facility staff trained on conducting maternal death audits

Indicator	Target	Year 3 Achievements	Endline	% Achieved
# of health workers (and facilities) trained on maternal death reviews disaggregated by cadre/sex	335	190	375	111%
# of maternal death reviews conducted	100%	-	60-100%	60-100%

A Maternal Death Review (MDR) is a comprehensive assessment of the causes of and circumstances surrounding a maternal death within a health facility. MDRs contribute to improving the quality of maternal health services by examining the direct causes of death along with the cultural, institutional and other factors associated with maternal death. An MDR training was conducted as part of the

BEmONC training (output 2.1.1) to a total of 375 health care workers including 20 CHMT members from the seven districts.

Regarding the number of MDR conducted, an external evaluation showed a variation in results from one district to another. There is also variation wihin districts according to the health facility MDR process. In some cases, some health facility will conduct on a regular basis their Maternal Death Reviews, in other cases; it has been observed that not all the maternal deaths were rigorously reviewed following the procedures. More information about this indicator is provided under the Intermediate *Outcome 2: Improved quality of maternal and reproductive health services at government health facilities in the target district*

Output 2.1.5 MRH tools and equipment available at targeted facilities

Indicator	Target	Endline	% Achieved
# of MRH guidelines distributed	180	189	>100%
# of facilities receiving BEmONC equipment	180	181	100%

All Tabasam supported health facilities were provided with a package of national standard guidelines, including job aids, to improve quality BEmONC services. The tools were distributed through health facility participants attending the trainings in 2013. The package of BEmONC tools distributed to each health facility includes: BEmONC Participant's manual, BEmONC Checklists, BEmONC Job Aids, FANC quality improvement tool and Standards Based Management and Recognition Tool (SBM-R).

The equipment was distributed in three tranches between August and September 2014 to 182 facilities.

District	Total TABASAM-supported Facilities	Dispensaries	Health Centers	Hospital/non TABASAM facility	Total Facilities
Igunga	35	35	1		36
Nzega	36	35	1	1	37
Sikonge	19	23	3	-	26
Tabora Urban	24	24	1	2	27
Urambo	26	16	1	-	17
Uyui	38	38	1	-	39
Total	**178**	**171**	**8**	**3**	**182**

Equipment was also provided, at the Region's request, to the Kitete Regional Hospital and the Nzega District Hospital. One non-TABASAM health center also received equipment. Following the equipment delivery technicians went to each health facility to train health care workers on the equipment following which Jhpeigo conducted a Standard-Based Management and Recognition mentorship.

Output 2.1.6 Obstetric emergency referral system strengthened (year 3 activity)

Indicator	Target	Year 3	Endline	% Achieved
# of facilities with Contact list for emergency obstetric referrals available and updated regularly	100% of all facilities	97	178 facilities	100%
# of referrals made by CHWs to the health facilities	20% increase	2591 referrals/2 quarter	2591 referrals/2Q	156% increase
# of health facilities referrals	20% increase	>2000 referral/quarter	>2000 referral/Q	>100%

By the end of the project, all the facilities created a contact list for emergency obstetric referrals. The list has been used for health facilities referrals from dispensaries to health centers and to hospital in all 6 districts of Tabora. In the other hand, in 2012 and 2013, referral data was not collected rigorously and regularly at the health facility level as it was not a required indicator. The monitoring system has been improved throughout the implementation of the project and by April 2014, a data collection system was in place and in use by health staff. In fact, TABASAM emphasized the importance of having a successful referral system to the CHMTs and to advocate for closer monitoring and support of health facilities in this regard. Results show that more than 2000 ANC referral from dispensaries to health centers have been made in all the 6 districts. The number varied from one district to another (44 to 1120) according to its covered population but it definitely increased by more than 20% since the beginning of the project.

Finally, the referral system from the community (via the CHWs) to the health facility has also been problematic but improved over time; facility staff appreciated the CHW referrals as a good alternative to their system. Once the CHW program started (October 2013), the number of community referral increased.

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''Thank God for Tabasam introducing the program in our community" says Joyce Mayombo (CHW, Mwakabuta Health Facility, Igunga). *"Pregnant women and children were dying, it was so sad. But nowadays things are different; only few pregnant women are not attending ANC. As we know, changes need time. It's my hope that the remaining "reluctant few" will also change over time".* When speaking about her role as a CHW worker, Joyce says: *"I am not the same anymore - my status has changed. I am an important person in the lives of my community. They have been seeking advice on maternal issues, and when they notice any danger signs in an infant or a pregnant woman they come running for a referral. They value my advice which makes me feel proud of my work. They always want me to visit them regularly even if it's not the day for their visit: this shows me that they recognize my role and they need more education. They even ask me technical questions, and I always tell them to consult our nurse for more information. I can see hopes in their eyes ''* (Rolling Profile: 2nd Interview, 2014)

Output 2.1.7 Health workers trained in primary data collection, reporting for analysis and planning

Indicator	Target	Achievement	% Achieved
# of health workers trained on primary data collection and reporting, disaggregated by cadre and sex	150	247 (77m, 170f)	165%

In 2012 the Government of Tanzania introduced new health information system (HMIS) tools. The roll out through a Training of Trainers (ToT) was supposed to take place early 2013 and be completed within a few months. Delays in funding for the training and procurement of the HMIS (called MTUHA in Tanzania) resulted in an incomplete roll in out in many regions including Tabora. Throughout the region, the training reached only one-third of the target. In Nzega, for example, of the 520 employees from the Nkinga District Hospital and other health facilities identified for training, only 166 received it. Furthermore, the MTUHA books were not available on time and when they were eventually distributed many months later, many facilities did not receive them.

Tabasam staff undertook quarterly data audit visits to each facility starting in September 2013. Therefore, the project staff embarked on a series of visit aimed at strengthening the capacity of the districts to collect, store and analyze health data, assess the accuracy of the data collected and improve the tracking of health trends in the district. The visits were done in conjunction with the HMIS and DRCH coordinators. The observations from that first round of visits was alarming and resulted in a decision to provide MTUHA training to all Tabasam facilities in early in FY3. Data collection at the facility level improved significantly by the end of the project and health workers started to use the data to improve health services in a number of areas:

- Ordering of drugs;
- Planning and evaluating services;
- Identifying gap for health education; and,
- Measuring work performed and staff workload.

In April/May 2014, the staff conducted data quality audits in all facilities and recognized that while MTUHA books were now available, the lack of training at the facility level resulted in poor quality data entry. In the meantime, the project M & E Officer visited all health facility staff to assess their needs and performance. However, during the Year 3 Annual Workplan session, it was agreed by both Tabasam and district health staff, that formal training, at least to the Tabasam supported facilities would be conducted to complete the MTUHA roll out. Hence MTUHA training took place in all districts in October 2014 with specific attention to the books dealing with maternal health issues – books 6, 7, 12 and 13.
The objectives of the 4-day training were:

- To emphasize the importance of the timely collection of correct and reliable data (for the benefit of the community served as well as the nation as a whole)
- To learn how to correctly complete MTUHA books (the registers and tally forms as well as the summary report forms);

- To learn how to order new MTUHA tools. Most facilities were only provided with sufficient books until the end of April.

Representatives from all facilities were invited. The selection of candidates was based on whether they had not already received MTUHA training and whether they would be a focal point for data collection in their facility. The training was facilitated by Regional and District HMIS Coordinators, the Assistant DRCH Coordinators, and the District Nursing Officer.

Health Facility Staff Participating in MTUHA Training

District	Total Trained	Male	Female
Igunga	36	20	16
Nzega	48	16	32
Sikonge	30	11	19
Tabora Urban	39	8	31
Urambo	44	14	30
Uyui	50	8	42
Total	**247**	**77**	**170**

In addition to a general introduction to the HMIS manual, participant were taken through a number of modules which covered the following key sources of data collection for the : ANC register; Labour and delivery register; Infant and child register; Family planning register; Postnatal care register; Health staff register and Maternal death register. A final module focused on data quality and validation. It was widely recommended by participants that the district HMIS coordinator provide quarterly feedback to each facility regarding their report.

Some of the challenges noted were as follows:

- Continued lack of MTUHA tools (TABASAM printed 4,800 copies which were distributed in Sept/Oct 2014)
- The dependence on one health facility staff member to develop the end of month summary report. Facilitators suggested that the preparation of the summary should be done as a team activity to minimize data entry mistakes and clarify any questions/issues;
- Family planning tally sheets were difficult to complete since the numbers of condoms and cycles of pills provided to clients differs and is not constant.

Output 2.2.1 Mechanisms established for accountability dialogues between the community and health workers (This is a Community Score Card indicator)

Indicator	Project Target	Endline	% Achieved
# interface meetings	30	30	100%
# joint action plans developed	30	30	100%

The Community baseline survey conducted by Ifakara Health Institute in 2012 for TABASAM project showed that citizens were not happy with health services provided in government owned health facilities in the six districts of Tabora region. Sixty-seven percent of surveyed people complained about waiting for too long before being attended, 61% said they were not happy with regular stock outs of drugs and supplies while 62% were generally unsatisfied with labour and delivery services. More than a half of interviewed people were not satisfied with quality of health services provided by healthcare workers especially when seeking care from health facilities. Also, community members and healthcare workers were not sufficiently aware of clients' service charter of rights and the associated benefits. These were factors which contributed to low utilization of health services in Tabora.

To address and solve the problems mentioned above, TABASAM chose the Community Scorecard (CSC) as its main tool to promote maternal and reproductive health outcomes in the three districts of Igunga, Nzega and Uyui. Its main purpose was to improve responsiveness of healthcare workers in selected 30 health facilities to maternal and reproductive health needs of the community as well as to increase ability of Health Management Teams to manage and support MRH services. Through community scorecard process citizens were engaged in identification of their health needs, setting priorities, developing joint action plans which were then included in the district council plans and they were involved in monitoring implementation of the joint action plans at the community level.

Three local non – governmental organizations (NGOs) were contracted to conduct CSC activities in the selected 30 communities. These NGOs are Tabora Development Foundation Trust (TDFT) implemented CSC in Uyui, Tabora Centre for Advocacy Development (TACEDE) in Igunga and WEGCC in Nzega district from December 2013 to February 2015. The selected three NGOs (TDFT, TACEDE and WEGCC) were trained for four days on community scorecard methodology in December 2013 to build their capacities. They were also trained in policy analysis which was conducted in January 2014 for 2 days followed by the Outcome mapping method training in September 2014. Also, in February 2014 they were oriented for 2 days in Clients' service charter of rights. All these trainings focused to build their capacities on governance work so that they can perform their duties with the imparted skills.

Bearing in mind that community scorecard is a participatory monitoring and evaluation tool, a monitoring team assessed the implementation of joint action plans developed during interface meetings. The Action Plans developed during the interface meetings were robust and concrete. Participants identified 6-10 priority issues, the intervention to address the issue, and responsible person. Some of the common issues were: the provision of night security at the dispensary, the ongoing drug

and supply stock-outs; staff attitudes and behavior; lack of adolescent and sexual health information: the lack of health facility staff housing: the cost of transportation for referrals; and the charging of free health services by health staff. Communities were particularly angry about the fees charged for children under 5 and the elderly. One of the biggest challenges was convincing health workers that this was a process that could contribute positively to their work. A review undertaken by CARE Tanzania in November 2014 demonstrated how well the 3 implementing partners were able to overcome this concern and how health workers came to view it as an enriching experience. A 15-page Client Charter has been developed by the Ministry of Health in English and TABASAM funded the translation of a shortened "pamphlet". Several thousand copies were distributed throughout the region to all health facilities. Applying the client charter which describes community rights and facility obligations was one of the priorities of the CSC process in all 30 villages.

Outcome 3: Strengthened management and accountability for MRH services in Tabora Region

Output 3.1.1 Coordination meetings conducted in districts between HMTs and Stakeholders

Indicator	Target	Endline	% Achieved
# of coordination meetings by district	4 meetings per district/year = 48	50	104%

Through these coordination meetings, it has been demonstrated that CHMT made use of the health facility and CHW data for the planning and implementation of activities. The presentation of the quarterly MTUHA data is on every agenda. While there is recognition of ongoing weaknesses and that health facilities are still not collecting and documenting all interventions, the data is certainly sufficient to be able to identify trends such as an increase in facility deliveries, an increase in ANC visits and an increase uptake of family planning. TBA deliveries continue to be a concern. Although they are decreasing, the CHMTs understand that in some areas TBAs are well respected in their communities. The CHMTs are therefore in a dilemma as to how to handle the situation particularly in those in which there are no CHWs to sensitize pregnant women and their families about the importance of health facility delivery.

There has also been a positive shift in the CHMTs commitment to support the CHW program in 2015/6. Increasingly, the CHWs were viewed as a key delivery component of the health system - from visiting households and providing MRH information, collecting data on births before arrival (BBAs), TBAs and home deliveries, participating in district/regional vaccination to assisting health workers at the facilities. At the regional level, the RMO has insisted that CHWs must be integrated in the next round of CCHPs; at the district level, Igunga and Sikonge have already began the process of incorporating them into their 2015/6 budgets but most are waiting to see whether additional resources will be allocated from elsewhere.

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Dr. Philipina Philipo is the District Medical Officer for Sikonge and her comments about the project are typical of the feedback from other CHMT personnel throughout the region *"It is wonderful. I wouldn't have expected that the TABASAM project could implement what is now happening in my district. The*

CHW's intervention has filled the communities' gap of information. Now, thanks to the Tabasam project, the number of home deliveries and deliveries done by traditional birth attendants are captured and integrated into the new District HMIS monthly reports. This data did not exist before".

Within a short period of time, by having CHWs in the community attached to the health facilities, she has seen a noticeable positive impact. The number of antenatal (ANC) visits and facility deliveries increased, which means that the community is changing, and opting-into the heath facilities' services. CHWs are helping health workers to register clients and weigh pregnant women and babies at the reproductive child clinics. At the same time, they provide maternal and reproductive health education to households and in the clinic, which covers work normally overloaded to facility staffs.

"BEmONC and Family Planning training sessions offered by the project to the health facility workers actually helped build their confidence, knowledge and skills. This has helped improve the quality of services to the facility and they are managing pregnancy complications, which has reduced their referrals (as compared to peripheral dispensaries which are not under the program). That shows that there is a big impact from the community-level, up to the health-facility level, of the TABASAM project". She added, *"The quarterly review meetings which are facilitated by the project are the platform for the CHMT. They allow reflection by every unit to measure their performance and evaluate them if the quality of services delivered are or aren't meeting the required standards".* That's where the TABASAM project differs from other projects in the district. Through these meetings, partners and CHMT members are sharing experience and discussing challenges, for example related to supportive supervision visits. Together, they find collective solutions to tackle the problems. Also the units use the meetings to share forthcoming activities, which help with resource utilization. (from 2014 Rolling Profile: 2nd interview)

Output 3.2.1 HMTs mentored in effective supportive supervision

Indicator	Project Target	Endline	% Achieved
# of supportive supervision visits conducted	178	178	100%
# of supportive supervision visits conducted that integrate MRH issues	178	202	100%

Supportive Supervision has been a challenge for most Tabora districts. Part of the difficulty is due to a genuine lack of clarity on the part of the CHMT members of their supervisory roles and responsibilities and a lack of knowledge as to how to write up reports. The other challenge is the existence of multiple tools and checklists and a general confusion as to which is to be followed, what questions are to be asked and how to integrate all components of health services into a single supportive supervision visit. Consequently, between July and September 2014, TABASAM hosted 3-day workshops for CHMT members. The first was in Nzega for Nzega/Igunga, the second was in Tabora for Tabora Urban/Uyui and the third was in Tabora again for Urambo/Sikonge. The objective was to strengthen CHMT supportive supervision capacity. Each workshop was facilitated by Dr. Mgongo, the DMO from Nzega, who had attended the national supportive supervision training program under the MOHSW.
The results from the training were as follows:

- an agreed upon set of supportive supervision tools including checklists and logs (for dispensaries, health centers and hospitals) to be used throughout the region in all districts;
- guidance around how to write a post-supervision report (which included names and titles of facility staff, documentation review, gaps and feedback and signatures) which must be forwarded to the health facility and accompany the CHMT team at its subsequent visit to the facility;
- establishing holistic objectives and creating a conducive and supportive environment for the visit that facilitates a culture of communication and problem solving.

The general feedback from the participants has been very positive as it increases the effectiveness of this activity. As a result, the number of supportive supervision visits increased over time.

Facilities Receiving Standardized Supervision Visits during the April-September Period

District	# TABASAM-supported Facilities	# Supp. Supervision visits conducted in Year 3	% Achieved	# Supp Supervision visits to which TABASAM provided staff and/or fuel
Igunga	35	35	100%	30
Nzega	36	36	100%	14
Sikonge	19	19	100%	3
Tabora Urban	24	48	200%	48
Urambo	26	26	100%	26
Uyui	38	38	100%	3
Total	**178**	**202**	**100%**	**124**

Output 3.2.2 HMTs trained in RBM methodology for evidence based, gender sensitive planning, budgeting and monitoring

Indicator	Target	Endline	% Achieved
# of CHMT members trained in RBM	30	30	100%
# of CHMT members trained on gender planning	20	20 (8 F, and 12 M)	100%

In February 2015, the project hosted a workshop to integrate gender issues into district CCH plans. CARE Canada's Gender Advisor was engaged to prepare and facilitate the workshop in cooperation with the TABASAM Deputy Program Coordinator. The workshop involved eight female and 12 male participants from seven districts, including CHMT members and co-opted members such as Social Health Welfare Officers, Community Development Officers and District Health Secretaries. The objectives of the workshop were to improve their understanding of basic gender equality concepts; identify gender issues that can be addressed in district and regional health plan and explore ways of addressing these gender issues through practical exercises using past and present CCHP experiences.

Participants strengthened their capacity by:

- Undertaking a situational analysis and health priority setting (using a problem tree methodology);
- Setting district priorities, objectives, activities and cost analysis (using comparative analysis);
- Reviewing risks and assumptions (using the Gender Continuum);
- Conducting performance monitoring (using selected most significant change concepts).

The situational analysis looked at three gender issues:

- The social acceptable for women, but not men, to be involved in reproductive health
- The Gender dimensions of human resources
- Poor transportation infrastructure and distance affect women's access to health services more than men's.

In the evaluations, 78% of workshop participants stated that they would show their CHMTs how to integrate gender issues into district plans.

At least two male and four female participants act as CHM team gender focal points, and are responsible for ensuring gender issues are considered in CHMT plans. One of the goals of the workshop was to change the attitudes of fellow team members sufficiently to create an enabling environment for the staff. Fifty percent of participants who are not gender focal points made statements indicating that they will be in a position to provide passive or tacit support to gender focal points in the future.

Output 3.2.3 Logistics, IT and transportation support provided to CHMTs for supervision and monitoring visits

Indicator	Target	Endline	% Achieved
# of supportive supervision visits supported directly through the contribution of fuel and/or TABASAM staff participation	4 /quarter/district	4 to 5/ quarter/district	>100%
# of CHMTs with computers received from CARE	1 computer/district	1 computer/district	114%

Two hundred and two supportive supervision visits took place in year 3 which exceeded the target of 178 largely because 2 visits were made to each of the Tabora Urban facilities. Of the 202 supportive supervision visits made, 124 of them were supported by the project through the provision of fuel, vehicle or personnel. TABASAM provided fuel for any visit which includes one or more TABASAM facility. In the past, the project provided fuel only if the route focused entirely on TABASAM facilities. NGOs are working closely with CHMTs to collaborate more closely and to support "holistic" supportive supervision visits which address the full supervision checklist.

Output 3.2.4 HMT members trained in HMIS data collection, reporting and utilization of data for planning and monitoring services

Indicator	Project Target	Endline	% Achieved
# of CHMT members trained in HMIS disaggregated by cadre and sex	30	30	100%

In December 2013 Damax conducted an assessment of HMIS system in Tabora. The analysis was utilized to improve the situation and will ensure that the collected data meets quality and reliability standards. In January 2014 a workshop was held (facilitated through CARE Canada) for District and regional Reproductive and Child Health Coordinators, MTUHA Coordinators and Data Entry Clerks. The workshop

focused on data analysis and the use of data for planning purposes. In the same quarter, TABASAM staff began to monitor/audit the data collection process at the facility level. In addition, the M & E Manager visited all health facilities in Igunga, Sikonge and Urambo to collect all relevant data in conjunction with the health facility in charge, the DRCHCo and the HMIS Coordinators. Based on his mentoring of heatlh facility staff, and in consultation with the RMO, Tabasam agreed to train 150 health workers from Tabasam supported facilities on filling out the new MTUHA books.

Output 3.2.5 Supply and commodity chain management strengthened at CHMT and health facility level

Indicator	Project Target	Endline	% Achieved
# of facilities who receive commodity chain management from CHMT (specifically District Pharmacists)	178 facilities trained	178	100%

To be effective, a health facility needs to establish a logistics system that will:

- improve the quality of care by ensuring the quality and availability of health commodities; and
- improve health system cost effectiveness by reducing stock-outs, overstocks, wastage, expiration, damages, and the consequences of poor ordering skills.

One of the often repeated discussions at the CHMT meetings is how the TABASAM project can strengthen commodity chain management. With the support of the district pharmacists and lab technicians, the project used an assortment of methodologies to transfer skills to the health facility staff (see table below). The topics covered were very practical and included:

- Drug arrangements in store room;
- How to fill bin cards;
- Commodity forecasting;
- Filling in the commodity/drug order form;
- Isolation and storage of expired drugs; and,
- How to complete the ledger books.

During Q2 2014, the training in each district was conducted by the pharmacist and he/she was usually assisted by the Assistant pharmacist and lab technician. Health facility visits lasted half a day and often coincided with supportive supervision visit - and established a baseline for ongoing monitoring thru future site visits by the pharmacists. In the case of Urambo, the district decided to combine a shorter workshop with on-site mentoring.

Commodity Training Methodology by District

District	Methodology	# Health Facilities trained	# of HF staff trained
Igunga	Individual facility visits and on the job training over 3 weeks	35	80
Nzega	Individual facility visits and on the job training over 3 weeks	36	70 approx.
Sikonge	3-day meeting	19	27
Tabora Urban	4-day meeting	24	56 (2/facility plus 6 from Kitete)
Urambo	2-day meeting followed by onsite mentoring over 11 days	26	26
Uyui	Individual facility visits and on the job training	38	76

5 Performance Assessment

In order to measure progress on project performance and monitor ongoing program implementation, the project implemented mixed methodologies including qualitative and quantitative methods. The quantitative data come from a baseline study in 2012, an endline in April 2015 that included a household surveys to women with children under 2 years. Another source of information used was the Health Information System (MTUHA) for key health system indicators related to maternal and reproductive health. In addition, there has been a client satisfaction assessment in March 2015 that measured through exit interviews the level of satisfaction of MNCH services. For the qualitative method, focus groups discussions (FDGs) with women and men were also conducted at baseline and endline. Finally, rolling profiles are a qualitative tool for longitudinal study. The project conducted interviews with the same households/key informants periodically (every 6 months) across the life of a project. The section below represents the findings using these different types of data sources.

5.1 Immediate Outcome Achievements

Outcome 1.1: Increased access to MRH services by women and adolescent girls in target communities

Indicator	Target	Endline	Achievement
% CHW attrition rate by district	12%	Igunga 7% Nzega 10% Sikonge 7% Tabora Urban 5% Urambo 8% Uyui 5%	Achieved ✓
# of ANC visits*	50% increase	188% increase	Achieved ✓

* Baseline April 2014 – March 2012 and endline April 2014 to March 2015 to account for seasonal and other effects

Tabasam significantly increased access to maternal and reproductive health services by women and adolescent girls. One of the key reasons for this success was the CHW program implemented in over 473 villages. The CHWs are responsible for up to 60 households in their villages which can range from several households in village to hundreds of households in a few villages. Through a mapping exercise every six months the CHW identifies households (maximum 60) with pregnant women or women with children under-5 within their catchment area which they will plan to visit and provide information using a visiting schedule set out in their guidelines. On average the CHW spends between 3 to 24 hours a week carrying out the various roles above.

Rural catchment areas for CHWs are generally much larger and in urban areas the number of families per household is larger. It also appears that in urban areas, CHWs have many other competing interests for their time and dedicate lesser time to roles, while in rural areas CHWs are more available to dedicate more time to their roles. Although the CHWs were generally satisfied, the attrition rate remains very low. A total of 54 CHW (22 men, 31 women) dropped out of the program. Marriage, education and relocating were key reasons why CHW quit their assignments. In fact, most of the CHWs are very young and ambitious people, so it is normal that they will look after new opportunities. In fact, 20 CHWs

dropped out during this final six month reporting period, possibly because the project was ending and they started looking for other job opportunities.

Some of the successes of the program included:

- An increase in the number of men accompanying their partners to ANC and post-delivery visits
- A high degree of community acceptance and trust of CHWs particularly around family planning
- Household visits became one of the most effective methods of reaching people and the confidential one-on-one discussions between household members and the CHWs were valued
- CHW referral to health facilities worked successfully. The clinics are signing the referrals and the clients are returning them to the CHWs
- CHW support to health facilities such as client registration, weighing children and recording clinic cards

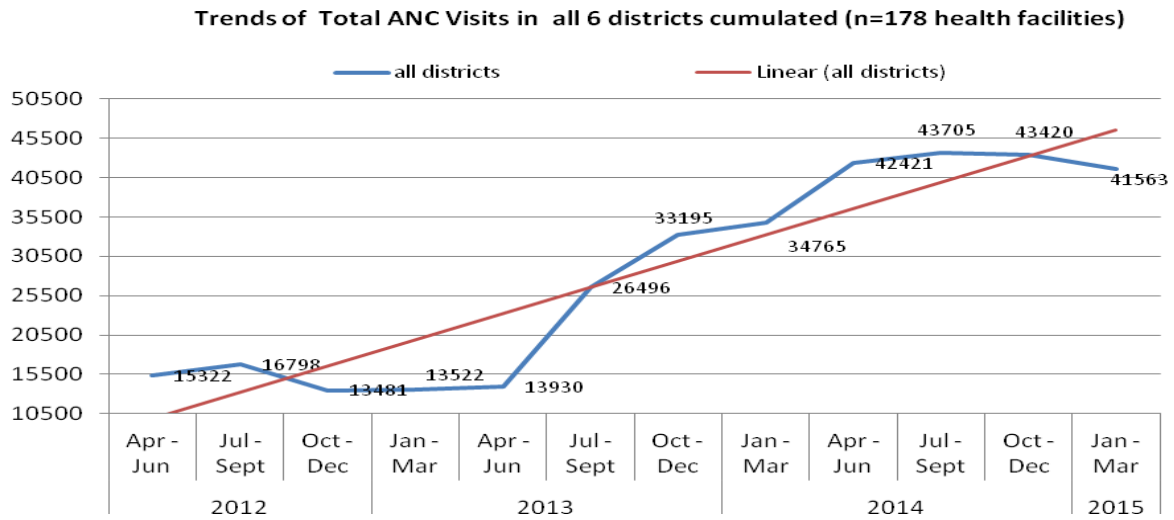
There have been a number of common challenges faced by CHWs:

- High turnover of health facility staff trained as CHW supervisors
- Long distances to health facilities for clients and the isolation of some facilities
- Infrastructure particularly roads are poor and difficult for CHW to access households in rainy season also difficult for community to access facilities.
- Sometimes CHWs are viewed as "nurses" or health professionals therefore the community does not understand their knowledge and skills limitations.

CHWs became a critical link between the dispensary or health centre and the community and a needed support for health care workers. One such example is Zainab Ibrahim, a CHW from Nzega who splits her time between the local dispensary and household visits in the village of Nyasa. *"I am so confident, now, more than ever, compared to last year when I started the Tabasam project. I can now stand before a crowd and speak with no fear. I am so glad that even the community I serve is not letting me down".* Zainab explained how she has transformed the previous status of the area she works; these days, the majority of pregnant women are able to attend 4 ANC visits. When pregnant women are referred to the district hospital, she follows up and gets feedback on their experience. Ms. Zainab spends 3 days at the Samora dispensary per week, which on those days hosts special clinics for pregnant women, child vaccinations and counseling and testing. She assists in registering clients, weighing children and provides MRH education. In one month, Zainab is able to visit 9 households of Nyasa, where she is located. Ms. Zainab is pleased with how well things are going in her working area, and very thankful that she is well supported and accepted by the community she serves. Even if the Tabasam project phases out, she doesn't expect to leave her position (Rolling Profile, second interview, 2014). Since Tabasam project was introduced to her locality, the number of home deliveries decreased from 3 to 0 and it's something she feels very proud of. The number of maternal deaths also decreased from 4 to 1 between 2013 and 2014. Neonatal death has also

decreased from 2 to 0, and children under five deaths are no longer reported in her area (previously there were 2-3 per month). On family planning services, Ms. Zainab elaborated that more women are asking for the services than men, and their requests are different: men only go for condoms and women asks for implants.

As a result of the CHWs, there was a dramatic increase in pregnant women attending ante natal care clinics. Looking at results from the health facilities in Tabora supported by the Tabasam project there was a 188% increase with 59,123 visits in 2012/2013 and 1780,109 visits in 2014/2015.



We also observed that a high percentage of women have some knowledge of danger signs during pregnancy (95%). This increased of knowledge happened through various channels including community health workers, proper counseling during antenatal clinics and improve quality of health services delivery. The community health workers were educating community members on the danger signs and the needs to deliver at the health facilities. This means that men and women are more aware of both risks associated with home delivery and the advantages of delivering at the health facility. This is evidenced by the following quote:

> *¨Women deliver at the health center because we are afraid when someone is pregnant and deliver at home it may cause problems. It is better for the complications to happen when the woman is at the health facility as she will be attended by health workers who know how to address the problem¨* (FGD Male Nzega, 2015)

Outcome 1.2: Increased knowledge and authority of women and adolescent girls to seek MRH services in target communities

Social Analysis and Action activity cancelled.

Outcome 1.3: Women have access to and control of financial resources

Indicator	Target	Endline	Achievement
% of VSL groups using social funds for MRH purposes	80%	82%	Achieved ✓

Village Savings and Loans (VSL) groups have been used as a vehicle for improving the financial autonomy of women, serving as a conduit for the discussion of MRH issues and providing emergency funding to support MRH needs through the Social Fund. The project supported 124 VSL groups with a total membership of 2,839 of which 930 (33%) are men and 1,909 (67%) are women. The Social Fund is the basket of non-refundable funds contributed in equal amounts by each member of a VSL group. Unlike other funds in the VSL group, social funds belong to the group and not to individual members. Its expenditure is guided by the group constitution under group leadership. During this project, a total of TSH 12,756,600 (approx. 7100 CAD$) was spent on MRH issues to support 362 individuals of which 283 were women and 79 were men. Mostly the social fund was used to pay for transportation costs related deliveries particularly referrals due to complications and the purchase of soap, gloves, kerosene, basins and birthing kits as families prepared for delivery.

Rehema Hamisi (32 years old) is a VSL member in Imalakaseko in Uyui district. During her second pregnancy, she had abdominal pain and went to Imalakaseko dispensary for a check-up. The doctor identified a possible risk and referred her to Kitete hospital. She was diagnosed to have ectopic pregnancy case and underwent an operation. By using 20,000 TSH (11CAD$) from the social funds, she was able to reach the district hospital and pay for the treatment costs. She had no personal saving that would have allowed her to pay for these expenses otherwise (Rolling Profile, first interview, 2014).

Outcome 2.1 Improved capacity of targeted facilities to provide MRH services to women and adolescent girls

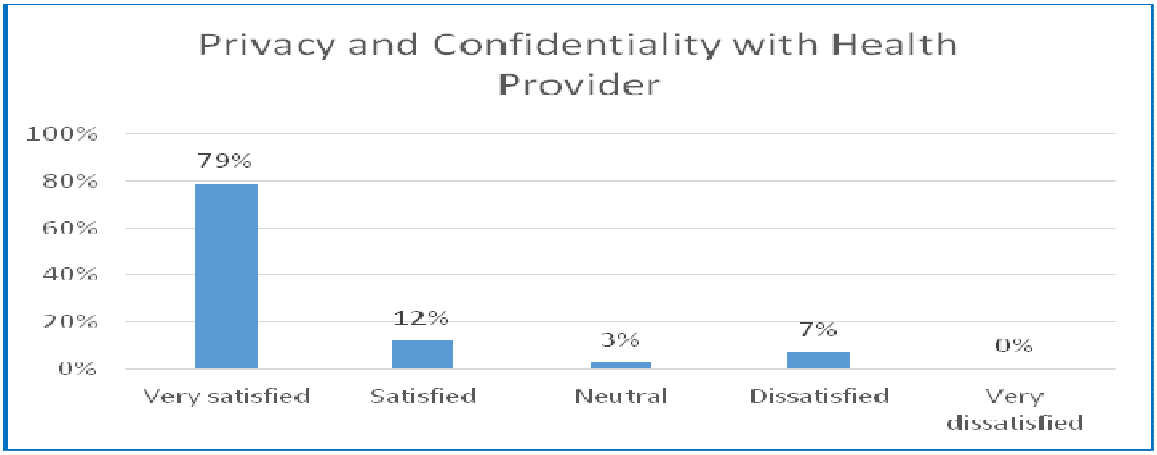
Indicator	Target	Endline	Achievement
% of health workers who achieve competency in MRH training package disaggregated by sex and cadre	Igunga 70% Nzega 77% Sikonge 41% Tabora Urban 48% Urambo 52% Uyui 76%	Short-term F/P Training Av. Results=62.8% Long-term F/P Training Av. Results=86.4% Permanent F/P Training Av. Results = 80.7%	Achieved ✓
% of facilities receiving BEmONC equipment through the project	178	182	Achieved ✓

Tabasam significantly improved the capacity of 178 dispensaries and health centres in Tabora to provide maternal and reproductive service to women and adolescent girls. A total of Equipment was distributed in August 2014 to 182 health facilities. At the request of the Regional Medical Officer, 4 non-TABASAM supported facilities were included in the distribution, thereby increasing distribution to 102% of the target. The hard-over was publicized through reports on the television news and in national newspapers.

Outcome 2.2: Improved responsiveness of health workers in the targeted facilities to the MRH needs of the community

Indicator	Baseline	Target	Endline	Achievement
% of community members reporting satisfaction with provider interaction	Women and men 56%	Women and men 80%	Women and men > 80%	Achieved ✓

TABASAM commissioned a study in February 2015 to look at client satisfaction in a sample of TABASAM facilities in each of the districts. Two of the issues examined were client satisfaction with provider interaction and confidentiality which is associated with service attitudes and behaviors. Most of the clients interviewed at the exit of their visit to the health center were very satisfied with the treatment received by health service providers. Clients appreciated the friendly service received; the information and education provided and the respect from health workers. The respondents were also asked if they felt that privacy and confidentiality was maintained when they visited the health provider. The diagram below shows the satisfaction based on privacy and confidentiality with health provider. In some cases, the physical structure of the health facility inhibited privacy. The labor room was shared for general consultation. Additionally, the top wall had a gap thus allowing for conversations to be heard in the waiting area. Overall, the clients generally felt comfortable with the health providers and could discuss issues of concern and felt that privacy and confidentiality was maintained. All respondents unanimously concurred to providing their consent to testing and receiving services.



Household survey and focus group discussions confirmed the results from the client satisfaction study. In fact, both male and female were satisfied with how the service providers have changed since introduction of TABASAM project. It seems the health care providers gained adequate knowledge and skills on how to provide services to mothers and their partners:

> *Due to availability of equipment at the health facility and the training provided to health providers, the personnel are well equipped with requisite skills, that means they have increased the knowledge and skills compare to the past.* (FDG,-IGUNGA, 2015).

Outcome 3.1: Increased ability of health management teams (HMTs) to coordinate and lead technical support and MRH services in the Tabora region

Indicator	Target	Endline	Achievement
# of actions agreed and implemented in consultative meetings which address MRH	4/district/year = 24 (Year 3)	45	Achieved ✓
# of health facilities reporting improvement in the technical support received from HMTs	60%	100%	Achieved ✓
% joint action plans implemented (health facility/community) CSC	30	30	Achieved ✓
# of CCHPs that incorporate support for the CHW MNCH Program	6	7 (including Kaliua)	Achieved ✓

There was a significant improvement in the ability of CHMTs to coordinate and lead technical support and maternal and reproductive health services in the Tabora region. With embedded CARE staff in each of the districts holding quarterly CHMT meetings to address maternal and reproductive health, concomitant MoHSW policies to strengthen maternal health, Tabora has now clearly prioritized this issue with regards to planning its health and social services. Each district at the quarterly CHMT meetings with Tabasam agreed to take action on key issues related to maternal and reproductive health. Below is a summary of those actions:

Leadership and Governance

- Implement a standardized approach to supportive supervision (all districts)
- Review issues which hinder women/girls access to maternal and reproductive health services (Igunga)
- Review causes of maternal and neonatal deaths and implemented recommendations (Igunga, Urambo)
- Examine the practice of using Traditional Birth Attendants (Urambo)
- Create policy for blood availability (3 maternal deaths at the district hospital in August/September 2014 due to lack of blood in the blood bank) (Sikonge)

Health Services

- Pay for CHWs through existing budgets or community health funds (all districts)
- Pay for fuel and drivers for the emergency transportation vehicles purchased by Tabasam (all districts)
- Construct a maternity ward at the district hospital (Igunga) and rehabilitate/construct dispensaries (Nzega)
- Ensure that there is kerosene for all autoclaves (Sikonge)
- Conduct family planning awareness campaign (Urambo)

Health human resources

- Hire additional staff for dispensaries (Nzega, Sikonge) with a goal to increase total number of health care workers in the district
- Create incentives to reduce staff transfers at health facilities (Tabora Urban)
- Create policy for Medical Attendants conducting deliveries when nurses are present and available
- Reduce staff negligence by providing written warnings and reprimands (Tabora Urban)
- Incorporate quality improvement into supportive supervision visits (Uyui)

Health information system

- Set target of 60% contraceptive prevalence up from 45% using HMIS data (Urambo)
- Increase number of deliveries at health facility and track using CHW and HMIS databases
- Conduct MTUHA training for all new employees (Igunga)
- Commit financial resource to improve data quality (Uyui)

Health financing

- Sustain VSL program through support from the DCDO office
- Increase community health fund to overcome drug and supplies shortage (Uyui)

Essential Supplies and Commodities

- Prevent stock outs of anti-malarial drugs for pregnant women (Igunga), round strips for haemoglometre and glucopus (Sikonge)
- Address the issue of drugs from government facilities being sold privately (Tabora Urban)

The CHMTs addressed a wide range of issues across the health system to improve maternal and reproductive health depending on the context of each of the districts. There was a clear commitment to improve the quality of maternal and reproductive health services. All facilities involved in the Tabasam project reported improved technical support from the CHMTs not only in terms of frequency but in the quality of support they received. All 30 of the villages involved in the CSC had significant involvement by the district councils and CHMTS. District councils provided approximately $15,000 in funding projects and supplies identified through the CSC process including water storage so that dispensaries could have a safe source of water for the health facility, generators and medical equipment.

All CCHPs except Tabora Urban have incorporated support for the CHW program. In addition, In February 2015, EGPAF indicated to the RHMT and all CHMTs that it would absorb all CHWs and their TSH 15,000 monthly allowances for the full 2015/6 financial year. In late May 2015, one week before the closure of the TABASAM office, it informed the RMO that it was limiting the number of health facilities in its program to 102. A comparison of TABASAM and EGPAF facilities indicated an overlap of only 64. Thus, EGPAF can absorb only 362/929 CHWs and 64/178 Supervisors. TABASAM, the RHMT and EGPAF met multiple times to resolve the issue - without success. Marie Stopes is likely to engage 70 TABASAM CHWs in Igunga. Consequently only 496 of the 1107 CHWs and Supervisors will be retained. At this late

date, it is impossible to assess the impact of this unfortunate set of events on the long term sustainability of the program.

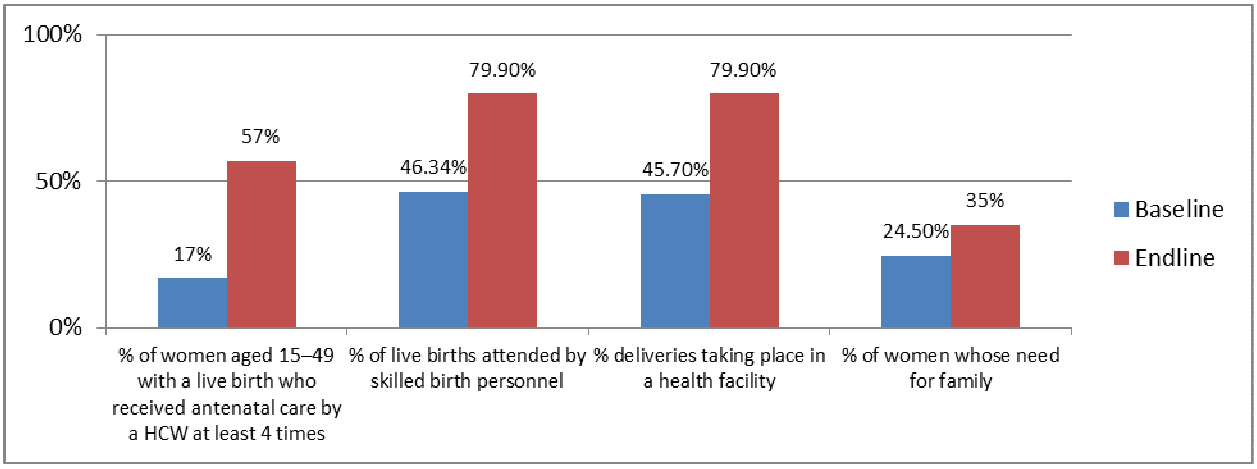
5.2 Intermediate Outcome Achievements

Intermediate Outcome 1: Increased utilization of MRH services by women and adolescent girls in the target communities

Indicator	Baseline	Target	Endline	Change	Achievement
% of women aged 15–49 with a live birth who received antenatal care by a skilled health provider at least 4 times during pregnancy	17%	50%	57%	40% increase	Achieved ✓
% of live births attended by skilled birth personnel	46.34% (TDHS)	54.4%	79.9%	25.5% increase	Achieved ✓
% deliveries taking place in a health facility	45.7%	60%	79.9%	34.2% increase	Achieved ✓
% of women whose need for family planning has been met	24.5%	50%	35%	10.5% increase	Underachieved

Tabasam significantly increased the utilization of maternal and reproductive health services in the Tabora region between 2012 and 2015. Significant increases in utilization of services related to pregnancy and delivery with a 40% increase in the number of women who attended ante natal care four or more times by a skilled birth attendant and a 25.5% increase in the number of women who had a live birth with the aid of a skilled birth attendant.

Maternal and reproductive health continuum



Significant overachievement occurred in utilization of services related to pregnancy and delivery with a 25.5% increase in the number of women who had a live birth that was attended by a skilled birth attendant and a 40% increase in the number of women who attended ante natal care four or more time with a skilled health provider. There was 10.5% increase in the percentage of women whose need for family planning was met, though not achieving the target of 50%, represents a significant increase.

Tabasam was very successful in improving the utilization of maternal and reproductive health services by women aged 15 – 49 from 2012 to 2015.

What accounts for improvements in utilization of MRH services

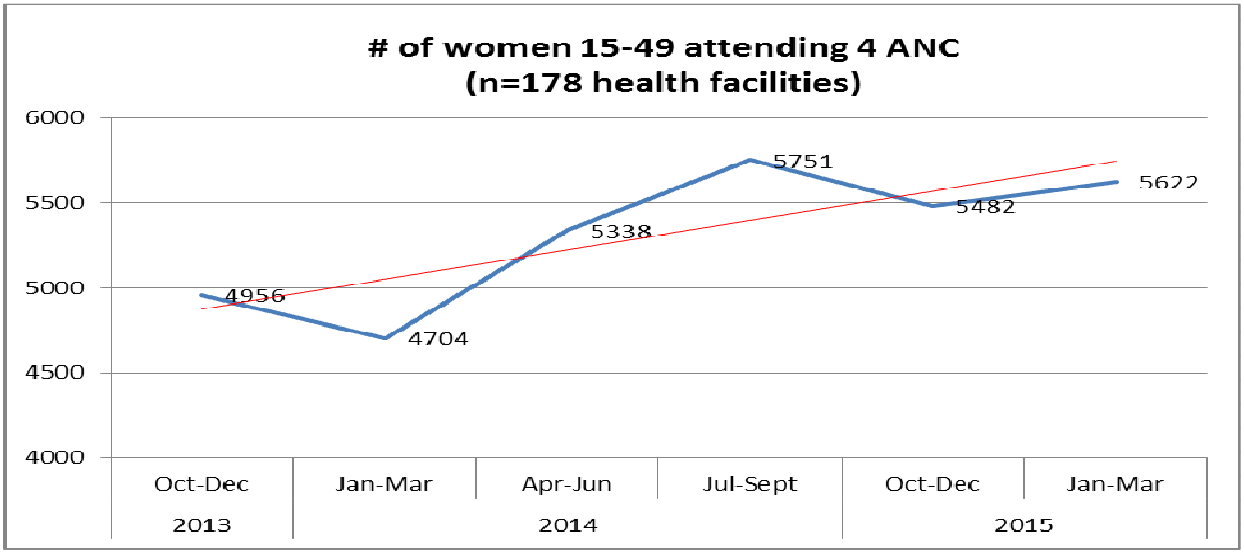
- Men and women have been sensitized on the gender equality concerns and the importance of male involvement during pregnancy and delivery
- CHWs have been instrumental in sensitizing men and women/girls on the MRH issues especially the importance of attending ANC and delivering at the facility
- The perception that a woman can just deliver at home has been challenged through CHWs' campaigns and other TABASAM interventions
- Improvement on the quality of MRH service delivery in the public health facilities in terms of training, equipment and supplies motivated beneficiaries to utilize health services

Ante natal Care

Antenatal care (ANC) provides an important opportunity for pregnant women with a wide range of interventions including education, counseling, screening, treatment, monitoring and promoting the well-being of the mother and fetus. Tanzania has adopted the World Health Organization (WHO) recommendation of a minimum of four goal-oriented ANC visits during a woman's pregnancy. It is the opportunity for women to receive different tests such as: blood pressure, weight gain, testing of urine for albumin and sugar, fetal lie and movements/ or heart rate assessments, tests for syphilis and HIV. This is also the space and time to detect complications and high-risk pregnancy in order to act accordingly.

Tabasam contributed to a significant increase in the number of women who attended 4 ANC visits. During the household survey, it was found that there has been significant increase in this indicator: 57% of women aged 15–49 with a live birth who received antenatal care by a skilled health provider at least 4 times during pregnancy. It represents about 40% increase from the baseline of 17%. Furthermore, 43% of the mothers in Tabora reported to have attended ANC less than 4 times due to several reasons mainly; the distance to the health facility, and cost incurred at the health facility. According to FGDs conducted at endline, CHWs were instrumental in sensitizing men and women/girls on the MRH issues especially the importance of attending ANC and delivering at the facility. Some of the women are visited by the CHWs from the early months of pregnancy right up to delivery. As a result more men and women report attending ANC services now compared to the period before the project with more men accompanying their wives at least once during ANC. Attending ANC increased the likelihood of institutional delivery;

therefore, women who had at least 4 ANC visits were more likely to make preparations and go to a facility for delivery.



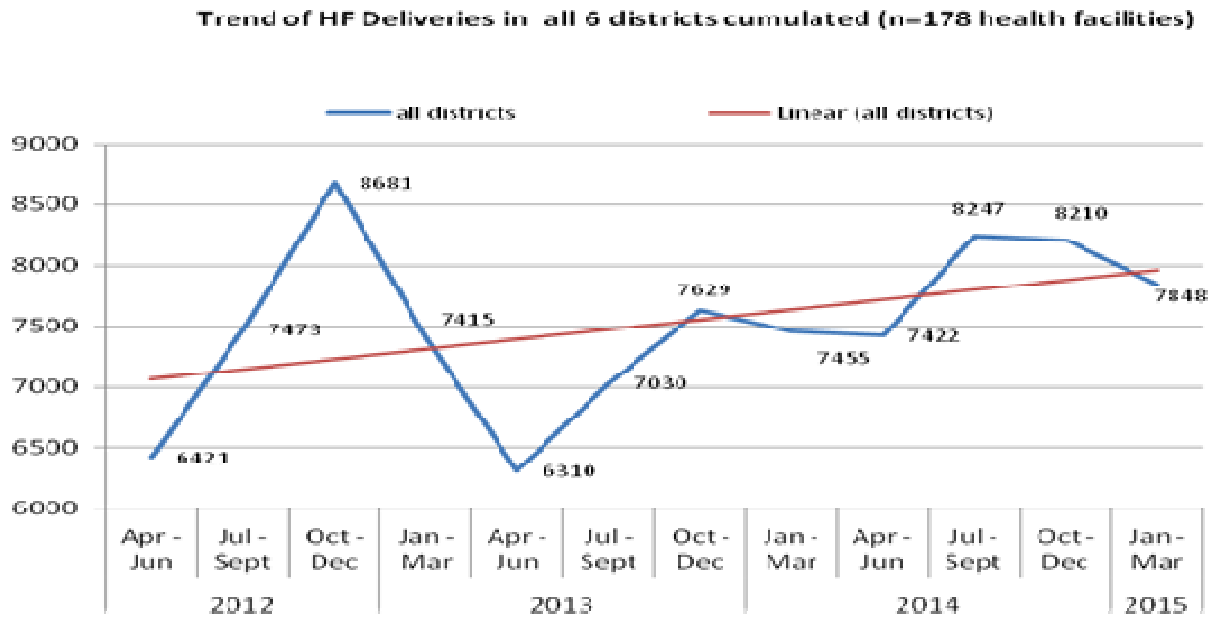
The graph above shows the number of women (15-49 years) who attended 4 ANC visits in the 178 project-targeted health facilities. The trend shows an important increase since the beginning of the project consistent with the household survey findings. Overall, the importance of attending all four visits is certainly gaining credence amongst the population. For example, Doto Mussa (Jionemwenyewe Dispensary, Urambo) is eight months pregnant and undertaking prenatal care as recommended by her CHW. She has already had three visits and her fourth is scheduled for later this month. At 36 years of age, Doto is the mother of 10 children, her eldest being 20 years old. Most of her past births have been at the dispensary. There were instances in the past when she didn't have the time to make it to the clinic, in which case she gave birth at home. Doto says education from her CARE-trained CHW has helped encourage her attendance to the prenatal visits and felt more confident she'll have a healthy delivery. CHWs helped her identify danger signs during pregnancies. She has also decided to no longer have any more children and her husband agrees. They want to use family planning, but don't know very much about it; she says she will go to the dispensary to learn more after giving birth (from Rolling Profile, 2014).

The household survey results found positive and significant associations between CHWs and improvement on maternal and Reproductive Health performance in Tabora region. More women in

villages with CHWs (63%) attended ANC at least four times compared to woman in villages without CHWs (37%). In addition CHW are able to speak local tribal language (apart from Kiswahili) hence able to explain clearly MRH issues making it sensible and clearer to most of women and men. Being members of the same community, CHWs have adequately been able to deconstruct local beliefs, traditions, and customs that affect MRH of women and adolescent girls in their communities. In some of the settings especially in rural areas, CHWs have been institutionalized to such an extent that community members approach them for advice on maternal and reproductive health, or recommend others members, or/and introduce them to potential clients.

Health facility deliveries

Receiving proper care during labour and delivery constitutes an important prerequisite for reducing morbidity and mortality risks for both mothers and babies. Therefore, health facility delivery and delivery with a skilled health care provider in attendance is encouraged as an important strategy in preventing those risks. The number of women with delivery at a health facility has gone up dramatically since the start of the Tabasam project a demonstration of the success of the CHW program and the improvement in quality of health care services delivered at the dispensaries and health centres. CHWs have actively encouraged women not to give birth in the community but to plan their delivery at a health facility. Of the 79.9% of women who delivered at a health facility, 71% of those were in villages supported by a CHW and 29% were in villages that had no CHW. In the 178 health facilities where CARE has worked, the number of deliveries increased from 6421 in April – June 2012 to 7848 in January to March 2015.



There is some variability in the number of health facility deliveries throughout the year with a decline in the April – June period when seasonal rains often make roads difficult to navigate. FGDs conducted at endline suggest that there is a slow shift in how women and men value health facility deliveries:

- More awareness not only on risks associated with home delivery but also advantages of delivery at health facility. Men and women are informed about the danger signs during pregnancy.
- Sensitization and campaign undertaken by CHW and health care providers are increasingly challenging traditional/local conception around MRH.
- Preference on health facility was associated with distance (close/near by) along with quality of treatment and past experience.
- The notion that a woman can just deliver safely at home has been challenged.
- The ability to control complications is one of the most cited reasons for delivering at the facility.

"Nowadays to be honest, many women deliver at health centres, this is something quite different from previous years, because presently there are lot of campaigns, and when you educate people they understand and comply with recommendations, therefore many women deliver to a large extent at the health centres"(FGD male respondent, Nzega, 2015)

We deliver in the health center because there are so many problems when you deliver at home, you can bleed and have more complications. At the hospital, they take care of you, it's safer!" (FDG women respondents, Igunga, 2015)

Women still face many challenges in delivering at a health facility in Tabora. Firstly, there is lack of affordable and accessible transportation to the health centers. According to a nurse from Itago Dispensary in Tabora Municipal. "Mothers are getting education and they are aware of the benefits to visit health centers, but when they want to access dispensaries, they are deterred by transport challenges. Some houses are very scattered which makes them opt to give birth with the help of unskilled neighbors and take risks". To mitigate those risks, the project has purchased 16 emergency vehicles and cell phones in May 2015 for dispensaries and health centers in the region. These ambulances should substantially improve village access to adequate and timely health services. When women reach the health facility for their delivery, they still have to face different type of challenges: 1) out-of-pocket expenditures - in cases of drug stock-out, to have access to medicines needed during labour and complications, such as oxytocin or misoprostol for post-partum hemorrhage; families need to purchase them themselves. 2) An environment that is not always clean and safe for the childbirth - some health facilities do not count with running neither water nor electricity, which makes performing deliveries more difficult and limited. The inability of facilities to function at night was often identified as a major impediment to seeking health facility delivery. The cleanliness of a health facility is highly dependent on the availability of water. 3) Health facilities with limited delivery beds, no laboratory service, no blood bank available on site. It is clear that weak health systems limit healthcare access and

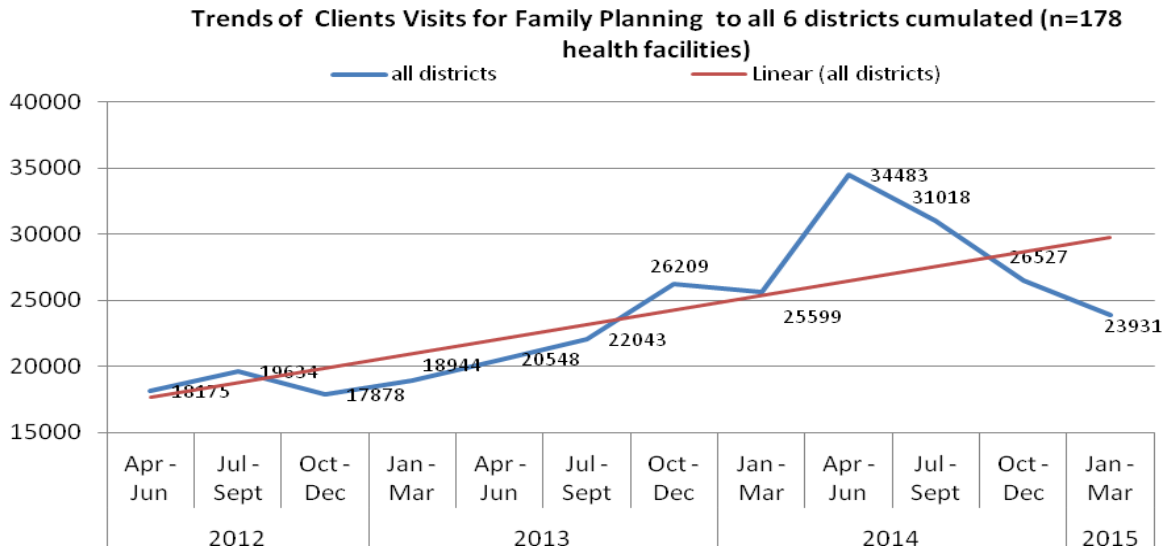
"One of the obstacles is that some health workers don't respect pregnant mothers especially during birth." (FGD Males, Isevya, 2015) "The attendance is good but the nurses pretend to be very busy and come to work at the time they wish." (FGD Female, Tabora Municipal, 2015)

delivery of services to mothers and children, which are essential to improving maternal and child health outcomes. 4) Health professionals with inadequate attitude and communication. Even though the project has played a critical role to change the attitude of health care providers on providing respectful maternal health services, there are cases where women are complaining on the treatment they receive from some of the providers. Some respondents indicated to be treated without dignity. 5) There continues to be a preference for traditional birth attendants depending on a pregnant woman's circumstances. The endline survey showed that 14% (n=168) of the women delivered at home including two women with the assistance of a Traditional Birth Attendants (TBA).

"Women deliver at their homes because of our health facility has few attendants; sometime a pregnant woman has to travel long distance to district headquarters [Sikonge] or regional hospital [Tabora]. Then, they won't accept her. Because the pregnant woman has no money she has to go back home and deliver with the help of traditional birth attendant. I don't know if the government has a plan to increase the number of birth attendants to support us with required skills so that women will be able to deliver there from first to the last born." (FGD MALE MPOMBWE, 2015)

Met need for family planning

Met need for family planning measures the percentage of women who do not want to become pregnant and are using contraception. It is important to understand that a woman's need for family planning changes over her life, so this indicator should be carefully interpreted at it related to a woman's circumstances at a given point in time. In addition, there is a portion of women that participated in the household survey that did not considered themselves at risk of becoming pregnant as they were in a post-partum period. Results demonstrate a great progress in family planning utilization among the population, met need increased by 10% since the beginning of the project. When effective contraceptives are available and used consistently and correctly, unplanned pregnancies can be preventable. Promoting family planning through CHWs has been a promising platform to increase contraceptive use through improving knowledge of the methods available and how to access them. In fact, among the 35% of women with met need on family planning, most of them (>70%) come from villages where CHWs intervened. Data from the HMIS for the Tabasam facilities shows a similar improvement in the access to and availability of family planning services. Results show that family planning visits increased by 80% since 2012. Several issues around family planning include stock outs in some health facilities and lack of client centred family planning services. In many facilities, no client counseling nor post-service customer care are provided.



One of the major challenges in the region is the very high number of pregnancies among teenage girls. Tabora, as part of the Western Zone has the one of the highest fertility rates and the lowest literacy rates in the nation. Women on average have 7.1 children (TDHS). Twenty-three percent of young women age 15-19 have already begun childbearing. Zena Sare, 19, is one such example. She became pregnant while in school (approximately 9th grade). She has left school now, but would like to go back when her son Karori reaches his first birthday. She says she enjoys studying and hopes to one day become a teacher. Her CARE-trained CHW told her about the importance of prenatal visits and that's why she attended them diligently. Zena says the services she received were good and she most enjoyed the information on her health during pregnancy and how to take care of the baby. Her partner attended the first prenatal visit with her and has continued to take financial responsibility for her and the child since he learned she was pregnant. Zena says she knows about family planning and its importance and she and her partner have agreed to have no more than three children in the future (from Rolling profile, 2014).

Intermediate Outcome 2: Improved quality of maternal and reproductive health services at government health facilities in the target district

Indicator	Baseline	Target	Endline	Achievement
% of clients satisfied with facility based services	Female: 52% Male 44%	Female 60% Male 52%	Female:90% Male: 78%	Achieved ✓
% of health facilities that reach a minimum SBM-R score of 40%	n/a	40%	100%	Achieved ✓
% of maternal death reviews conducted		100%	60-100%	Underachieved

Tabasam dramatically improved the quality of maternal and reproductive health services at government facilities in all districts in the Tabora region. As part of quality improvement strategy, Tabasam trained health care providers on family planning, BEMONC and HMIS, provided essential equipment and conducted supportive supervision. The use of community health workers as a bridge between community members with the health providers also added on the quality of services. In order to measure the quality of services, the household survey included satisfaction question. In addition to the household survey questions that measured women and men satisfaction, in February 2015, Tabasam commissioned a study to look at client satisfaction in a sample of Tabasam facilities in all six districts. This study assessed several aspects including: Location of services (accessibility); Types of services received; Frequency of visits; Partner support; Waiting times; Attitudes and behavior of health workers towards the client (helpfulness, politeness); Privacy and confidentiality issues including consent for testing/treatment; Associated costs; Cleanliness; Key service attributes for clients; Overall satisfaction and Service gaps and improvement. Despite the numerous constraints faced at the health facilities in all six districts, the study reflects an overall positive rating. This lies between satisfied and neutral. Clients are very satisfied with the treatment of health workers. This level of confidence among health service providers is encouraging as it a key foundation in providing quality health services. However, several key gaps in the health system were identified as important attributes to a health system including staff, infrastructure (water and electricity), equipment, laboratory services and availability of drugs. Adolescent sexual and reproductive health services were almost non-existent and this is an area that requires further strengthening. These gaps are not unique to this region and are quite universal attributes that are necessary to strengthen the health services and increase client satisfaction. It is hoped that many of these gaps will be addressed so that the health facilities can be adequately staffed and equipped to provide efficient and effective health services to their clients.

The attitudes and behavior of the service providers can be a challenge, particularly at the district/regional hospital level. The project has been influential in improving the attitudes and responsiveness of health workers through the simple act of developing a summarized and translated version of the MOHSW's *Client Charter of Rights* which outlines patient rights and obligations. This 15 - page Charter was developed only in English which makes it inaccessible to most of the Tabora population. Three thousand copies of the pamphlet were distributed to all Tabasam facilities as well as the district and regional hospitals.

Respondents were also happy with laboratory testing. Compared to only one test or none in the past, health facilities offer several tests today during ANC visits. The condition of the delivery rooms has improved in terms of the essential equipment and infrastructure such as reliable lump, and a delivery bed. There are many hard-working and dedicated health workers who are committed to delivering high quality care. One such example is Flora Ngasa (Clinical Officer, Itebulando Health Facility, Urambo). Flora and her colleagues have continued to educate communities during their clinic time. In the past 6 months, Flora reported that family planning has been accepted by many members of the community, and was understood as being central to improving the health and lives of its residents. Other notable successes during this period include the use of pantographs in daily practice, an increased number of facility deliveries, and increased referrals (helping to reduce risks related to unnecessary delays). Flora managed to influence administrators to purchase 4 mattresses and two bed in order for women to rest after deliveries (as opposed to previously, when mothers had to sleep on the floor). To challenge some of the cultural barriers, Flora's best approach is to continue working closely with the Community Health Workers in order to influence the community to accept the services that are provided at the facility. Finally, it seems that Flora's gender has not prevented men from accepting and trusting her work. She is overseeing all types of health issues, and men are coming to seek information, with seemingly no reservations about her being a woman. She has charismatic leadership that seems to help convince people, even men, of her abilities and knowledge (Rolling Profile, second interview).

During focus group discussion, men revealed their satisfaction with counseling session provided by the health care providers to couples. As a result, men realized the importance of supporting their wives during pregnancy:

> *When you come to clinic with your wife, there are learning and counseling sessions where you are both involved…we are told to protect our wives and their health will be better. We learn, if your wife's pregnancy has reached six to seven months, she doesn't have to do tough jobs. If you see there is shortage of firewood go yourself or buy charcoal… and do other things that you will help her… by doing so you will be protecting her health, she will continue attending ANC services as usual until the day of giving birth (FGD, Male, Sojo, Nzega)*

Even though most of the respondents indicated to be satisfied with the services provided, there are still areas for improvement. Some of the remaining gaps are scarcity of health workers, staff housing and health personnel attitude. Pursuing efforts to achieve comprehensive quality of care at the clinical, interpersonal and contextual levels is essential.

TABASAM instituted a comprehensive system of training, coaching, mentoring, and quality improvement to strengthen the provision of key maternal and newborn interventions. The project used the government training package in BEmONC and Family Planning, clinical skills including adolescent sexual and reproductive health, training of supervisors and trainers, Standards-based Management-Recognition (SBM-R) modules, and external verification. All facilities underwent a baseline assessment by Jhpeigo using SBM-R followed by ongoing supportive supervision visits and SBM-R. Based on SBM-R scores from, facilities that met performance criteria underwent external assessments for official recognition of their achievements. The project focussed entirely on the three clinical areas –NLD (Normal Labour and Delivery), MCDL (Management of Complications During Delivery) and PNC (Post Natal Care). Infrastructure and Human Resources and Support Systems were viewed as outside of the scope and impact of the project. Each of the three areas were measured during Jhpiego's post-training coaching and mentoring visits to the facilities. The table below demonstrates the number of facilities included in each of the series of visits. Significant progress has been made since the baseline.

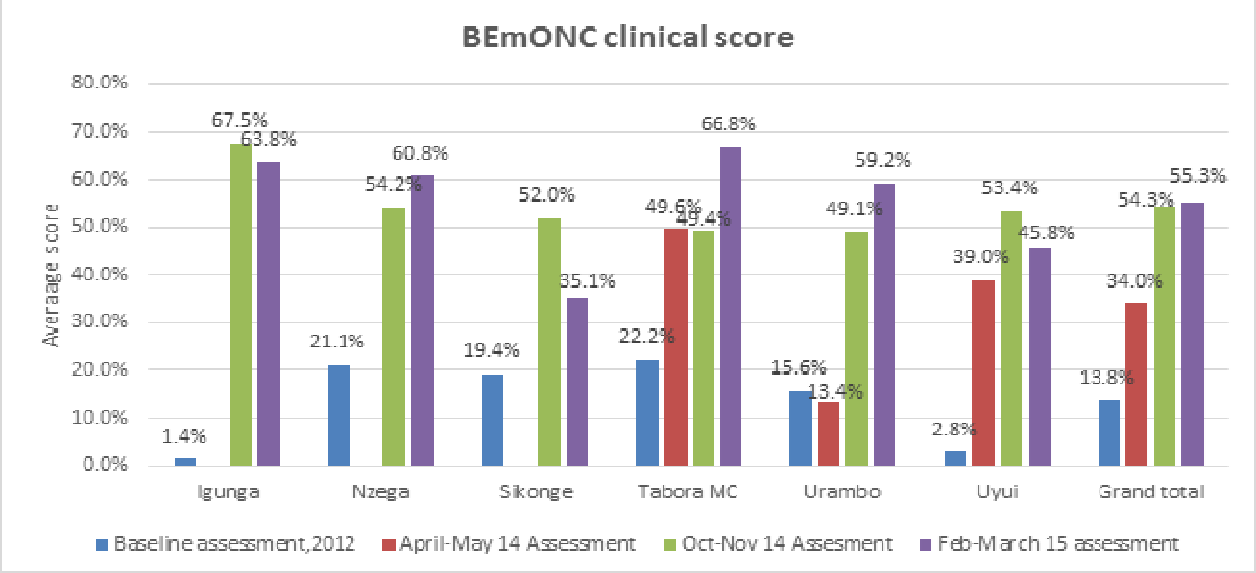
Date	# Facilities	Comments
August-September 2012	26	Baseline: No facility reached the target; average clinical score among the 26 facilities was 7%
April-May 2014	32	Post training to selected facilities in three districts (Uyui, Urambo and Tabora Urban). Average score 34.3%
October-November 2014	134	Post delivery of BEmONC equipment. Average score 54%
February-March	120	Average score for all districts 55%

All districts received a score of at least 40% achievement of standards during the life of project, with four districts having at least 60% achievement and 1 district with 55%. However, Sikonge district is an exception: it increased from its baseline result to its final assessment (19% to 52%) but then dropped to 35% during the final visit. Some reasons for a decline in performance in Sikonge include management of pre-eclampsia, post-partum haemorage, newborn resuscitation, lack of emergency tray in labor and delivery, lack of standard infection prevention and control (IPC) practices, and insufficient cleaning procedures for the labor ward.

District	NLD	MCDL	PNC	Overall	Improvement over baseline
Igunga(18HF)	61.9%	61.1%	72.2%	63.8%	59.1%
Nzega(19 HF)	57.9%	60.5%	68.4%	60.8%	47.1%
Sikonge(18 HF)	35.5%	27.3%	46.5%	35.1%	15.7%
Tabora MC(14 HF)	65.4%	69.6%	66.1%	66.8%	51.1%
Urambo(28 HF)	61.4%	53.0%	62.9%	59.3%	43.5%
Uyui (23HF)	45.0%	46.4%	46.7%	45.8%	44.2%

Total	**54.5%**	**53.0%**	**60.5%**	**55.3%**	**39.4%**

The graph below shows the improvement in terms of perfromance in basic emergency obstetrical care by district. Following the baseline in 2012, Jpiego conducted 3 assessments in the different health facilities to measure their level of performance.



TABASAM undertook additional monitoring and mentoring through the Qualitative Improvement Initiative. This initiative focuses on building the capacity of the district to support follow-up and mentorship of the facilities, particularly once Jhpiego is no longer implementing this component of the project. In collaboration with regional representatives, 30 health facilities were selected from the districts to be part of the initiative. The QI teams (37 female, 13 male) began their work on 30 March 2014 by visiting the health providers. A number of gaps/weaknesses were identified by the QI team:

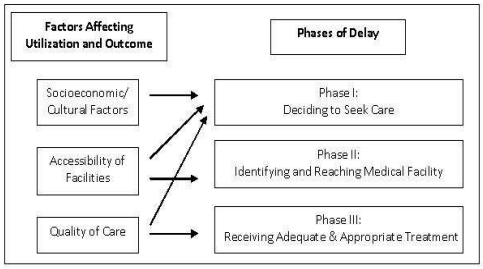
- There was inadequate space for the provision of RCH services in 3/30 facilities;
- Inadequate infection prevention equipment (i.e. coloured buckets according to the type of waste disposal);
- Poor documentation and reporting i.e. monthly summary reports differ from the registers;
- Lack of Intra-uterine devices and implants;
- Lack of commitment on the part of health providers;
- Shortage of drugs, equipment and supplies

In April an assessment of the Maternal Death Review process was undertaken at the Regional Hospital, four district hospitals, one faith based hospital and two dispensaries. This study has been conducted through the examination of patient files (maternal death cases from January 2012 to December 2014) and facility staff interviews. The number of maternal deaths occurring at the Tabasam supported facilities is very low which is perhaps indicative of the success of the referral system since the vast

majority of the deaths are occurring at the referral hospital or health center. For the 178 TABASAM facilities there were only two maternal deaths in year 3 and both happened en route to the referral hospital. On the other hand, there were 19 maternal deaths at Kitete Regional Hospital in 2012, 19 in 2013 and 27 in 2014.

Given the low number of maternal deaths at the dispensaries, the project opted to focus specifically on the institutions where the deaths were occurring and undertook an assessment of the maternal death reviews of the Regional Hospital and the four district hospitals in Urambo, Sikonge, Nzega and Igunga. Neither Uyui nor Tabora Municipal have district hospital and consequently Tabasam selected St. Ann's Hospital in Ipuli which is the largest facility in Tabora Region except for Kitete and sometimes serves as the District Hospital for Tabora Municipal even though it is a privately run faith-based facility. Goweko Health Dispensary in Uyui was selected to help the project understand the context and challenges of providing maternal services in an area lacking a hospital. Since all of these facilities were outside the scope of the project, the project also selected Tutuo Health Center in Sikonge in order to gain insight into the experiences, challenges and practice of a Tabasam-supported facility.

Women and children continue to die from three key delays: seeking care, reaching the health facility, and receiving appropriate case management by health workers. The maternal death review conducted used the 'three delays' model to identify the points at which delays occurred and contributed to the obstetric complication and death.



It is important to understand the care-seeking processes and treatment actions that occurred before each death to improve programmes and policies. Unfortunately, in many cases, the information provided on the patient files is insufficient to provide a full assessment of the causes of maternal death. However, in many of the cases, there is a combination of delays that occurred. Some women felt abdominal pain for more than 10 hours before deciding to seeking appropriate care, others took some traditional herbs to calm the pain before realizing it is urgent. The second level of delay was related to reaching a health care facility. In some cases, 12 hours passed between the referral from a dispensary to the district hospital, in other cases the family had difficulties finding transportation and financial means for transportation to reach health facilities. Finally, what was mostly reported in the patient files was the third delay issues. These are problems related to the quality of the care provided to women and their infants. Shortages in supplies, equipment, lack of (trained) personnel and incompetence of staff were identified as causes of maternal death. In some cases, it is reported that the nurse called urgently for the doctor, but the latter came it a couple of hours later. This MDR assessment demonstrates the importance to continue working on improving access to maternal health care by intervening in both the supply and demand sides of the health system.

Intermediate Outcome 3: Strengthened management and accountability for MRH services in Tabora Region

Indicator	Baseline	Target	Endline	Achievement
% of districts setting MNCH targets using processed HMIS data	17% (1/6)	100% (6/6)	100% (6/6)	Achieved ✓
% of facilities who received standardized supervision visits from CHMT representatives	50% at least 1X per year = 89 visits	202 visits	100% at least 1x per year	Achieved ✓

Tabasam succeeded in strengthening the management and accountability for maternal and reproductive services in Tabora through its work with the CHMTs. Tanzania's decentralization of health services has placed management and delivery of services within district level government authorities. The central government through the Ministry of Health and social welfare (MoHSW) is responsible for policy formulation and overall monitoring of health care provision. In local governments, the CHMTs are the entity responsible for planning and overall management of health services in their districts.

Tabasam supported the CHMTs in terms of trainings and resources to conduct regular supervisory visits. All supportive supervision visits were undertaken by the CHMT teams – and all 178 facilities were visited at least once/year – with the Tabor Municipal facilities all being visited twice. In addition, all districts reached a consensus around a set of standard supportive supervision tools for the region; and all districts have committed to visiting each facility at least once annually. Besides reaching the quantitative indicator, regular CHMT supervisory visits had fundamentally contributed to MRH service providers' responsiveness. Understanding that the CHMT will visit their facilities within a specified period of time created a sense of responsiveness on the part of the providers who reported to constantly implement what was instructed in the previous CHMT. This way, CHMTs were strengthening the supply side of MRH service provision. To put this is a perspective, it was repeatedly reported by the district officials and health providers that before the project, CHMT had limited capacity to regularly and effectively carry out their supervisory duties.

The collaboration between the CHMTs and Tabasam proved to be helpful to to the maternal and reproductive health service providers. Beyond the common composition of CHMT (dominantly medical practitioners), supportive supervision visits with Tabasam were multisectoral and included members with diverse expertise such as community mobilization and community development. The approach used was more participatory than directive to the extent that health providers reported to have gained new insights from the supervisory visits. This was said with reference to previous tendency among CHMTs to simply instruct and at time threaten the health providers. The CHMT members, as a critical stakeholder in promoting maternal and reproductive health in the respective districts, gained first hand experiences of what it takes to provide maternal and reproductive health services in some of the challenging conditions of acute shortage of health personnel. During the supervisory visits, CHMT members observed how beneficiaries would wait in long queues before getting any services. This situation served to remind the CHMT of their role to secure more health personnel in the district. The

supportive supervision allowed regular contact between CHMT and health providers which contributed to establishing or/and enhancing smooth ties and linkages. This has been a fundamental effort towards improving MRH services in the region.

¨With Tabasam staff, we did joint supervisory visits that helped us improving our roles and responsibilities. Now we have a closer relationship with health staff. Before the implementation of the project, it was hard for us to go to the field regularly and to visit health facilities to support them in the health management. We are capable of making better decisions based on what we observed and discussed within CHMT members, health staff and the community.¨ (DMO, Urambo, 2015).

A key function of the HMTs is to develop a Comprehensive Community Health Plan (CCHP) which guides the health programming for the region/district. The CCHP is a planning, budgeting and monitoring tool for district health financing and represents the principal prerequisite for any well-functioning district health system. It includes objectives; strategies, activities to address health priorities and indicators to measure progress. The CCHP plans for all financial resources available for health in each district on the region. Tabasam focused on strengthening the capacity of the CHMTs to plan, cost, monitor and evaluate their activities and programs. On the 18-20 February 2015, the project hosted a meeting of regional and district CHMT officials, along with representatives from the Regional Hospital and NGO partners. The meeting provided an opportunity for participants to discuss broad data management issues and to analyze trends in some of the key health delivery services. A final day was spent on prioritizing the present and future needs of individual districts, the region and the regional hospital. The specific objectives were as follows:

- To ensure a common understanding of district/regional data collection methods and data flow:
- To assess challenges to data management and reach consensus on solutions;
- To analyze district and regional trends in key service delivery areas;
- To identify and prioritize district and regional needs which can be used as a basis for future funding proposals

All districts presented the challenges they were facing in terms of obtaining accurate and timely data. A number of common issues were identified ranging from training of newly employed staff, network problems, lack of data collection tools, insufficient time for data auditing etc. A consensus was then reached on how to resolve these issues. The topics and the district presenting were as follows: health facility deliveries (Urambo); community deliveries (Sikonge); maternal and newborn deaths (Kitete); ANC/PNC visits (Kaliua); family planning (Tabora Municipal); commodity chain management (Uyui); supportive supervision (Igunga); and referrals (Nzega). This was followed by a commitment to a series of 12 resolutions to improve data collection and analysis. The insight and knowledge developed through this workshop was utilized immediately to develop the Comprehensive Community Health Plans (CCHP) for each district. Given the much improved quality of the plans from previous years, CHMT demonstrated evidence in using the health information system during the planning process.

6 Project Management

Project partners DFATD, CARE Canada, CARE Tanzania, Jhpeigo and the Ministry of Health and Social Welfare performed their functions as outlined in the Project Implementation Plan (PIP). Jhpeigo's contract with the CARE Tanzania was extended until March 2015 to finalize the work on health facility strengthening. The project was managed using the logic model, performance measurement framework, risk register and budget developed during the PIP and revised in September 2014. CARE Canada was the grant holder and had ultimate responsibility for delivering on results. The project was implemented by CARE Tanzania through its office in Tabora. A Program Coordinator led the Tabasam staff team in the Tabora office. The PIP was developed with the participation of local stakeholders (see Appendix II). Implementation of activities was done in coordination with the CHMTs as the Tabasam staff offices were located at the District Health Offices of each of the six regions of Tabora. Coordination meetings were held quarterly with CHMTs and on a regular basis with other NGOs involved in the sector. Workplanning was conducted annually on a April 1 – March 31 cycle. Annual workplans were developed jointly with R/CHMTs. The only difficulty was that the project cycle and the CCHP planning cycle were slightly off, which meant that the project could have better supported the CCHP if the cycles were aligned.

Logistics were managed out of the Tabora office, which had the schedules for travel including drivers, scheduled and approved travel within the region. CARE Tanzania had responsibility for procurement and compliance with donor and CARE procurement processes. Finances were monitored by the Project Accountant, which provided regular advances to the district managers based on reconciliations of advances and forecasts. Capacity Building Managers in each district were responsible for spending and reporting on funds received. The Tabora office would report to CARE Tanzania which would then report financially to CARE Canada. CARE Canada bore responsibility for financial oversight of project expenses.

Monitoring of project activities and workplans was done by CARE Canada and CARE Tanzania along with the Tabora-base Program Coordinator through a management team. CARE Tanzania and CARE Canada would be regularly updated as to project progress and discuss mitigation for any delays. A monitoring system was established to assess progress toward outcomes. The Health Facility database included data from 1 January 2012 and involved TABASAM staff visiting every all 178 TABASAM-supported facilities. From the 1st January 2014, the responsibility for the collection of the data has shifted from the M & E Officer to the TABASAM district personnel in conjunction with the District Reproductive Child Health Coordinators (DRCHCo) and the MTUHA/HMIS Coordinators. The data for each district was drawn from the relevant MTUHA registers. The CHW data base collects data at the household level and is drawn from the registers submitted by each of the 977 CHWs to their 180 Supervisors on a monthly basis. The data is collected and analyzed by the project on a quarterly basis. Payment of the CHW allowances is dependent on the timely submission of the reports. Databases were stored on a shared CARE dropbox site. In terms of qualitative data, the project has finalized its Outcome Mapping process, which is a systematized qualitative data collection framework designed to measuring progress on intermediate outcomes. The tools developed include Rolling Profiles and Progress Markers. Quarterly staff meetings

in Tabora will continue to be held under the direction of the Program Coordinator to conduct sense making exercises and review progress toward results.

All project activities except for the distribution of EmONC vehicles, monitoring and evaluation and knowledge management were completed by March 2015. The April to May period was spent final managing project endline surveys, data analysis, research and sharing the lessons learned at the regional, national and international level. All staff contracts terminated on the 31 May 2015 and the disposal of assets and the physical closure of the office took place by 29 May. At the AWP meeting with district, regional and TABASAM staff in March 2014, there were substantial and practical discussions on how CHWs would be integrated into the district CCHPs during the 2014/5 and 2015/6 financial years. The regional representative emphasized that CCHPs would not be approved should CHW integration not be immediately addressed in district plans. Five of six districts (plus Kaliua) incorporated financial support for the CHWs into their CCHPs and EGPAF has committed to funding the allowance during 2015/6 financial year. In February 2015, EGPAF indicated to the RHMT and all CHMTs that it would absorb all CHWs and their TSH 15,000 monthly allowances for the full 2015/6 financial year. In late May 2015, one week before the closure of the TABASAM office, it informed the RMO that it was limiting the number of health facilities in its program to 102. A comparison of TABASAM and EGPAF facilities indicated an overlap of only 64. Thus, EGPAF can absorb only 362/929 CHWs and 64/178 Supervisors. TABASAM, the RHMT and EGPAF met multiple times to resolve the issue - without success. Marie Stopes is likely to engage 70 TABASAM CHWs in Igunga. Consequently only 496 of the 1107 CHWs and Supervisors will be retained.

7 Risk Register

Title		TABASAM: Tabora Adolescent and Safe Motherhood Project		No.	
Country/Region/ Institution		Tanzania/East Africa/CARE		Budget	CAD 10,971,139
Risk Definition		Risk Level		Indicate Investment LM Result Level	Risk Response
Operational Risks		Initial rating	Residual Risk	Investment Level	Risk Response
Op 1	Key stakeholders are not included in the planning and implementation of the TABASAM project	Low (1)	None	Whole project	Mitigated. Stakeholders included in all project planning.
Op 2	Limited participation of men, women and male and female youth in TABASAM	Medium (2)	Residual risk with female youth	Intermediate outcomes	Mitigated. Equal participation of men and women in the project. Female youth were not specifically targeted.
Op 3	Shortages of equipment, drugs and other supplies at supported health facilities	High (3)	Residual risk	Intermediate outcomes	Health facilities are better equipped and stocked especially with family planning methods, but still experience stock outs.
Op 4	Inadequate number and distribution of skilled Human Resources for Health (HRH)	High (3)	Residual risk	Intermediate outcomes	Tabasam advocacy through CHMTs resulted in increased number of health facilties with skilled health workers, but HHR remains a huge challenge in the region.
Op 5	High attrition of CHWs in TABASAM	Medium (2)	None		Provided CHW incentives, tools and materials commensurate with assigned duties; ensured that CHWs receive adequate support from communities and health facilities, including supportive supervision; ensure that CHW criteria are agreed with communities and CHWs recruited according to this; recognition of CHW role and performance in TABASAM.
Financial Risks					
Fin1	Adequate financial resources are not released to CHMTs in	Medium	Residual risk	Immediate Outcomes	CHMTs still experience delays in receiving budget allocations

	a timely manner	(2)			
Fin 2	Fund mis-use or mismanagment.	Low (1)	Mitigated	Immediate outcomes	Employed a robust financial management systems (CARE and Jhpiego); regularly monitored primary financial risks through spot checks; reduced cash transactions and centralise disbursements. Used M-Pesa to pay stipends to CHWs.
Development Risks					
Dev 1	Natural disasters such as erratic weather patterns (eg floods or drought) and disease epidemics affect access to project sites and participation of stakeholders.	Low (1)	Mitigated	Immediate outcomes	While there is seasonal variation in relation to utilization of services, Tabasam was able to successful increase utilization rates in every single quarter including rainy season with strong community programming.
Dev2	Backlash and resistance to addressing gender issues at the CHMT and health care design/management levels .	Low (1)	Mitigated	Immediate outcome	
Dev 3	Limited ability of project staff (CARE and Jhpiego) or unwillingness of stakeholders to address gender issues in MRH and household decision making.	Medium (2)	Residual risk	Intermediate Outcomes	Social Analysis and Action cancelled
Dev 4	Stakeholder expectations incompatible with or exceed project remit and resources	Medium (2)	Mitigated	Immediate outcomes	Regular meetings with R/CHMT members both informal and formal
Dev 5	Willingness of Local Government Authorities (LGA) to participate in governance and accountability dialogues with communities	Medium (2)	Mitigated	Immediate Outcome	Included participation in CSC and interface meetings in MoUs signed with LGAs; facilitated understanding of CSC and interface processes; support LGA exchanges for peer learning and reflection.
Reputation Risks					

Rep1	Canadian stakeholders may publicly not support program .	Low (1)	Mitigated	Ultimate outcome	Participation in Can-MNCH, public awareness raising about MNCH through CARE's donors and public.

8 Gender Equality Results

This section uses data from Tabasam project reports as well as end line qualitative and quantitative data to identify the extent to which gender integrated and specific activities implemented during the lifetime of the project led to changes in the gender dynamics that influence maternal and newborn child health. FGDs, particularly, were broken down into statements on key issues in health service access and decision making, and statements were organized and collated along a spectrum from more to less equality and autonomy. The focus is on the extent to which project activities influence gender relations, deep social structures and gender stereotypes related to women's position and status as well as to their access to and control over resources such as land, business profits and transportation as needed to fund a safe and healthy delivery. The analysis is divided by project intermediate outcome.

Increased utilisation of MRH services by women and adolescent girls in target communities

Gender Results As Planned in the Gender Strategy

- increased role of women in household decision making as relates to MRH and health seeking.
- increased capacity and authority of women and adolescent girls to access MRH services.
- increased men's acceptance of women accessing and utilising MRH services.
- increased men's participation at MRH services together with their intimate partner/wife.

Planned Gender Equality Activities

Develop gender-sensitive emergency transportation, communication and blood donation plans; train communities and health leaders on ways in which gender inequalities cause maternal deaths and incorporate a gender analysis into maternal death reviews; incorporate gender equality content, messages and modules into CHW and community facilitator training and into IEC materials and messages; implement social analysis and action, including leader training and community dialogues; ensure VSLAs are in themselves gender transformative.

Actual Gender Equality Activities under Intermediate Outcome 1

Roughly equal numbers of CHWs and CHW trainers and 51 male and 124 female CHW supervisors were trained, but there is no indication that this included specific gender equality content, or that CHWs, trainers and supervisors were cultivated specifically as gender change champions. There is no indication that supervision plans, technical support to CHWs on community sensitisation or quarterly review meetings held with CHW supervisors assisted CHWs with gender equality problem solving. While 141 public awareness meetings were held with 18,975 men and 15,028 women, there is no indication of how any gender equality content from those meetings was linked to messages provided through home visits. The social analysis and action component of the project was dropped within the first 18 months, and no other gender specific activities were implemented as part of the project. Given that SAA is CARE's cornerstone methodology for specifically addressing the gender inequalities that affect MNCH, this left the project without the skills and tools necessary to address underlying causes of maternal morbidity and mortality. Only about 50% of the targeted number of male role models were trained by the end of the project, and there is no indication of what they were trained in or what their roles were in changing gender relations. IEC messages emphasized the role of both women and men in improving maternal and reproductive health outcomes. VSLA groups became an entry point for addressing gender dynamics related to positive maternal health outcomes. Groups discussed male accompaniment and support, and open and equal couple discussions on family planning. Seventy-five percent of groups established social funds to with paying for birth costs. Eighty percent of those who used the funds were women, and the majority of funds were used to pay for transportation to referral medical centers.

> *As we [women] are the main stakeholders here, it is our health and not that of a man that matters. You have to be keen enough to look up for it.*
>
> *He will know later, once you have already inserted it. He might beat you, but the issue is finished because the implant is there.*
>
> *I think if the man resists, you have to take measures on your own. It is your health. Men can make you a reproductive machine from morning to evening, and at the end leave you for another woman. You are left with the problems and the kids. Me, I advise women that if he does not want family planning, go and do it secretly.*

Related Gender Equality Results

The inability of the project to integrate gender specific activities into its work with women and men, either at the household or higher levels, has resulted in some increased agency for women to earn a living and mobilise themselves to address health, but in continuing uneven gender relations in terms of decision making on key issues that affect the three delays. FGDs show that men are more aware of the technical aspects of pregnancy and birth, and of a need for a technical response, but they have not significantly changed their attitudes around family planning or overall household decision making. Health information reached men through meetings or home visits, but the lack of specific gender work meant little change in the attitudes that determine women's timely access to health services. An example from family planning results illustrates the point.

Women's Autonomy in Family Planning

	Sure	Not Sure
Women sure they can bring up the topic of family planning	85%	16%
Women who are able to tell their husbands or partners that they want to use family planning	85%	16%
Women who are able to use family planning methods even if their husbands do not approve	65%	35%
Women and girls reporting autonomy to make FP decisions	59%	41%

The table above shows that women are able to bring up the topic of family planning and discuss it, FGDs show that this autonomy is qualified. Forty percent of the statements that women made in FGDs about family planning showed that they access birth control secretly, and 22% note that men will not accept family planning under any terms. Only 24% of women's statements indicate they are not going openly with freedom, while 13% reference as a mutual decision. The majority of men's statements indicate that family planning is an issue for "mutual discussion," with the implication that normal gender relations in decision making, in which men have the final say, dictate these conversations. In other words, women are able to raise the issue, assert themselves and access services independently, but they are unable to be heard as equals in couple discussions on family planning.

Improved quality of maternal and reproductive health services at government health facilities in the targeted districts includes

Gender Results As Planned in the Gender Strategy

- MRH services are delivered in a gender sensitive way and are appreciated by women, men and adolescent girls and boys
- Increased capacity and understanding on health related gender issues of HMT staff and Community Development Officers

Planned Gender Equality Activities

Strengthen health worker communication and interaction skills to address gender stereotypes and biases; ensure that gender analysis is part of MDRs and ensure that the CSC collects sex-disaggregated data, identifies gender issues in health service delivery and includes gender equality actions and goals.

Actual Gender Equality Activities under Intermediate Outcome 2

There is no indication that health service provider training included or integrated information or modules on gender equality, although cumulatively 165 women and 105 men were trained. 203 women and 87 men were trained to provide family planning services of all terms, and as part of the practicum for long-term and permanent methods, 455 women were inserted with IUCDs and 1,082 women with implants. Twenty four male and 43 female primary care staff were trained to conduct maternal death reviews, although there is no evidence that this training included an analysis of the degree to which

gender inequalities or women's low social status affected their mortality. There is no indication that community scorecard processes identified and planned to address gender issues in service delivery.

Related Gender Equality Results

Data related to gender changes in agency, relations or structure garnered through these activities are inconclusive. The table below shows women to be by-and-large more satisfied with maternal health services than men, but this does not bear out when referring to FGDs.

	satisfied with FP services	satisfied with FP services in their community	satisfied with ANC services	satisfied with delivery services	satisfied with post-partum care	satisfied with CHW services
women	88%	87%	87%	70%	75%	46%
Men	69%	81%	80%	60%	65%	46%

A more rigorous analysis of FGDs is needed, but preliminary analysis shows men being largely unsatisfied with the distance to services and a lack of transport, while women's stories reflect mistreatment, bribery, malpractice and the absence of basic supplies. There is a need to determine the degree to which women and men are basing their satisfaction on a complete range of services. Forty six percent of women's statements indicate that men either do not accompany them to the clinic at all, or that they accompany only for the first visit. Ten percent of these note that women are turned away if men do not accompany them. Thirty one percent of women's statements note that men do accompany, 6% because of what they learned from Tabasam. On the other hand, at least 38% of men's statements note that men only come for the first visit while 48% indicate greater levels of involvement. More analysis is needed to determine whether men's levels of satisfaction are tied to the overall birth process or only to the preliminary encounters that target them with HIV testing and counselling and birth information.

Strengthened management and accountability for MRH services in Tabora region

The key gender equality work under this package was to mainstream gender issues into health service management and accountability cycles and activities. This was not completed in a timely and fully integrated manner. Instead, a three day training to incorporate a gender analysis and sex-disaggregated data into CMHT plans was delivered in the final six months of the project.

Addressing gender issues in health service delivery calls for a sophisticated and multi-layered approach to mentoring, capacity building, project management and community championing that implicates health service providers and professionals at the first instance, following on with mentored community

work. Where Tabasam activities focused on changing women's agency to access specific health services using an approach of information sharing and mobilisation, it was successful. Where the project was required to use a more sophisticated approach, it did not succeed in changing gender relations and dynamics at deeper levels in ways that support sustained maternal health outcomes. Dedicated resources and political will to implement gender specific activities beginning in the sixth month of the project are necessary in order to see changes at these levels.

9 Environment

The TABASAM project did not involve any additional construction, modification, decommissioning, or abandonment of buildings. All project activities that had any impact on the environment were done in an environmentally sustainable way. Community based initiatives through the community scorecard saw the construction of placenta pits and latrines.

10 Success Factors

Relevance

The Tabasam project was designed to improve the maternal and reproductive health of women of Tabora Tanzania. This project was consistent with the national priorities of the Government of Tanzania, which since 2008 has prioritized reducing maternal mortality as it remains one of the countries with the least progress toward achieving MDG5. Tabasam also aligns with the Government of Canada's focus on improving maternal, newborn and child health and is funded through the DFATD Muskoka Initiative. Key Tabasam indicators are consistent with those identified by the Commission on Information and Accountability and the DFATD Muskoka indicators.

Appropriateness of Design

Tabasam's design was appropriate and based on a sound understanding of the local context. The project goals and outcomes were defined using participatory Project Implementation Plan and Annual Workplanning processes that included Regional and District health personnel. Annual workplans both responded to the results-based management framework for the Tabasam project and local and contextual needs and factors of the individual districts and region of Tabora. The intermediate and immediate outcomes of the project remained relevant throughout the project and the indicators were well selected to align with Government of Tanzania and global MNCH measures. Project resources were allocated to meet the size and scope of the project, which covered approximately 56% of the population of the Tabora region and in fact the project was able to exceed its reach and outcome targets in key areas with the project budget. The community based programs including the CHWs, Community Scorecard and VSL were highly relevant to the context and filled a definite gap in community health services along with creating a vital link to the health facility. A comprehensive training and coaching plan for health care workers on BEmONC and family planning was implemented using the national curriculum in coordination with the R/CHMTs.

Sustainability

By working in partnership with the R/CHMTs, Tabasam interventions and approaches are integrated in the Comprehensive Council Health Plans through two planning cycles. CHMTs members were actively involved in the monitoring of the CHWs and consequently viewed this cadre as an important asset in terms of health service delivery, particularly in such a resource-limited setting. The CHMTs have incorporated CHWs into their CCHPs and have already identified sources for ongoing funding of CHW allowances until the end of 2015. Regional staff are actively lobbying for central government support for the cadre to be incorporated into MOHSW human resource planning.

At the health facility level, 178 facilities are now delivering improved maternal and reproductive health services and receiving more regular supportive supervision from the CHMTs, which will continue. Data collected through the MTUHA is now of sufficient quality to be used for planning of maternal and reproductive health services. Communities have now greater capacity to support maternal and reproductive health through VSL, which historically have a high longevity (on average 90% continue operating 5 years after being started), space for community engagement in planning and supporting health services through the CSC and a critical link between community and health services using CHWs. It is likely that the utilization of services will remain high, while at the same time ongoing investment is needed to maintain the quality of health care services delivered at the health facility level.

Partnership

Tabasam partnered with the Regional Health Management Team and District Health Management Team and embedded staff in each of the Regional and District Medical Offices. This was an effective means of collaboration between CARE and local government enabling the smooth implementation of activities and capacity building of local government structures. CARE had an excellent relationship with its project partner Jhpeigo, which took on the project component of improving quality of health services. Also, at the regional and district level Tabasam partnered with 3 local NGOs to conduct the Community Scorecard, which had the added value of being trusted entities within communities helping to get good community engagement in the process. Lastly, the partnership that was formed around the Muskoka projects and the coordination from DFATD in Dar es Salaam was excellent and provided a necessary platform to share lessons and contribute to the DFATD country level program.

Innovation

CARE predominantly innovates in the area of creating simple, cost-effective community-based solutions to improve maternal and reproductive health. The use of the VSL social fund as an innovative community financing model for maternal and reproductive health has been highly successful in the Tabasam project. VSLAs are a CARE innovation, they create economic opportunities for the most vulnerable communities; in this case it also empowered women in making decisions around accessing maternal health services. VSLA provided an economic safety net to respond to routine as well as emergent obstetric needs. The Community Scorecard has also been highly successful at enabling

community participation in the design and delivery of maternal health services. It created spaces for constructive engagement to improve basic service provision. This social accountability tool contributed to better service delivery through improvements in the management, access and quality of services. It was well received by health providers and the communities.

Appropriateness of resource utilization

Financial and human resources were utilized well in the achievement of the Tabasam results. The project was implemented at scale within the Tabora region and covered approximately 56% of the population of the region. The 10 million dollar budget resulted in a cost per beneficiary per year of about $10 CAD.

11 Lessons Learned and Recommendations

Women's health needs to be a continued health and development priority

Women's health outcomes are hard measures to move in short-term interventions as the direct causes and underlying determinants of maternal health are affected by complex and entrenched cultural practices, beliefs, relationships and structures. Initiatives that work with women and men in the community and within the health system help shift those beliefs and practices that have a pernicious influence on women's health and well-being. Local leadership structures and policies create the enabling environment without which lasting efforts toward gender equality cannot take place. Programs working to address issues of women's health necessarily must consider the multi-dimensional, multi-sectoral and multi-level determinants of a woman's health and well-being. But this kind of change takes time.

Lasting achievements in maternal health will take time

While we saw significant improvements through the Tabasam Muskoka project between 2012 and 2015 in the number of women accessing health services such ANC, delivering at a health facility and family planning; there needs to be a lot more investment to ensure that the health outcomes improvements that will result from these investments will continue in the long-term. These investment are both in terms of financial resources but more importantly time. Changing social and cultural norms, behaviors and practices that drive many of the underlying determinants of women's health do not change quickly. For instance, it is possible to increase ANC and male involvement in attending ANC at the same time not addressing many of the gender inequalities that place at woman at risk of having a high risk pregnancy such as lack of autonomy, malnutrition, adolescent pregnancy, multiple pregnancies and having children too close together.

Community-based models of maternal health are cost effective and impactful

Community-based interventions for improving maternal health are both effective in achieving improvement in utilization of health services and health practices as well as being cost-effective, scaleable and sustainable strategies for lasting achievement. Introducing the right model for the context

is critical to the success of any community – based maternal health. The CHW model worked extremely well in Tanzania to support maternal and reproductive health in communities and for a small investment, pays huge dividends in terms of improving community health. Investment in community-based models for maternal and reproductive health must come from the communities themselves and local and upper levels of government, including the MoHSW in Tanzania for this program to fully reach its potential in Tanzania.

Measuring change in maternal and child health and nutrition is complex

What determines maternal and reproductive health is complex and it therefore stands to reason that measuring progress toward achieving results in this area is also complex. Millennium Development Goal indicators and those identified through the MNCH Commission on Information and Accountability are helpful standardized outcome measures assessed usually through baseline and endline household surveys. More sector – wide coordination and leadership in MNCH around metrics and measurement is needed for the information to be user-friendly and useful to beneficiaries. Ongoing monitoring through the government health information system is useful to a point, though data quality is generally poor. Tabasam made extraordinary progress in establishing a culture that values quality data collection in Tabora, but the MTUHA books used to collect the data are physically cumbersome and require much more data that can possibly be meaningfully used at the regional or district levels. Identifying a few key important indicators and focusing on regularly analyzing those was a one successful strategy to improve monitoring of maternal and reproductive health services. However, it was also important to have qualitative tools such as rolling profiles and supportive supervision observation to understand how change was taking place resulting for the project interventions.

Supply and demand side interventions are needed to improve maternal health

Weak health systems can be quickly overrun. While the CHW program was highly successful in increasing the utilization rates of maternal health services around ANC and delivery at a health facility, the facilities in terms of staffing and coordination were not necessarily equipped or prepared to provide the full suite of services to everyone who needs them in their health centre catchment area. In the end many CHWs were frequently tasked with supporting health care workers for ANC clinics and record keeping. While the health care workers were trained on BEmONC and family planning and could provide improved quality of services, the need to increase health human resources is undeniable and not something that the project could directly influence – outside of raising the concern at CHMT meetings and providing analysis on service utilization to help make health human resource allocations. In many cases this was successful and the overall number of facilities with skilled health providers did increase over the course of the project but the overall health human resources situation remains critical.

Ongoing Mentoring and Coaching is Important

The focus on the project on continuous mentoring and coaching was important. All facilities who were trained in BEmONC received at least two coaching follow up visits one immediately after the training and one in year three. The result is that 100% of the average SBM-R score for all districts with the exception of Sikonge (39.4%) reached the minimum SBM-R score of 40% in the three clinical

components (NLD, MCDL, PNC). Similarly, during the second quarter of Year 3, the project conducted a series of refresher trainings for CHWs and their supervisors. The purpose of the workshops was to provide a platform to discuss their common experiences and to strengthen CHW data collection skills. A standard list of topics was developed to strengthen CHW capacity in the following areas: review of job responsibilities of CHWs and Supervisors; completing the registrars; monthly report writing; developing a weekly and monthly Action Plan (a basic "to do" list); providing sexual and reproductive health information, particularly for adolescents; managing referrals and finally, providing an opportunity for CHWs to share their experiences and challenges. Feed-back from CHWs was very positive and what was a decline in the number of CHW visits reversed itself. The refresher training clearly demonstrated the importance of ongoing training as well as the opportunity to continually share ideas and challenges.

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