Year 4 Annual Project Results

Reporting Period: April 1, 2020—March 31, 2021
Region/Country: Tabora, Tanzania
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Tabora Maternal & Newborn Health Initiative (TAMANI):
Project Number #D-003063, PO 7063009

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Contents

List of Abbreviations
ASRH – Adolescent Sexual and Reproductive Health
AGOTA – Association of Obstetricians and Gynecologists of Tanzania
ANC – Antenatal Care
BCC – Behaviour Change Communication
BEmONC – Basic Emergency Obstetric Maternal Neonatal Care
CBHPC - Community Based Health Promotion Coordinators
CCHP – Comprehensive Council Health Plan
CHWCo – Community Health Worker Coordinator
CEmONC – Comprehensive Emergency Obstetric Maternal & Neonatal Care
CHMT – Council Health Management Team
CHW – Community Health Worker
CSC – Community Score Card
CSIH – Canadian Society for International Health
DHIS – District Health Information System
DMO – District Medical Officer
DQA – Data Quality Assessment
DRCHco – District Reproductive Child Health Coordinator
ESIA – Environmental & Social Impact Assessment
GII – Gender Inequality Index
GoT – Government of Tanzania
HF – Health Facility
HMIS – Health Management Information System (MTUHA)
IDSR - Integrated Disease Surveillance and Response
IHI - Ifakara Health Institute
MDR – Maternal Death Review
MMR – Maternal Mortality Ratio
MNCH – Maternal, Newborn & Child Health
MoHCDGEC - Ministry of Health, Community Development, Gender, Elderly and Children
MPDSR - Maternal Perinatal Death Surveillance & Response
NMR – Newborn Mortality Ratio
OSCE - Observed Structured Clinical Examination
OPD – Out Patient Department
PIP – Program Implementation Plan
PO-RALG - Prime Minister's Office - Regional Administration and Local Government
PSC – Program Steering Committee
RAS - Regional Administrative Secretary
RBF – Results Based Financing
RMC – Respectful Maternity Care
RHMT – Regional Health Management Team
RMNH – Reproductive Maternal Newborn Health
RMNCH – Reproductive Maternal Newborn Child Health
RMO – Regional Medical Officer
SAA – Social Analysis & Action

SBCC – Social Behaviour Change Communication
SOGC – Society of Obstetricians & Gynaecologists of Canada
SRH – Sexual Reproductive Health
TAMANI – Tabora Maternal Newborn Health Initiative
TNA – Training Needs Assessment
WDC – Ward Development Committee

Executive Summary

The Tabora Maternal and Newborn Health Initiative (TAMANI) is a five-year project led by CARE in partnership with the Government of Tanzania's Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) and the Prime Minister's Office for Regional and Local Government (PO-RALG). Implementing partners include the Society of Obstetricians and Gynecologists of Canada (SOGC), the Association of Gynecologists and Obstetricians of Tanzania (AGOTA), the Canadian Society for International Health (CSIH), McGill University's Institute for Health & Social Policy, and Ifakara Health Institute (IHI). The project is financially supported by the Government of Canada and is closely aligned to Government of Tanzania (GoT) health polices, strategies and guidelines.

The Annual Report covers the period of April 1, 2020, to March 31, 2021.The report provides an analysis on operations to date against the Year Four Annual Work Plan. This report also highlights how the project pivoted to respond to the COVID-19 global pandemic and includes reporting on COVID response programming as approved by GAC in March 2020.

Key Activities Completed Against the Year Four AWP:

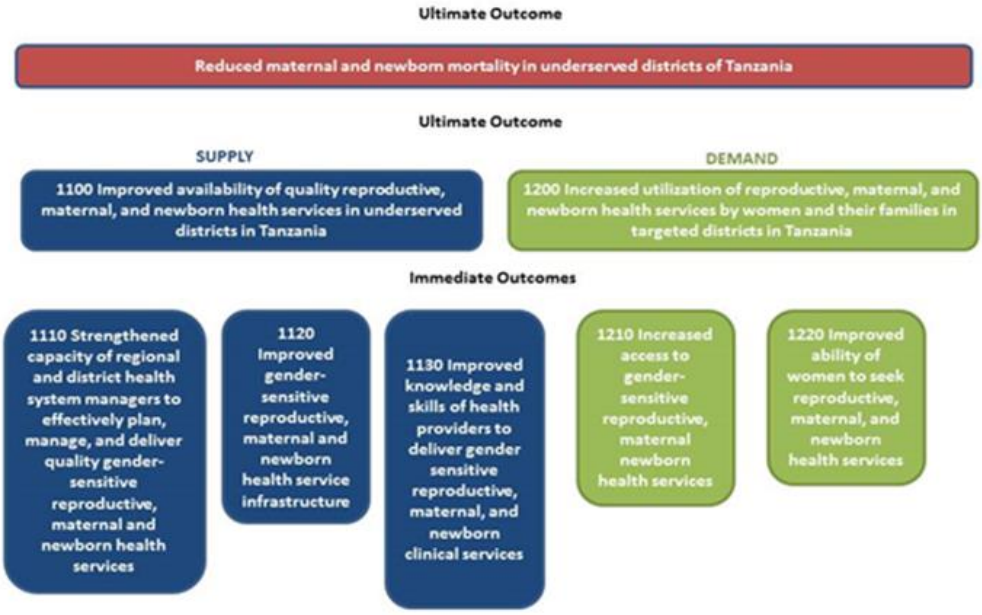
- Implemented COVID-19 Response Activities
- Adapted and delivered R/CHMTs on-the-job Supporting Supervision Program
- Completed training on for Health Facility Staff on HMIS, DHIS2, Data Analysis/Utilization
- ASRH Training Completed for Health Care Workers
- Completed Remaining Health Facility Rehabilitation Project
- Completed Coaching & Mentoring visits
- Implemented Community Based CSC and SAA dialogues
- Completed Endline Data Collection

The last full year of project implementation has been an exceptional one in Tabora. The TAMANI team has successfully implemented the TAMANI project against a continually evolving and difficult context. Overall implementation has continued with limited changes to planned activities, while pivoting quickly to implement COVID-19 response programming.

Project Description & Context

Global Affairs Canada established the Ultimate Outcome and Intermediate Outcomes in the call for proposals, which are presented below as part of the TAMANI logic model. The project addresses issues both on the supply side (1100) as well as the demand side (1200) in contributing to reduced maternal and newborn mortality in Tabora, Tanzania. The logic model remains unchanged from the PIP aside from one slight edit changing reference to MDR to MPDSR to align with the GoT policy.

Project outputs under 1100 (SUPPLY):	Project outputs under 1200 (DEMAND):
1111 - Regional and district health authorities trained and mentored in gender sensitive supportive supervision for reproductive, maternal and newborn health services **1112 -** Regional and district health authorities trained and mentored on HMIS and effective planning and budgeting for reproductive, maternal and newborn health services **1113 -** Reproductive, maternal and newborn health systems research projects conducted **1114 -** Policy briefs on priority issues related to RMNH written and disseminated for district, regional and national decision making **1121 -** Emergency transportation system for pregnant and postpartum women and newborns developed **1122 -** Health facilities equipped and rehabilitated **1131 -** Job aids disseminated based on GoT's RMNH clinical practice guidelines **1132 -** Health care workers trained on CE/BEmONC and family planning **1133 -** Health care workers mentored on CE/BEmONC and family planning **1134 -** Maternal Perinatal Death Surveillance & Response audit developed and implemented	**1211** - CHW program for reproductive, maternal and newborn health and family planning implemented **1212** - Youth friendly sexual and reproductive health services developed and implemented **1221** - Gender-sensitive reproductive, maternal and newborn health community scorecards conducted **1222** - Communities sensitized on gender-sensitive reproductive, maternal and newborn health



Reach – Beneficiaries & Intermediaries

Intermediaries for the TAMANI project are the Regional Health Management Team (RHMT) and the Council Health Management Teams, Health Care Workers, and Community Health Workers. The table below shows estimated intermediaries reached through the overall project:

Intermediary	Activity	M	F	Total	Outcome
RHMT's	Trained on Health Systems Governance	8	4	12	1110
CHMT's	Trained on Health Systems Governance	40	24	64	1110
	Trained on HMIS & Data Utilization	40	24	64	1110
	Trained on Planning, Budgeting & Financial Management	40	24	64	1110
Health Care Workers	Trained on Planning, Budgeting & Financial Management	50	50	100	1130
	Trained on BEmONC	120	120	240	1130
	Trained on CEmONC	18	12	30	1130
	Mentored on BEmONC & CEmONC	138	132	270	1130
	Trained on Adolescent Friendly Health Services	80	80	160	1130
Community Health Workers	Trained as GoT CHW's	500	500	1000	1210
CHW Supervisors	Trained on CHW Supervision	40	20	60	1210
Community Facilitators	Trained on SAA	35	35	70	1220
	Trained on CSC	35	35	70	1220

Indirect beneficiaries of the project are based on the expected coverage of BEmONC services. Population estimates were based on 2012 census projections. The Project expects to cover approximately 50% BEmONC in Tabora. Indirect beneficiaries also include those receiving emergency transportation services and CEmONC services. Additionally, they include those participating in Community Scorecard and Social Analysis and Action and receiving Youth Friendly Services. These reach numbers below reflect the total expected reach of TAMANI.

Total Expected Beneficiaries

Beneficiary Estimates				
District	Male (total)	Female (15-49 yrs)	Births	Total
Nzega	143,244	65,310	14,947	223,500
Igunga	114,364	52,076	11,977	178,417
Uyui	114,854	49,810	11,456	176,121
Urambo	56,126	24,581	5,654	86,360
Sikonge	52,004	22,994	5,289	80,286
Tabora Mc	65,108	34,447	7,923	107,478
Kaliua	114,809	49,779	11,449	176,038
Total	660,510	298,995	68,695	1,028,199

Operations & Outcomes to Date

This section summarizes progress on the implementation of activities and associated outputs against the Year four Annual Work Plan (AWP) and overall project targets. Year four of TAMANI focused on demand creation activities, responding to COVID-19, implementing the sustainability strategy and planning for project close out.

Update on Context & Rationale

On March 11th, 2020, the WHO declared COVID-19 a global pandemic. The first reported case in Tanzania was on March 15, 2020, and the last report indicated 509 confirmed cases and 21 deaths. While data on COVID-19 cases were originally reported through the MoHCDGEC this stopped in May 2020 and in early June, the Government opened borders for normal business to resume.

The Government of Tanzania launched an updated National COVID-19 Response Plan from July 2020 – June 2021 which aimed to reinforce existing COVID-19 measures while ensuring continuity of essential health services and social protection. CARE was granted approval from Global Affairs Canada in March 2020 to repurpose $96,000 of the TAMANI budget to respond to COVID-19. However, management of COVID-19 at policy level in Tanzania escalated into more uncertainty as the country chose unique approaches and methods that veered away from WHO recommendations, including a declaration that the country was free from COVID-19 in June 2020. Despite this, the country witnessed another wave of infections from January 2021 to March 2021 which was termed 'severe pneumonia'. With the inauguration of the new President in March 2021, Samia Suluhu Hassan, there have been promising statements to align global efforts in the fight against the pandemic. It is expected there will be policy reforms to guide Tanzania's response to COVID-19 and participate in vaccination efforts. To ensure staff and community safety, CARE Tanzania continued to monitor the situation while ensuring preventive protocols are observed.

The roll-out of approved reproductive, maternal and newborn health policies and guidelines has been stalled with the COVID-19 pandemic and unexpected change in leadership. As noted in the Year three Annual Report, the MOHCDGEC developed and approved the National Guidelines for Gender & Respectful Care in Tanzania. As of the writing of this report, the guidelines had yet to be disseminated to facilities, because of limited resources and the pandemic. In addition, the National roll out of the Makole model aimed at improving health facility efficiencies and accountability, and the Uturo community based CHW model were both planned during the reporting period, with the Tabora RMO selecting key districts to pilot. However, debate has emerged within the GoT on the effectiveness of these models resulting in the MOHCDGEC delaying roll-out so that further revisions can be made to both models. The National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing has been approved, though the official launch was delayed due to the October 2020 elections. It is now confirmed that the official launch will be on April 17th, 2021.

Project Operations

COVID-19 Response Activities

CARE Tanzania worked quickly to pivot TAMANI programming to implement COVID-19 response activities at the start of year 4 in coordination with Global Affairs Canada and the Tabora RMO. Activities were focused on providing evidence-based information to communities as quickly as possible, and training Health Care Workers and Community Health Care Workers to be able to respond to the pandemic, as well as keep themselves safe. These activities were largely implemented in Q1 and Q2 (between April and September 2020).

In addition, the project distributed PPE and worked with the RHMT to ensure that essential services such as access to contraception and delivery services remained available, and to think through the way that the pandemic would impact women and girls differently from men and boys, and plan accordingly. CARE has advocated for the inclusion of women at all levels of the response, as well as to ensure SGBV messaging, and referral information is integrated into all communications. CARE Tanzania worked closely to ensure that all COVID-19 messaging was approved by the MoHCDGEC and was part of the Risk Communication and Community Engagement (RCCE) pillar of the National COVID-19 Task Force.

In addition to support from GAC, CARE Tanzania received additional funds from Bloomberg foundation to support COVID-19 response work in Tabora region, leveraging the work of TAMANI. Through this support, TAMANI expanded COVID-19 interventions to train Regional/District Health Managers 54 (37m/17f) on Integrated Disease Surveillance & Response (IDSR), support infection prevention measures, including the provision of 416 handwashing stations to health facilities. The funding also supported training for local NGOs/CSO/CBOs, District NPA-VAWC Coordinators and District NGOs Coordinators responding to Gender Based Violence to map referral pathways and strengthen service provision, as well as supported training for TAMANI CHW's on household hygiene and facilitating SAA dialogues on the gendered impact of COVID-19.

Support from GAC and Bloomberg has been critical for the region, given Tabora has not received any of the COVID-19 response funds requested from the central government.

See below, a table summarizing reach data for the TAMANI COVID-19 response activities in Tabora.

Pillar	Response	Activity Details	Period	Partner
RCCE	# of radio talk shows conducted through Digital Based Communication (DBC) and audio messages (Covid, Project Specific, GBV), Safeguarding SMS	• 940 CHWs, 40 Youth champion included project beneficiaries reached • 3 local radio talk shows focus on danger signs during pregnancy and child health, CHWs roles and hygiene during coronavirus outbreak.	Apr. – Aug 2020	CG FM Radio 88.5MHZ
Health	# of HCW's trained on COVID-19 event-based surveillance and contact	• 40 (17f: 23m) HCWs trained on COVID-19 case management, event-based surveillance and contact	June – July 2020	Tabora RHMT, PORALG
Health	# of CHWs and Community leaders oriented on COVID-19	•465 (240f; 225m) CHWs and 21 (13f; 8m) community leaders oriented on COVID-19 event-based surveillance and contact tracing	June – July 2020	RHMT and CHMTs

Mobile Calls & Messaging

CARE Tanzania partnered with VIAMO, a social enterprise that implements interactive and targeted mobile engagement campaigns and surveys to deliver the COVID-19 education and prevention campaign. The messaging was adapted to evolving caseloads, expected heightened food and economic insecurity, and anticipated increases in SGBV. Donor funds were pooled to leverage scale and scope for the mobile campaign given the upfront costs and the ability to use the translated COVID-19 information across projects and regions. These messages were endorsed by the Government of Tanzania through the MoHCDGEC.

In total, across all CARE Tanzania projects the mobile communications campaign reached 13,283 CARE program participants (Male 5982, Female 7301) including TAMANI beneficiaries. Out of the targeted participant list, 88% (2054 – 1064 Male, 952 Female, 38 Not revealed) consented to receive life-saving information on COVID-19, GBV, project specific messages, school, safeguarding and mobile surveys. TAMANI CHW's and Youth Champions received 4-5 calls per week with COVID information. And recipients were provided the option to access additional COVID information free of charge, as well as access GBV counselling and referrals.

From May to August, a total of 346,894 recorded calls were made sharing MoHCDGEC approved COVID-19 messaging. In addition, 211,224 calls provided GBV messaging (both prevention and referral), 211,224 project specific messages were sent out, which for TAMANI included social distancing and hygiene information for CHW's and Youth Champions. Ahead of schools re-opening 53,490 calls were made to provide school safety information, and 146,113 safeguarding texts were made to remind project participants channels for reporting. An additional 13,283 calls were made to collect information to inform the rapid gender analysis and 13,283 texts messages were sent out to wrap up the campaign. In summary CARE Tanzania disseminated a total of 671,745 calls.

See below as summary of the Campaign Calls and % Listened

Messages	Total Calls	Listens	% Listens
COVID-19	346,894	172,148	50%
GBV Female	53,132	27,471	52%
GBV Male	158,092	65,100	41%
Project Specific Message (1-8)	39,849	29,543	74%
Project Specific Message (9-16)	13,641	7,080	52%
School	39,849	20,510	51%
TOTAL	**671,745**	**321,852**	**49%**

TAMANI project participants were included in the CARE Tanzania mobile campaign. See below a summary of the total calls and % listened specific to TAMANI.

No.	Messages	Number of messages	Target Participants	Total calls/ messages	Listen	% Listen
1	COVID-19	26	965	25,090	13,479	54%
2	GBV	13	965	12,545	6,778	54%
3	Project Specific Messages	6	965	5,790	1,763	30%
4	School messages	4	965	3,860	1,840	48%
	TOTAL			**47,285**	**23,860**	**50%**

Radio Campaign

CARE Tanzania contracted five local radio stations with a total listening coverage estimated at 30 million people across CARE Tanzania programming areas. This included CG FM which broadcasts to Tabora with an estimated listenership of 980,000. Radio talk shows were developed that included messages about COVID-19, social distancing, adherence to handwashing, and other hygiene practices and communicated a toll-free number for more information about the pandemic. The radio talk shows included project participants, CHW's, RHMT members and HCW's to highlight key COVID prevention linked to TAMANI and provided an opportunity for listeners to call in and ask questions on what they heard.

Health Care Worker Training

A three-day training on COVID-19 response was supported by TAMANI and facilitated by PO-RALG at Nzega Town Council from June 23-25th 2020. In total 40 (17f; 23m) health care providers were selected to participate from across the eight districts of Tabora. Each district council was represented by 5 participants from various specialties and included nurses, clinicians, laboratory technologists and environmental health officers. During the training, the regional COVID-19 response team supported participants with practical materials (PPE, chlorine and buckets for hand washing). The COVID -19 Training package covered:

- Surveillance, Screening, Identification and Triage of COVID-19
- Isolation and notification of COVID-19 Suspects
- Transportation of COVID-19 Suspect
- HIDTU Management (design, flow pattern for staff and patient)
- Case Management Teams Composition and Roles included Clinical Care of COVID-19 Case
- Overview of Infection Prevention and Control (IPC), Hand hygiene, Chlorine preparation, decontamination and waste management during HID Management.
- Psychological Support and Care to Survivors including Occupational Safety and Health Authority (OSHA)
- Introduction to Safe and Dignified Burial including Overview of PPE for HID Management
- Demonstration of IPC: Hand hygiene, donning and doffing of individual PPE, including proper disposal.

An increase in knowledge gained after training was noted by facilitators in their closing remarks (though no marks were shared by PO-RALG). The practical session provided space for health care providers to practice social distancing and included the use of PPE.

CHW Trainings

As part of TAMANI's COVID - 19 response, the project trained 465 (240f; 225m) CHWs and 21 (13f; 8m) community leaders from all 8 district councils. The training covered community surveillance and contact tracing and was conducted at ward level with a total of 27 venues across the region.

CHWs participants were divided into smaller groups and each group attended the training on a different day. The facilitators used the CHW COVID - 19 response training package developed by stakeholders and approved by the Government of Tanzania as part of the MoHCDGEC COVID-19 guidelines. Participants were trained to identify suspected cases as well as how to do contact tracing.

During the training all necessary protective measures were in place to protect participants against COVID-19 pandemic. At each venue cloth masks were provided to each participant, hand washing stations were equipped with liquid soap, clean water/with chlorine and hand sanitizers. Thermal Scanners were used to measure participants' body temperature before the sessions and facilitators demonstrated hand washing techniques. The participants observed to adhere proper mask wearing, regular hand washing and distancing.

Qualitative monitoring data suggests that both digital messaging and training on COVID-19 influenced Youth Champions and CHWs' ability to integrate this knowledge into their household visits. For example, a young mother described how the CHW explained COVID-19 to her, "*I was not aware about this before, but now I am familiar on protecting myself and protecting others. In fact, the education he gave me helped me a lot and I applied some of the instructions he gave me. For example, in the beginning I used regular water for washing but the health worker instructed me to use running water and soap and I bought a special bucket with a watering can for hand washing*." (WRA, Kaliua District)

Another woman noted, "*Regardless of the myth within our community that COVID-19 won't affect black people the CHW visited us and shared information regarding hand washing and insisted each household wash their hands using running water and soap. I insist that my children wash their hands thoroughly as you know kids play with their friends in the neighbourhood so I make sure once they return home they wash their hands*." (WRA, Igunga District)

A Youth Champion explained how he utilized the digital messages he received on his phone, "*The SMS messages I received from CARE were helpful, I have been receiving the right information about COVID-19. I am sharing the information with my relatives and community as well. They have had a positive response because the information is direct from a reliable source like CARE and the Ministry of Health. The information has benefited the community to understand the ways of becoming infected and preventive measures*." (Youth Champion, Uyui District)

While the qualitative interviews revealed that COVID-19 awareness messaging was useful to the work of CHWs and Youth Champions, challenges in community adherence to protective guidelines at health facility level was still noted by some Health Care Workers. "*During the pandemic, we received fewer clients, people were afraid to visit the health facility to avoid contamination and others said that HCWs had corona virus. PPE were not supplied timely. Imagine we ordered sanitizer, soap and masks to the*

medical store department and they have supplied these supplies only recently. We insisted that people who come to the health facility wash their hands and maintain social distancing. Community members refused to wear masks until the District Commissioner and DED ordered all people to wear a mask when visiting a health facility, that is where people started to wear masks. Precautions made us free to continue providing services, but our worries did not stop." (Male HCW, Igunga District)

Provision of Personal Protective Equipment (PPE)

In collaboration with the R/CHMT's, PPE gaps were identified and purchased with the support of TAMANI. Necessary personal protective equipment (PPE) as indicated in the table below was procured and distributed during the reporting period. PPE equipment was purchased from the relevant government institutes, though procurement was delayed due to quality and safety verification checks by the authorized government agencies ahead of distribution. Distribution of PPE equipment will be finalized at beginning of Q1 Year 5.

Procured items to support COVID -19 response in Tabora region

Item	Unit	Description	Quantity
Mask N95	Boxes	Pack of 2 pieces	200
Surgical Masks	Boxes	Pack of 50 pieces	32
Examination Gloves	Boxes	Pack of 50 pairs/100 pieces	16
Chlorine tabs	Tin	Pack of 100 tabs	24
Alcohol based hand sanitizer (5 Liters)	Bottle	5 liters	24
Liquid Soap	Set	Pack of 16 bottles (500 Mil)	24
Heavy duty PPE (30M, 40L, 30XL)	Set	Face shield gown and top cover	100
Thermo-scanners	Each		16
Body bags (burial bags)	Each		30

R/CHMT Support

To support the COVID-19 response in Tabora, CSIH organized two trainings delivered virtually. The first was entitled *Maintaining Essential Health Services during an Emergency* in response to this being identified as a challenge by the Tabora RHMT. This was also integrated into the Supportive Supervision Mentorship program with the long-term aim of cascading the learning within the region to other districts. Four members of the RHMT and each CHMT were nominated by their teams to be Supportive Supervision Mentors (4 RHMT (2 m, 2 f) and 32 (21 m, 11 f) CHMT). Mentors were expected to participate directly in

the online training program as well as being responsible for cascading lessons and learnings and mentoring the other members on their team.

The second training was on *Health* Promotion. The main goal of this online program was to support the ongoing Health Promotion initiatives within the Tabora Region with a focus on refreshing and improving knowledge and skills of R/CHMTs on various aspects of Health Promotion including principles, processes, strategies and approaches.

More details on the program content, learning outcomes and achievements of both trainings can be found under **Progress on Implementation – Output 1111 and 1112**

Endline Data Collection

The quantitative household baseline survey and the qualitative gender survey were carried out in Q4 of this reporting year. Ifakara Health Institute has led on both quantitative and qualitative data collection, while McGill has largely supported on the quantitative data analysis which is now underway. An external consultant was hired to lead on the development of the gender qualitative tools, approach and analysis as part of the endline qualitative gender research. Using CARE's approach to Gender Equality, with a focus on addressing agency, structure, and relations, the study is focused on what changes in knowledge, attitudes and behaviours of women, men, adolescent girls and boys have been impacted by TAMANI that influence access to reproductive, maternal and newborn child health services. Analysis of both the quantitative data from the household survey and gender research is ongoing, and results will be reported in the final report.

Progress on Implementation: Outputs & Activities

Intermediate Outcome 1100 (Supply): Improved availability of quality reproductive maternal and newborn health services in underserved areas of Tanzania

Output 1111 - Regional and district health authorities trained and mentored in gender sensitive supportive supervision for reproductive, maternal and newborn health services

	ACTIVITIES	2020/2021 Year 4			
		April-June	July-Sept	Oct-Dec	Jan-Mar
		Q1	Q2	Q3	Q4
1111	**1111 Supportive supervision system for improved MNCH implemented**				
1111.4	On the Job SS R/CHMT Coaching			X	X
1111.5	Conduct joint supportive supervision visits		x	x	x

Progress on Output 1111:

Indicators	Project Target	Y4 Target	Y4 Performance (April 1, 2020-March 31, 2021)	Cumulative against Project Target
#/% RMNH joint supportive supervision visits per health facility	1 Visit/Q/HF	1 visit/HF/Q	1.5 visits/HF	76%=807/ (265*4)
# of m/f CHMT members trained to conduct regular RMNCH supportive supervision	8 RHMT members & 5 CHMT members/district (=40 CHMT members)	Completed No Y4 target	4 (2 m; 2 f) RHMT members & 32 (21 m; 11 f) CHMT members	150% RHMT 160% CHMT

Supportive Supervision (SS) Visits

Between April 2020 and March 2021 a total of 807 supportive supervision visits were conducted out of the 1060 visits required as per GoT guidelines (1 visit/quarter/ facility). Out of the 265 HFs supported by TAMANI 49 (18%) were visited four times or more. In total, 109 HF's (41%) were visited three times, 76 HF's (29%) were visited twice, 25 HF's (9%) were visited once and 6 (2%) were not visited. The visits are intended to work with health staff to monitor performance, identify and correct problems and proactively improve service quality. The visits are also an opportunity to encourage good practice and support health workers to maintain high quality service delivery standards. Supportive supervision visits in Q2 & Q3 were negatively impacted by the General Election and campaigning conducted in October and November 2020, as a result planning and budgeting processes were shifted from November 2020 to mid February 2021.

The project is providing limited support to the region to conduct the supportive supervision visits (100 litres of fuel/quarter which allows for 600km of travel). While costs to cover supportive supervision were included in the region's approved budget no funds have been disbursed since July 2020. This makes meeting the supportive supervision targets very difficult, while the RHMT understands the importance and value of these touch points.

R/CHMTs On-the-Job Supporting Supervision Virtual Training

CSIH in consultation with local and national government authorities (i.e. representatives from the RHMT, PO-RALG, and MoHCDGEC) designed a four-part program to provide Supportive Supervision Coaching in year four of TAMANI. Following a Plan-Do-Study-Act (PDSA) cycle, program participants learn together in a facilitated environment, and practice new methods, skills, and behaviour for supportive supervision with

coaching by facilitators. However, given all field activities were suspended before this program could be initiated in Tabora, the training was shifted to a virtual format and integrated COVID-19 topics as noted above.

The program was launched in Tabora in July 2020. The program consisted of pre-recorded videos/ presentations that could be watched at the Mentor's convenience, and live discussions and Questions & Answer (Q&A) sessions corresponding to each video. Ten modules were developed, that covered the following topics:

1. Supportive Supervision Basics
2. Framework for Effective Supportive Supervision during an Emergency
3. Governance and Coordination during an Emergency
4. Prioritizing Essential Health Services during an Emergency
5. Optimizing Health Service Delivery during an Emergency
6. Establishing Safe and effective Patient Flow
7. Optimizing Health Workforce Capacity
8. Communications and Use of Digital Technologies
9. Maintaining Availability of Essential Health Supplies
10. Strengthening Monitoring of Essential Health Services

An average of 12 participants joined each discussion session on Zoom. A pre-test was conducted prior to the first Module (n=24), and a post-test was conducted after the final Module (n=11) to understand the extent of participant's learning. Unfortunately, participation in the post-test was low, but did reflect those most actively involved in the online program. Average scores increased only slightly from 80% on the pre-test to 84% on the post-test, with the most improvement noted around mentor's ability to identify additional workforce capacity during an emergency, identifying and communicating with specific agencies to provide support during an emergency, and using digital methods to supervise facilities during an emergency. A final program evaluation was also conducted to obtain feedback on various aspects of the program (structure, content, online learning forums, etc.). Key feedback from this evaluation included:

- *Program Structure*: When respondents were asked if they reviewed module content prior to Zoom Discussions, 82% indicated they either 'always' or 'sometimes' review content in advance. When asked whether the discussion online were useful to increasing understanding on the sessions content, 91% responded favourably.
- *Program Content:* 73% of respondents fully agreed that content covered in the program was relevant to their work. The majority of respondents (91%) indicated the program contained a mix of new and refresher content.
- *Cascade of Knowledge:* 91% of respondents had shared lessons from the program with other members on their team. This was typically done by discussing topics during morning meetings or sharing materials from the sessions with their colleagues. 91% of respondents stated that they had applied learning from this program to improve their work and how they supervise health facility workers.

- *Suggestions:* The main suggestion received was to conduct the program in-person for enhanced learning and to avoid problems with the network. Participants were assured that in-person activities would resume from the end of the calendar, and there would be on-job coaching for supportive supervision.

Supportive Supervision On-Job Coaching

CSIH was able to initiate the in-person Supportive Supervision Mentorship Program in Q3 of Year 4, building from the content presented and discussed through the virtual/online program conducted with select supportive supervision mentors from each Regional and Council Health Management Team. The original Mentorship Program was designed to take place over four in-person coaching sessions, however due to the setbacks caused by the pandemic, the program was reduced to two in-person sessions.

The first of these sessions took place in November 2020 with all identified mentors and aimed to continue building capacity and skills for conducting effective supportive supervision. Specifically, the exercise was designed to provide mentors with the confidence to develop critical and reflective thinking abilities to effectively lead change, mentor, coach, and use new and creative approaches and tools throughout the full supportive supervision process. The exercise included 2-days of classroom sessions to go through planning and preparation processes and procedures for supportive supervision and discuss how an effective supportive supervision visit should proceed, followed by 2-days of on-job visits to dispensaries and health centres to practice mentoring and coaching skills as well as action planning and reporting.

Mentors were highly motivated and interested in this exercise and demonstrated self-drive and ownership in improving supportive supervision in their region/district. Supervisees at health facilities were impressed with the new method of supportive supervision being practiced, finding the visits very friendly and useful. The GROW model of coaching is still new and requires more practice for supervisors to become comfortable with this approach, and supervisees also need to become familiarised with the process to ensure they are actively involved in identifying challenges and action planning. These skills will continue to be practised during the second on-job training session with mentors in Q1 of Year 5.

During the workshop it was discussed and recommended that the supportive supervision guides and tools being tested be formally reviewed by the region for approval and dissemination region wide. Regions have the authorization to develop and adapt tools for supportive supervision if they align with the national policy and guidelines.

Regional Consensus Building Workshop on Supportive Supervision Process and Tools

A workshop was held with Tabora RHMT and CHMT representatives from each district to review, tailor and approve a new package of tools for conducting routine Supportive Supervision visits in Tabora through a regionally owned process. The workshop also served as an opportunity to plan for the cascade of knowledge and dissemination of tools to all councils in Tabora, and to develop a process for monitoring the supportive supervision process at council and regional levels.

All tools presented were reviewed and accepted by the region with some minor adjustments to suit region specific needs. Significant discussion was on adapting innovative approaches of conducting supportive supervision visits while adhering to the national supportive supervision guidelines. It was emphasized that this process is not indented to replace the guideline nor the existing systems, but to make the current system more efficient. Introducing the application of GROW and identification of prioritized area for supportive supervision was seen as contrary to the current comprehensive approach (supervising all areas within the health facilities). However, consensus was reached on how to carry out the GROW and prioritization using the themes that will be identified using facility information.

The workshop evaluation indicated that all participants felt that the trainings and workshops on supportive supervision to date had resulted in significant positive improvements across different areas in the supportive supervision process. CSIH has subsequently developed a Supportive Supervision Tools Booklet has been developed and presented to the Tabora Region for dissemination and use.

Output 1112 - Regional and district health authorities trained and mentored on planning, budgeting and monitoring of MNH plans

	ACTIVITIES	2020/2021 Year 4			
		April-June	July-Sept	Oct-Dec	Jan-Mar
		Q1	Q2	Q3	Q4
1112	1112 R/CHMTs trained and mentored on planning, budgeting and monitoring of MNH plans				
1112.3	Conduct quarterly CHMT Meetings and joint work planning	x	x	x	x
1112.5	Train R/CHMTs on HMIS			X	x

Indicators	Project Target	Y4 Target	Y4 Performance (April 1, 2020 – March 31, 2021)	Cumulative against Project Target
#/% of f/m CHMT members trained on developing CCHPs for RMNCH services	5 CHMT/district (40) 100 HF Staff	No target Completed	76 CHMT (41m, 35f)	119 CHMT (297%) 94 HF Staff (94%) 2 RHMT
# of f/m CHMT members trained on RMNH data analysis and utilization	1 CHMT member trained per district (8)	30 Health Facility Managers (18 Health Centres and 12 Dispensaries)	20 Health Facility Staff (12m, 8f) 8 CHMT (7m, 1f) (1 per district) 1 RHMT (m)	20 Health Facility Staff (12m, 8f) 72 CHMT members (180%) 2 RHMT (200%)

Support CHMT and Health Facilities on 2021/2022 Annual Health Facility Plans and CCHPs

While no CCHP training was planned in year four, an online training program was delivered at the request of the region to support the ongoing Health Promotion initiatives within the Tabora Region with a focus on refreshing and improving knowledge and skills of R/CHMTs on various aspects of Health Promotion including principles, processes, strategies and approaches (see COVID response activities above). In total, thirty participants were invited to participate in the program specifically, regional and district health promotion focal persons, regional and district Integrated Disease Surveillance and Response (IDSR) focal persons, and regional and district Community Based Health Promotion (CBHP) coordinators. Program sessions were held weekly for 1.5 hours over Zoom. CSIH facilitators presented the content for the weekly discussion, and participants were able to ask questions throughout the presentation, followed.

Health Facility Plan Assessment Tool

Up until the 2021/2022 planning and budgeting cycle, there had never been any requirement to conduct a formal assessment of plans (i.e., use of checklist/ assessment tool to score the performances of the health facility plans by the councils). The assessment process was previously not standardized, and each CHMT had their own customised approaches of aggregating their respective health facility plans to align with the CCHP guideline, and in the process, they would identify gaps and provide feedback to their respective health facilities. As this process was not documented, it was not possible to know precisely which facilities had weaknesses and strengths in which specific areas over time. The feedback mechanisms were also not standardized and often CHMT would make revisions to facility plans without informing them of the changes.

To address this issue, CSIH developed an assessment tool in 2019 to support the standardization of the assessment process in Tabora Region. Throughout this period of using the tool (i.e., piloting period), the tool has been continuously modified and improved so that the assessment process can be efficient, thorough and more objective. While it was planned to hand over the final version of this tool to the MoHCDGEC at the end of the TAMANI Project, the MoHCDGEC institutionalized their own assessment tool this year, requiring districts across the country to perform formal assessments of health facility plans in their catchment areas. Both the CSIH and MoHCDGEC tools are very similar, but considering that CSIH's tool has been tested and improved over three years of use, we feel it provides several advantages including:

- While lengthy, the tool covers all sections in the National Planning and Budgeting Guidelines for Health Centres and Dispensaries.
- The tool has weighted scores for different criteria.
- Most criteria are described in detail so that each assessor understands what to assess, and hence resulting in a more standardized process.
- An 'All or None' approach is used, meaning that there is no room for in-between scores particularly for this level where the information needs to be thorough and precise (this also reduces subjectivity by different evaluators).

Given what that CSIH and many of the Tabora CHMT have noted as advantages in the CSIH tool over the National Tool, there are still plans to present the tool to the MoHCDGEC in May 2021 along with recommendations on how to update/improve the national tools for roll-out prior to the 2022/2023 planning cycle.

Supporting CHMT to Assess Annual Health Facility Plans

In February 2021, CSIH facilitators provided technical assistance to CHMT from each of the 8 districts in Tabora to assess the submitted plans and provide feedback to the health facilities where necessary. The timing of this activity purposefully coincided with the timing of submission of 2021/2022 annual plans and budgets from health facilities to the CHMT to ensure maximum support and benefit. A total of 76 CHMTs were involved in the exercise in which a total of 63 health facility plans were assessed. This support builds on training provided to CHMT and Health Facilities on developing annual health plans, and support provided to CHMT in 2020 for assessing plans and providing feedback to health facilities.

It is noteworthy that this was the first time that a complete assessment of plans was done for the health facility plans for the upcoming fiscal year (in this case 2021/22). In similar previous activities, it was not possible to go through all components of the tool due to time limits and/or other additional objectives of those activities; and therefore, in most cases participants only had an opportunity to evaluate the first three (3) components of the tool (i.e., General Layout of the Plan, Executive Summary and Introduction). By conducting a full assessment of their respective health facility plans using the HFP Assessment Tool, most participants acknowledged that the exercise and the tool were very helpful to make them identify numerous weaknesses and hence understand what feedback (and how to provide the feedback) to the health facilities so that they can revise and improve their plans before final submission.

Overall, an improvement of performance scores was noted in many of the facilities that were assessed. Of all 63 plans assessed, 25 scored 80% and above, and 5 scored 90% and above. Ten health facilities did not perform well (below 70%) which contributed to a lower performance score of their respective councils. The CHMTs were advised accordingly to re-visit those with low scores and support them in improving their plans

In evaluating the plan assessment process, most participants were very happy with the exercises and commended the use of the too, noting it provided good guidance on how to identify errors, gaps and weaknesses of the plans, as well as how to provide feedback to staff of the health facilities. Participants committed to ensure that they apply the tool not only in assessing the plans but also in guiding revisions of plans before they are submitted to the RHMT. Participants also highlighted some areas for future improvement including having more time with facilitators to assess plans together, and timely dissemination of revised/updated guidelines to ensure that planners at facility level are informed in time.

Health Data Management and Analysis for Health Centres

A workshop to orient health facility staff from Health Centres on the DHIS2 platform use for data management and analysis was conducted in March 2021 with HMIS focal persons from 20 Health Centres across Tabora Region, as well as representatives from each CHMT and the RHMT. The RHMT selected Health Centres for participation based on greatest need for enhanced skills in this area.

This training was developed to fill gaps identified through previous activities focused on developing annual health facility plans and budgets. Although health centers were provided with access to DHIS2 in 2020 to conduct digital data entry, their personnel have not been provided with formal training to navigate or effectively manage data within the platform. As such, it was agreed that training on the use of DHIS2 for data management and analysis had to be conducted, in line with an orientation on MS Excel; a tool that most staff use for their basic data analysis.

A pre- and post-test was conducted to determine extent of learning from the workshop, and found knowledge improvement, with scores across all topic areas shifting from an average of 2.5 out of 5 up to 4.5 out of 5 following the workshop. Though the overall workshop was quite successful, with participants feeling that both the content covered and facilitation met or exceeded their expectations, several challenges were identified with the overall data management process at health centres. Not all health centres are adequately equipped with laptops for digital data entry. Another significant challenge is that those responsible for data management at the health centres are often not included in the planning and budgeting process, which results in poor quality or inappropriate data being used in the development of annual health facility plans. Finally, Health Centres expressed the need for further trainings and hands-on practice with data management and analysis, and it was suggested that CHMT continue to work with these health centres, and others across their districts to improve skills.

Conduct quarterly CHMT Meetings and joint work planning

Nine quarterly CHMT meetings were conducted between April 2020 – March 2021 in Tabora municipal, Igunga, Nzega TC and Urambo district councils. The need to maintain social distancing and limiting the number of people in gatherings led to postponing many of these meetings. A total of 154 participants (92f; 62m) participated in the meetings. The project phased out support to CHMTs meeting in Q3.

The main discussion topics included technical support in planning and budgeting preparation at facility level and clear observed challenges occurred in previous plan with timely submission at regional level. Other issues discussed were report submission, data quality of reports, sustainability of CHWs performance following TAMANI project phasing out for maintaining RCH indicators performance.

In Igunga, Nzega TC and Urambo the CHMT meetings focused on CHW sustainability and supporting data quality assessment to ensure availability accurate quality data for planning and budgeting based on actual community needs. At Tabora municipal CHMT agenda focused on making close follow to contractors who builds the new district hospital and Tumbi dispensary buildings are implemented according to agreed contract and finish on time with quality. All CHMT meetings conducted in this reporting period were done without close project support, but feedback provided to project staff. In Urambo CHMTs discussed possibilities of incorporating 2 CHWs per health facilities in payments for budget of 2021/2022 and linking them to another existing program under UAMTI and MDH.

Output 1113 - Reproductive, maternal and newborn health systems research projects conducted

	ACTIVITIES	2020/2021 Year 4			
		April-June	July-Sept	Oct-Dec	Jan-Mar
		Q1	Q2	Q3	Q4
1113	1113 Maternal and newborn health systems research projects conducted				
1113.4	Conduct research dissemination workshops				X

Indicators	Project Target	Y4 Target	Y4 Performance to date (April 1, 2020– March 31, 2021)	Cumulative against Project Target
# of research projects	2 research projects	2		1 (50%)
# of reproductive, maternal and newborn health publications written	3 publications	1	1	2 (66.6%)

Health Research Projects

The gender qualitative research was completed. The second research project is the step wedge evaluation, which will be completed at the end of the project but is well underway.

Health Publications

The project previously participated in the White Ribbon Alliance's "What Women Want" global campaign, collecting 1600 responses from women and girls in Tabora on their one RMNH priority. This data has been analyzed and the project developed and disseminated an infographic (previously shared). In addition, the evaluation protocol was finalized in Year three and submitted for publishing by McGill. It is also being published by McGill via their Website in Q3. With the policy briefs being finalized in May 2021, the publications have been pushed to Q1 of year five and will be reported on in the Final Report.

Conduct Research Dissemination Workshops

Research dissemination workshops were originally planned as part of the endline data dissemination and sense making by McGill University. Given that travel from Canada to Tanzania is still not advised, these plans have been revised to an online learning session in August 2021 to present the endline analysis.

Output 1114 - Policy briefs on priority issues related to RMNH written and disseminated for district, regional and national decision making

	ACTIVITIES	2020/2021 Year 4			
		April-June	July-Sept	Oct-Dec	Jan-Mar
		Q1	Q2	Q3	Q4
1114	Policy briefs on priority issues related to RMNH written and disseminated for district, regional and national decision making				
1114.2	Develop policy briefs			X	X
1114.3	Conduct Consultations on Research Findings				

Indicators	Project Target	Y4 Target	Y4 Performance to date (April 1, 2020 – March 31, 2021)	Cumulative against Project Target
# of policy briefs written and disseminated	5 policy briefs	5 Policy Briefs	1	1
# of reproductive, maternal and newborn health consultations held at local, district, regional and national levels	5 consultations	10 Consultations	0	0

Policy Briefs & Consultations

The development of the policy briefs are driven both by key learning and project outcomes, as well as policy interests and gaps in Tanzania. These themes were selected to fill research and evidence-based policy gaps both in the healthcare and research landscapes of Tanzania.

SOGC and AGOTA have completed a policy brief highlighting learning related to the EmONC simulation-based evaluation and coaching strategy implemented within the project. The analysis focuses on the knowledge and skills retained by the health providers related to the management of four neonatal and obstetrical complications captured via the OSCE's and provides high level recommendations for the MoHCDGEC (See Annex F). Once the respectful maternity data is available from the endline household survey, SOGC will work with McGill to develop a policy brief integrating learning on this aspect of the project to be finalized in May 2021.

CSIH is drafting two Policy Briefs to inform decision making at the regional and national levels on the overall planning and budgeting process for health service delivery, highlighting key resources, challenges, and areas for improvement. These policy briefs will be finalized in Q1 of Year 5 following the integration of CSIH's endline evaluation data.

CARE is working on a paper on CHW influence on access to services and behaviour change at the household level, which will be complemented by the endline gender qualitative research as well as CHW exit survey data that looks at CHW change at the individual level. This includes their role as agents of change and promoting change through household counselling and their position within their communities.

IHI is contributing substantive expertise on research and policy needs, while McGill is supporting on the analysis side. These policy briefs will be completed during Q1 of Year 5.

Output 1121 - Emergency transportation system for pregnant and postpartum women and newborns developed

	ACTIVITIES	2019/2020 Year 4			
		April-June	July-Sept	Oct-Dec	Jan-Mar
		Q1	Q2	Q3	Q4
1121	1121 Emergency transportation system developed				
1121.3	Conduct quarterly monitoring for emergency transportation	X	x	X	x

Indicators	Project Target	Y4 Target	Y4 Performance (April 1, 2020 – March 31, 2021)	Cumulative against Project Target
#/% of villages with emergency transportation systems	20 villages	37 villages	37 village	40/20 200%
#/% of pregnant women, and adolescent girls using emergency transportation	10 referrals/ ambulance/ month	10 referrals/ ambulance/ month	8 referrals/ ambulance/ month	80%

Quarterly Monitoring for Emergency Transportation

Between April 1st, 2020, to March 31st, 2021, TAMANI monitored the function and utilization of emergency transportation. All four ambulances are in good condition and continue to operate well and are maintained under district communities and council management. During this period the project noted that district councils increased monitoring and support to running costs including drivers salaries, fuel, and maintenance costs for both new and old ambulances.

Status for each ambulance is summarized below:

- Mibono dispensary (Sikonge district): the vehicle is in good condition and working, it continues to serve the assigned community and surrounding villages in the Mibono catchment area and has a permanent driver assigned.
- Goweko dispensary (Uyui district): the vehicle has a permanent driver employed by the district council in the FY 20/21
- Tura dispensary (Uyui district): working in good condition, operation costs are covered by the community, while maintenance costs are covered by the district councils. Both Goweko and Tura drivers have been employed by the district council.
- Usinge dispensary (Kaliua district): the vehicle is in good condition, the district council has made minor maintenance and tire replacement.

The ambulances served a total of 354 referrals from April 1st, 2020, to March 31st, 2021 (169- Q1 and Q2, 185-Q3 and Q4).

The clients included pregnant women and children that required emergency services and were referred because of poor progress of labor, prolonged labor, post-partum hemorrhage, anemia and malaria. The project is expecting the number of referrals per ambulance per month will continue to increase now that permanent drivers have been employed. The construction of new health centers which provide CEmONC services closer to communities is also reducing referrals for C-sections.

Lessons learned from TABASAM indicate the management of ambulances works best if it is in partnership between the government and communities. Left alone, communities are unable to foot costs for major maintenance or driver's salary. Similarly, the government cannot cover all costs due to limited budget. Hence, the project has advocated for a community-government ownership model.

Ambulance Referrals Per Community

Ambulance	Q1	Q2	Q3	Q4	Total
Mibono	21	27	16	18	82
Goweko	9	12	10	11	42
Tura	25	10	19	15	69
Usinge	19	46	42	53	160
Total	74	95	87	98	354

TABASAM Ambulances

The project continues to monitor the 16 ambulances supplied by TABASAM. During this reporting period, they served a total of 1,131 referral cases. The ambulance located at Ubinga dispensary in Nzega DC is under major maintenance financed by the council following road accident due to heavy rainfall, however no injuries occurred. All vehicles are currently in good condition and continue to serve project beneficiaries.

Output 1122 - Health facilities equipped and rehabilitated

	ACTIVITIES	2020/2021 Year 4			
		April-June	July-Sept	Oct-Dec	Jan-Mar
		Q1	Q2	Q3	Q4
1122	1122 Health facilities equipped and rehabilitated				
1122.2	Health facilities rehabilitated	x	x		

Indicators	Project Target	Y4 Target	Y4 Performance (April 1, 2020 – Sep 30, 2020)	Cumulative against Project Target
#/% of health facilities equipped and/or rehabilitated to provide BEmONC & CEmONC	4 Health centers (CEmONC) 70 Dispensaries (BEmONC)	1 Rehabilitation project *	1 Rehabilitation project completed	11 Health Centers (275%) & 158 Disp. (225.7%)

*Note the target was incorrectly noted as 11 in the Y4AWP, it should have read 1

Health facilities equipped to meet C/EmONC standards

The project completed the supply of EmONC equipment to health facilities in Year 3. Project monitoring on the use of the equipment has been integrated into various activities such as coaching and mentorship, CHMT supportive supervision visits, and when project staff visit communities for other project activities.

During the EmONC coaching and mentorship sessions to the four councils of Tabora Municipal, Uyui, Nzega TC and Sikonge DC the coaches looked at the efficiency and utilization of the distributed equipment. Health care providers provided feedback that the equipment is very useful and enabled them to use their acquired knowledge and skills in providing services to pregnant women at RCH clinics. For example, delivery kits assisted with performing safe deliveries in the labor rooms, weighing scales for measuring newborn weight and blood refrigerators at CEmONC centers. The project team also learned that the challenge with some facilities not having enough cuvettes for HB machine is more of a priority setting issue as opposed to an actual availability issue. The project continues to advocate for budgets for cuvettes and ensuring safeties to equipment provided to all CHMTs.

Health facilities rehabilitated

The final rehabilitation project was completed in Q2 of Year four. The table below summarizes the final list of rehabilitated facilities. Given that all but one project was non-structural in nature, CARE has followed the Contribution Agreement guidelines and included regular updates in project reports, as well as updated the construction plan for the structural Zogolo HC project in the Semi-Annual Operations Report submitted to GAC in November 2021.

In total 21 rehabilitation projects were completed including the solar power projects.

District	Facility	Works	Status
Urambo DC	Urambo Hospital	Rehabilitation of maternity ward	Completed
Nzega DC	Bukene HC	Rain water harvesting system: Guttering, water tank and base	Completed
	Kahama Nhalanga	200W solar system	Completed
	Igusule Dispensary	200W solar system	Completed
	Ugembe Dispensary	200W solar system	Completed
	Nkindu Dispensary	200W solar system	Completed
Uyui DC	Miswaki Dispensary	Rain water harvesting system: Guttering, water tank and base 200W solar system	Completed
	Miyenze Dispensary	Rain water harvesting system: Guttering, water tank and base 200W solar system	Completed
	Ishihimulwa Dispensary	200W solar system	Completed
TMC	Tumbi Dispensary	Rain water harvesting system: Guttering, water tank and base	Completed
	Kakola Dispensary	200W solar system	Completed
	Umanda Dispensary	Rain water harvesting system: Guttering, water tank and base	Completed
Kaliua DC	Nsimbo Dispensary	Finishing works: Tiling, and RWH System: Guttering, water tank and base	Completed
Igunga DC	Majengo Dispensary	Rain water harvesting system: Guttering, water tank and base	Completed
	Mwamashinga Dispensary		Completed
	Mwanyagula Dispensary		Completed
	Tambalale Dispensary		Completed
Nzega TC	Zogolo HC	Water Tower, Rain water harvesting system and Plumbing	Completed

	Undomo Dispensary	Installation of 200W solar system	Completed
Sikonge DC	Kipili Dispensary	Finishing works: Ceiling, Doors, Windows, Plastering, Painting	Completed
	Igalula Dispensary	200W solar system	Completed

The maternity word rehabilitated by TAMANI project at Urambo district hospital has attracted more pregnant women to use delivery services. According to Urambo DRCHCo, between May 2020 to March 2021 a total of 2,426 women came to the facility to deliver which is a 6% (137) increase in deliveries compared to the previous period. The maternity ward is now more comfortable and provides privacy following exterior and interior painting, partitioning, the fixing of tiles and installation of a new entrance door. Following the completion of the rehabilitation, the facility hosted a special room for Kangaroo mother care (KMC) services for the labor ward building.

Figure 1 Urambo District Maternity ward rehabilitated

Figure2 Client supporter Asha Juma fetching water at Bukene H/C

At Sikonge DC the Kipili facility RCH building is completed and MNCH services are now underway. A community member explained, “before the new building women were getting services in a small room with congestion that led pregnant women to wait outside, it was worse during the rainy season”. And a health care provider noted, “Thanks to the TAMANI project for improving the maternity wing, I now feel very comfortable with the environment which enables us to work extra time serving mothers while pregnant and other clients who seek MNCH services like FP have space for confidentiality. The building is also used to for vital medication and equipment.

Safe and readily available water at the health facility is important for public health, whether it is used for drinking, hygiene and sanitation. Improved water supply and sanitation, including better management of water resources can prevent infections and the spread of disease, protect staff and patients, and uphold the dignity of vulnerable populations.

In Kaliua district at Nsimbo dispensary, the health facility in charge Madina Haji revealed explained that before the rain water harvest system was installed the facility was using water from a local vendor who supplied water through buckets of 20 liters costing 100 TSH each. The facility was using maximum of 10

buckets of water for cleaning and client use per day equalling 1000 TSH. Availability of rainwater harvest system with capacity of 5000 liters is now serving the facility. A full tank can serve the facility for 50 days which is equal to 50,000 TSH savings.

Primary health care facilities are frequently the first point of care, especially for those in rural areas. They also are critical in responding to disease outbreaks, such as diarrhea, cholera and waterborne diseases.

The health facilities demonstrated simple measures on hygiene such as improving cleanliness of toilets or installing low-cost handwashing stations and water treatment at health care facilities improved quality of care, increased uptake of services and encouraged community members to change hygiene practices at home (e.g. regular handwashing with soap).

The burden of infections is especially high in newborns as sepsis and other severe infections are major killers of newborn at peripheral areas. Lack of access to water and sanitation in health care facilities may discourage women from giving birth in these facilities or cause delays in care seeking. Conversely, improving hygiene and sanitation conditions can help establish trust in health services and encourage mothers to seek prenatal care and deliver in facilities rather than at home thus reduce maternal mortality.

Installation of solar system to support night deliveries

From April 1st, 2020, to March 31st, 2021, a total of 1,561 night deliveries occurred at 10 health facilities that received solar power from the project. The solar power system has improved the delivery of medical services by ensuring quality light during treatment of nighttime emergencies, emergency deliveries and for security purposes at the main building and staff quarters. It reduced expenditure on energy sources for lighting and anecdotally has increased motivation and morale of health staff who can work safely at night and is a source of charge for cell phones, especially in remote rural areas with no access to grid power. According to HMIS data, a 203% increase was noted in nighttime deliveries at these health facilities comparing the period of Oct 2019-Mar 2020 (320 deliveries) to Oct 2020 to March 2021 (971 deliveries).

Follow-up and Monitoring of Rehabilitation Projects

Site inspections were either initiated by the project or requested by contractors. A typical site inspection involved TAMANI project engineer, district engineer, the contractor, and representatives from Health Facility Governing Committee. Assessments focused on preliminary work (e.g., mobilization and demobilization), as well as progress made on the work as per the BOQ including how the ongoing or completed project adhered to the recommendations from ESIA. Feedback on project performance is provided on site and thereafter documented in an assessment report signed by the district engineer. To date, all projects have received two of these visits. For more information on the audit findings, see the Environmental Sustainability section.

Output 1131 - Job aids disseminated based on GoT's RMNH clinical practice guidelines

	ACTIVITIES	2020/2021 Year 4			
		April-June	July-Sept	Oct-Dec	Jan-Mar
		Q1	Q2	Q3	Q4
1131	1131 GoT maternal and newborn care clinical practice guidelines adapted and implemented				
1131.2	Develop Job Aids				

Indicators	Project Target	Y4 Target	Y4 Performance (April 1, 2020 – Mar 31, 2021)	Cumulative against Project Target
# of job aids developed	4 Job Aids	Completed No Y4 target	Completed No Y4 target	4 Job Aids 100%
# of health facilities with job aids	140 Health Facilities	n/a	Completed No Y4 target	265 Health Facilities 189%

The four job aids were developed and approved by the MoHCDGEC and printed in year two and distributed in Q1 of year three. The job aids are in Swahili and provide guidance on the management of PPH, Eclampsia, Newborn Resuscitation, and the Active Management of Third Stage of Labor. Before distribution to the health facilities, the DRCHCO's were oriented on the use of the job aids and will serve as the contact persons in case health providers have questions. As part of the distribution process, health care providers were oriented on the use of the job aids. The project staff continue to monitor the use of job aids at health facilities.

Output 1133 - Health care workers mentored on CE/BEmONC and family planning

	ACTIVITIES	2020/2021 Year 4			
		April-June	July-Sept	Oct-Dec	Jan-Mar
		Q1	Q2	Q3	Q4
1133	1133 Health care workers mentored on BEmONC, CEmONC and family planning				
1133.2	Mentoring visits at 6 and 12-month post-training using OSCE's		x	x	

Indicators	Project Target	Y4 Project Target	Y4 Performance (April 1, 2020 – March 31, 2021, 2021)	Cumulative against Project Target
# of m/f health care workers mentored on CE/BEmONC and family planning	270 health care workers (12 months post-training)	270 health care workers (12-months post-training) (Target Y4 should have been 130)	91 HCW (51f; 40m) (91/130) = 70%	200 (93m&107f))/270 (149m&121f) health care workers at 12 months post training 74%

In this reporting period, the final 12-month coaching and mentoring visits were completed for EmONC graduates in Uyui district and Tabora Municipal council and Sikonge & Nzega TC. In total 91 HCW's (51f; 40m) were coached on clinical skills at the facility in which they are based. Coaching sessions promote the retention of knowledge, skills and confidence through competency-based clinical skills practice with anatomical models to build confidence while protecting patients from harm. Out of a total of 130 trained graduates, 91 HCW's were coached and mentored at these 12-month visits reaching 70% of trainees. The reason for missing these training graduates included annual, maternity and study leaves. An additional 77 (48f; 29m) HCW's were coached and mentored as part of these visits, given their role in providing labour and delivery services at the visited facilities.

During the reporting period, AGOTA President and Honorary General Secretary joined the field team to monitor and follow-up on AGOTA activities. This included discussions with various TAMANI staff, visits to the Tabora RHMT Office and participation in the coaching and mentorship visits with feedback provided to the coaches post-mentoring. In order to promote transfer of skills, the team was also joined by CHMT members from respective districts.

Demo: How to perform neonatal resuscitation

Demo: Administering of magnesium sulphate

To protect everyone's safety, each coach was provided with hand sanitizer, surgical masks and spent nights at guest houses that required visitors to wash hands before entering and when exiting. Coaches maintained social distancing while conducting C&M at HFs. Drivers of project vehicles followed hygiene protocols as provided by the organization i.e. sanitizing door handles, and interiors surfaces right after each use and maintaining a maximum number of four passengers during any trip.

Completed Coaching and Mentoring Missions

Dates	Districts	Male	Female	Total	Additional HCP's
Sep-18	6 month Urambo & Kaliua	31	31	62/70	n/a
May-19	12 month Urambo & Kaliua	27	31	58/70	21 (9m/12f)
July – August 2019	6 month Igunga & Nzega DC	28	30	58/70	37 (15m/22f)
Nov-19	6 month Tabora Municipal & Uyui	20	35	55/65	68 (19m/49)
Jan – Feb 2020	6 month Sikonge & Nzega TC	24	29	53/65	32(14m/18f)
Mar-20	12 month Igunga and Nzega DC	26	25	51/70	36(11m/25f)
August - Sept 2020	12 month Tabora Municipal & Uyui	18	29	47/65	43 (13m/30f)
Nov – Dec 2020	12 months Sikonge & Nzega TC	22	22	44/65 (68%)	34 (16m/18f)

EmONC mentorship and coaching intervention was completed during the reporting period, successfully reaching 200 participants at the 6- and 12-month mark (74%). CARE and AGOTA will takes highlighted key learning and policy recommendations to MoHCDGEC and PO-RALG for future programming as well as present key learning in the related policy brief in development.

Output 1134 - Maternal death audit developed and implemented

	ACTIVITIES	2020/2021 Year 4			
		April-June	July-Sept	Oct-Dec	Jan-Mar
		Q1	Q2	Q3	Q4
1134	1134 Maternal death audit system developed				
1134.2	Conduct quarterly maternal death review meetings	x	x	x	x

Indicators	Project Target	Y4 Project Target	Y4 Performance (April 1, 2020 – March 31 2021, 2021)	Cumulative against Project Target
# of meetings and workshops to sensitize R/CHMT on MPDSR process and gaps, to align with GoT priority to follow MPDSR policy	10 meetings	6 meetings	7 meetings	26/10 260%

During this reporting period, seven maternal death review meetings were conducted in Kaliua, Urambo, Nzega TC and Sikonge between April 1st, 2020 – March 31st, 2021, to review a total of 14 deaths. The main causes of maternal mortality were hypovolemic shock secondary to post-partum hemorrhage, eclampsia, puerperal sepsis and severe anemia, severe malaria, and rupture of the uterus.

In addition to the district meetings, between November 5th to 7th, 2020 the Tabora region conducted the regional Maternal Perinatal Death Surveillance and Response (MPSDR) meetings in Nzega town council. The objective of the meeting was to review regional level strategies and progress made on MPDSR and put forward recommendations to reduce maternal and perinatal death in the region. A total of 78 (28 f; 50 m) participants attended who were comprised of RHMT, CHMTs, HCWs, and implementing partners. The meeting was held without TAMANI support.

The following key points were shared regarding progress in the region:

- Reported maternal Deaths declining 69 (2018); 62 (2019); and 42 (Jan – Sep 2020). Sikonge district is leading in maternal deaths due to home deliveries and remoteness of health facilities.
- While health facilities are expected to budget for MNCH services, there are very limited resources: reductions in basket and RBF funding
- Now that Uturo model has been suspended, the government needs to come up with an alternative model to continue support demand creation
- Strategies for collecting blood need to be reworked, while districts are investing high efforts, they don't receive the required amount for supporting emergency cases

The following action points for 2020/21 were agreed upon:

- Districts together with communities to plan for sustainability of TAMANI supported CHWs
- Review performance of all HB machines, stop using the ones with malfunctions
- Provide on the job coaching to lab technicians when new machines are supplied
- Provide more internship opportunities for new HCWs before deployment to HFs

Intermediate Outcome 1200 (Demand): Increased utilization of reproductive, maternal and newborn health services by women and their families in targeted districts of Tanzania

Output 1211 - CHW program for reproductive, maternal and newborn health and family planning implemented

	ACTIVITIES	2020/2021 Year 4			
		April-June	July-Sept	Oct-Dec	Jan-Mar
		Q1	Q2	Q3	Q4
1211	1211 CHW program for MNH and FP implemented				
1211.4	Provide stipends for CHWs	x	x	x	x

Indicators	Project Target	Y4 Target	Y4 Performance (April 1, 2020– Sept March 31, 2021)	Cumulative against Project Target
# of m/f CHWs trained	1000 m/f CHWs	No Target Completed	Completed	997 (459m/538f) CHW's (99.7%)
# of m/f CHWs equipped with bicycles, bags etc.	1000 m/f CHWs	No Target Completed	Completed	997 (459m/538f) CHW's (99.7%)

CHW Training

The process of phasing out TAMANI support for CHW stipends was completed in Q3 of Y4, the last district councils were Uyui, Tabora Municipal, Sikonge and Nzega TC. The district councils and CHMTs are working to sustain and motivate CHWs but resource limitations remain a challenge. To date there are 595 (317m, 278f) active CHWs as shown in table below:

Community Health Workers Retention to Date

District	Date	Male	Female	Total CHW's
Igunga	2021 - March	38	36	74
Kaliua	2021 - March	52	16	68
Urambo	2021 - March	54	39	93
Nzega DC	2021 - March	40	46	86
Nzega TC	2021 - March	13	18	31
Sikonge	2021 - March	44	36	80
Tabora MC	2021 - March	29	54	83
Uyui	2021 - March	47	33	80
		317	**278**	**595**

The 595 CHWs (317m; 278f) are active across all eight districts. four clusters. The CHMTs and CHW Supervisors are continuing to motivate the CHWs at their respective facilities by including them in Family Planning campaigns and vaccination mobilization activities which have CHW incentives. Those who dropped out stated that it difficult to continue the work without the financial stipend which their families depend on. For those that have been retained, the good working relationship they have with the communities and the health facilities was indicated as a major motivation.

According Karitu facility in charge, there is still a shortage of human resources in most of health facilities in Nzega DC so CHWs play a big role in supporting staff. "We have managed to retain all four TAMANI CHWs, they are very helpful to us and are included in our staff roaster and assigned various roles in RCH and CTC in addition to visiting households." And at Jionee Mwenyewe dispensary in Urambo district CHWs have

been included in the HF annual plan budget through Basket Fund FY 20/20-2021 and RBF as one of the retention mechanisms.

Other health facilities in Utambo e.g. Igunguli, Nsongolo, and Kiloleni dispensaries committed to sustain CHWs through a partnership with the community. For example, CHWs participate in monthly outreach activities and are paid per year through village revenues (SESI). Each CHW is granted a CHF card that is deducted from the RBF fund payment

In Kaliua, the district has implemented a CHW sustainability strategy that includes incorporating CHW's as part of the CCHP, orienting ward and village leaders on the roles of CHWs as a helping hand in promoting community healthcare and as an important link between the community and facility. The district is engaging CHWs as CHF enrollment officers in the areas that have no such services, and in important health campaigns such as immunization week. In addition, CHWs are exempt from participating in community monetary contributions in exchange for their work.

1212 - Youth friendly sexual and reproductive health services developed and implemented

	ACTIVITIES	2020/2021 Year 4			
		April-June	July-Sept	Oct-Dec	Jan-Mar
		Q1	Q2	Q3	Q4
1212	1212 Youth friendly SRHR developed and integrated into care				
1212.4	Train health care workers on youth friendly services			x	
1212.5	Mentor health care workers on youth friendly services			x	x
1212.6	Conduct community youth sexual education meetings			x	x

Indicators	Project Target	Y4 Target	Y4 Performance (April 1, 2020 – March 31, 2021)	Cumulative against Project Target
# of Youth and HCW's trained on Youth SRHR friendly spaces	160 m/f HCW 80 m/f Youth	80 health care workers 4 m/f Youth	80 (32m/48f) HCWs on youth friendly	160 HCW's (55 m; 105 f) 100% 76 Youth (38 m;38 f) 95%
# of districts (CHMTs) with m/f Youth SRHR focal points	8	Completed No Y4 target	Completed No Y4 target	8(2 m;6 f) CHMT Adolescent focal person trained on ASRH 100%

Train Health Care Workers on youth friendly services

During the reporting period TAMANI trained an additional 80 (32m; 48f) HCWs on youth friendly services. This was the last phase of training of HCP's from TAMANI supported facilities on the provision of youth friendly services at their respective health facilities reaching the project target.

Community ASRH education meetings

During the reporting period, the project did not facilitate any large community ASRH education meetings with youth champions to minimize the risk of COVID-19. Trained youth champions have conducted individual awareness sessions and outreach with in school & out of school youth on ASRH in collaboration with health facilities in their respective areas without the support of TAMANI, in Igunga DC, Sikonge DC, Kaliua DC and Tabora Municipal. A total of 1734 (898m; 836f) youth have been reached. Topics covered included sexually transmitted infections, life skills, drug abuse, reproductive health and rights including early pregnancy and family planning. These sessions play dual roles in the project; to inform youth on ASRH issues as well as building a base for continuation of youth work with the absence of project staff.

''I share information with my fellow youth every day on the street especially issues related to sexually transmitted diseases like gonorrhea and symphysis. Mostly we discuss about the ways of infection and prevention. I have seen changes in the community as young people are keeping themselves busy rather than remaining idle. In the evening hours youth engage in sports so as to prevent themselves from engaging in spaces where there are drugs and risky sexual behaviors. I provided this advice to my fellow youth in the community, and I am glad I am seeing those changes. This has benefits because it prevents youth from engaging in negative behavior but also it increases the welfare of the community''. (Male Youth Champion, Kigwa B).

1221 - Gender-sensitive reproductive, maternal and newborn health community scorecards conducted

	ACTIVITIES	2020/2021 Y4			
		April-June	July-Sept	Oct-Dec	Jan-Mar
		Q1	Q2	Q3	Q4
1221	1221 Gender-sensitive MNH community scorecards conducted				
1221.2	Conduct Community Meetings			x	x
1221.3	Conduct interface Meetings			x	x

Indicators	Project Target	Y4 Target	Y4 Performance (April 1, 2020 – March 31, 2021)	Cumulative against Project Target
# of communities using community scorecards	24	24	24	100%

Gender-Sensitive RMNH Community score cards (CSC)

The goal of the CSC process has been to engage community members in health policy and planning to ensure health facility and government accountability to community needs. Between April 1st, 2020 and March 31st, 2021, the project did not conduct any CSC sessions due to Covid-19, but the project has been working with the CSC task force teams in each community to follow up on the action plans. Community leaders and facilitators were encouraged to use the CSC approach during village meetings to assess progress made in implementation of action plans

CSC Action Plan Updates:

- Uyui District Council at Itinka village hired a security guard and another health care worker which has helped to decrease wait times. According to a community leader the attitude and practices of service providers has improved, and community members are reporting that they receive services without being insulted. At Shitage village they addressed the emergency transportation issues by using Ishihimulwa ambulance with affordable price of TZS 80,000/ trip compared to private costs of 200,000-300,000/- Tzs. At Shitage dispensary, toilet doors have been installed with District Council support. The village-led building of a toilet building is in progress at the Shitage dispensary.
- In Kaliua district council at Kashishi village, the construction of 6 latrines for patients is planned to start in on the of 1st April 2021. A meeting was held to discuss the construction of a health facility, and community members agreed to collect a contribution of TZS 700/- per household which started on the 1st of April, 2021. The area for construction has already been allocated. According to the VEO, the CSC approach is now used as reference platform when new development projects are being planned.
- Tabora municipal has demonstrated responsiveness towards requests from the community at Tumbi village of employing staff. An additional six staff were employed increasing the number of HCWs from 3 to 9. Two dialogues were conducted, and special days were selected to sensitize men on accompanying their partners for RMNCAH services. The community and government have worked together to start building a Health Centre with 8 staff houses, currently the OPD building has been constructed and the village has received a 200 million TSH fund from the government to contribute to the construction.
- Urambo district council allocated one health care provider to compliment the shortage of staff at Itebulanda dispensary, while community concerns led the village government to hire a security guard immediately after the CSC session. Community concerns at Izimbili dispensary led to the construction of additional maternity rooms which received financial support from one of the national natural reserve authorities bordering Izimbili village (via corporate social responsibility funding) and village collections. In this reporting period, the facility used its own funds and other support from central government to complete the roof. Emergency numbers and contact persons'

names have been displayed at the facility as agreed in the meeting, which includes the numbers for the HCW in charge, DMO, RMO and PO-LARG. At Itebulanda community concerns led to the hiring of a security guard, the dispensary hired and paid from the facility fund. The facility also managed to buy a water tank for reducing the shortage of water at the facility.

- In Igunga district the community of Mwisi village has contributed to finishing the RCH building and some services such as ANC and family planning have been shifted to the new building to reduce the congestion of services. Mwisi dispensary has also included a plan to install water taps allocated from the main source of the facility budget for FY 2021/2022. Ndembezi dispensary is working to finish the remaining rehabilitation work (floor tiles, colors and gypsum board) of the RCH building which will be covered in the budget for FY 2021/2022.

1222 - Communities sensitized on gender-sensitive reproductive, maternal and newborn health

	ACTIVITIES	2020/2021 Year 4			
		April-June	July-Sept	Oct-Dec	Jan-Mar
		Q1	Q2	Q3	Q4
1222.3	Conduct community dialogues on SRHR/MNH with VSLA and community groups			x	x
1222.4	Conduct community awareness for SRHR			x	x

Indicators	Project Target	Y4 Target	Y4 Performance (April 1, 2020 – Mar 31, 2021)	Cumulative against Project Target
# of men engaged on RMNCH issues	1500	500	No community meetings conducted due to COVID-19	2495 166%

TAMANI has used different approaches to engage communities in discussions on issues related to SRHR and RMNCH. SAA dialogues were organized by VSLA also organized to engage the wider community through drama and group discussions. See below reporting on each activity. Important to note that to avoid double counting the indicator above was calculated by counting men who attended the large community events.

SAA Dialogues

In total 79 SAA meetings were facilitated to follow-up on SAA action plans. These included issues related to male engagement and support for MNH services, barriers to facility-based births, teen pregnancies, use of local herbs in pregnancy and delivery and addressing the unequal division of household's tasks including women's burden of care, and improving couple communications.

A total of 3941 (1669m/2272f) community members participated in the meetings conducted in Mwisi and Ndembezi village in Igunga, Kisanga village in Sikonge, Shitaga village in Uyui, Kashishi village in Kaliua, and Izimbili, Itebulanda & Songambele village in Urambo districts.

- At Igunga District Council at Mwisi and Ndembezi village the focus of the meetings were to improve male engagement and increasing awareness on MNH issues and services. In total 48 meetings were conducted, which included targeted meetings with traditional and religious leaders to encourage male education, involvement and participation.
- At Uyui district at Shitage village, Village leaders decided to address couple communication on MNH as a permanent agenda in every meeting. To date, four meetings were conducted where 244 (241m/203f) couples participating to discuss and improve couple communication with respect to family planning services.
- At Kaliua District awareness sessions were carried out with targeted messages on discouraging home delivery and the possible risks for mother and child and the importance of facility delivery. The sessions were facilitated by CHWs and a registered nurse and included participatory decision-making targeting male partners/spouses.
- At Sikonge the focus of the follow-up meeting was on male involvement in MNH services and encouraging male participation and support for MNH and FP services.
- At Urambo district sessions were held with VSLA members and adolescent girls on the negative impact of using local medicine, attending MNH services, dangers with home delivery/TBA, and family planning. The meeting led by village leaders, CHWs, VSLAs leaders and health care workers was reported as resulting in 30 girls choosing a family planning method at the local health facility.

During this reporting period, TAMANI conducted six SAA dialogues that integrated COVID-19 issues into the discussions. Participants noted that families have been affected by the pandemic and this has been experienced by men and women differently. Participants noted that women were less likely to attend ANC clinics and access family planning and an increasing number of home deliveries because of fears of contracting COVID-19 at health facilities. Similarly, adolescent girls and boys feared to seek reproductive health services. Early pregnancies, abortion and early marriages were noted as on the rise as girls and boys remained home from school. An increase of SGBV cases were also noted as a resut of Linked to increased stress and decreased mobiltity.

While community members explained that they adhered to government protective measures such as wearing a mask, social distancing, regular hand washing and avoiding social gatherings, they had also their own preventive strategies such as traditional herbs and steam inhalation which included drinking lemon, ginger, tree leaf juice, working under the sun and praying to God and their ancestors. Misinformation related to COVID-19 will likely be a key issue to address in future vaccine roll-out campaigns.

The SAA dialogues were also used to generate new action plans. During the discussion which also involved health care providers, the community development officer, and social welfare focal person, the following new community actions were committed to:

Theme	Action	Responsible
Home delivery & Traditional birth attendants	- Education provision via mobilization, sensitization and encouraging women on utilizing health facility services. - Awareness creation on adverse effects of home delivery within a group and during village meetings. - -Conduct meeting with TBAs and oriented their roles, government policies and guidelines towards home delivery.	Groups, Village leaders, religion leaders, HCWs, Community facilitators, Male champions and influential people.
Use of local herbs as family planning methods	- Awareness creation on participatory decision making among partners/spouse. The awareness to be done both within a group and during village meetings. - -Awareness creation on participatory decision making in family planning issues.	Village leaders, VSLAs member, CFs & CHWs
Increased of teenage pregnancy	- Community awareness on impact of pregnancies on adolescent girls. - Awareness creation on joint childcare among adolescent girls and boys, including support from their parents	Village leaders, health care workers, CHWs, groups, health in charge, PEs and CFs
Poor/lack of participation of men in MNH services	- VSLA group in collaboration with CHW & CF to conduct Community sensitization during community meeting and religion session	Village leaders, religious leaders, Health care providers, CHW & CFs
Increase of family conflicts due to dropping of income during the pandemic	- Awareness creation on participatory decision making among partners/spouse. The awareness to be	-Group chairman/secretary for coordination -HF In Charge for technical issues

	done both within a group and during village meetings.	
Poor birth preparedness	- Conduct community education and sensitization meetings on the importance of facility-based deliveries and disadvantages of home deliveries/TBA for the safety of both pregnant mother and unborn child. - -Provide entrepreneurship education and opportunities to women and youths (girls in particular) and encourage them to join women economic groups so as to empower themselves financially/ give them financial decision-making power. - -Sensitize male involvement in maternal health care services and encourage them to attend ANC visits with their partners and having collective birth preparedness plan. - -CHWs and Community leaders (VEOs, Chairpersons) to conduct home visits to sensitize community members on the importance of facility-based deliveries, identify all pregnant women in their communities and link with the nearby facility for ANC clinic on time. - Village and hamlet governments to enact by Laws that will take into account partners/family members whenever a pregnant woman deliver at home so as to discourage home deliveries and TBA services	Ward Executive Officer (WEO), Village Executive Officer (VEO), Chairperson, Religious leaders, CHWs, HCWs, CFs
Men/mother in law/father in law has final decision making on place of delivery	- Awareness creation on importance of participatory decision-making during village meetings and VSLA groups	Groups, chairman/Secretary for coordination, religious leaders, CHWs & Village leaders

Conduct community awareness for SRHR

During this reporting period, no large community awareness activities for SRHR meetings were conducted due to the Covid-19 outbreak in Tanzania and directives from the government and CARE to minimize gatherings which could pose risks to project participants and staff. Community awareness meetings that were cancelled due to evidence of another wave of infections in the country. Awareness raising on SRHR has continued partly through CHW's work during household visits and SAA dialogues. Given that SAA dialogues are conducted in smaller groups with participants from the same community, the project was able to ensure safety protocols

Management Issues & Adjustments

With the outbreak of COVID-19 in Tanzania and directives from the government, the project adjusted the implementation of planned activities to minimize risks to project participants and staff. Project staff in Tanzania and Canada were guided to work from home in March 2020 and activities that were able to proceed without gatherings or were part of normal community and government activity continued as usual. Demand side activities, aside from the CHW interventions, were delayed or cancelled where they required large gatherings. Selected supply-side activities continued where they required minimal physical presence such as CHMT meetings, supportive supervision visits, and the last rehabilitation project. Partners adapted activities to comply with regulations, avoid gatherings and protect against furthering transmission.

In mid-July 2020, CARE Tanzania commenced with a phased re-opening based on revised norms in terms operational and activity levels, and a principled approach to 'protect oneself, and protect others at all times' by mandating wearing of masks, distancing, handwashing and increasingly moving events outdoors.

CSIH developed virtual/remote activities where field-based activities were planned, and field-based activities remained suspended through to the end of the second quarter with local consultants' travel resuming in October 2020. New operational guidelines were developed and presented to CARE Tanzania Staff and CSIH Consultants based in Tanzania.

SOGC made the decision to suspend all future volunteer travel to Tanzania, and as such, GAC approved a reduction in the in-kind target for the project to accommodate the changing context for international travel. SOGC immediately focused efforts on the production, collection and sharing of evidence-based sexual and reproductive health resources related to COVID-19, including resources for the international context. These included statements, clinical tools and evidence-based guidance produced by their members and network. These resources were shared with AGOTA to maintain quality of care and the health and safety of their members. These resources included, among others, advocacy statements related to:

- Birth partners during labor
- Protection of the Pregnant Health Care Workers
- Prenatal screening during Covid-19
- Breastfeeding during Covid19
- Covid19 Vaccination and pregnancy
- Covid19 vaccination and fertility

On December 31st, 2020, AGOTA's contract expired in alignment with the completion of the EmONC coaching and mentoring visits. As part of the official end of AGOTA's participation in TAMANI, SOGC and AGOTA developed a learning document that highlighted the mutual learning, successes and challenges of the two associations working together (see Annex G). AGOTA has committed to continue to engage with TAMANI on the finalisation and sharing of project learning as part of dissemination activities.

Changes to Risks & Analysis

The Risk Register remains unchanged from the Year Four semi-annual report. Risks related to COVID-19 remain with respect to access and uptake of health services. Risks related to the election and travel restrictions of government employees were removed. Please See Annex A.

Changes to Theory of Change, LM and PMF

No changes to the Theory of Change and Logic Model have been made since the PIP. No changes to the PMF have been made since the last report was submitted.

Gender Equality & Women's Empowerment

The TAMANI gender strategy is aligned with Canada's Feminist International Assistance Policy (FIAP) under the core action area of Gender equality and the Empowerment of Women and Girls. In addition, TAMANI's focus on supporting positive health outcomes for women and girls, especially in sexual and reproductive health fits within the Human Dignity action area which aims to improve health outcomes for women and girls in developing countries.

TAMANI's gender strategy is focused on addressing the gender barriers to access family planning and modern contraception, supporting community acceptance of women's autonomy to seek health services and family planning, and through improved access to SRH education and services for young men and women and increased respectful woman-centered care for women and girls in labour and delivery. The strategy was developed in response to the qualitative gender research conducted at baseline.

CARE uses the CARE Gender Marker on an annual basis, to assess the integration of gender into the project. The CARE marker uses a gender continuum from harmful to transformative (score from 0-4). In reviewing project implementation for the last year, TAMANI has been scored as 3 or Gender Responsive, the same as the last three years. CARE's definition of a gender responsive project is programming that challenges inequitable gender norms and responds to the different needs and constraints of individuals based on their gender and sexuality. This includes opening space for discussing, challenging, and engaging inequitable gender structures, systems, divisions, and power relations. This includes providing the opportunity for participants to question, experiment and challenge gender inequities that they have observed or experienced.

TAMANI continues to integrate gender transformative interventions that are aimed at challenging harmful gender norms at the community level through SAA and CSC dialogues. At the health system level TAMANI is responding to concerns about disrespectful care, and elevating women's voices and priorities in conversations with government actors. At the structures level, we are working with Government stakeholders to advocate for policy and planning processes to integrate gender considerations, and that

resources are allocated to support services prioritized by women and girls. This includes the collection of endline learning and evidence to engage GoT representatives in policy discussions.

Changes in Context for Women & Girls

The COVID-19 pandemic has impacted women and men differently in Tabora. CARE has continued to monitor the gendered impact of the pandemic through the COVID-19 CARE Tanzania Rapid Gender Analysis conducted in April 2020 and using follow-up surveys and SAA dialogues. Two sets of questionnaires were administered through mobile phones for the rapid gender analysis. In total, 1170 respondents fully completed the first RGA survey and a total of 888 participants fully completed the second RGA survey. Women and men responded equally, 63% and 65% respectively, and both sexes reported having access to a lot of information on COVID-19.

In total, 63% of female respondents and 60% of male respondents reported life to be either a little or much worse than before the pandemic. Examining the burden of work due to the pandemic, revealed that women and men equally reported being impacted with 51% of female respondents and 49% of males reporting an increase in the burden of work. Over half of female respondents (52%) reported a decrease of control over family resources as compared to 48% of male respondents.

A GBV survey was also conducted given that the pandemic can both exacerbate and pose specific barriers to seeking help and or reporting cases of GBV. In total 1177 participants responded. Both men and women, 54% and 56% respectively, reported an increase of harassment and violence during the pandemic at the time of survey collection. Survey results also revealed that while women reported the *ability* to report cases of GBV much fewer were willing to report cases. This is aligned with evidence around the many barriers that still exist for women and girls to report GBV and how stigma and fear of discrimination leads to significant under-reporting. In addition, mistrust in formal institutions to handle GBV cases is compounded by the internationalization that violence against women and girls is acceptable. This was validated in the most recent SAA dialogues. TAMANI continues to integrate GBV messaging into our programming and work with partners to strengthen response structures and mechanisms.

The following section summarizes progress under each outcome area on the gender equality indicators the project is using to track gender equality programming both in the PMF and Gender Equality Measurement Framework at the intermediate and immediate outcome level (Annex B & C).

Outcome 1100 (Supply): Improved availability of quality reproductive maternal and newborn health services in underserved areas of Tanzania

Intermediate Outcome 1100: To Improve availability of quality reproductive, maternal and newborn health services in underserved districts of Tanzania

1100 GE Indicator

1) % change in Respectful Maternity Care

Percent change in respectful maternal care is measured through a series of questions included in the Household Survey that include experiences with the last birth including communication with health care provider, choice of birth position and option and choice of birth companion. Rolling Profile interviews are providing additional insight into health facility experiences for women and the changes they are observing when it comes to the quality of service, they receive from health providers. At mid-term, there was a 6.5 percentage point decrease from baseline, while the overall project target is a 20% increase.

The project is focused both on improving HCP attitudes, as well as working on facilitating open communication and trust building with community members.

One young mother described the changes she has seen in attitudes of HCPs,

> *The community is more aware and concerned about health care services and how to access them and the bad traditional beliefs that could affect the health of mothers and children has stopped. On the side of the health facilities a lot has improved, the language used by health care providers towards patients is more professional and they are more dedicated now in their work.* (WRA, Kaliua District)

Another woman described how she sees the Community Scorecard meetings as playing an important role in improving respectful maternal care at her health facility.

> *Currently I'm not visiting the facility regularly because my child has completed all vaccines. I now visit the facility once per month to check my baby's weight. In general, the service provided is good and I have seen an improvement in services. The number of pregnant women attending the clinic has increased as well as the number of women giving birth at the health facility. Respectful maternity care has improved. I think it is due to the meetings (CSC) conducted in our village have increased the efficiency of service and helped to change the attitudes of health providers.* (WRA, Igunga District)

Immediate Outcome 1110: Strengthened capacity of regional and district health system managers to effectively plan, manage, and deliver quality gender-sensitive reproductive, maternal and newborn health services.

1110 GE Indicators:

1) % CHMTs with knowledge of gender issues related to RMNH services
2) #/% of R/CHMTs that can provide gender-based analysis of sex disaggregated data
3) # of R/CHMT's trained in the Prevention of Sexual Exploitation and Abuse (PSEA)

CSIH has integrated gender issues into all training materials and has designed an endline R/CHMT survey to assess knowledge of gender issues related to RMNH services and to measure as capacity in conducting gender-based analysis of sex-disaggregated data. The results of this survey will be reported in the final report. The COVID-19 context has been an excellent opportunity to engage the R/CHMT in discussing the gendered impacts of the pandemic. Project staff have seen a shift in how the R/CHMT are understanding the need to consider the differing needs and impacts that this evolving context is having on women and men.

TAMANI continues to monitor changes related to GVB and sexual harassment awareness activities delivered to Government and non-government partners and continues to follow up on district action plans for implementation. During the reporting period, districts implemented their PSEA action plans by training Council Health Management Team (CHMT), Council Management Team (CMT), staff, district GBV/VAC committee and GBV/VAC committees at village and household level on the importance of community reporting on violence against women and children. Note that this indicator was added to the GE PMF when the gender strategy was last updated.

The following activities were by the districts:

Uyui DC

- Three cases of GBV reported during the reporting period; one case of rape reported where the accuser was arrested and the case went to court, two cases of intimate partner violence were handled by social welfare officers

Tabora municipal

- 19 (4m/15f) staff and head of departments provided feedback on sexual harassment during a workplace training. 123 workers attended a feedback training session provided to the workers committee. The municipal also introduced a claim desk, in total 9 cases of sexual harassment were reported during the reporting period.

Igunga DC

- During the reporting period, the DMOs' office established a claim book (for both clients and health care workers) to report any form of gender-based violence. From October 2020 to March 2021, 17 cases of verbal abuse were reported based on insults and bad language directed from health care workers to clients. District officials provided education on GBV issues to the community, 121 cases were reported; 23 physical abuse cases, 43 cases of emotional abuse, 19 sexual abuse cases and 36 cases of neglect and these cases were referred to relevant authorities i.e police, gender desk, social welfare desk. Fear of reporting sexual harassment by workers remains due to mistrust in the ability to address the case and fear of losing their employment.

Urambo DC

- The district has changed the office for the person who handles workplaces complaints including sexual harassment. The officer now has an isolated room for consultation. Data from DHIS2 shows that more females are reporting cases of GBV, an most cases reported are during tobacco harvesting and selling.

In addition to working with government partners, TAMANI leveraged additional donor funds during the reporting period to implement a mass radio series to address GBV as well as trained HCW's on screening and referrals for SGBV in Tabora.

Immediate Outcome 1120: Improved gender-sensitive reproductive, maternal and newborn health service infrastructure.

1120 GE Indicators:

1) #/% of health facilities with improved infrastructure that reflects the priorities of women and girls in the catchment communities

TAMNI staff consulted with women and girls on the focus on the health facility rehabilitation projects which led to the prioritisation of improved power (i.e., lighting at night) and water at health facilities. Out of the total 23 rehabilitation projects (including solar power installation) 20 of these projects (87%) focused on women and girls' priorities of improving power and water.

Immediate Outcome 1130: Improved knowledge and skills of health providers to deliver gender sensitive reproductive, maternal, and newborn clinical services.

1130 GE Indicators:

1) #/% of health care workers with knowledge of Respectful Maternity Care and patient rights

Respectful Maternity Care was part of the EmONC training (based on GoT guidelines) delivered to the 270 (100%) providers trained, and RMC was reinforced through coaching and mentoring post-training every 6 and 12 months (200 HCW's mentored). In addition to a self-reflection tool (365 responses) and on-site discussions with mentors at each facility, communication cues for RMC were also included in the four Job aids disseminated at the 265 health facilities.

Clinical evaluations (OSCEs) are a type of examination to help assess essential skills and are best to assess communication skills, physical examination techniques, professionalism, and attitudes for effectively interacting with patients. The coaches and mentors used these clinical examinations immediately post-training and at 6- and 12-months intervals to assess skills retention. RMC points were included in each of the OSCEs which included actions such as *greet the women*, *inform her of the findings*, *explain the procedure*, *reassure the mother* integrated and assigned at different steps in the 4 clinical procedures.

RMC elements include not only items focused on the mother only but also towards respectful care for their newborns considering the mother-newborn dyad of Respectful Maternity Care. For example, immediate skin to skin contact is a practice identified as respectful care, as promoted by the Respectful Maternity Care Charter: Universal Rights of Mothers and Newborn (2019) by the White Ribbon Alliance (WRA). In the 4 OSCEs combined, 13 items/123 total (11%) pertains directly to RMC attitudes and skills.

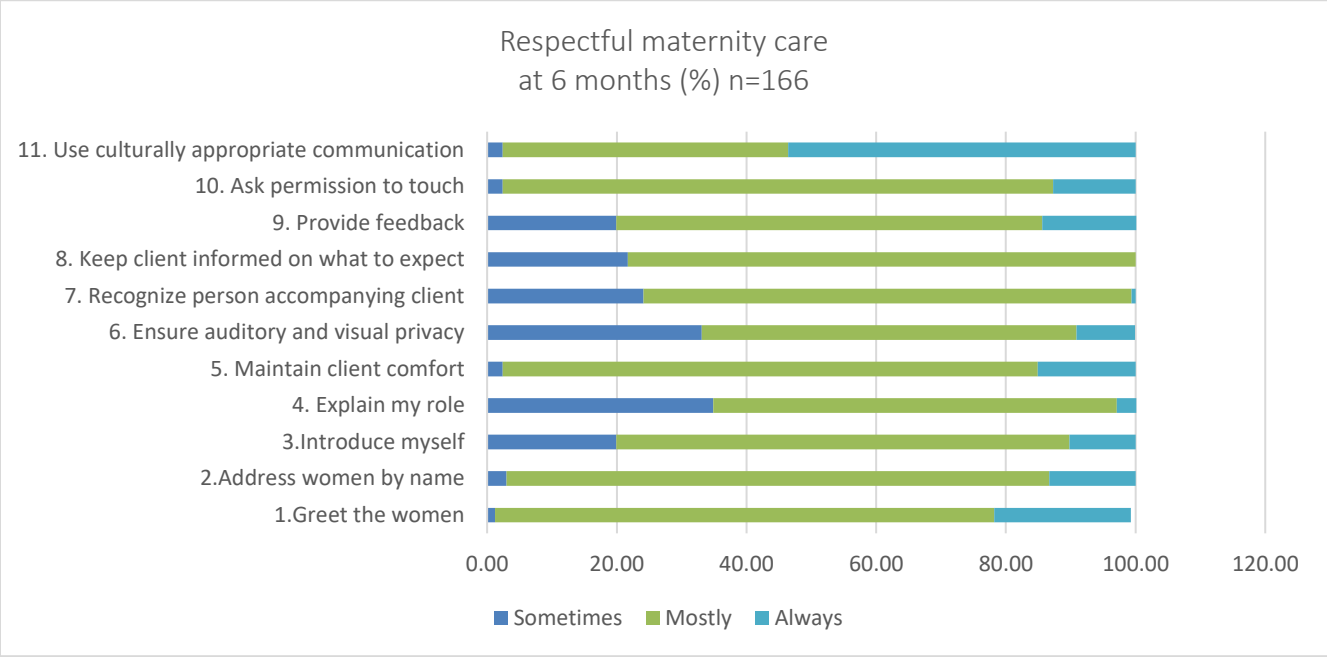
SOGC wanted to understand if the RMC items performed as well as the other questions in the OSCEs. They compared trainees' points on RMC items and non-RMC items, in each OSCE, over time. Keeping in mind that the low number of RMC items in each OSCE can be a limitation for a fair comparison. Overall, health care providers demonstrated similar competency for RMC as other technical skills and maintained this ability across 6- and 12-month follow-ups. In addition to RMC items in the OSCEs, SOGC and AGOTA developed and delivered an orientation package on Respectful Maternity Care in year one, which included tools and resources to support the coaches in modelling respectful communication and the use of the patient charter.

A reflection tool for Health Care Workers was developed in year two. Although the tool was primarily designed as a self-assessment for HCPs, analyzing the overall anonymous answers helped the project see trends in the perception of the trained HPCs in providing RMC in their daily practice.

Questions were designed in line with generally accepted RMC indicators for provider/client communication, EmONC training communication module and in accordance with the Tanzania Patient Charter (GOT, (2013) and (2015)). The first part of the short questionnaire was a reflection on communication in their daily practice. The second part related to the interpersonal qualities required by providers and the last pertained to the availability and knowledge of the Tanzania Patient Charter.

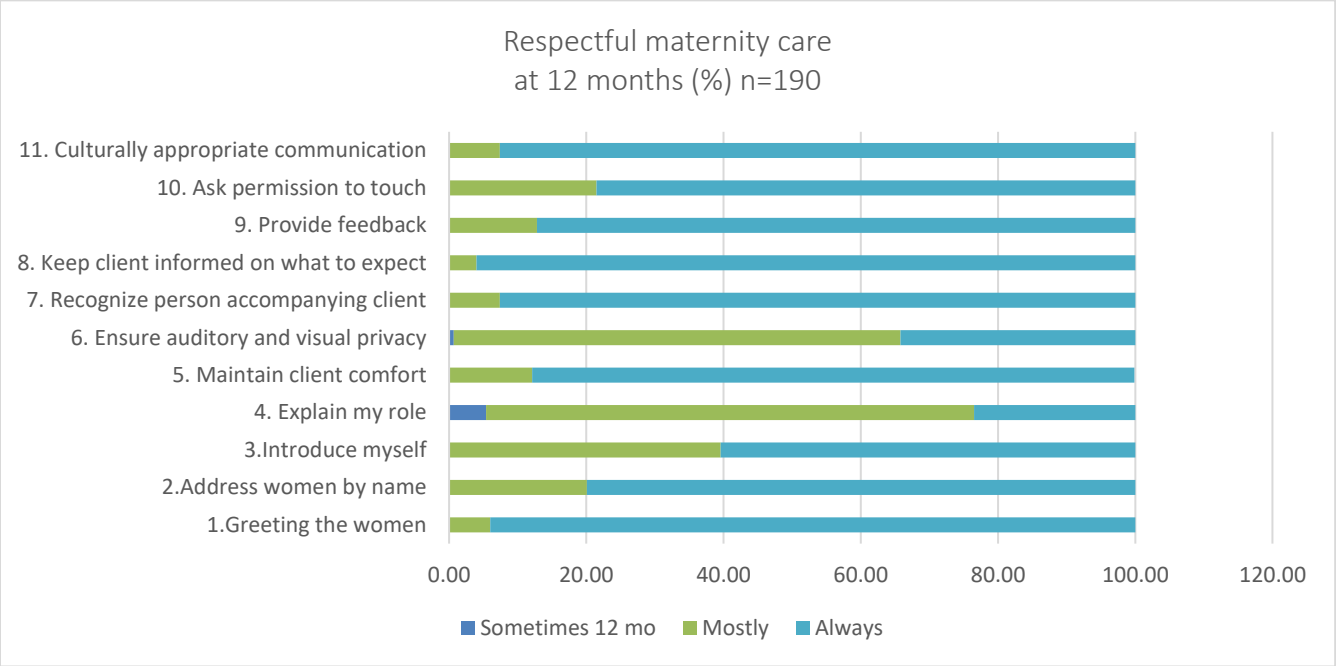
Keeping potential bias of participants in mind in filling out the tool, the findings suggest provide some understanding of the health care provider’s perception of their own gaps and strengths regarding RMC provision.

The results of the self-reflection tool show a trend in the HCP's own perception of RMC. HCPs felt that they provided respectful maternity care frequently (mostly or always) to mothers and babies at 6 months see graph below.

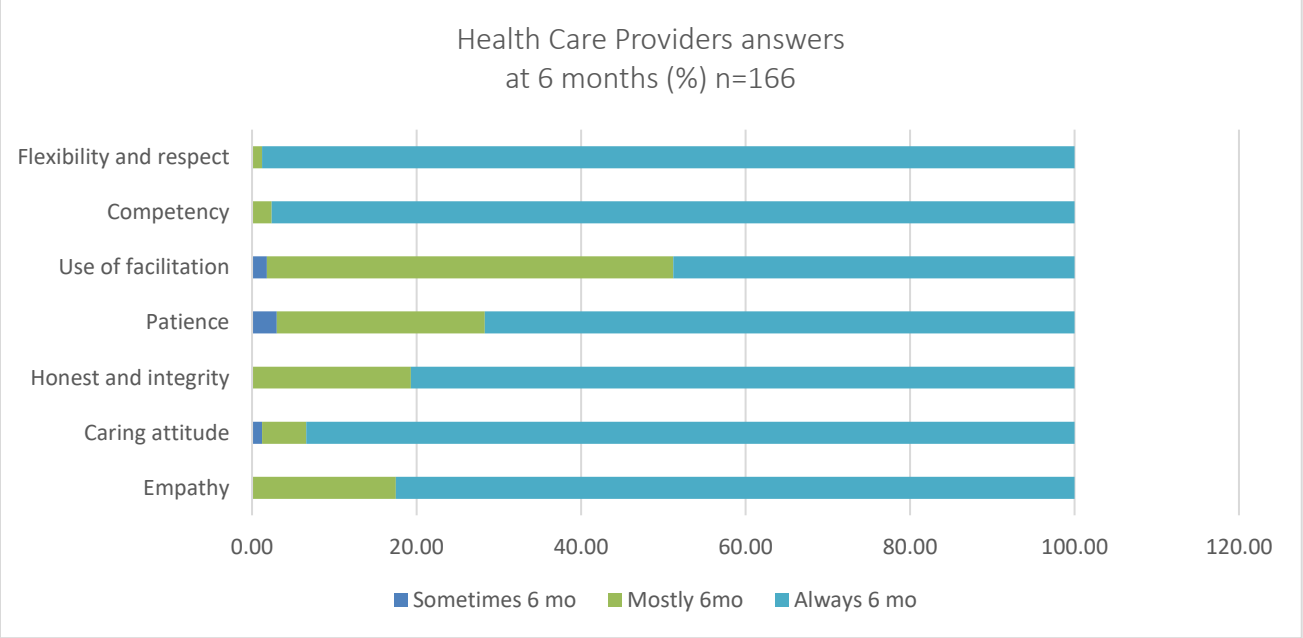


At 6 months, responses showed that many health care providers answered they were not always (but mostly or sometimes) ensuring auditory and visual privacy and not always explaining their role to the women when attending to them. In contrast, a great number of them answered they always keep the client informed of what to expect throughout care, communicated in a manner that is culturally appropriate to the client and recognized persons accompanying the client.

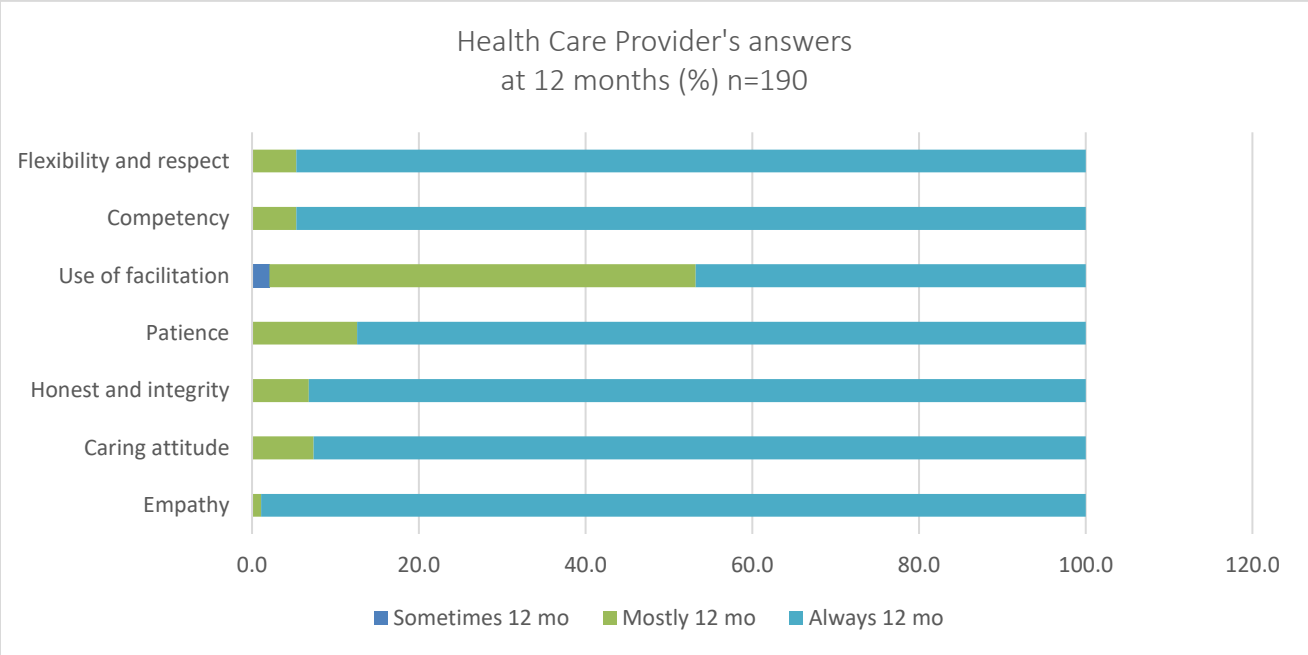
In the graph below HCPs felt that they provided respectful maternity care frequently (mostly or always) further improved 12 months after training see graph below.

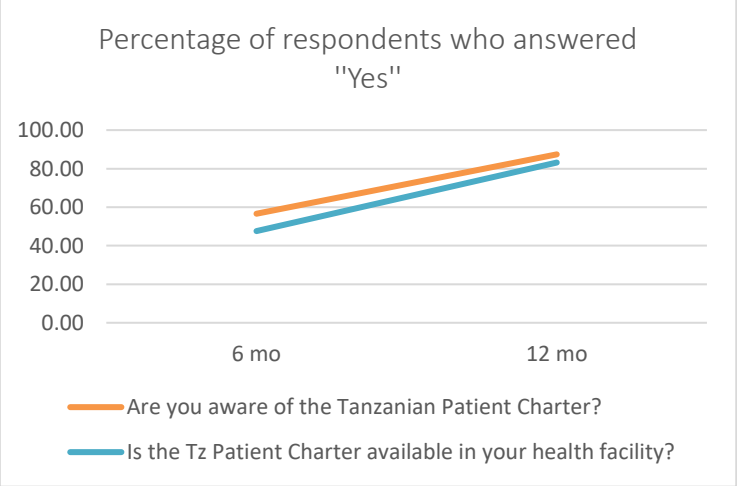


Data analysis for section 2 of the tool brought additional findings (Graph below), including the comparison between 6- and 12-months visit results and perception on interpersonal factors - such as empathy, honesty, caring attitude that promotes good communication between provider and patient. From 6 months and 12 months, improvements (from Mostly to Always) are noted mostly in the Caring attitude, Empathy, Honesty and integrity responses. See below the 6 month results.



The graph below shows the 12 month results.





Finally, analysis of data (3rd section of SAT) revealed an increase in both awareness (+30.8 percentage point) and availability (+35.57 percentage point) of the Tanzanian Patient Charter over time.

A focus group conducted in December 2020 on the coaching and mentoring experience, including the utilization of the RMC self-assessment tool, suggested that the experience was mostly positive and deemed helpful by coaches.

Some coaches stated that this tool and discussions *"reminded the service provider on the importance of communication and positive attitude" and " increases healthy and productive relationships between client and health provider and between mentor and mentee"*.

Intermediate Outcome 1200 (Demand): Increased utilization of reproductive, maternal and newborn health services by women and their families in targeted districts of Tanzania

Interventions to support gender equality under this outcome are aimed at strengthening community awareness and accountability on SRH services and empowering women in decision making and addressing harmful gender norms and power dynamics that are barriers to accessing SRH information and services. This is aligned with the FIAP that focuses support on programs and projects that put gender at the heart of their efforts to improve health care.

GE Indicator:

1) % change in women's satisfaction with health facility rehabilitation projects

Follow-up on women and girls' satisfaction was included in the endline household survey as well as the qualitative gender research conducted in March 2021. These finding will be included in the final report.

Immediate Outcome 1210: Increased access to gender-sensitive reproductive, maternal newborn health services.

GE Indicator:

1) #/% of adolescent boys and girls satisfied with SRH services

TAMANI's work with youth champions on Adolescent Sexual Reproductive Health and Rights (ASRHR) and Health Care Workers on youth friendly services to increase access to, and utilization of, reproductive services through conduct of community youth education meetings. Youth Champions are organizing dialogues in their communities and referring youth to trained HCW's. As noted in the report, adolescent mystery clients were recruited in Year three to assess the availability of youth-friendly ASRH services, the attitude and behavior of health care workers towards adolescents, and the required privacy and confidentiality for adolescents to receive ASRH services.

The project has used a total of 38 (20m/18f) mystery clients who have reported that service providers are overall providing youth-friendly services and have provided feedback where there are gaps (i.e arranging convenient days/hours for youth friendly services). The project repeated this exercise in Q4 after the completion of the HCP training, where 22 (13m/9f) adolescents participated as mystery clients. Improvements in privacy, confidentiality, and respective services have been observed by mystery clients at 22 sampled facilities except for Igigwa in Sikonge district where the provider was not available to offer services. Adolescent boy's and girl's satisfaction of services was also included in the endline qualitative data collection in March 2021 and findings will be included in the final report.

Immediate Outcome 1220: Improved ability of women to seek reproductive, maternal and newborn health services.

GE Indicators:

1) #/% of CHW's that can identify at least 2 gender issues related to FP/RMNH

As CHW's began phase out from TAMANI, CARE Tanzania developed a survey to capture CHW's understanding of gender barriers to RMNH services. A random selection of 71 CHW's (30m/41f) out of 940 were asked questions from across the 8 districts. CHW's overall demonstrated knowledge of community perceptions, beliefs and power dynamics that impact access to these services. Only 5 CHW respondents did not answer the questions.

When the 30 male CHW's were asked about what gender barriers they see impacting men's use of modern family planning methods, 8 (27%) responded that there is fear of becoming infertile as having many children is associated with wealth, 9(30%) responded that the uptake of modern FP methods is seen as a women's issue while 2(7%) responded that modern FP methods are seen to reduce sexual pleasure/comfort, and 11 (37%) males did not respond.

Out of the 41 female respondents, 10 (24%) of women responded that they see lack of power in decision making about modern family planning limiting uptake by women, and 18 (44%) responded that myths in the community exist on the side effects of family planning. An additional, 6 (15%) responded that women fear negative perceptions from the community, including verbal abuse, while 4 (10%) responded women fear conflict with their spouse which may lead to divorce. In total, 3 (7%) of female CHW's did not respond.

Gender norms which limit male utilization of MNCH services

When male CHW's were asked about what gender norms limit male involvement in MNCH services 13 (43%) responded that men in their community perceive SRH services as women's issues. When female CHW's were asked what gender norms limit female utilization of MNCH services 17 (14%) responded that lack of male involvement on SRH services limits women, and 10 (23%) responded that the lack of women's power in decision making on where and when to get SRH services limits their utilization.

Gender and social norms transformation of CHW's themselves, will be further explored though the gender qualitative endline data collection. TAMANI has worked with male and female CHWs to raise awareness on gender norms and power imbalances that hinder women's and girls' access to reproductive health services with heads of families including religious and local leaders. A key focus of male engagement has been to improve communication among couples, and share messages related to maternal health and women's rights to seek health care. A female CHW shared some changes she has seen in relation to male engagement in household responsibilities placed on women.

Gender roles at the household level have improved, couples are now helping each other to improve the wellbeing of their family. Women nowadays can make decision for seeking health services without the consent of their husband or they can sell domestic resource for the purpose of covering the family needs for example school fees, health expenses and food. TAMANI interventions such as SAA and community awareness meetings increased awareness on the importance of gender equality in the household as now men help their wives after understanding the impact of heavy workloads performed by their wives at the

family level which impacts women's health. In addition, there is increase of male involvement in maternal and reproductive health as more men are now escorting their wives to the clinic. (Female CHW, Urambo District)

During the reporting period, the project collected the fifth round of rolling profile interviews (the third round using mobile phones and the fourth round conducted with COVID-19 preventative measures in place). Respondents included CHWs, community facilitators, health care workers, members of Council Health Management Team (CHMT), Youth Champions and target beneficiaries (WRA). This monitoring data continues to help project staff identify change at the community level, as well as make tweaks to project activities as per the data that is received.

Environmental Sustainability

The health facility rehabilitation projects prioritized water catchment and solar power reflecting environmentally sustainable projects. As noted in the outputs section, the health facility rehabilitation projects have been completed and assessed by the TAMANI project engineer, district engineer, the contractor, and representatives from the Health Facility Governing Committee. Assessments focused on progress made on the work as per the BOQ and adherence to the recommendations from the ESIA. An environmental audit was conducted in Q4 to follow-up and address any issues now that the work is completed.

As guided by ESIA, the project undertook environmental monitoring to all rehabilitation projects to assess which measures were put into place to ensure minimum degradation of the environment at rehabilitation sites. The activity was conducted in collaboration between HF's, contractors with technical backstopping from CARE TAMANI Project to follow-up on the ESIA recommendations.

Key findings are highlighted in table below:

Parameters	Observations
Soil erosion, landscape and vegetation management	There were limited activities that affected landscaping especially where rehabilitation processes were interior. Demolished materials were sometimes piled in one area but later were cleared. All sites were observed to be regularly cleaned with re –vegetation and removal of the topsoil during the construction for re –use in landscaping. For projects focused on rainwater harvesting, foundations for tank bases required removal of soil which was later re applied around the bases.
Occupation, health and safety	All buildings that were rehabilitated were unused while the work was completed as both clients and health worker were evacuated to other buildings. Workers wore PPE including caps, hard gloves and reflectors. There were signboards showing rehabilitation in progress.

Solid waste, biomedical hazardous waste and wastewater management wastes	The project generated demolished materials from the old walls and tiles. The materials were collected in one area and cleared. Minor solid waste was generated and disposed of properly and in a timely manner.
Sewerage and Sanitation	Sewerage and sanitation systems at most rehabilitation sites were functional except at Urambo hospital where rehabilitation of maternity ward was taking place. The project recommended hospital management to use internal revenue to renovate sewage and ensure water supply in the building. Hospital management accepted the idea, and it was implemented.
Air pollution control	Minor waste materials produced were properly and timely disposed of.
Noise management	All rehabilitation activities were found to generate very little noise produced during the construction without the use of a sound management device. Mostly non-mechanical machines were used to cut hard materials like tiles.
Labour management	There was fair involvement of the local workforce, but women were not involved. With exception of two projects in Nzega and Sikonge, all projects were implemented by local contractors based within the respective districts.

In addition to the health facility projects, COVID-19 funding that leveraged TAMANI included COVID-19 Health Care Worker training that integrated waste management components, as part of the Infection Prevention and Control (IPC) modules and included decontamination and waste management, safe and dignified Burials and proper disposal of PPE. While GAC funds were not used for these activities, the project was leveraged to attract additional donor funds that supported TAMANI health facilities. The project has also promoted the purchase and use of reusable cloth masks for non-clinical project participants such as CHW's.

Good Governance & Human Rights

The TAMANI project has continued to focus on enhancing the accountability and transparency of health systems in Tabora while supporting citizen participation in, and ownership of, decision-making processes related to health service delivery at the community level. During the reporting period, activities were very much focused on addressing the COVID-19 context.

CSIH worked closely with the TAMANI team as well as the R/CHMT's to support the region to respond to the pandemic. This included ensuring a gender lens was applied to response activities and supporting the region to plan for the delivery of uninterrupted essential health services, particularly SRHR and RMNCAH services. CSIH continues to involve stakeholders at the National and Regional levels in the design of

activities, and ensuring relevant stakeholders have input into training content and materials disseminated with health managers and facility staff in Tabora. CSIH continues to work to improve the accountability and transparency of the health system in Tabora, particularly through quality improvement approaches, and through improved data collection and reporting, as well as planning, budgeting and financial management of health facilities.

While Community scorecard meetings were paused during the reporting period, good progress continues with the CSC action plans as discussed above, such as improvements in infrastructure (with a focus on WASH projects which are even more essential within the COVID-19 context), staff attitudes and human resources.

While the above interventions are targeted at promoting good governance on the side of duty bearers and right holders, the project has also worked towards becoming more transparent to the communities in Tabora. Using the COVID-19 digital campaign as a springboard, a package of Push Messages was sent out to CHW's focused on safeguarding (PSHEA and fraud) and provided information on where to report. A dedicated hotline (kept by the internal auditor) was used to collect feedback and is documented in a confidential database. Feedback received to date for TAMANI was related to seeking more clarity on whether the project will have a second phase, future training plans, and suggestions on improvements on how monthly stipends are paid.

Financial Report

Please see the separate financial report accompanying this narrative report. As of March 31, 2021, cumulative project expenditure stood at 97%.

Progress Towards Outcomes

The section below provides details on progress towards the achievement of the outcomes included in the PMF (Annex B). Note that in response to feedback provided by the Monitors, changes are now being presented in percentage points, which is a subtraction between mid-term and baseline evaluation, as indicated by project targets.

Ultimate Outcome Expected Results	Indicators	Baseline	Mid-Term	Project Target (in percentage points)
1000 Reduced maternal and newborn mortality and morbidity in underserved districts in Tanzania	MMR (per 100,000 live births) national estimate	556		70*
	NMR (per 1000 live births) national average	25		12**
	Adolescent pregnancy (% of women ages 15-19 who are pregnant or have given birth)	43%		38%

***** SDG 3 MMR Indicator
****** SDG 3 NMR Indicator

Explanation/Assessment of Performance:

Newborn and Maternal Mortality

The ultimate outcome indicators for MMR and NMR were planned to be reported by the project using updated DHS data in the final report. However, given there has not been a DHS survey in Tanzania since 2015, using this data source is not possible. Two alternate data sources have been identified for reporting MMR and NMR in the final report. The first is UNICEF's 2019 NMR figures (though important to note that this calculation was slightly different from the DHS so the baseline figure would need to be updated). UNICEF estimates that NMR has been slightly reduced from 21-22 deaths per 1000 live births in 2015 to 20 deaths per 1000 live births in 2019.

The latest data on MMR figures is from 2017 from a WHO, UNICEF,WBG, UNFPA report. This report estimates that the MMR has dropped from 556 in 2015 to 524 in 2017. CARE welcomes GAC's feedback on including these figures in the final report.

Adolescent pregnancy

From the mid-term household survey, adolescent pregnancy indicated a 3.4 percentage point decrease from baseline (43.4%) to mid-term in June 2019 (39.9%). The endline data is currently under review and will be included in the final report.

SAA dialogues on COVID-19 did indicate concerns that school closures will have a negative impact on adolescent pregnancy, which is also a concern highlighted in the Tanzania COVID-19 Rapid Gender Analysis.

Intermediate Outcome Expected Results	Indicators	Baseline	Mid-Term	Project Target (in percentage points)
1100 Improved availability of quality reproductive maternal and newborn health services in underserved districts in Tanzania	% of women and adolescent girls with an unmet need for family planning	W:29% A:41%	W: 35% A: 33%	W:5pp decrease A:10pp decrease
	% deliveries assisted by a skilled birth attendant	W:65% A:77%	W: 73% A: 79%	10pp increase
	% change in Respectful Maternity Care	22%	15.5%	20pp increase

Unmet need of family planning

As indicated in the mid-term household survey, the unmet need for family planning among women showed an increase of 6-percentage points from baseline (29%) to mid-term (35%) (June 2019), while adolescent girls reported an 8-percentage point decrease in unmet need for family planning from baseline (41%) to mid-term (33%). We continue to monitor HMIS data and do note the monitors concerns that given the project is not working on commodity availability, this indicator is difficult to influence.

Qualitative monitoring data suggests that some project participants note the impact CHW's are having on access and information about family planning. The CHWs play a crucial role on educating and supporting women to access reproductive health services this can be observed through qualitative data collected through rolling profile interviews. For example, the Nzega Township Reproductive Child Health Coordinator (TRCHCo) noted the number of women seeking family planning is increasing and women have shared that this is improving their livelihoods. This indicator will be updated in the final report using endline data.

As noted in the monitor's feedback report, there was success at mid-line at reducing unmet need for adolescents, and this may be linked to Youth Champions. Youth champions share information received from training with their peers and changes in community perecptions have been noted at the community and health facility level on the increase in use of modern family planning methods instead of local herbs. The Nzega Township Reproductive Child Health Coordinator (TRCHCo) said that the number of adolescent girls seeking family planning has increased

> "*ASRHP trainings to HCWs and services has also helped in reduction of early pregnancies among girls below 20 years of age from 670 in 2019 to 279 cases in 2021. There is also a special timetable for ASRHS services on a weekly basis whereby HCWs are involving youth champions to provide youth*

friendly sexual and reproductive health education to their fellow youth groups. ASRHS have been a routine service to youth whenever they visit a heath facility. Youth are not regarded as "just a client", they are given ASRHS counselling that is relevant to them, testing and family planning. Consequently, this has increased the use of family planning among adolescent girls" (TRCHCo, Nzega TC)

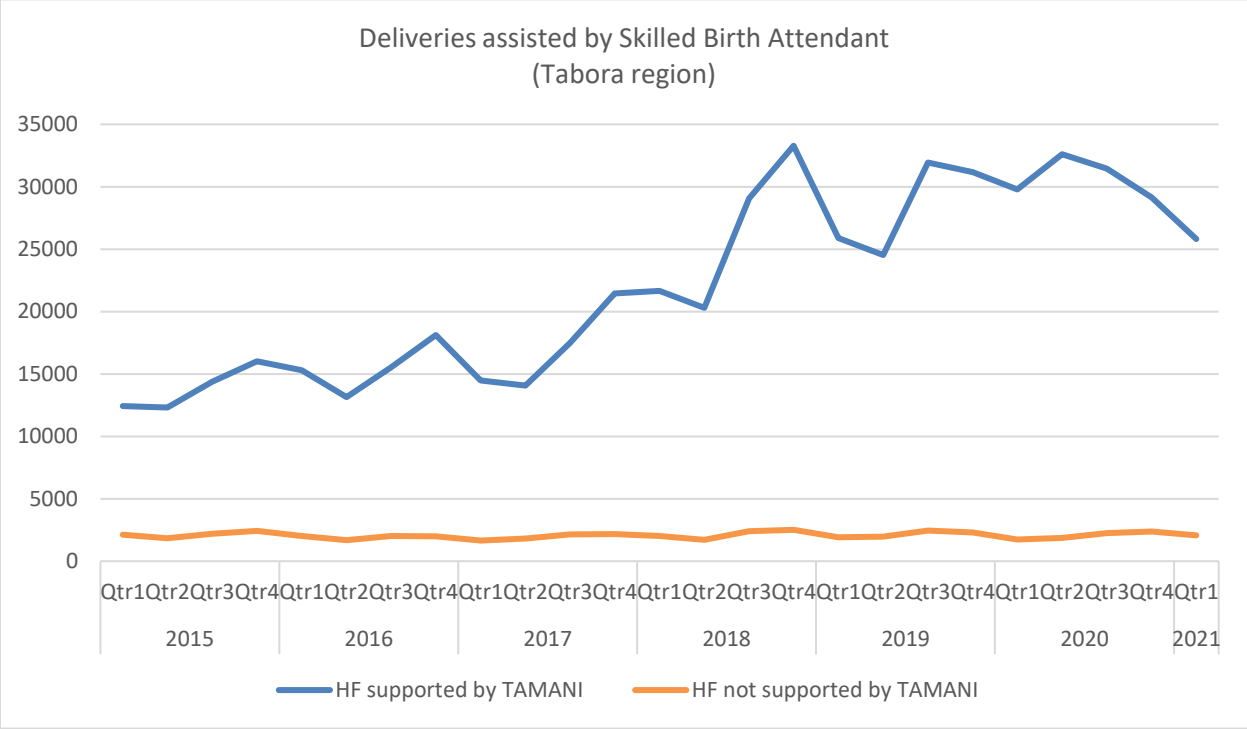
A CHW in Kaliua District also shared similar observations based on the changes he has seen at the community level, especially in relation to the uptake in family planning methods by adolescents,

"*Young people have greatly increased their use of family planning which has led to a reduction of early pregnancy among youth. Previously there was a lot of misinformation about the effects of methods of contraception, which made it difficult to influence young people to use contraceptives, but now more young people are more informed*" (Male CHW, Kaliua District)

Skilled birth attendants

Skilled birth attendants are defined as doctors, nurses, assistant nurses, clinical officers, assistant clinical officers, and midwives who have been trained and are proficient in maternal and newborn care. The port, the mid-term analyses for the region comparing baseline showed a statistically significant change in deliveries assisted by a skilled birth attendant and will be updated in the final report. Like adolescent pregnancy, qualitative monitoring data suggests that COVID-19 may be negatively impacting SBA given community fears of contracting the virus at health facilities.

The graph below shows HMIS data on the number of deliveries assisted by Skilled Birth Attendants for two groups of Health Facilities, the (265) supported by TAMANI and the (93) facilities not supported by the project. As suggested above, a decrease is noted in deliveries assisted by Skilled Birth Attendants from Apr-June 2020 until the end of March 2021 at TAMANI supported facilities.



According to the graph above, there has been a consistent increase in deliveries assisted by Skilled Birth Attendants at health facilities supported by TAMANI, with a sharp upward trend in Jan-Mar of 2018, and again in Jan-March 2019 with a steady increase until September 2020. There has been a decline seen since Apr-June 2020 which coincides with the first wave of the pandemic. From the end of December until the middle of March there was a significant spike in COVID-19 in Tanzania which could have contributed to women choosing to birth at home out of fears of contracting the virus at health facilities. In August 2020 CHWs began to transition from the TAMANI project, which may have also contributed to the reduction of facility-births.

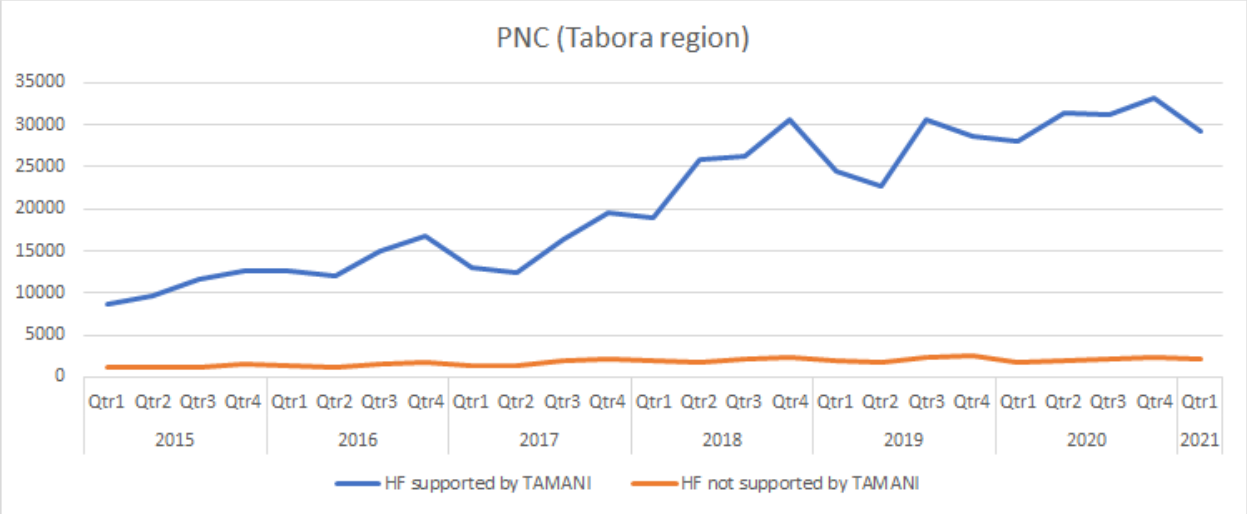
One CHW described how he sees the Community Scorecard meetings as playing an important role in also improving the communities understanding of the benefits of in facility births,

> *"Before women were usually giving birth using Traditional Birth Attendants (TBAS) when we began our counselling services at the community level, the TBAs saw us as a competition to their service but when we educated them and informed them on the govt guidelines most of them understood and were willing to facilitate women to go to the HFs instead of at home. TBAs have mostly stopped performing their traditional trade and now they assist women getting to the health facilities. This has to do with community meetings which were held between the leaders of the village, the dispensary, and community members to help understand the risks of home delivery*

and herbs to facilitate birth and the benefits of delivering in a health facility." (CHW, Kaliua District)

Postnatal Care

The graph below shows HMIS data on the number of newborns receiving post-natal care services in the first 48 hours after birth, for health facilities being supported by TAMANI and those with no support.



The graph shows a significant increase over the 2018 year in the number of PNC visits, though this upward trend slowed in 2019 and 2020. Similar to what was observed in the first quarter of every year, there was a significant reduction in PNC visits in January – March 2021, which could be attributed to the rainy season and farming during which women play a major role for labour. Overall, this is a positive trend demonstrating that women were still able to access health facilities for post-natal care services despite the impact of COVID-19. Non-supported health facilities saw an overall increase of number of newborns receiving postnatal care since the start of the project, but at a lower rate when compared to health facilities supported by TAMANI. In the past year non-supported health facilities reported an increased number of PNC visits, even though the last quarter presented smaller number of visits due to COVID-19.

Change in Respectful Maternity Care

The endline household survey will provide us with updated data on this indicator to include in the final report. Rolling Profile qualitative interviews continue to provide additional data on women's experiences with RMNCH services,

> *"On the side of the health facilities a lot has improved, there has been an improvement in health care services and provision especially for mothers and their children, the language used by health care providers is more respectful and they are more dedicated now in their work. The challenge that remains is health facilities being understaffed and the ratio between health care providers and patients."* (WRA, Kaliua District)

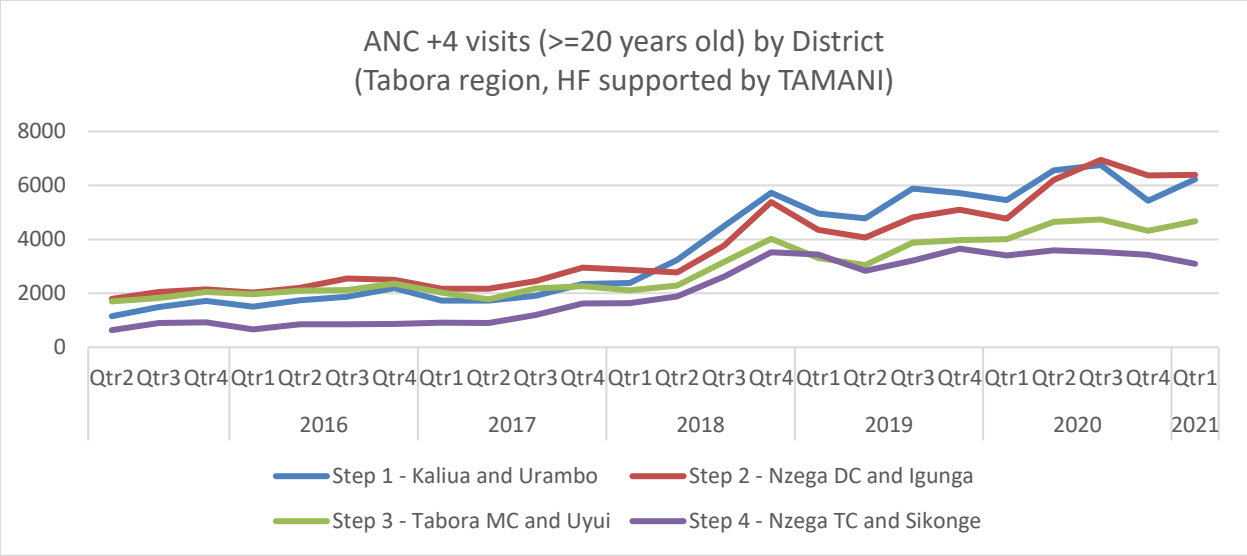
Intermediate Outcome Expected Results	Indicators	Baseline	Mid-Term	Project Target (in percentage points)
1200 Increased utilization of reproductive maternal and newborn health services by women and their families in targeted districts in Tanzania	% women 15 - 49 with a live birth attending ANC 4 or more times	W: 54% A: 54%	W: 63% A: 62%	10pp increase
	Contraceptive Prevalence Rate	W: 33% A: 17%	W: 33% A: 14%	W: 5pp increase A:10pp increase
	%/# of women who are autonomous to visit health facility	W: 36% A:26%	W: 54% A: 36%	10pp increase

Explanation/Assessment of Performance:

Antenatal Care

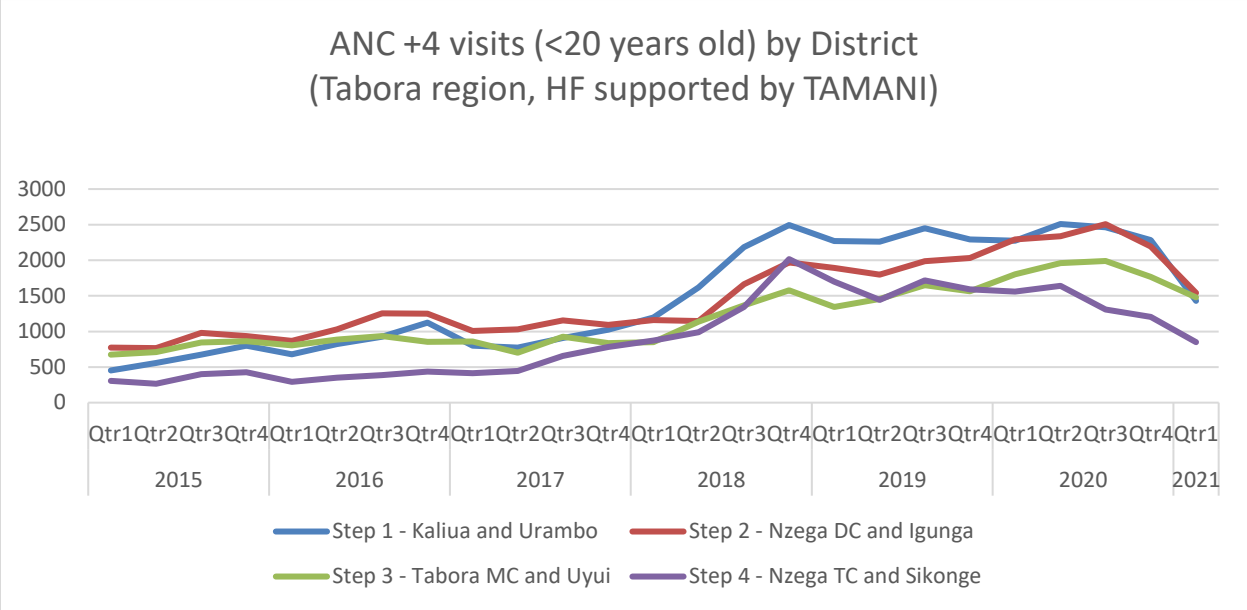
TAMANI support to health facilities includes either clinical training support, and/or CHW presence that may have contributed to an increased demand for antenatal care services. As noted in the last report, from the mid-term data we see a 9pp increase in women attending four or more antenatal care services during their most recent pregnancy (from 54% at baseline to 63% at mid-term) and among adolescents, an 8pp increase in antenatal care visits (from 54% at baseline to 62% at mid-term).

The graph below shows HMIS data on ANC+4 visits for health facilities supported by TAMANI by district clusters of CHW roll-out for WRA over 20 years of age:



Overall, we see a steady increase in the number of WRA over the age of 20 attending 4+ ANC visits across all districts with HFs supported by TAMANI.

The graph below shows HMIS data on ANC+4 visits for health facilities supported by TAMANI by district clusters of CHW roll-out for adolescent girls under 20 years of age:



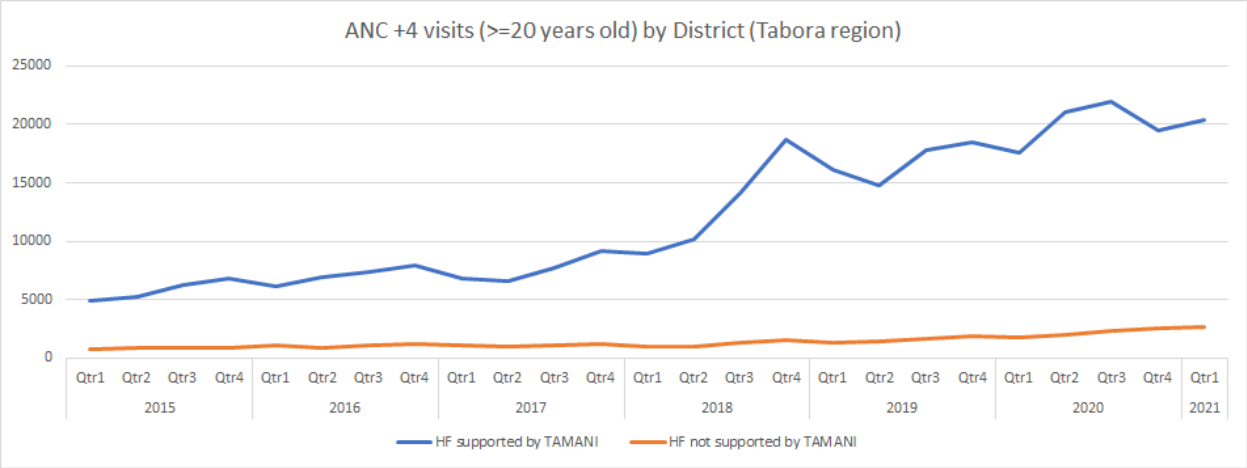
The data above demonstrates significant increases in ANC+4 visits across all ages and districts, with Kaliua and Urambo still representing the largest increases followed by the other clusters in the same order they were phased in. Since mid 2020 the number of ANC+4 visits for adolescent girls have decreased in all districts suggesting that the phase out of CHW's and the pandemic may be negatively influencing these visits. The endline gender qualitative data to be included in the final report may provide more details.

The table below shows the annual percentage change in ANC+4 visits among women above and below 20 years of age for Health Facilities supported and not supported by TAMANI:

	2018 compared to 2017	2019 compared to 2018	2020 compared to 2019	2021 Q1 compared to 2020 Q1	2021 Q1 compared to 2018 Q1
ANC <20					
HF supported by TAMANI	76%	24%	9%	-33%	30%
HF not supported by TAMANI	8%	33%	-10%	-35%	-3%
ANC >=20					
HF supported by TAMANI	71%	30%	19%	16%	126%
HF not supported by TAMANI	14%	22%	37%	48%	160%

As the data above suggests, overall, the region has observed a large increase in ANC visits for both women below and above 20 years of age, with gains at both TAMANI and non-TAMANI supported health facilities. All districts reported reduced number of ANC+4 visits for adolescents in the first quarter of 2021. Despite the COVID-19 pandemic, TAMANI contributed to a 30% increase in adolescents and 126% increase in adult women receiving full coverage of antenatal care services since the beginning of the project.

The graph below shows ANC+4 visits for health facilities supported and not supported by TAMANI:



A historical trend of dips in all maternal health services coinciding with Q2 is evident when accessing HMIS data over the last 5-10 years. It is important to note when contextualizing performance trends in post-natal and antenatal care visits that CARE has noted that there is a cyclical trend for delivery and pregnancy in Tabora, related to farming practices. As stated above, there is a continued increase in demand for ANC over the course of 2020 and into 2021.

Qualitative interviews reflect the trend being observed in ANC attendance. A CHW Coordinator revealed,

> "*Before we had very few or no referrals at all but now there is the increasing number of women who seek for RCH services at the facilities. The reason behind it is the efforts of CHWs to educate the community through community awareness meetings and household visits on the importance of attending clinic and giving birth at the facilities. As a result, there are decreasing number of home deliveries and less women giving birth with traditional birth attendants.*" (CHW Coordinator, Nzega District Council)

One CHMT member described the increase in the number of women attending ANC in her district,

"*There is an increase ANC visits at health facilities by 60% before 12 weeks, this is because of the kind of services offered at clinics, women are now getting full ANC package at health facilities, so they sensitize others to come for the services and also the continued sensitization from CHWs to women and the community at large to utilize ANC services has led this increase.*" (CHMT member, Nzega DC)

Contraceptive Prevalence Rate

The contraceptive prevalence rate is defined as the percentage of married women using a method of contraception or family planning. The mid-term data suggested that there was a small, non-significant decrease in the contraceptive prevalence rate among married women. This data will be updated in the final report using endline household survey data. This is consistent with the increase in unmet need for family planning found at mid-term for adult women highlighted above. However, as we note below, we see an

upward trend of family planning visits, so the project continues to monitor, though like ANC and SBA, fears of visiting health facilities during COVID-19 may continue to constrain uptake of family planning.

A Community Health Worker shares the trend he has seen in the use of contraceptives by adolescents,

> *"Increased adolescent use of contraceptives has significantly contributed to reducing teenage pregnancies. We have often provided family planning education with its benefits. Many young people are now encouraged to go to the center for these services. The situation was much worse before, many young people believed that family planning methods had serious health consequences, so it was not easy to accept them."* (Male CHW, Kaliua District)

A woman described how the information she received from health care workers enabled her to understand the myths around modern family planning methods which made her switch from natural methods to prevent pregnancy.

> *"Initially the community members advised me to use more natural methods for contraception believing that hospital methods have serious health consequences. But through the training I received from the nurse, and various media outlets on the side effects of those natural methods I decided to use modern family planning methods to prevent pregnancy."* (WRA, Kaliua District)

Women's Autonomy to Seek Care

The project is also monitoring women's autonomy in health care decision-making at the intermediate outcome level. This is defined as the percentage of women who agree/strongly agree that they can go to the health facility without their husband's permission. As noted in the last report, comparing baseline to mid-term data shows that adolescents reported a 10-percentage point increase and women reported an 18-percentage point increase in autonomy to visit health facility with or without their husband's permission. This may suggest that interventions such as SAA are positively impacting decision-making dynamics within households in Tabora. This will be further explored as part of the endline data analysis presented in the final report.

Immediate Outcome Expected Results	Indicators	Baseline	Project Target	Y4 Target	Cumulative Results to Date
1110 Strengthened capacity of regional and district health system managers to effectively plan, manage, and deliver quality gender sensitive reproductive maternal and newborn health services	#/% of health facilities reporting quality* RMNH related HMIS data monthly	117	150	150	309/363 HF =85% of HF 206% against target
	District CCHP's scores in DQA 70* or higher	Uyui = 57.5% Urambo=57.5% Sikonge =70% Nzega DC=65% Kaliua =67.5% **Igunga =71.8% **Tabora=MC=85%	8	9.28% Increased	Uyui = 72.99% (15.49% increase) Urambo = 78.10% (20.6% increase) Sikonge = 74.45% (4.45% increase) Nzega DC= 70.07% (5.07% increase) Kaliua=73.26% (5.76% increase) Nzega TC= 81.02% Igunga= 83.21% (11.41% increased Tabora MC=83.21% (1.79% decreased)

*quality will be defined as receiving a score of >95% on data completeness using DHIS2

**Scores from 2018/19 as baseline scores were unavailable

Explanation/Assessment of Performance:

In every financial year CHMTs are assessed on quality of CCHP's presented to PORALG, including a set of criteria required from the facility to district level. A key challenge has been the introduction of ad-hoc changes from MoHCDGEC and Local Government Authorities (LGAs) which requires Health Facilities to add or omit priorities during planning resulting in some errors and therefore, a reduced score.

In the 2019/2020 Tanzania financial year the total number of facilities reporting >95% data completeness is 309. Out of 363 Health Facilities, 47 did not report any RMNH quality data in HMIS, 287 other Health Facilities had missing scores for specific services. Project partners indicate that RBF and TAMANI have contributed to quality data improvements, with Tabora being recognized as a region that has made significant improvements.

In this reporting period, the regional average of the CCHP score increased by 9% percentage points, from 68% at baseline to 77% in March 2021.

Immediate Outcome Expected Results	Indicators	Baseline	Project Target	Y4 Target	Cumulative Results to Date
1120 Improved gender-sensitive reproductive maternal and newborn health service infrastructure	#/% of women and adolescent girls satisfied with improved health facilities and emergency transportation	53%	10pp increase	10pp increase	21pp increase
	#/% of health facilities equipped and supplied to deliver CE/BEmONC	0	150	125 HFs	169 HF (11 Health Centers and 158 Dispensaries)
	#/% total health care facilities with regular access to water	139[1]	170	170	220 (129% against target)

Explanation/Assessment of Performance:

Satisfaction with improved health facilities and emergency transportation

The mid-term data collected in June 2019 showed a 21pp increase in satisfaction of women and adolescent girls with improved health facilities and emergency transportation from the baseline survey.

The project committed to equip 74 HFs with EmONC equipment based on the gaps identified through the Health Facility Assessment Survey, which was validated with CHMT and RHMT members. To date, the project has exceeded the target and equipped a total of 169 health facilities. In addition, 21 rehabilitation projects have been completed that prioritized water and power which was identified as a key priority in consultations with women and girls.

In addition to the facility upgrades directly supported by TAMANI, see below a list of eleven infrastructure projects that are underway that are linked to the Community Score Card actions plans.

	Health facility	District	Type of work	Status
1	Itinka Dispensary	Uyui DC	Construction of maternity ward	Ongoing
2	Sigili Dispensary	Nzega DC	Construction of house for health providers	Ongoing
3	Ndembezi dispensary	Igunga DC	– Finishing of maternity ward – Installation of additional tank for rainwater harvesting system	Ongoing
4	Mwisi Dispensary	Igunga DC	Finishing of maternity ward	Ongoing

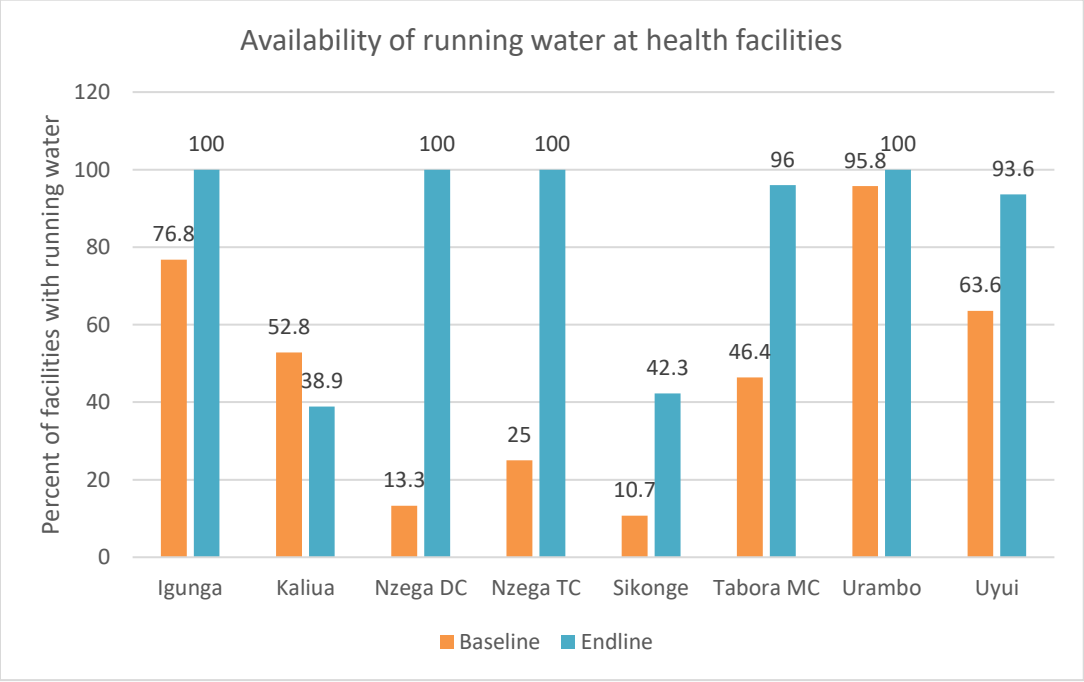
[1] TAMANI Public Health Facility Assessment Report, Regional Summary, January 2018

5	Itumba dispensary	Igunga DC	Construction of a new latrine	Ongoing
6	Kingwang'ko Village	Kaliua DC	Construction of a dispensary, the district contributed CAD 8,400	Ongoing
7	Kashishi dispensary	Kaliua DC	Construction of latrine for health providers	Ongoing
8	Igagala dispensary	Kaliua DC	Fast-tracked finishing of maternity ward funded by RBF	Ongoing
9	Igagala dispensary	Kaliua DC	Shallow well for supply of water	Ongoing
10	Izimbili dispensary	Urambo DC	Construction of foundation and walling for maternity ward	Ongoing
11	Miguwa dispensary	Nzega TC	Construction of youth corner	Ongoing

Access to Water

The endline health facility assessment was carried out at the end of November which examined the available resources available at health facilities across all 8 districts of implementation. TAMANI has supported rainwater harvesting systems at 11 health facilities.

See below a graph that shows access to water at health facilities from baseline to endline.



As the graph above illustrates, significant improvements have been noted between baseline and endline across all districts beyond health facilities supported by TAMANI. Kaliua is the only district where a slight decrease is noted in the availability of running water at health facilities. Most health facilities in Kaliua have access nearby water wells which are their main source of water, water is supplied through a vendor and is treated in health facility holding tanks in accordance with government infection and prevention guidelines.

Installation of a rainwater harvesting system at Bukene HC in Nzega DC has influenced the HF Governing Committee to fund a similar project to ensure harvesting of more water for use during the dry season. The district authority, health care providers and the community view these initiatives as reducing the burden on caregivers accompanying patients to the health facility (primarily women) in walking long distances to collect water.

One community member who was taking care of a pregnant woman at a labour ward at Bukene HC said *"Previously we were required to bring water from home for our patients but now we are happy to access water at the HF, thanks to those who supported the installation of running water in this health facility."*

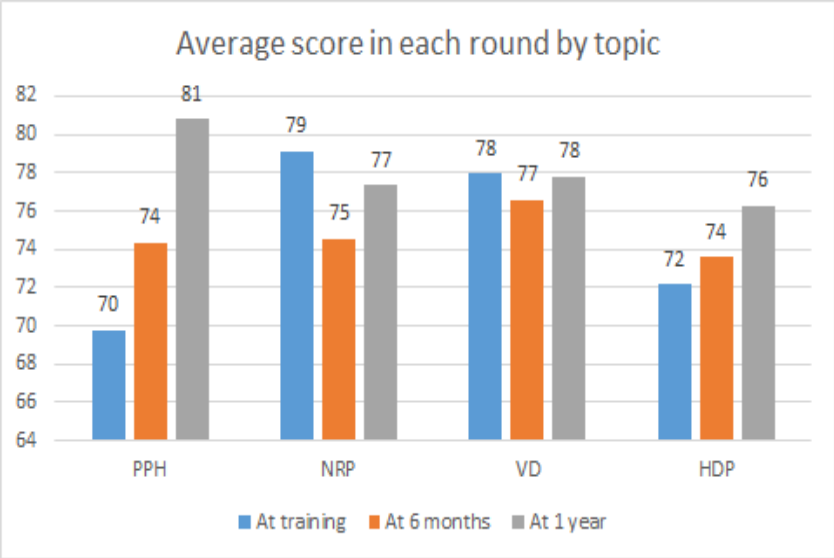
Expected Results	Indicators	Baseline	Project Target	Y4 Target	Cumulative Results to Date
Immediate Outcomes					
1130 Improved knowledge and skills of health providers to deliver gender sensitive reproductive maternal and newborn clinical services	% retention of skills and knowledge of m/f health care workers in CE/BEmONC	n/a	100% Retention	100% Retention	104% Average Retention of score (F: 105% / M: 103%
	#/% of health facilities providing Respectful Maternity Care	n/a	150 Health Facilities	150 Health Facilities	174 Health facilities (116% against project target)

Explanation/Assessment of Performance:

EmONC Knowledge & Skills Retention

The project used OSCE's immediately post-training and at six- and 12-months' post training to assess the retention of knowledge and skills of trained HCP's. The project trained a total of 270 HCP's and reached (84%) of trainees at 6 months and 74% at 12 months post-training.

As shown in the graphs below, the average score across all four OCSES's either increased (PPH and Hypertension in pregnancy) or were maintained (Vacuum delivery and Neonatal Resuscitation).



The combination of EmONC training combined with post-training coaching and mentoring visits at 6 and 12 month is shown to be effective in improving and/or retaining 4 lifesaving skills in obstetric and newborn emergency care.

Overall, post-partum hemorrhage (PPH) competency (OSCE #1) had low baseline scores but improved over time indicating a strong grasp of PPH management for all training curriculums.

Newborn resuscitation (OSCE #2) and Vacuum delivery (OSCE #3) skills were maintained over time up to one year after the training, indicating consistently high performance in these two areas. Combined scores for OSCE #4 (Hypertensive disorder of Pregnancy) were not significantly different across time points, therefore skills were maintained one-year post-training.

Individual data was stratified by numerous variables including sex, designation, facility type, and district, to assess for differences in performance. The variables present in the evaluation (district, sex, designation, facility type) did not appear to affect the retention of scores, thus training for was successful for a wide variety of HCP demographics. Overall, retention of knowledge and skills in TAMANI graduates was exceptional for all 4 OSCEs that were evaluated in the different training curriculum and follow-up coaching and mentoring sessions.

One explanation for the high retention percentage could be that trained health care providers had a chance to practice these skills in the interim, bringing confidence and support in the retention of specific steps to perform these life-saving actions. Post-training coaching is very effective in reinforcing learning processes, improving provider motivation, and improving clinical performance (McAuliffe E et al. 2013).

The hypertensive disorder evaluation average scores are lower than other clinical evaluations. However, the average score still steadily increased between baseline, 6- and 12 months, demonstrating an encouraging retention of skills compared to Neonatal resuscitation or Vacuum delivery. Although this may not be a significant difference, in the final analysis we plan to break down the different sections of this OSCE (different sections including loading dose of MGs04, maintenance dose of MGS04, Monitoring of Toxicity), to understand which component in this specific clinical skill had the most gaps.

One Health Care Worker described how he has used the knowledge gained in the training and put into practice,

> "*I have noticed improvements in the way I do my job, before I never came across a woman with eclampsia but between July to September 2020, my colleague and I managed 3 cases of eclampsia. In the medical field we say "the disease does not read like a book" not all clients might show all signs and symptoms of a certain condition, only one or two signs might lead you to act. This happened in all three cases of eclampsia they did not show common symptoms. I am telling you if it was not for the knowledge I gained during the training I could not have served them. I have gained experience and confidence in the way I do my job, a good example is when you arrived here you found me in a family planning room, I was attending a woman to remove an implant, before I used to only to read about it in books.*" (Male HCW, Igunga DC)

Respectful Maternity Care

The performance of RMC specific items in the OSCEs followed the same trend as non-RMC items, demonstrating that these items are not considered soft skills and are given the same importance as clinical actions such as giving an injection or doing a uterine revision.

HCPs have a good understanding that consent, confidentiality and reassurance are part of a complete experience of quality of care, and can help reduce maternal mortality and morbidity. The project chose to focus on consent and communication attitudes but other topics such as women choosing their birthing position (patient autonomy) would be a great addition to the discussion.

The inclusion of C/RHMT members in coaching and mentoring visits also appeared to be a promising approach to improving quality of care, including RMC since they could discuss with HCPs health systemic barriers they face in providing RMC, for example human resources shortage, stress, Infrastructure for confidentiality, etc. During the mentoring and coaching visits, more than 190 HCP were invited to complete the self-reflection tool after the completion of the OSCEs. These self-reflection opportunities on RMC enable HCPs to critically review their own practice, recall material pertaining specifically to RMC and make improvements on their own to continue to deliver high quality care to all women. Additionally, job aids containing RMC messages were disseminated in more than 265 facilities.

Immediate Outcome Expected Results	Indicators	Baseline	Project Target	Y4 Target	Cumulative Results to Date
1210 Increased access to gender-sensitive reproductive maternal and newborn health services	#/% of household visits by CHW's per quarter	n/a	10 HH visits/ month	10 HH visits/ month	10 HH visits/month
	#/% of communities providing comprehensive Youth SRHR education and services	n/a	36	n/a	38

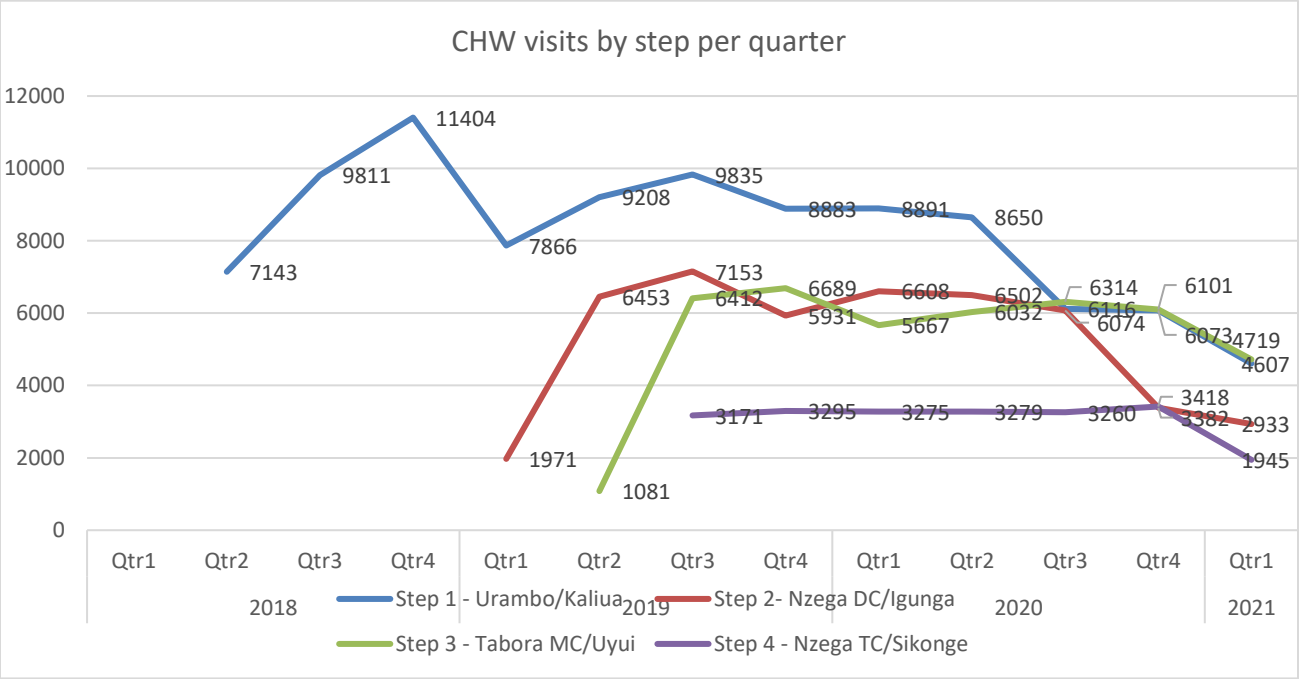
Explanation/Assessment of Performance:

CHW Visits

CHW household visits cover a range of topics included in the CHW Scope of Practice that include antenatal, postpartum and newborn care, family planning, community based RMNCH activities, referral systems, maternal death reporting, and monitoring of community RMNCH services.

To date there are 595 (317m, 278f) active CHWs across all 8 districts. The data above represents the average number of household visits up until the end of July while the full CHW program was supported by the project.

Coinciding with the reduction of stipends for each respective step, monthly visits dropped between April to June 2020 in Urambo and Kaliua and between July to September in Nzega DC and Igunga. The number of visits then leveled out in Quarter 3 for Kaliua and Urambo and Quarter 4 for Nzega DC and Igunga. Smaller drops in visits are seen in Tabora Mc and Uyui and Nzega TC and Sikonge between October to December. In addition, the prolonged rains in Tabora made some visits in April 2020 and January to February 2021 challenging, the COVID-19 pandemic and the changing status of RBF has likely influenced the drops in household visits.



Rolling Profile qualitative interview data suggests, participants attribute many positive changes in the status of their community as a result of an increase in health facility births, more women receiving antenatal care and more women having contact with skilled birth attendants during labour. The improved function of community health workers and their ability to provide information on family planning and support during pregnancy was also mentioned by respondents as contributing to improved community health status. Several women described the number of women giving birth in health facilities has greatly increased and how women understand the risks of home delivery.

"CHWs have been doing remarkable work in our society, I remember there use to be a big number of community members who were giving birth at home and used traditional herbs. The number of women attending ANC has also greatly increased." (WRA, Igunga District)

One mother described how the information she has received from a CHW improved the health of her child and how this information was cascaded to other community members,

"CHWs have been a big help in helping me understand different things in relation to hygiene and how to keep the child in a safe environment. I remember there was a day a CHW visited me and found my child not in a good state of hygiene they helped me understand what to do better. I have shared information with people like my friends, family members and neighbours. Most of the time the information I received on reproductive health has been a big help to my neighbours, they will ask why my child is doing better health wise than their children and I will always try to share the information so they are well informed." (WRA, Kaliua District)

Comprehensive Youth SRHR Dialogues

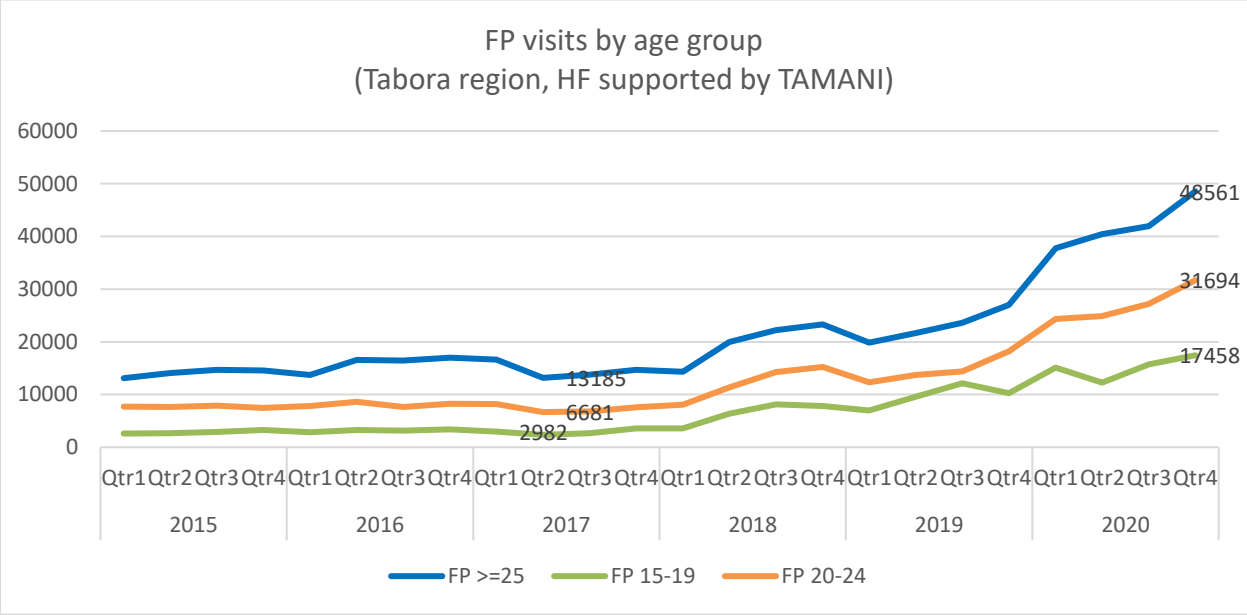
During the reporting period, the trained youth champions conducted individual awareness sessions and community outreach with in and out of school youth on ASRH in collaboration with health facilities in their respective communities without TAMANI support. These sessions were held all 8 districts. A total of 3168 (1665m; 1503f) youth were reached on discussions that included STI's, life skills, drug abuse, reproductive health and rights, early pregnancy and family planning. These sessions play dual roles in the project, both informing youth with ASRH information as well as building a base for continuation of youth work with the absence of project staff by strengthening connections with local health facility staff.

Immediate Outcome Expected Results	Indicators	Baseline	Project Target	Y4Target	Cumulative Results to Date
1220 Improved ability of women, men and adolescent boys and girls to seek reproductive, maternal and newborn health services	#/% of women and adolescent girls receiving modern contraception at health facilities.	Adults (25+): 16,643 Youth (20-24): 8,201 Adolescents (15-19): 2,982*	Adult:5pp increase Youth: 10pp increase Adolescent: 10pp increase	n/a	Adults (25+): 41,980 (152% increase) Youth (20-24): 27,175 (231% increase) Adolescents (15-19): 15,708 (427% increase)**
	%/# of men and adolescent boys who agree/strongly agree with women's right to seek health care	M:34% A:27%	10% increase	n/a	M: 40pp A: 36pp

*HMIS Jan-Mar 2017 **HMIS Jul-Sep 2020

Family Planning visits

The graph below is showing historical HMIS data on family planning visits at health facilities supported by TAMANI. Notably, there are two points where visits increase. The first began in April 2018 and continued into March 2019. The second wave began in January 2020. The increase is observed in all age groups, though adolescents (15-19) had the largest overall increase.



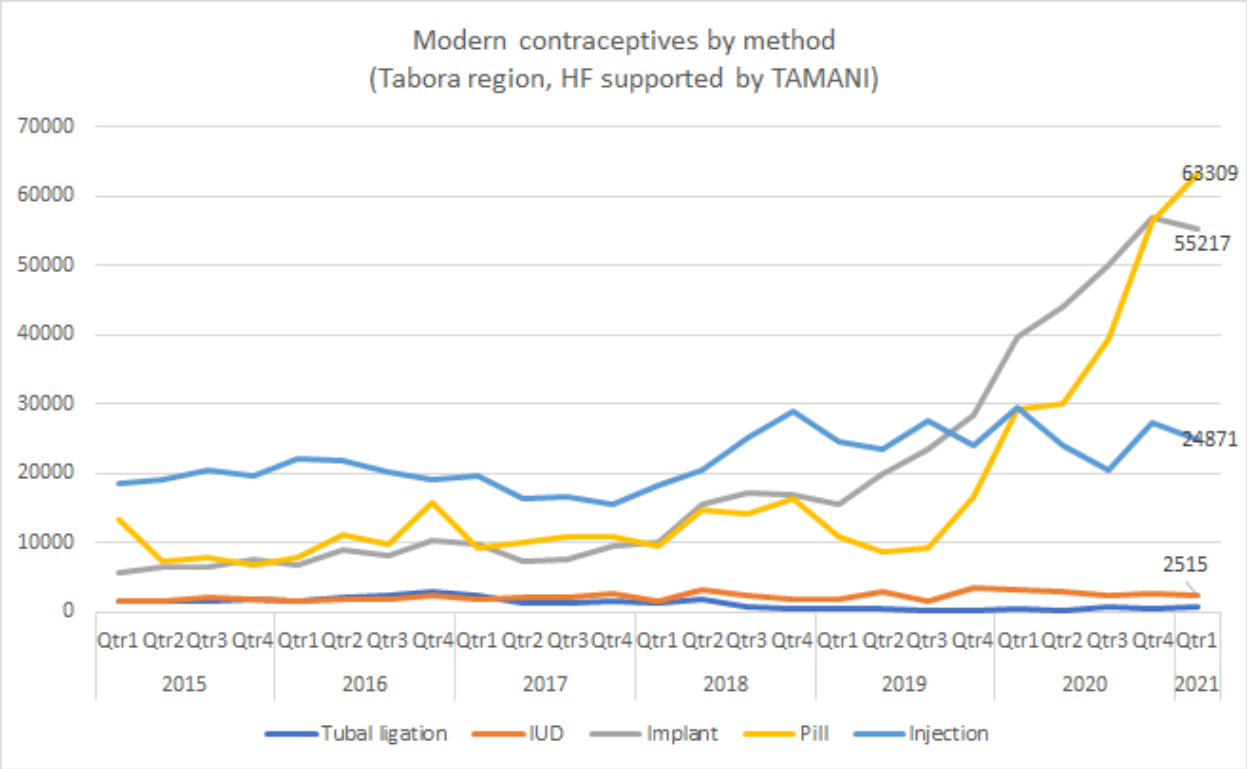
As the graph reflect above, there has been a steady increase in the overall number of family planning visits in health facilities supported by TAMANI since the start of the project. The upward trend is more significant in health facilities supported by TAMANI when compared to the other health facilities in the region. Only for women between the ages of 15-19 was there a reduction in family planning visits between April-June 2020, which coincides with the first wave of the COVID-19 pandemic in Tanzania. Family planning visits continued to increase thereafter for all age groups.

HMIS data on family planning visits through DHIS2 was only available until the end of 2020. A discontinuity has been noted in this variable which could be due to improvements in the system to refine level of disaggregation. Additional follow up will be made for the final report to extract data for the final two quarters.

As of December 2020, the number of family planning visits is 2 times the number of visits reported in December 2017 for women over the age of 25, 3 times the number of visits for women between the ages of 20-24, and almost 4 times the time for adolescents between 15-19. Several factors have likely contributed to the observed changes including government outreach services at district levels which normally happen on a quarterly basis.

Distribution of Modern Contraceptives

The TAMANI team has extracted data on the number of contraceptives distributed by method across the region from HMIS. See below a table on the distribution of contraceptives by method for the region:



As noted in the graph above, since 2018 there has been a spike in the number of women using implants and pills, initially in Apr-Jun of 2018 and again in 2019 which has continued to rise at a steady rate. We see a decline between January-March 2021 which coincides with the rainy season, which makes some health facilities more difficult to access and is when women are more heavily involved in agricultural activities. This was supported by one of the CHMT members at Nzega District Council,

"There is also a problem of poor infrastructure as some facilities are not easily accessed. There tends to be a decrease in service utilization at this time of the year rainy season which is planting season." (CHMT member, Nzega District Council)

As noted in other parts of the report, COVID-19 has had an impact on accessing primary health services in the last year. However, we don't see a major impact on most contraceptive methods, except for a slight decline in the overall number of injections and IUDs.

Sustainability

TAMANI has completed its last full year of implementation, with a strong focus on transitioning key project activities to the R/CHMT. The project will shift focus in Q1 of Y5 to focus on the dissemination of project results and learning to the region and districts. The section below provides an update on the Y4 AWP sustainability strategy. Note that some of these plans were modified given the shift in priority to respond to COVID-19 for both project staff and R/CHMT members.

Sustained Capacity and Resources

R/CHMT members continued to engage co-trainers and coaches on supportive supervision and health system strengthening activities. CHMTs budgets for FY20/21 have included CHW costs at various levels, however execution of the budgets hasn't been possible due to ceilings received from PORALG. For example, Urambo district had budgeted at least one CHW per facility, but they did not receive approval for these funds. Project discussions with CHMTs have continued to encourage use of non-monetary incentives such as excusing CHWs from community duties and the districts have taken up discussions with communities to co-support the continuation of CHW visits. See the previous CHW sections above for more information on the partnership models being adopted between communities and CHMT's to retain CHW's.

During the reporting period, TAMANI staff finalized sustainability plans with CHMT's in each of the 8 districts. As reported above, TAMANI staff have been monitoring ambulance-operating costs with good success over the last 6 months in ensuring required costs are covered. Supportive supervision resources were integrated in the district budgets for FY20/21 however, disbursement of funds remains a challenge.

All 24 communities implementing CSC were encouraged to synchronize the CSC process with the CCHP development cycle through the engagement of community facilitators in plans and budgets for health facilities. However, plans to pilot this approach were cancelled to reduce risks of COVID-19 with large groups and interactions between urban and rural communities.

The TAMANI Project Coordinator has been working with the RHMT to utilize CHMT members trained as EmONC coaches and to transition project training equipment to the region to support ongoing coaching.

MPDSR meetings have fully transitioned to the region and continue without project support.

Project partners worked to finalize tools, resources and learning and engage with Government partners. SOGC and AGOTA have developed policy briefs and learning which involved engaging the MoHCDGEC, and the CSIH training packages are now finalized and TAMANI staff are working to schedule a handover meeting with CSIH and Local Government Authorities, MoHCDGEC and PORALG in early Q1 of Year 5.

TAMANI staff have worked with trained CHMT Youth focal points to follow-up in coordination with Youth providing feedback on quality of ASRH services. During the reporting period, the trained youth champions

conducted individual awareness sessions and community outreach without TAMANI support in all eight districts. The RMO has prioritized investment in monitoring performance of facilities where TAMANI has trained HCWs on ASRH services. The monitoring will be done by both RHMT and CHMTs through supportive supervision visits

Handover Activities and Rehabilitation Schedule

Activity	Districts	Timing	Notes
Ambulances	All Districts	Completed	Integration of maintenance costs in district budgets and /or arrangements with community.
EmONC Equipment	All Districts	Completed	Budget to cover maintenance included in district/ HF budgets.
EmONC Coaching Equipment	RHMT	Completed	Equipment kept at project office, waiting for the last coaching mission in Q3. Thereafter will be handed over to RHMT to coordinate usage
MPDSR Meetings	RHMT	Completed	R/CHMT holding MPDSR meetings regularly without project support
Community Health Worker program	Kaliua & Urambo	Completed	Project continues to advocate for national funding for CHW's. Districts have been including costs in the budget but they have not been approved. Community partnership models are in place in many districts.
	Nzega DC & Igunga	Completed	
	Sikonge & Nzega TC	Completed	
	Uyui & Tabora Municipal	Completed	
R/CHMT Training Packages	RHMT	May 2021	Training packages are now finalized. TAMANI and CSIH are planning handover meetings with LGAS, MoHCDGEC and PORALG
Community Score Card	All Districts	Not Completed	TAMANI staff planned to support the synchronization of the CSC process with the CCHP development cycle. This was not possible because of the risks related to COVID-19.
Supportive Supervision Visits	All Districts	Completed	Integration of supportive supervision program into district budgets.

Youth Champions	All districts	Completed	Strengthening linkage with HFs to continue using trained youths when conducting outreach activities in communities. YC's already conducting outreach without TAMANI support.

Lessons Learned and Next Steps

Overall, most project activities have been completed, with minimal delays or adjustments related to COVID-19 and the general election. Continuing the project under these exceptional circumstances, and continuing essential support to the Tabora region, is a testament to the TAMANI teams' commitment and professionalism. Indeed, we continue to see strong success at the outcomes level of the project and look forward to reporting endline data in the final report.

Key learning from year four implementation has largely related to TAMANI's COVID-19 response programming. The team quickly learned how to roll out of a digital communications campaign, learned how to best do remote surveys, as well as how to transition training to online platforms.

At this point in time, project staff are now shifting away from project implementation to collate learning, tools and resources, and to validate endline data with project staff and communities.

Annex A - Risk Register

1. Risk (Definition)	2. Risk Response	3. Initiative LM Outcome Statement	4. Residual Risk
Development Risks			
Risk 1: COVID-19 cases across Tanzania will undermine and potentially undo support to RMNCAH services and negatively impact planned project activities and outcomes.	*CARE Tanzania has developed and continues to update the CARE Tanzania COVID-19 Response Plan. *Project team is working with RHMT and GoT on the COVID-19 response and to ensure RMNCAH resources are not re-directed and essential SRHR services continue.	1100 Improved availability of quality reproductive, maternal and newborn health services in underserved districts in Tanzania	Impact: 3 Likelihood: 3
Risk 2: Beneficiaries, health care workers, R/CHMTs and project staff perpetuate harmful gender attitudes and beliefs	*Train staff early in the project on gender equality. *Work with CHMTs to include gender as a standing issue at meetings and in planning *Include women-centred approaches to EmONC training (Respectful Maternity Care) *Engage men at the community level in maternal and newborn health education	1220 Improved ability for women to seek maternal and newborn health services 1200 Increased utilization of reproductive, maternal and newborn health services by women and their families in targeted district of Tanzania	Impact: 2 Likelihood: 3
Risk 3: Government in Tanzania appears to be committed to RMNCAH programs, with the endorsement of the One Plan II and financing for the health sector outlined in the National Five Year Development Plan 2016-2021. However, statements related to family planning may have a negative impact on access to contraception for women and girls.	*CARE Tanzania will work closely with national partners to advocate for continued Government support for reproductive, maternal and newborn health as a priority area of investment and identify appropriate opportunities for policy engagement. *The project will work closely with the PSC members and others to stress the importance of access to contraception as part of RMNCAH programming/funding.	1110 Strengthened capacity of regional and district health system mangers to effectively plan, manage, and deliver quality gender-sensitive maternal and newborn health services 1114 Policy briefs on priority issues related to RMNH written and disseminated for district, regional and national decision making	Impact: 3 Likelihood: 3

Annex B – Performance Measurement Framework

Expected results	Indicators	Baseline data[2]	Targets	Data Sources	Data collection methods	Frequency	Responsibility
Ultimate outcome							
1000 Reduced maternal and newborn mortality and morbidity in underserved districts in Tanzania	MMR (per 100,000 live births) national estimate	556	70[3]	TDHS 2015	Document Review	Baseline, Endline	CARE
	NMR (per 1000 live births) national average	25	12[4]	TDHS 2015	Document Review	Baseline, Endline	CARE
	Adolescent pregnancy (% of women ages 15-19 who are pregnant or have given birth)	43%	38%	Beneficiaries	Household Survey	Baseline, Endline	CARE
Intermediate outcomes							
1100 Improved availability of quality reproductive maternal and newborn health services in underserved districts in Tanzania	% of women and adolescent girls with an unmet need for family planning	W:29% A: 41%	W: 5% decrease A: 10% decrease	Beneficiaries	Household Survey	Baseline, Endline	CARE
	% deliveries assisted by a skilled birth attendant	W:68% A:76%	10% increase	Beneficiaries	Household Survey	Baseline, Endline	CARE
	% change in Respectful Maternity Care	22%	20% increase	Beneficiaries	Household Survey	Baseline, Endline	CARE
1200 Increased utilization of reproductive maternal and	% women 15 - 49 with a live birth attending ANC 4 or more times	W: 55% A: 53%	10% increase	Beneficiaries	Household Survey	Baseline, Endline	CARE
	Contraceptive Prevalence Rate	W: 33% A: 16%	W:5% increase A:10% increase	Beneficiaries	Household Survey	Baseline, Endline	CARE

[2] Initial baseline data is taken from the 2015 TZ DHS, but will be updated once the baseline report is completed.
[3] SDG 3 MMR Indicator
[4] SDG 3 NMR Indicator

Expected results	Indicators	Baseline data[2]	Targets	Data Sources	Data collection methods	Frequency	Responsibility
newborn health services by women and their families in targeted districts in Tanzania	%/# of women who are autonomous to visit health facility	W:31% A:26%	10% increase	Beneficiaries	Household Survey	Baseline, Endline	CARE
Immediate outcomes							
1110 Strengthened capacity of regional and district health system managers to effectively plan, manage, and deliver quality gender sensitive reproductive maternal and newborn health services	#/% of health facilities reporting quality[5] RMNH related HMIS data monthly	117	150	Health Facility	Monthly Report	Annually	CSIH
	#/% of District CCHP's scored 70% or higher in DQA	Uyui 57.5% Urambo 57.5% Sikonge 70% Nzega DC 65% Kaliua 67.5%	8 districts		CCHP Scorecards	Annually	CSIH
1120 Improved gender-sensitive reproductive maternal and newborn health service infrastructure	#/% of women and adolescent girls satisfied with improved health facilities and emergency transportation	53 %	10% increase	Beneficiaries (women, adolescent girls)	Household Survey	Annually	CARE
	#/% of health facilities equipped and supplied to deliver CE/BEmONC	0	150 facilities	Health Facility	Survey/ Observation	Baseline, Endline	CARE
	#/% total health care facilities with regular access to water	139	170 facilities	Health Facility	Survey/Observation	Annually	CARE

[5] "quality" will be defined as receiving a score of >95% on data completeness using DHIS2

Expected results	Indicators	Baseline data[2]	Targets	Data Sources	Data collection methods	Frequency	Responsibility
1130 Improved knowledge and skills of health providers to deliver gender sensitive reproductive maternal and newborn clinical services	% change of skills and knowledge of m/f health care workers in CE/BEmONC	N/A	20% improvement	Health Care Workers	Objective Structured Clinical Examination (OSCE)	12 months post-training	SOGC
	#/% of health facilities providing Respectful Maternity Care	N/A	150 facilities	Health Care Workers	RMC Tool/Quality of Care Tool	12 months post-training	SOGC
1210 Increased access to gender-sensitive reproductive maternal and newborn health services	#/% of household visits by CHW's per quarter	N/A	10/ households/ month	CHW's	CHW Reports	Annually	CARE
	#/% of communities providing comprehensive Youth SRHR education and services	N/A	36	Youth/Health Facility	Survey/ Observation/ Project reports	Annually	CARE
1220 Improved ability of women, men and adolescent boys and girls to seek reproductive, maternal and newborn health services	#/% of women and adolescent girls receiving modern contraception at health facilities.	6%	Adult:5% increase Adolescent: 10% increase	Health Facilities	HMIS	Annually	CARE
	%/# of men and adolescent boys who agree/strongly agree with women's right to seek health care	M: 34% A:27%	10% increase	Beneficiaries	Household Survey	Baseline, Endline	CARE
Outputs							
1111 Regional and district health authorities trained and mentored in gender sensitive	#/% of f/m RMNH joint supportive supervision visits per health facility	N/A	Quarterly	R/CHMT's	Review of CHMT Supportive Supervision log books/records	Semi-Annually	CSIH

Expected results	Indicators	Baseline data[2]	Targets	Data Sources	Data collection methods	Frequency	Responsibility
supportive supervision for reproductive, maternal and newborn health services	# of m/f R/CHMT members trained to conduct regular RMNCH supportive supervision	N/A	8 RHMT members & 5 CHMT members/district	Facilitators	Training Reports	Semi-Annually	CSIH
1112 Regional and district health authorities trained and mentored on HMIS and effective planning and budgeting for reproductive, maternal and newborn health services	#/% of f/m CHMT members and HF Staff trained on developing CCHPs for RMNCH services	N/A	5 CHMT members /district 100 HF Staff	Facilitators	Training Reports	Semi-annually	CSIH
	# of f/m CHMT members trained on RMNH data analysis and utilization	N/A	1 CHMT members/ district	Facilitators	Training Reports	Semi-annually	CSIH
1113 Reproductive, maternal and newborn health systems research projects conducted	# of research projects	N/A	2 research projects	Publication	Project reports	Semi-Annually	CARE
	# of reproductive, maternal and newborn health publications written	N/A	3 publications	Publications	Project Reports	Year 3 & 4	CARE
1114 Policy briefs on priority issues related to RMNH written and disseminated for district, regional	# of policy briefs written and disseminated	N/A	5 policy briefs	Policy Briefs	Project Reports	Year 3 & 4	CARE
	# of reproductive, maternal and newborn health consultations held at local, district, regional and national levels	N/A	5 consultations	Project Staff	Project Reports	Year 3 & 4	CARE

Expected results	Indicators	Baseline data[2]	Targets	Data Sources	Data collection methods	Frequency	Responsibility
and national decision making							
1121 Emergency transportation system for pregnant and postpartum women and newborns developed	#/% of villages with emergency transportation systems	N/A	20 villages	Project Staff	Project Reports	Semi-Annually	CARE
	#/% of pregnant women, and adolescent girls using emergency transportation	N/A	10 referrals/ ambulance/ month	Drivers	Vehicle Log	Semi-Annually	CARE
1122 Health facilities equipped and rehabilitated	#/% of health facilities equipped and/or rehabilitated to provide BEmONC & CEmONC	N/A	4 health centers (CEmONC) and 70 dispensaries (BEmONC)	Project Staff	Project Reports	Semi-Annually	CARE
1131 Job aids disseminated based on GoT's RMNH clinical practice guidelines	# of job aids developed	N/A	4 job aids	Job Aid	Project Reports	Semi-Annually	CARE
	# of health facilities with job aids	N/A	140 health care facilities	Project Staff	Project Reports	Semi-Annually	CARE
1132 Health care workers trained on CE/BEmONC and family planning	# of m/f health care workers trained on CE/BEmONC and family planning	N/A	270 health care workers	Facilitators	Training Reports	Semi-Annually	CARE
	% change in knowledge of m/f health workers of CE/BEmONC (pre-test/post-test)	N/A	20% improvement in knowledge	Health Care Workers	Pre/Post Training Tests	Semi-Annually	CARE
1133 Health care workers mentored on CE/BEmONC and family planning	# of m/f health care workers mentored on CE/BEmONC and family planning	N/A	270 health care workers (6 & 12 months post-training)	Mentors	Project Reports	Semi-Annually	SOGC
1134 Maternal Perinatal Death	# of # of meetings to sensitize R/CHMT on MPDSR process and gaps	N/A	10 meetings	Project Staff	Project Reports	Semi-Annually	CARE

Expected results	Indicators	Baseline data[2]	Targets	Data Sources	Data collection methods	Frequency	Responsibility
Surveillance & Response Audit developed and implemented	# of maternal death review assessments	N/A	1	MDR Assessment Report	MDR Assessment Report	Once	CARE
1211 CHW program for reproductive, maternal and newborn health and family planning implemented	# of m/f CHWs trained (using pre-test/post-test as method)	N/A	1000 m/f CHWs	Facilitator	Training Report	Semi-Annually	CARE
	# of m/f CHWs equipped with bicycles, bags etc.	N/A	1000 m/f CHWs	Project Staff	Project Reports	Semi-Annually	CARE
1212 Youth friendly sexual and reproductive health services developed and implemented	# of Youth and HCW's trained on Youth SRHR friendly spaces	N/A	160m/f HCW/80m/f Youth	Facilitators	Training Reports	Semi-Annually	CARE
	# of districts (CHMTs) with m/f Youth SRHR focal points	N/A	8	Project Staff	Project Reports	Semi-Annually	CARE
1221 Gender-sensitive reproductive, maternal and newborn health community scorecards conducted	# of communities trained on using community scorecards	N/A	24	Project Staff	Project Reports	Semi-Annually	CARE
1222 Communities sensitized on	# of men engaged on RMNCH issues	N/A	1500	Project Staff	Project Reports	Semi-Annually	CARE

Expected results	Indicators	Baseline data[2]	Targets	Data Sources	Data collection methods	Frequency	Responsibility
gender-sensitive reproductive, maternal and newborn health							

Appendix C – Gender Equality Measurement Framework

Expected results	GE Indicators	Notes	Data sources	Data collection methods	Frequency	Results

Ultimate outcome						
1000 Reduced maternal and newborn mortality and morbidity in underserved districts in Tanzania	% change in women's empowerment	Empowerment domains are included in the household survey. Women's empowerment analysis will focus on risk factors and vulnerabilities specific to women's and girl's health outcomes in Tabora.	Beneficiaries	Household survey	Baseline/ Endline	
Intermediate outcomes						
1100 Improved availability of quality reproductive maternal and newborn health services in underserved districts in Tanzania	% change in Respectful Maternity Care	Respectful maternity care questions based on the RMC charter on the rights of childbearing women have been integrated into the household survey.	Beneficiaries	Household Survey	Baseline, Endline	
1200 Increased utilization of reproductive maternal and newborn health services by women and their families in targeted districts in Tanzania	% change of women's satisfaction with health facility rehabilitation projects	The household survey includes questions on women's satisfaction with health facility rehabilitation projects.	Beneficiaries	Household Survey	Baseline/ Endline	
Immediate outcomes						
1110 Strengthened capacity of regional and district health system managers to effectively plan, manage, and deliver quality gender sensitive reproductive maternal and newborn health services	% CHMTs with knowledge of gender issues related to FP/RMNH services % of CHMT's with ability to do gender based analysis of sex disaggregated data	Training for R/CHMTs will include key findings from the gender research. Initial findings from TNA suggested there are gaps in understanding how gender relates to the role of CHMT's.	R/CHMT members	CHMT Survey	Endline Survey	
1120 Improved gender-sensitive reproductive maternal and newborn	#/% of health facilities with improved infrastructure that	Women identified improving access to water and power as initial priority rehabilitation projects. The health facility	Beneficiaries	Consultation Reports/ Project Reports	Year 4	19/21 HF Projects (91%)

health service infrastructure	reflects the priorities of women and girls in the catchment communities	rehabilitation strategy will be driven by the priorities of women and girls.				
1130 Improved knowledge and skills of health providers to deliver gender sensitive reproductive maternal and newborn clinical services	#/% health care workers with knowledge of Respectful Maternity Care	Respectful Maternity Care is part of the EmONC training (based on GoT guidelines). RMC will be reinforced through coaching and mentoring post-training.	HCWs	OSCE's	Year 4	270/100%
1210 Increased access to gender-sensitive reproductive maternal and newborn health services	# of adolescent boys and girls satisfied with RMNH health care services	CARE will conduct follow-up Youth SRHR surveys using exit interviews and community surveys	Beneficiaries	Youth KAP surveys	Endline Gender Qualitative Research	
1220 Improved ability of women to seek reproductive, maternal and newborn health services	#/% of CHWs that can identify at least 2 gender issues related to FP/RMNH	SBCC messages developed from formative research that address harmful gender norms and support positive gender norms for the health of women and girls shared with CHWs	CHWs	Survey using CHW sample	Year 4	19/64% male CHW's 38/78% of female CHW's
Outputs						
1111 Regional and district health authorities trained and mentored in gender sensitive supportive supervision for reproductive, maternal and newborn health services	#/% of R/CHMT supportive supervision trainings that review key findings from gender research	Supportive supervision training will integrate gender issues identified from baseline as key to supporting women centered health care	HCWs	Training Curriculum	Endline	
1112 Regional and district health authorities trained and mentored on HMIS and effective planning and budgeting for reproductive, maternal	#/% of R/CHMTs that can provide gender-based analysis of sex disaggregated data	This was integrated into the data utilization training curriculum.	R/CHMT's	CHMT Survey	Endline Survey	

and newborn health services						
1113 Reproductive, maternal and newborn health systems research projects conducted	# of research projects that include on gender	The project will conduct at least one of its research projects on gender norms that determine FP/RMNH outcomes.	Research Papers	Document Review	Annually	2
1114 Policy briefs on priority issues related to RMNH written and disseminated for district, regional and national decision making	# of project briefs that address gender norms that affect FP/RMNH		Policy Briefs		Year 4	3
1121 Emergency transportation system for pregnant and postpartum women and newborns developed	Women's satisfaction with emergency vehicles	There have been issues with emergency vehicles in Tabora in the past as they were not suitable for pregnant women.	Beneficiaries	Household Survey	Baseline and Endline	
1122 Health facilities equipped and rehabilitated	#/% of women informing rehabilitation of health facilities	The project will consult with women in the villages of the catchment area of the health facilities to be rehabilitated to inform the rehabilitation projects.	Beneficiaries	Focus Group Discussions	Baseline	192 women
1131 Job aids disseminated based on GoT's RMNH clinical practice guidelines	#/% of job aids that address women centred health care	The job aids will be based on the MoHCDGEC BEmONC/CEmONC curriculum. The HH survey and gender research will also be used to inform job aids to address women specific issues.	Job Aids	Document Review	After completion of job aids.	4/4 100%
1132 Health care workers trained on CE/BEmONC and family planning	#/% of Health Care Workers trained on RMC	The training curriculum for BEmONC/CEmONC will include a module on RMC	Health Care Workers	Training Curriculum Pre/post - test	Each training	270/270 100%
1133 Health care workers mentored on CE/BEmONC and family planning	OSCE with Respectful Maternity CARE assessment	OSCE's integrate respectful care, with a focus on communication and consent.	OSCE	Document Review	6 and 12 months post-training	4/4 100%

1134 Maternal death audit developed and implemented	#/% of MPDSR meetings that include gender determinants of death	MPDSR meetings to include gender barriers to highlight issues that may contribute to maternal deaths.	R/CHMTs/HF staff	Meeting Notes	Annually	
1211 CHW program for reproductive, maternal and newborn health and family planning implemented	#/% of CHWs that are trained on gender issues	CHW curriculum includes gender, GBV, engaging men, and promoting participatory household decision making on RMNH.	CHW Curriculum	Document Review	After completion of CHW Training	997/997 100%
1212 Youth friendly sexual and reproductive health services developed and implemented	#/% of youth friendly materials and services that take into account the different needs of boys and girls	While the GoT AFRHS curriculum cannot be modified, the related project resources and community engagement activities will be informed by the formative research on gender norms.	Youth SRHR resources developed	Document Review	Endline	
1221 Gender-sensitive reproductive, maternal and newborn health community scorecards conducted	#/% of community scorecards that include gender specific indicators % change in gender specific indicators	The CSC is meant to ensure that duty bearers fulfill their obligations. CSC in the project will more specifically ensure that duty bearers fulfil their obligations towards the rights of women and girls.	Beneficiaries	Scorecard	Endline	
1222 Communities sensitized on gender-sensitive reproductive, maternal and newborn health	# of men and women participating in Social Analysis and Action	Social Analysis and Action seeks to change harmful and unequal gender norms and promote positive and equal gender norms. Findings from the HH survey and formative research will be applied to Social Analysis and Action activity	Beneficiaries	Project activity report	After completion of each activity	

Annex D - Communications Annex

Project Description

The Tabora Maternal Newborn Health Initiative (TAMANI) aims to improve the quality of reproductive, maternal, and newborn health services available, and to address the existing barriers women and girls face in accessing care. It is expected to *directly* support 56 health planners, 270 health care workers and 1000 community health workers, and to *indirectly* support 298,900 women and girls of reproductive age, 660,500 men and boys, and 68,600 newborns.

TAMANI Project Summary	
Project name:	Tabora Maternal Newborn Health Initiative (TAMANI)
Donor:	Government of Canada
Project lifespan:	January 2017 – December 2021
Project Partners:	CARE Association of Gynecologists & Obstetricians of Tanzania (AGOTA) Canadian Society for International Health (CSIH) Ifakara Health Institute McGill University Institute for Health Policy & Social Research Society of Obstetricians & Gynecologists of Canada (SOGC)
Government of Tanzania partners:	Tabora Regional Health Management Team Ministry of Health, Community Development, Gender, Elderly & Children (MoHCDGEC) The Prime Minister's Office for Regional and Local Governance (PO-RALG)
Project ultimate outcome:	Reduced maternal/newborn mortality and morbidity in underserved districts in Tanzania
Intermediate outcomes:	-Improved availability of quality reproductive, maternal, and newborn health services in underserved districts in Tanzania -Increased utilization of reproductive, maternal, and newborn health services by women and their families in targeted districts in Tanzania
Communities Targeted:	The project covers all districts in Tabora Region: Igunga, Kaliua, Nzega, Sikonge, Tabora, Tabora Municipal, Urambo & Uyui
Number of beneficiaries:	Directly: -56 health planners -270 health care workers -1000 community health workers Indirectly: -298,995 women of reproductive age -669,510 men and boys -68,695 newborns.

Annex E – List of Partners

CARE Canada is responsible for the overall coordination of TAMANI and is legally responsible for the implementation of the project. The CARE Canada Program Manager works closely with all partners and manages communication and coordination, as well as donor reporting.

Contact: Rebecca Davidson, Head of Programs – Global Health

Email: Rebecca.davidson@care.ca

CARE Tanzania is responsible for the bulk of project implementation and coordinates the work of partners in Tabora. The Project Coordinator leads on engagement with the GoT and works closely to coordinate project activities with the Regional Medical Officer and the RHMT.

Contact: Flavian Lihwa, Program Coordinator – Tabora

Email: FLihwa@care.org

The Canadian Society for International Health (CSIH) is supporting the implementation of health system strengthening activities under Intermediate Outcome 1100 specifically providing training and support to both Regional Health Management Teams and Council Health Management Teams to increase capacity in the areas of supportive supervision, gender sensitive RMNCAH planning and budgeting, and HMIS data quality.

Contact: Hanan Muharram, Project Coordinator

Email: calexander@csih.org

The Society for Obstetricians and Gynecologists of Canada (SOGC) is supporting the coaching and mentoring activities following EmONC training and working with AGOTA to facilitate learning and knowledge exchange between the two professional associations.

Contact: Catherine Savoie, Project Manager

Email: csavoie@sogc.com

The Association of Gynaecologists and Obstetricians of Tanzania (AGOTA), is working with SOGC to support improved quality EmONC training, coaching and mentoring and support to simulation and review and guidance on GoT MoHCDGEC policies.

Contact: Dr. Elias Kweyamba MD, Mmed. Obstetrics & Gynaecology, Consultant

Email: ellyambag@yahoo.com

McGill University's Institute for Health and Social Policy (IHSP) is supporting the project to conduct evaluation activities, finalizing the monitoring and evaluation plan, and providing data analysis on the health facility assessment survey, and the baseline household survey.

Contact: Dr. Arijit Nandi, PhD, Associate Professor

Email: arijit.nandi@mcgill.ca

Ifakara Health Institute (IHI) is responsible for data collection for the project's baseline household survey and led on the formative gender research.

Contact: Dr. Sally Mtenga, MA PhD (Dis), Research Scientist

Email: smtenga@ihi.or.tz

The Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) provides technical oversight to TAMANI and ensures the project is aligned with current and relevant GoT health policies and priorities. A senior representative of the MoHCDGEC participates on the TAMANI Project

Steering Committee, and TAMANI staff participate in relevant technical working groups at MoHCDGEC, such as the Safe Motherhood Technical Working Group coordinated by the RCHS unit.

Contact: Dr. A.M. Makuwani, A/Deputy Director of Reproductive and Child Health

Email: amakuwani@gmail.com

The Prime Ministers Office for Regional and Local Governance (PO-RALG) provides oversight and approval of the engagement of government employees in TAMANI, and plays an on overall coordination and approval role in supporting TAMANI implementation. A senior representative of PO-RALG participates on the Project Steering Committee.

Contact: Dr. Ntuli, Director of Health, Social Welfare and Nutrition Services, PO-RALG

Email: nkapologwe2002@gmail.com

The Regional Health Management Team (RHMT) is a key partner in implementing the project in Tabora and provides key decision-making in the selection and approval of specific project activities. The RHMT, led by the RMO prioritizes where and when certain activities are implemented within the region and plays a critical coordination role, especially within the RBF context.

Contact: Dr. Honoratha F. Rutatinisibwa, RMO, Tabora

Email: honorwe@yahoo.com

TAMANI

Tabora Maternal Newborn Health Initiative

Policy Brief

Skills Retention in Emergency Obstetric and Newborn Care program and Perspectives on Respectful Maternity Care

EXECUTIVE SUMMARY

Maternal Mortality remains high in Tanzania and it is well-recognized that access to high quality, skilled care before, during and after childbirth can help manage and prevent complications to save the lives of women and newborns.

TAMANI is a CARE led initiative funded by the Government of Canada which aims to reduce maternal and newborn mortality and morbidity in the Tabora region (Tanzania). In this initiative, we evaluated the extent to which the Emergency obstetrics (EmONC) training, including coaching and mentoring visits implemented within the project, contributed to improvements in the skills of health care providers (HCPs). We explored how different variables may have affected retention of these competencies. The evaluation also aimed to gather insights into HCPs' perceptions of providing respectful maternity care (RMC).

We concluded that the combination of Emergency Obstetrics and Newborn Care (EmONC) training paired with coaching and mentoring visits 6- and 12-months post-training was effective for improving or retaining lifesaving obstetric skills.

Furthermore, our findings show that health care providers have a good understanding that consent, confidentiality and reassurance are part of a complete experience of quality of care and can help reduce maternal mortality and morbidity.

INTRODUCTION

In recent years, great strides have been made to reduce global maternal mortality rates, however maternal mortality remains unacceptably high in numerous regions. The majority of maternal deaths are a result of complications that occur during pregnancy and childbirth, most of which are preventable or treatable. Such complications, including severe bleeding, high blood pressure, and difficulties during delivery, account for nearly 75% of all maternal deaths.[i]

While Tanzania has made progress, the maternal mortality ratio remains high at 556 deaths per 100,000 live births[1] (DHS 2015-2016). The primary challenges facing this region include inadequate access to emergency obstetric care or skilled health care professionals and low quality of services.

Within the Tabora region of Tanzania, the health of women and newborns is further compounded by poverty and rurality, which impacts access to health services. Little more than half of the of births in this region occur in a health facility and only 54% of births are attended to by a skilled provider.[ii]

While we know that quality care can improve outcomes, improving access and coverage alone are not enough to reduce mortality.

To truly move towards elimination of maternal and newborn death, improved quality, respectful maternity care (RMC) including equity and dignity is necessary in all areas of care through improved safety, trust, and communication.

A woman, or her family, should understand what to expect and what is happening at all stages of her care, and be treated with respect.

APPROACHES AND RESULTS

As part of TAMANI, the Association of Gynecologists and Obstetricians of Tanzania (AGOTA) and the Society of Gynecologist and Obstetricians of Canada (SOGC) expertise was engaged to strengthen the availability of quality maternal and newborn health services through two primary objectives:

- Improved knowledge and skills of health care providers
- Improved adherence to the provision of gender sensitive maternal and newborn clinical services and promotion of respectful maternity care (RMC).

The activities took place in 8 districts of Tabora region targeting health care providers in 140 health care facilities. In total, 270 (124m/146f) Health Care providers from lower to higher cadres were trained using one of the National Learning Resource Packages (CEmONC, BEmONC, or EmONC)[2] and evaluated using 4 clinical simulations (OSCEs) to assess skills and competencies related to common complications associated with high rates of maternal and newborn death;

1) Management of post-partum Hemorrhage
2) Newborn resuscitation
3) Manual vacuum delivery
4) Management of hypertensive disorders in pregnancy

[1] Ministry of Health, Community Development, Gender, Elderly and Children - MoHCDGEC/Tanzania Mainland, Ministry of Health - MoH/Zanzibar, National Bureau of Statistics - NBS/Tanzania, Office of Chief Government Statistician - OCGS/Zanzibar, and ICF. 2016. Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015-16. Dar es Salaam/Tanzania: MoHCDGEC, MoH, NBS, OCGS, and ICF.

[2] National Learning Resource Packages curriculums: Basic Emergency Obstetric and Newborn Care (BEmONC 2 weeks program), Comprehensive Emergency Obstetric and Newborn Care (CEmONC-3 weeks program) and the 5-days EmONC pre-mentorship program.

In addition to the more formal evaluations (OSCEs), a simple self-reflection tool for health care providers was created, enabling HCPs to reflect on their own attitudes regarding the provision of RMC in their daily practice.

The initial training session (baseline) was followed by two further coaching and mentoring visits, at home facilities, 6 and 12 months after training was completed.

Overall scores show that the TAMANI graduates improved or retained their skills for all OSCEs up to 1 year after training making this program very effective. This is in contrast with similar studies where skills declined over time.

Furthermore, when individual data was stratified by numerous variables including sex, designation, facility type, and district, there did not appear to be gross differences in performance between the groups for any OSCE.

One of the primary take away from this project is that the shorter, 5 day pre-mentorship EmONC curriculum is as effective, if not more effective, than other multi-week training programs for a wide variety of demographics.

The 5 day pre-mentorship EmONC training curriculum was more oriented towards skills with fewer lectures and modules than CEmONC and BEmONC curriculums. This hands on training seems to be very effective for skills retention in the majority of the groups and the short time period for off-site training is a great advantage logistically as it limits time away from work for participants.

Additionally, the results of the self-reflection tool showed a positive trend in HCP's own perceptions of RMC. HCPs felt that they provided respectful maternity care frequently (mostly or always) to mothers and babies at 6 months and further improved their abilities 12 months after training.

Performance of Respectful Maternity Care specific items in the OSCEs followed the same trend as non-RMC items, demonstrating that these items are not considered *soft* skills and are given the same importance as clinical actions such as giving an injection or doing a uterine revision.

HCPs demonstrated a good understanding that consent, confidentiality and reassurance are part of a complete experience of quality of care and can help reduce maternal mortality and morbidity.

OPPORTUNITIES AND RECOMMENDATIONS

Overall, skills for the management of post-partum hemorrhage improved over time. Furthermore, skills related to newborn resuscitation skill, vacuum delivery and management of hypertensive disorders in pregnancy were retained up to 1 year after training. This program was also effective for various professional designations working in different health facility types.

It is recommended that each health facility supports mentees by taking a leading role in organising mentorship sessions for retention of skills related to managing emergency obstetric conditions. Initiation of such continuous medical education sessions, facilitated by the graduates of previous courses, could ensure retention of skills and share this knowledge with others through peer-to-peer learning.

To ensure retention of competencies, it is also advisable that trained personnel remain in maternity departments for at least 2 years post-training, thus strengthening their skills and modeling excellence of care to others.

Although the EmONC curriculum covers several important competencies, it would be beneficial to add an additional Infection Prevention and Control (IPC) OSCE module. Along with post-partum hemorrhage and pre-eclampsia/eclampsia, infection is one of the primary causes of maternal mortality in Tanzania. Thus, these skills would improve the program and benefit health care workers and their patients.

Brief self-reflection opportunities on RMC enable HCPs to critically review their own practice, recall material pertaining specifically to RMC and make improvements on their own to continue to deliver high quality care to all women.

With continuing education opportunities and integration of RMC into core curricula and coaching and mentoring opportunities, these core principles can be reinforced and thus, enhance delivery of equitable high-quality care for all women.

Further, the inclusion of Council/Regional Health Management Team (C/RHMT) and AGOTA members in coaching and mentoring visits appeared to be a promising approach to improving quality of care, including RMC, as these individuals are best positioned to conduct simulations and visits. They are also well suited to lead discussions with other health providers regarding systemic barriers they face in providing RMC.

Therefore, we strongly recommend that:

- **EmONC coaching and mentoring visits become a regular program with a dedicated budget and include specialists that can conduct structured simulation, not for evaluation purposes, but as a method of continuous medical education for life saving skills and reminder of best practices, including RMC, in daily practice.**

- **Integration of RMC in EmONC training is maintained as an essential component of Emergency Obstetric and Newborn Care, both in case simulations as specific items and as discussions in mentoring visits.**

- **Ministry of Health (MoHCDGEC) to continue working with the AGOTA and other relevant stakeholders to scale up the program to other regions in Tanzania.**

ENDNOTES

[i] World Health Organization. (2019, September 19). *Maternal mortality*. WHO.

[ii] Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) [Tanzania Mainland], Ministry of Health (MoH) [Zanzibar], National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF. 2016. *Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015-16*. Dar es Salaam, Tanzania, and Rockville, Maryland, USA: MoHCDGEC, MoH, NBS, OCGS, and ICF.

March 2021

Annex F – SOGC/AGOTA Policy Brief

TAMANI

Tabora Maternal Newborn Health Initiative

Policy Brief

Skills Retention in Emergency Obstetric and Newborn Care program and Perspectives on Respectful Maternity Care

EXECUTIVE SUMMARY

Maternal Mortality remains high in Tanzania and it is well-recognized that access to high quality, skilled care before, during and after childbirth can help manage and prevent complications to save the lives of women and newborns.

TAMANI is a CARE led initiative funded by the Government of Canada which aims to reduce maternal and newborn mortality and morbidity in the Tabora region (Tanzania). In this initiative, we evaluated the extent to which the Emergency obstetrics (EmONC) training, including coaching and mentoring visits implemented within the project, contributed to improvements in the skills of health care providers (HCPs). We explored how different variables may have affected retention of these competencies. The evaluation also aimed to gather insights into HCPs' perceptions of providing respectful maternity care (RMC).

We concluded that the combination of Emergency Obstetrics and Newborn Care (EmONC) training paired with coaching and mentoring visits 6- and 12-months post-training was effective for improving or retaining lifesaving obstetric skills.

Furthermore, our findings show that health care providers have a good understanding that consent, confidentiality and reassurance are part of a complete experience of quality of care and can help reduce maternal mortality and morbidity.

INTRODUCTION

In recent years, great strides have been made to reduce global maternal mortality rates, however maternal mortality remains unacceptably high in numerous regions. The majority of maternal deaths are a result of complications that occur during pregnancy and childbirth, most of which are preventable or treatable. Such complications, including severe bleeding, high blood pressure, and difficulties during delivery, account for nearly 75% of all maternal deaths.[i]

While Tanzania has made progress, the maternal mortality ratio remains high at 556 deaths per 100,000 live births[1] (DHS 2015-2016). The primary challenges facing this region include inadequate access to emergency obstetric care or skilled health care professionals and low quality of services.

Within the Tabora region of Tanzania, the health of women and newborns is further compounded by poverty and rurality, which impacts access to health services. Little more than half of the of births in this region occur in a health facility and only 54% of births are attended to by a skilled provider.[ii]

While we know that quality care can improve outcomes, improving access and coverage alone are not enough to reduce mortality.

To truly move towards elimination of maternal and newborn death, improved quality, respectful maternity care (RMC) including equity and dignity is necessary in all areas of care through improved safety, trust, and communication.

A woman, or her family, should understand what to expect and what is happening at all stages of her care, and be treated with respect.

APPROACHES AND RESULTS

As part of TAMANI, the Association of Gynecologists and Obstetricians of Tanzania (AGOTA) and the Society of Gynecologist and Obstetricians of Canada (SOGC) expertise was engaged to strengthen the availability of quality maternal and newborn health services through two primary objectives:

- Improved knowledge and skills of health care providers
- Improved adherence to the provision of gender sensitive maternal and newborn clinical services and promotion of respectful maternity care (RMC).

The activities took place in 8 districts of Tabora region targeting health care providers in 140 health care facilities. In total, 270 (124m/146f) Health Care providers from lower to higher cadres were trained using one of the National Learning Resource Packages (CEmONC, BEmONC, or EmONC)[2] and evaluated using 4 clinical simulations (OSCEs) to assess skills and competencies related to common complications associated with high rates of maternal and newborn death;

1) Management of post-partum Hemorrhage
2) Newborn resuscitation
3) Manual vacuum delivery
4) Management of hypertensive disorders in pregnancy

[1] Ministry of Health, Community Development, Gender, Elderly and Children - MoHCDGEC/Tanzania Mainland, Ministry of Health - MoH/Zanzibar, National Bureau of Statistics - NBS/Tanzania, Office of Chief Government Statistician - OCGS/Zanzibar, and ICF. 2016. Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015-16. Dar es Salaam/Tanzania: MoHCDGEC, MoH, NBS, OCGS, and ICF.

[2] National Learning Resource Packages curriculums: Basic Emergency Obstetric and Newborn Care (BEmONC 2 weeks program), Comprehensive Emergency Obstetric and Newborn Care (CEmONC-3 weeks program) and the 5-days EmONC pre-mentorship program.

In addition to the more formal evaluations (OSCEs), a simple self-reflection tool for health care providers was created, enabling HCPs to reflect on their own attitudes regarding the provision of RMC in their daily practice.

The initial training session (baseline) was followed by two further coaching and mentoring visits, at home facilities, 6 and 12 months after training was completed.

Overall scores show that the TAMANI graduates improved or retained their skills for all OSCEs up to 1 year after training making this program very effective. This is in contrast with similar studies where skills declined over time.

Furthermore, when individual data was stratified by numerous variables including sex, designation, facility type, and district, there did not appear to be gross differences in performance between the groups for any OSCE.

One of the primary take away from this project is that the shorter, 5 day pre-mentorship EmONC curriculum is as effective, if not more effective, than other multi-week training programs for a wide variety of demographics.

The 5 day pre-mentorship EmONC training curriculum was more oriented towards skills with fewer lectures and modules than CEmONC and BEmONC curriculums. This hands on training seems to be very effective for skills retention in the majority of the groups and the short time period for off-site training is a great advantage logistically as it limits time away from work for participants.

Additionally, the results of the self-reflection tool showed a positive trend in HCP's own perceptions of RMC. HCPs felt that they provided respectful maternity care frequently (mostly or always) to mothers and babies at 6 months and further improved their abilities 12 months after training.

Performance of Respectful Maternity Care specific items in the OSCEs followed the same trend as non-RMC items, demonstrating that these items are not considered *soft* skills and are given the same importance as clinical actions such as giving an injection or doing a uterine revision.

HCPs demonstrated a good understanding that consent, confidentiality and reassurance are part of a complete experience of quality of care and can help reduce maternal mortality and morbidity.

OPPORTUNITIES AND RECOMMENDATIONS

Overall, skills for the management of post-partum hemorrhage improved over time. Furthermore, skills related to newborn resuscitation skill, vacuum delivery and management of hypertensive disorders in pregnancy were retained up to 1 year after training. This program was also effective for various professional designations working in different health facility types.

It is recommended that each health facility supports mentees by taking a leading role in organising mentorship sessions for retention of skills related to managing emergency obstetric conditions. Initiation of such continuous medical education sessions, facilitated by the graduates of previous courses, could ensure retention of skills and share this knowledge with others through peer-to-peer learning.

To ensure retention of competencies, it is also advisable that trained personnel remain in maternity departments for at least 2 years post-training, thus strengthening their skills and modeling excellence of care to others.

Although the EmONC curriculum covers several important competencies, it would be beneficial to add an additional Infection Prevention and Control (IPC) OSCE module. Along with post-partum hemorrhage and pre-eclampsia/eclampsia, infection is one of the primary causes of maternal mortality in Tanzania. Thus, these skills would improve the program and benefit health care workers and their patients.

Brief self-reflection opportunities on RMC enable HCPs to critically review their own practice, recall material pertaining specifically to RMC and make improvements on their own to continue to deliver high quality care to all women.

With continuing education opportunities and integration of RMC into core curricula and coaching and mentoring opportunities, these core principles can be reinforced and thus, enhance delivery of equitable high-quality care for all women.

Further, the inclusion of Council/Regional Health Management Team (C/RHMT) and AGOTA members in coaching and mentoring visits appeared to be a promising approach to improving quality of care, including RMC, as these individuals are best positioned to conduct simulations and visits. They are also well suited to lead discussions with other health providers regarding systemic barriers they face in providing RMC.

Therefore, we strongly recommend that:

- **EmONC coaching and mentoring visits become a regular program with a dedicated budget and include specialists that can conduct structured simulation, not for evaluation purposes, but as a method of continuous medical education for life saving skills and reminder of best practices, including RMC, in daily practice.**

- **Integration of RMC in EmONC training is maintained as an essential component of Emergency Obstetric and Newborn Care, both in case simulations as specific items and as discussions in mentoring visits.**

- **Ministry of Health (MoHCDGEC) to continue working with the AGOTA and other relevant stakeholders to scale up the program to other regions in Tanzania.**

ENDNOTES

[i] World Health Organization. (2019, September 19). *Maternal mortality*. WHO.

[ii] Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) [Tanzania Mainland], Ministry of Health (MoH) [Zanzibar], National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF. 2016. *Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015-16*. Dar es Salaam, Tanzania, and Rockville, Maryland, USA: MoHCDGEC, MoH, NBS, OCGS, and ICF.

March 2021

Annex G – SOGC/AGOTA Partnership Paper

Tabora Maternal and Newborn Health Initiative (TAMANI) (Tanzania)

Evaluation of AGOTA's Perceptions related to the Value of the Partnerships Developed within the TAMANI Project

Date: March 15th, 2021

Evaluation completed by Liette Perron,

Capacity Building Consultant, SOGC

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Acknowledgement

The author would like to thank the members of the Association of Gynaecologists and Obstetricians of Tanzania (AGOTA) who graciously participated to this evaluation. The testimonies gathered during the interview process brought greater insight as to the value of partnerships with other stakeholders in the field and the potential contribution of professional health associations to national and international initiatives seeking to improve maternal and newborn health incomes. The appreciation is also extended to CARE Canada and GAC for their support.

ACRONYMS

AGOTA	Association of Gynaecologists and Obstetricians of Tanzania
GAC	Global Affairs Canada
BEmONC	Basic emergency obstetrical and neonatal care
CEmONC	Comprehensive emergency obstetrical and neonatal care
EmONC	Emergency obstetrical and neonatal care
Ob-gyns	Obstetricians and Gynaecologists
SOGC	Society of Obstetricians and Gynaecologists of Canada
TAMANI	Tabora Maternal and Newborn Health Initiative

EXECUTIVE SUMMARY

In 2017, CARE Canada implemented the Tabora Maternal and Newborn Health Initiative (TAMANI) project with the aim to reduce maternal and newborn mortality in Tabora region. Two strategies where retained to reach the project's goal: to improve the availability of quality maternal and newborn health services and increase the utilization of maternal and newborn health services by women and their families in targeted district. This five-year initiative (2017-2021) was funded by Global Affairs Canada (GAC) and implemented in collaboration of other Tanzanian and Canadian partners, of which the Society of Obstetricians and Gynaecologists of Canada (SOGC) and the Association of Gynaecologists and Obstetricians of Tanzania (AGOTA).

Within the TAMANI project, SOGC and AGOTA were responsible for contributing to the improved availability of quality maternal and newborn clinical services in the underserved district on Tabora through improved knowledge and skills of health providers to deliver gender-sensitive maternal and newborn clinical services. The SOGC and AGOTA component also included a «organizational capacity building component» aimed at facilitating AGOTA's full participation, as experts in EmONC, to the project and support their organizational capacity building efforts.

This end of project evaluation aimed to gain insight into how AGOTA perceived the value of the partnerships developed within TAMANI project and to determine the extent to which the its participation to these contributed to strengthening the association's organizational capacity.

A qualitative approach was used to explore the participants' perception of the value of the partnerships development between AGOTA and CARE International and AGOTA and SOGC within the TAMANI project, and further the organizational capacity strengthened as a results of these partnerships. Eleven semi-structured interviews were conducted with key informants (3W; 8M), all members of AGOTA, who in their position of office bearers or their implication in the project activities were involved in the TAMANI initiative.

The end of project evaluation showed that through TAMANI, the association had an opportunity not only to contribute to an initiative seeking to improve maternal and newborn health outcome in an undeserved region of the country, but also to improve its organizational capacity. Participants considered the partnerships with CARE International and SOGC transparent, productive and collaborative, even in time of divergence. A few areas of concerns were noted, of which difficulties in accessing per diems for mentors/coaches on time when in the field (at the beginning of the project), challenges faced when recruiting and scheduling the visits of SOGC members to the field and limited participation in the monitoring and evaluation activities. Finally, major organizational gains were noted in the core areas of operations, credibility, strategic directions, links with members and credibility.

BACKGROUND TO THE TAMANI PROJECT AND PROPOSED EVALUATION

In 2017, CARE Canada implemented the Tabora Maternal and Newborn Health Initiative (TAMANI) project with the aim to reduce maternal and newborn mortality in Tabora region by improving the availability of quality maternal and newborn health services and increasing the utilization of maternal and newborn health services by women and their families in targeted district. This five-year initiative (2017-2021) was funded by Global Affairs Canada (GAC) and implemented in collaboration of other Tanzanian and Canadian partners, of which the Society of Obstetricians and Gynaecologists of Canada (SOGC) and the Association of Gynaecologists and Obstetricians of Tanzania (AGOTA).

The TAMANI Project supported regional priorities of: sustainable scale-up of the community health worker program to the whole region; improved infrastructure of health facilities including placenta pits, power, water and sanitation; improved skills of health care workers in Basic Emergency Obstetric and Newborn Care (BEmONC) and Comprehensive Emergency Obstetric and Newborn Care (CEmONC); and improved supply of medical equipment for BEmONC and CEmONC in Tabora.

It is expected that these activities will contribute to increasing the number of safe deliveries taking place in health facilities; decreasing the number of women with unmet family planning needs; increasing the number of women who receive quality antenatal care of at least four times during pregnancy and increasing the contraceptive prevalence rate.

Within the TAMANI project, SOGC and AGOTA were responsible for contributing to the improved availability of quality maternal and newborn clinical services in the underserved district on Tabora (intermediate outcome 1100) through improved knowledge and skills of health providers to deliver gender-sensitive maternal and newborn clinical services (immediate outcome 1130). More specifically, they assumed responsibility for the following 4 components:

1. Conducting an initial survey to assess preparedness of health facilities to deliver maternal and newborn care, including EmONC and assisting in equipping of the health facilities in order to enable the trained health workers to effectively practice EmONC upon completion of training;
2. Training of health workers in BEmONC and CEmONC;
3. Conducting post training coaching and mentoring activities with all trainees, including 6 and 12 months post-training to measure retention;
4. Developing and distributing job aids.

Finally, the SOGC and AGOTA component also included a “organizational capacity building component” aimed at facilitating AGOTA’s full participation, as experts in EmONC, to the project and support their organizational capacity building efforts.

This evaluation aimed specifically to gain insight into how AGOTA perceived the value of the partnerships developed within TAMANI project and to determine the extent to which its participation to these contributed to strengthening the association’s organizational capacity. See annex 1 – Proposal: Evaluation of professional associations’ perceptions related to the value of partnerships developed within the maternal and newborn health projects.

EVALUATION QUESTIONS

As mentioned above, the main goal of the proposed evaluation was to gain insight into how AGOTA perceived the value of the partnerships developed within the TAMANI Project and to determine to which extent its participation to these contributed to the strengthening of its organizational capacity. Focus was put in exploring the partnerships developed between AGOTA and the project's main implementer, CARE International as well as between AGOTA and SOGC. More specifically, the evaluation sought to answer the following 6 questions:

- What were AGOTA's initial expectations related to the partnerships proposed?
- To what extent were these expectations met and/or not met?
- What worked well in each partnership and what did not work so well in each partnership?
- Did the work conducted and the experience gained from these partnerships contribute to strengthening the association's organizational capacity? If yes, how?
- What would the association do better when implementing similar partnerships in the future?

METHODOLOGY

A qualitative approach was used to explore the participants' perception of the value of the partnership development between AGOTA and CARE International and AGOTA and SOGC within the TAMANI project, and further the organizational capacity strengthened as a results of these partnerships. Eleven semi-structured interviews were conducted with key informants, all members of AGOTA, who in their position of office bearers or their implication in the project activities were involved in the TAMANI initiative. Five were past or present office bearers of the association (3W; 2M) and 6 (0W; 6M) actively contributed to the implementation of the EmONC component of the project as mentors/coaches. Although all of the office bearers came from the Eastern zonal branch, the others came from multiple zonal branches of the association, of which the Eastern zone (1M), the Lake zone (3M), the Central zone (1M) and the Western zone (1M). The interviews were held between January 27th to February 10th, 2021 and all were conducted using the Zoom platform. The interviews were recorded, transcribed and then analyzed for thematic content.

See annex 2 - Interview guide.

RESULTS

The following sections reports on the main results of the evaluation. These will be presented according to the 5 evaluation questions raised. In light of the quality of the data collected during the evaluation, the evaluator has opted to give the participants as much voice as possible and to share, in their own words, their perceptions of the value of partnerships developed within the TAMANI project. This

explains the great number and the variety of the testimonies chosen in support of the various themes identified in this part of the report.

AGOTA's expectations related to the proposed partnerships

- **An opportunity to contribute to an initiative seeking to improve maternal and newborn health and to fulfill the association's mission, vision and progress towards its objectives**

The evaluation's participants were all in agreement, the proposed partnerships would provide an opportunity for the association to contribute to an initiative seeking to improve maternal and newborn health outcomes in Tanzania and further, permit it to fulfil its mission and vision and progress toward reaching its objectives.

> «I wasn't there when TAMANI or SOGC or CARE negotiate the partnership with the TAMANI project, but what I can assume or imagine… the expectations they would have… they would be similar with any other projects or any other organizations we had previously… It is one of our objectives, as AGOTA, to partner with different NGOs so we can reach our mission and our goal. So I think that our expectations partnering with CARE International was also to carry forward our mission, our objectives and our vision as well. » (Participant 1)

> «As AGOTA, we are directly concerned with the health of mothers and newborns, because [all] of us are obstetricians-gynaecologists… so, it was an opportunity for us to… bridge the knowledge and skills of health professionals in Tabora, so that they can manage to tackle themselves obstetric and newborn complications… and at the end to reduce maternal and newborn mortality and morbidity. » (Participant 6)

- **An opportunity to strengthen its organizational capacity**

Half of the participants, mostly the office bearers, also reported that the proposed partnerships would provide an opportunity to the association to strengthen its organizational capacity, especially with regards to administration and financial, human resources and project management. Several further commented that the partnership between a Northern and Southern association would provide a unique opportunity to do so.

> «I would say that the collaboration was mainly the Northern and Southern collaboration in order to strengthen the Southern association of ob/gyns. Our association, as you know, is still very young and we needed strengthening in terms of administration, financial and at the same time human resource management. » (Participant 4)

> «In the beginning we also wanted to share our knowledge and to learn from SOGC, because SOGC is one of the most advance association in the world... they have done a lot of things... and working with them, we were very sure that we were going to learn a lot from them and see what we can take and improve in our association. » (Participant 7)

- **An opportunity to develop/strengthen the skills of members**

Finally, half of the participants also mentioned that it was hoped that the partnership would provide an opportunity for the association to strengthen the technical capacity of its members, especially with regard to mentorship.

> «I know that one of the competencies had been in mentorship which in Tanzania, by then, there were no guidelines on mentorship… there was a draft at the Ministry of Health but it had not been piloted or implemented in any part of the country. Therefore, we thought that by using this project, our colleagues, within AGOTA and outside, they may develop these competencies and we [could use these] later on to refine and improve the care of women. » (Participant 4)

> «I knew that most ob/gyns who would be working in the project would get experience in mentorship. Because mentorship is not something ob/gyns do most of the time, especially those who are not affiliated with the university hospitals... because those affiliated with university hospitals, they have students and they have residents, so they do mentor these young doctors… but the ones who are not affiliated, they do not get that chance. This was [an opportunity] for us to train our doctors in mentorship so that they [could] continue mentoring other cadres wherever they are working. » (Participant 7)

Extent to which AGOTA's expectations were met

All participants agreed that the association's initial expectation had been met with regards to the partnerships. The reasons given to justify this statement were varied. Table 1 lists the reasons provided in support of the statement. The responses are ranked according to number of participants who mentioned the issue.

Table 1 – Reasons justifying participants' perception that AGOTA's initial expectations had been met

Reasons justifying the statement	Selected testimonies
Opportunity to improve quality of care (mentioned by 8 participants)	«Yea, from my side, I think that our expectations were met… we managed to bridge the knowledge gap and skills gap… and then, as part of the commitment… when we visited some of our trainees and some of the facilities… [we] could see that there were changes … how they tackled these problems. And some of the care providers, … they go beyond our expectations because when we assess them, they go even better than we expected. » (Participant 6) «Definitely [our expectations were met], since we started that project in Tabora… the number of maternal and neonatal deaths has reduced very significantly. » (Participant 2)

Reasons justifying the statement	Selected testimonies
Opportunity to strengthen organizational capacity (mentioned by 4 participants)	«… this partnership has been very unique… the Canadian association of ob/gyns and CARE International… [left] AGOTA to control and build, within itself, a system of which they can make decisions, operate within the decisions while they are outside, and monitoring, just monitoring the situation. And this is very important for [an] association to grow. » (Participant 4) «Strengthening our association, I would say is 200% [in terms of expectations met]. » (Participation 7)
Opportunity to develop/strengthen skills of members (mentioned by 3 participants)	"… another aspect of … competencies … developed were on making … guidelines… there are so many… professional guidelines which were developed during the process. These are the competencies that you want most of the AGOTA members to have and we think that they had the opportunity [to do so in this initiative]. » (Participant 4) «... the experience of mentorship was 100%, [in terms of expectations met]. » (Participant 7) «"... I learned some skills as well because I was going to the field with Canadian obstetricians... [I learned] some skills when you are coaching and mentoring... also, when we were training, ... I was communicating with them and they teaching me how to use the models which we were using during the training. » (Participant 11)
Opportunity to gain insight of the challenges of practice in the field (mentioned by 2 participants)	«One of the expectation is... the ability to see how, despite having knowledge and skills, what other challenges [the health workers] are facing [in] … rural health facilities… I also notice another thing, which is very striking... the majority of health workers who were working in the rural areas... first of all, they are understaffed and they have to see many cases beyond their skills and knowledge... and sometime, they have limited resources... This were not in my mind; I was so surprised to see a single health worker ... let's say in an antenatal clinic, he or she is capable of managing or providing antenatal services to more than 50 women in a single visit... that was not in my mind at all... because where I am working... at a major facility... I am use to see... like 10 or 15 women a day… » (Participant 3) «I liked because I see how they work… the environment in which they work… we actually had the opportunity to discuss the challenges that had… it was good. » (Participant 6)
Opportunity to build confidence	«In total, I learned a lot… I saw that they gave me room, first to think, first to plan and then they corrected me… so it [made] me confident. » (Participant 11)

Reasons justifying the statement	Selected testimonies
(mentioned by 2 participants)	«But a second thing, … of course, our practice and their practice, there is differences... but when you talk to [SOGC volunteers] in terms of emergencies in obstetrics, the management is mostly the same. So, actually the partnership held me build some confidence... what I am doing is probably right, is acceptable internationally... in terms of improvement... because if you are psychologically satisfied that what you are doing is right... and somebody from another country can vouch for that, then you feel so, it is a provision of satisfaction. » (Participant 9)

Value of the partnerships established

- **AGOTA-CARE International Partnership: What worked well and what did not work so well**

All participants interviewed were in agreement that the AGOTA-CARE International partnership was very successful. It provided the association and its members opportunities to learn, was considered **transparent and collaborative in nature** and within it, **they felt respected, appreciated and valued**. Most appreciated was the quality of support provided, especially in assisting them to implement the EmONC component of the project. **Also appreciated was being included in the project from the very beginning and finally, being able to reach agreement on issues where consensus was not possible.**

When asked, what did not work so well, only a few issues were raised. These included **difficulties in getting per diems on times while in the field and lack of opportunity to conduct training while managing real cases.** Finally, one participant also mentioned a **missed opportunity of exposing more members of the association to the monitoring and evaluation activities in an effort to strengthen their capacities in this regard.** This last statement was directed as much to CARE International as to SOGC.

> «I felt that what we were imagining what the partnership would be, we got even more… we went beyond our expectations, I would say… because it did not just happen like in previous NGOs… like just having a project and we implemented… and we just give the report back, that is it. But this was, beyond that... we were getting much more support from the CARE International... it was not just giving us funds and implementing the project, but it was even supporting us... making sure that we finished the project successfully. The support was even without borders... if in case we faced any challenges, we needed any assistance, they [were] ready to support... and they wanted to make sure that we do not fail at any point... so I would say that the expectations were even beyond. » (Participant 1)
>
> «I like the CARE International… the way they arranged everything because the visits, it was not coming as a surprise… they arranged it, they would call us through our phone

and they asked you, do you wish to be in the first visits or second visits... because there were 2 shifts and we could choose. The information would come to us quite early, like one month before the activity, so it was not affecting my routine or activities because it allowed me to arrange my time properly prior to that visit... On the part of communication, I congratulate them. » (Participant 3)

«… the research component, which I mentioned… that was an opportunity which AGOTA missed… it would have been a best opportunity for AGOTA to participate in that [beginning of project] assessment and end evaluation… [it would have provided an opportunity where] we could learn more… doing research as well as … data [collection and analysis] ... other skills, which are quite important... some of our members are too young and have not had such opportunities. » (Participant 4)

« With AGOTA and CARE, I think that the partnership was very well, respectful… [CARE International] involved us from the very beginning even before the project came. It was not just like they came here and telling us "we want to do one, two, three, four, five…» (Participant 7)

«… with this project, we [were] happy… everybody knows where everything is going, everybody knows the next step, everybody knows what should be done… » (Participant 10)

«… when they had technical questions, any technical challenges, [CARE International] directly contacted AGOTA… and AGOTA gave them the solutions as seen in their capacity… so it was also good. » (Participant 11)

- **AGOTA – SOGC Partnership: What worked well and what did not work so well**

All participants interviewed were in agreement that the AGOTA-SOGC partnership had also been successful. Accordingly, the partnership **provided the association members an opportunity to learn, to share knowledge and experience and to expose SOGC members to the reality of practice in Tanzania**. Most appreciated was the **strong collaboration between both associations, even in time of disagreement and finally, the technical support provided in an effort to improve the organizational capacity of the associations.**

When asked what did not work so well, other than the issue above related to the limited participation of AGOTA members to the monitoring and evaluation activities of the project, challenges faced when recruiting and scheduling the visits of the SOGC volunteers to the field.

«They were also ready to support us... to develop some policy brief... like the Gender Base Violence (GBV)... and now we are also planning on doing some information tools for GBV, ... to get our members informed about how to screen GBV cases...» (Participant 1)

«So I can say that our association with [SOGC] was very valuable… some members of SOGC came down to the rural areas… if we talk to them that we have problem with maternal and newborn health in Tanzania, they will now understand, very well… because they now have experience from the field. And for use, AGOTA members, we gained something from them, … we gained experience from our colleagues who are working in high income countries. » (Participant 2)

«… we know that there was much challenges, especially in getting enough experts from Canada coming and team work with our colleagues here in Tanzania… there were times there [was] only one… [SOGC] people who [was] volunteering... we [had] to go according to their schedule and we ... [needed] to negotiate with the Ministry of Health... therefore, there were delays... their schedule comes with our schedule and compromise each other. » (Participant 4)

«… it was such a good partnership because in the beginning, you may know that [SOGC] [wanted] to use the ALARM training, but it was not to be a very good option for Tanzania because we already had CEmONC… and we talked about this and we agreed… with the CEmONC training. So, the partnership was really a good one in such a way that there was no... I would say like quarrels... we would sit down and decide together." (Participant 7)

«… their participation was good… the members of SOGC were actually willing to learn from us and also we learned from them… and actually, it was an enjoyable and productive partnership. » (Participant 9)

«... [SOGC is] the one who helped us to prepare our strategic plan, which is very important and it has put the association in a better place because we are focus, we now know [what] we want … to happen...» (Participant 10)

«There was strong collaboration with different SOGC members and AGOTA… AGOTA was learning from SOGC and SOGC was, as well, learning from AGOTA… and this learning was extremely sharp… it was a good relationship… which is not easy to get from other collaboration and other partners. » (Participant 11)

Organizational capacity strengthened

The majority of the evaluation's participants felt that the TAMANI project had provided AGOTA opportunities to strengthened its organizational capacity in several core areas. The following table provides a summary of the core areas mentioned by participants. As for table 1, the responses are ranked according to number of participants who commented on the issue.

Table 2 – Organizational capacity strengthened during the TAMANI project

Organizational area strengthened	Selected testimonies
Strengthened operational capacities – financial, administrative, project management (mentioned by 6 participants)	«[We] have learned a lot… it was one of the partnerships, I can say, that has advanced our capacities as far as administrative issues are concerned… it has also provided us with lots of opportunities to learn, … but also to reflect on how we work.... I think that in the previous projects that we have partnered with, we did not have this luxury of having partners who... you know, anytime, any day, they were ready to extend their support whenever you need them... and they can even go beyond TAMANI... » (Participant 1) «... the other thing is the financial management... even though we had the financial regulations... the TAMANI project helped us a lot in keeping our accounts... we learned a lot on how things are supposed to be done and everything else... and this has improved a lot the financial management of the association. » (Participant 7)
Enhanced credibility (mentioned by 5 participants)	«AGOTA now... I think has the good respect of the Ministry of Health ... we are being mentioned everywhere... Any project coming to Tanzania... USAID, Engender Health... all of them are told “contact AGOTA” ... we are a central pillar of the Ministry of Health... [we were] not there some years ago, now the Ministry is banking on us. » (Participant 5) «… the Ministry has recognized very well what we did in TAMANI and now they are telling all... Pathfinder, JHPIEGO, ... many of them, they are coming to us now asking us "please can we use you to apply for these big projects"... and everyone want AGOTA to work with them...» (Participant 10)
Defined strategic directions (mentioned by 4 participants)	«… the one thing I want to talk about is the strategic plan…. We did not have a strategic plan… so the TAMANI project helped us to have the first strategic plan for AGOTA… which is very big plus…" (Participant 7) «For our strategic plan, we got the assistance of SOGC... it is not only in place but it is now implemented... it is now shared among the members of AGOTA, everyone now has a copy…» (Participant 11)
Improved technical skills of members (mentioned by 4 participants)	«I remember, the first time, one of the gynaecologists from Canada… he trained us [on] how to conduct… good [coaching and mentoring sessions] … especially, about communication skills… [and the importance of not] being judgmental... we should be listening more and once, when we listen more, people become more open to discuss their problems ... But prior to that, ... people were judgmental and it was hard for health providers from rural areas to be open to us, especially us who were coming from higher centers. » (Participant 3)

Organizational area strengthened	Selected testimonies
	«I can say that we developed our capacity but at the same time we learned… you know, I have been in so many collaborations as an academician... some of our colleagues, they have not participated in most of these collaborations... therefore they are lacking some... social skills which are very, very important when you are in a collaboration.... » (Participant 4)
Developed links with members, especially those outside major centers (mentioned by 3 participants)	«So, at first, maybe AGOTA did not know the capabilities of some of its members but through this partnership… they had to organize… who could perform what kind of task… so they had to go through their members and they found out that we have these members who could be trainers on EmONC and they now know that we have members who are experts, let's say, in family planning. So, it helped them to reorganized the structure of AGOTA and try to have groups, like EmONC group, family planning working group and such group.... » (Participant 2) «… we used to say that we have doctors all over Tanzania but we were never in a position to use them and there was never a structure on how to work with them, but with the TAMANI project, we now really organized our zones …» (Participant 10)
Enhanced leadership (mentioned by 2 participants)	«This collaboration has brought us together, we worked as a team throughout the collaboration... even AGOTA council got much stronger by their decision making... this has been very, very useful in term of AGOTA ... because the leadership is where it has to be strengthened...» (Participant 4) «Though most ob/gyns live in Dar es Salaam… so the way we framed our leadership has helped others to participate fully and showing that AGOTA is well branched…» (Participant 10)

Lessons learned

The last part of the evaluation focused on gathering the participants' views on lessons learned. The lessons retained by the participants focused on the following:

- an appreciation of the design of the project, one which permitted the association to bring its specific expertise in a broader initiative aiming to improve maternal and newborn health outcomes and which can be reproduced in other underserved regions of the country;

- the approach used to implement the project: strong collaboration between different partners, international and national; community and government; involvement of all from the onset; capacity building component for the professional associations; opportunity to recruit designated project staff.

«I am sure I would not do things very differently… the only things would be to strengthen the few challenges of what we had…» (Participant 4)

«I think that this was an excellent opportunity for AGOTA to be able to showcase our local expertise in improving the quality of newborn health services in Tanzania and if this expertise is spread to other regions of Tanzania, we will definitely see good results in the form of indicators of maternal mortality and morbidity to go down dramatically. Still now, the biggest killer is post-partum hemorrhage. » (Participant 5)

« I would still do that the same... like how we had [a coordinator] taking care of the whole project, to be the contact person and to be notified and to take care of stuff... I would do that the same way... and having an assistant... and administrative assistance also, same way...» (resp. 7)

«In terms of implementation, I think that it is fine, in the way they selected [ob/gyns] of good standing who are committed and assigned them to the field, but the other thing they could do better, is the involvement of the main administrative body of AGOTA could have in so that they gained experience and use this experience to negotiate future partnerships. » (Participant 9)

« [The design of the project] was excellent.... I think that if we had a chance to get other funds, we could do a similar project in other areas or expand to other regions, because there are other regions who have worse bad outcomes that we have now in Tabora... same project, same model but in other regions. » (Participant 11)

CONCLUSION

«I can say that this is one of the big project that we did, especially with other organizations… which we actually go to the field and work with the community… directly with the community. So it unlocked the potential we have and it helped us realize how much we can accomplish if we put the effort...» (Participant 6)

The end of project evaluation showed that through TAMANI, the association had an opportunity not only to contribute to an initiative seeking to improve maternal and newborn health outcome in an undeserved region of the country, but also to improve its organizational capacity. Participants considered the partnerships with CARE International and SOGC transparent, productive and collaborative, even in time of divergence. They also reported that they felt respected, appreciated and valued by both partners. Most appreciated were the opportunities provided to learn, to share

knowledge and expertise and to share with SOGC members the reality of practice in Tanzania. A few areas of concerns were noted, of which difficulties in accessing per diems for mentors/coaches on time when in the field (at the beginning of the project), challenges faced when recruiting and scheduling the visits of SOGC members to the field and limited participation of AGOTA members in the monitoring and evaluation activities. Finally, with regards to the organizational capacities strengthened, major gains were noted in the core areas of operations (for ex. financial, administrative and project management capacities), credibility, strategic directions, technical skills of members, links with members and leadership.

The end of project evaluation also provides important insight of the targeted actions which can be taken to facilitate and support the participation of professional health associations in international initiatives seeking to improve maternal and newborn health. These included, facilitating the participation of the associations to the projects' life cycles (planning, implementation and closing), building in organizational capacity building opportunities which will permit them to strengthen their project management capacities and other core areas and finally providing opportunities to contribute concretely to project's clinical activities in the targeted regions.

Annex 1

Proposal (revised: 10112020)

Evaluation of professional associations' perceptions related to the value of partnerships developed within the MNCH projects

Background Information

The Society of Obstetricians and Gynecology of Canada (SOGC) is currently involved in several global health initiatives which aim to improve maternal, newborn and child health (MNCH) in several Sub Saharan countries. These are funded by Global Affairs Canada (GAC) and implemented by Canadian NGOs in partnership with other partners in Canada and in each country of interventions. All will be completed by 2021. SOGC's contribution to these were mainly directed toward:

- Improving the capacity of the health system to provide emergency obstetrical and newborn care (EMNOC); and
- Supporting the organizational capacity building efforts of national obstetricians-gynaecologists (ob/gyms) associations, especially with regards to lending their technical expertise in the EmONC activities implemented by such initiatives.

One of these MNCH initiatives is the Tabora Maternal and Newborn Health Initiative (TAMANI), implemented by CARE Canada, in the District of Tabora (Tanzania), in collaboration with Canadian and Tanzanian partners. The initiative started in 2017 and will be completed by 2021. The national professional association involved in this initiative is the Association of Gynaecologists and Obstetricians of Tanzania (AGOTA).

The proposed evaluation aims to gain insight into how the professional association (AGOTA) perceives the value of the partnerships developed within TAMANI project and to determine the extent to which its participation to this partnership contributed to strengthening its organizational capacity.

Evaluation Goal and Objectives:

As mentioned above, the main goal of this end of project evaluation is to gain insight into how AGOTA perceives the value of the partnerships developed within the TAMANI Project and to determine to which extent its participation to this partnership contributed to the strengthening of its organizational capacity. Focus will be put in exploring the partnerships developed between AGOTA and the project's main implementer, CARE Canada and AGOTA and SOGC. More specifically, the evaluation will seek to address the following 6 questions:

- What were AGOTA's initial expectations related to the partnerships proposed?
- To what extent these expectations were met and/or not met?
- What worked well in each partnership?
- What did not work so well in each partnership?
- Did the work conducted and the experience gained from these partnerships contribute to strengthening the association's organizational capacity? If yes, how?

- What would the association do better when implementing similar partnerships in the future?

Methodology

The evaluation will seek to gather and analyze qualitative data which will be gathered through key informants' interviews. The key informants will include 10-12 members of AGOTA who have been involved in the MNCH health projects either in negotiating the partnership agreements, managing and /or supporting project supported activities.

Evaluator: SOGC Capacity Building Expert or others (TBC)

Evaluation date: January to March 2021

Use of the results of the proposed evaluation

The results of the proposed evaluation will be used to:

- Inform AGOTA's capacity building process;
- Improve and inform the development of future partnerships with national professional associations;
- Promote the public image of partnerships with national professional associations;
- Provide accountability to funders and partners.

Timetable and Deliverables

Due date	Activities	Who is responsible	Deliverables
January 22, 2021	Development of the survey questionnaire	SOGC Capacity Building Expert	Survey questionnaire
January 22, 2021	Identification of key informants	AGOTA and project staff	List of key informants for the interviews
February 1-23, 2021	Key informants' interview	SOGC Capacity Building Expert	Interviews' raw data
March 5th, 2021	Analysis of data and preparation of preliminary report	SOGC Capacity Building Expert	Preliminary report
March 26, 2021	Finalization of final report		Final report

Annex 2

PARTICIPANT NO: _____

TAMANI – EVALUATION OF PROFESSIONAL ASSOCIATION'S PERCEPTION RELATED TO THE VALUE OF PARTNERSHIPS DEVELOPED WITH THE TAMANI PROJECT

INTERVIEW GUIDE – KEY MEMBERS INVOLVED IN THE TAMANI PROJECT

Date and time of the interview:

- Date : _____
- Time : _____

Introduction

Good evening, my name is Liette Perron and as a global health project manager with the SOGC. I am a colleague of Catherine Savoie, the SOGC project manager of the TAMANI project. As you know the TAMANI project is a 5-year initiative implemented by CARE Canada in collaboration with Tanzanian and Canadian organizations, of which AGOTA and SOGC.

Before starting, I would like to thank you for agreeing to participate in this evaluation. The evaluation seeks to better understand AGOTA members' perception of the value of the partnerships developed within the TAMANI project and to determine to which extent your association's participation to the project contributed to strengthening its organizational capacity. As a member of AGOTA who has been involved in managing or implementing the TAMANI project, your views are very important to us and will permit us to gain greater insight as to what makes partnerships between international NGOs and professional associations strong and of value to all.

My questions which focus on getting your views of the following 5 points:

- AGOTA's initial expectations related to the partnerships proposed within the TAMANI project;
- The extent to which these expectations were met and/or no met;
- Determining what worked well and did not worked well in each partnership, mainly within AGOTA and CARE's partnership and AGOTA and SOGC's partnership;

- Clear examples of how the work conducted and the experienced gained from these partnerships contributed to strengthening your association's organizational capacity;
- Lessons learned from these partnerships.

Before I begin, I would like to share the following information:

1. You have been selected to participate to this survey because of your involvement in the TAMANI project, either has a member involved in negotiating AGOTA's contribution to the project or again, participating in the implementation of the project's activities. Your views are important and valued. It will provide us with insight as to what make partnerships with and between professional associations and international NGOs strong and successful.
2. The interview will last approx. 30-45 min.
3. All the information collected during the interview will be treated in a way that protects the confidentiality of the sources. Thus, no names will be mentioned and the material will be code.
4. To facilitate my work as an interviewer, the interview will be recorded. However, the recording will be destroyed as soon as the transcript is completed.
5. You may refuse at any time to answer certain questions, address certain topics or even end the interview without prejudice.
6. The draft and final report of the evaluation will be shared with AGOTA's Executive Committee and the TAMANI project team and the results of the evaluation will be integrated into the project's final report.
7. Do you have any questions or concerns before we begin?

   Concerns raised: _____

   _____

   _____

8. Can we pursue the interview?

   ☐ YES ☐ NO

Personal information about the participant

1. Participant no : _____

2. Gender : ☐ Male ☐ Female

3. To which category of members do you belong?

☐ Ordinary member ☐ Honorary member ☐ Associate member

4. To what zonal branch do you belong?

☐ Lake Zone ☐ Coast Zone ☐ Northern Zone

☐ Central Zone ☐ Southern Highlands ☐ Western Zone

☐ Southern Zone

5. Are you an office bearer within the Executive Council?

☐ Yes ☐ No

If yes, to which position (President, VP, President Elect, Honorary General Secretary, Publicity Secretary, Treasurer, Immediate Past President, Academic Institutions Rep, Private Hospitals Rep, Zone Branch Rep): _____

6. Are you a member of a Zonal Branch Committee?

☐ Yes ☐ No

If yes, to which position (Chairperson, Secretary, Treasurer): _____

Guiding Questions

1. AGOTA's involvement in the TAMANI project

Guiding question	Possible follow up questions
What do you know the TAMANI project, and more specifically AGOTA's involvement in it?	Are you aware of the goal and objectives of the project? Do you know here it is implemented? What do you know of AGOTA's contribution or involvement in the project? Can you name the project's partners? AGOTA's main partners? Were you involved in the project? If yes, how?

2. AGOTA's expectations related to its participation in the TAMANI project

Guiding question	Possible follow up questions
	Why did AGOTA want to be part of this initiative? What did the association hope to gain from the project? What were your own personal/professional expectations? Where AGOTA's expectations met? If yes, can you provide examples? If no, can you explain? Where your own personal/professional expectations met? If yes, can you provide examples? If no, can you explain?

3. Value of partnership: AGOTA and CARE (Canada and Tanzania)

Guiding question	Possible follow up questions
Was the partnership developed between AGOTA and CARE (Canada and Tanzania) successful?	What did AGOTA hope to gain specifically from the partnership between AGOTA and CARE? Where AGOTA's expectations met? What worked well in this specific partnership? What did not work well? Can you provide concrete examples?

4. Value of partnership: AGOTA and SOGC

Guiding question	Possible follow up questions
Was the partnership developed between AGOTA and SOGC successful?	What did AGOTA hope to gain from the partnership between AGOTA and SOGC? Where AGOTA's expectations met? What worked well? What did not work well? Can you provide concrete examples?

5. Building greater organizational capacity

Guiding question	Possible follow up questions
Did AGOTA's participation to this project permit the association to strengthen its organizational capacities?	How has the association become stronger? More credible due to its participation in the project? Can you provide concrete examples?

6. Lessons learned

Guiding question	Possible follow up questions
What lessons did AGOTA learn from this experience?	Looking back to the beginning of the project, what would the association do differently? What would the association do the same? How can this be translated to lessons learned?