United Republic of Tanzania

Ministry of Health Community Development Gender Elderly and Children

Mid Term Review of the Health Sector Strategic Plan IV 2015 - 2020

REPORT OF THE HSSP IV/ ONE PLAN II MID-TERM REVIEW (2016-2020)

THEMATIC AREA: REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH:

QUALITATIVE RMNCAH STUDY

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EXECUTIVE SUMMARY 3
1 Background 7
1.1 Justification 8
1.2 Methodology 9
1.3 Data management and analysis 10
2 Results 11
2.1 Family Planning 11
2.2 Antenatal care services 13
2.3 Delivery 14
2.4 Postnatal care services 16
2.5 Prevention of Mother to Child Transmission of HIV 16
2.6 Adolescent Health 17
2.7 Reproductive Cancer 19
2.8 Gender-based violence (GBV) and violence against children (VAC) 19
2.9 Newborn and Child Health 21
3 SWOC Analysis from qualitative study 22
4 RECOMMENDATIONS 23
5 References 24
Appendix 1: FOCUS GROUP DISCUSSION GUIDE FOR MEMBERS OF RHMT AND CHMT 26
5.1 Appendix 2: FOCUS GROUP DISCUSSION GUIDE FOR HEALTH CARE PROVIDERS 32
Appendix 3: FOCUS GROUP DISCUSSION GUIDE FOR RMNCAH USERS 36

EXECUTIVE SUMMARY

Background: To improve Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) services in Tanzania, the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) developed the One Plan II for a period from 2016 to 2020. The overall mission is to promote, facilitate and support, in an integrated manner, the provision of comprehensive, high impact and cost-effective RMNCAH and nutrition services, along the continuum of care to men, women, newborn, children and adolescents. MOHCDGEC and partners involved in RMNCAH conducted a mid-term review (MTR) of One Plan II to identify the priority areas that need to be strengthened and interventions that need to be scaled up nationally to achieve the objectives and targets and develop a plan of action that will be implemented in the remaining period.

Methods: One Plan II MTR has used the qualitative approach to explore the predisposing and hindering factors for uptake of RMNCAH interventions tailored to improve RMNCAH and also to gain insights as to *why* and *how* the implementation processes were done, challenges encountered in 8 selected regions, namely, Geita, Lindi, Tanga, Katavi, Dodoma, Kigoma, Dar es Salaam and Mbeya. Focus groups discussions (FGDs) were used to elicit information from members of the regional health management teams in Geita, Lindi, Tanga and Katavi regions, CHMT members in selected district/town councils in Geita, Lindi, Tanga and Katavi regions, health workers in selected health facilities in the district/town councils in Geita, Lindi, Tanga and Katavi regions and RMNCAH users (women of reproductive age) in the visited health facilities in the 8 regions. In additional, in-depth interviews were conducted with key informants at MoHCDGEC. Focus group discussion guides for RHMT, CHMT, health care providers and RMNCAH service users and the in-depth interview guide were used to collect required information. a total of ten (10) assistant data collectors were oriented on the MTR objectives and outcomes, overview on the research principles, specifically on qualitative research methods, familiarized with interview guides, methodologies and research ethics. The tools were piloted in Dar es Salaam. Data analysis was done after each interview to develop meaningful results. Data analysis was manually and continuously done during the data collection period.

Findings:

Maternal health

EmONC services: Basic Emergency Obstetric and Newborn Care (BEmONC) services were offered in all visited dispensaries in all surveyed regions though some signal functions were missing. The hospitals

were found to provide Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services more than the health centers. The main constraints were infrastructure, few trained staff on EmONC and lack of blood transfusion services.

Family planning: Family planning (FP) services were available in most of the facilities in the surveyed regions indicative of prioritization of the services in the country. However, utilization of the services was still low in almost all of the regions. Both short- and long-term modern FP methods were available in most of the regions. The most preferred methods across all surveyed regions were implants, intrauterine contraceptive device (IUCD) and injectables. Barriers to access FP services included: fear of consequences (including infertility, cancer and intolerable side-effects or other health concerns related to contraceptive methods); men's desire for large families; Shortage of staff; lack of skills in FP methods; and lack of preferred FP commodities.

Antenatal care services: ANC services were offered in all the visited facilities but ANC visits below 12 weeks gestation were found to be low in all regions. The reasons mentioned for late first ANC booking were related to cultural beliefs and misconceptions, distance to reach the health facility and travel-related costs, peer influence, absence of male partner involvement, infrastructure (small multiservice rooms resulting in time wasting and lack of confidentiality) and fear of wasting time in the clinic due to staff shortage.

Delivery services: In all the visited regions, women knew the importance of facility delivery assisted by skilled health provider and was mentioned to be common. However, motivation to deliver at the facility is hindered by long distance to the facility, the cost to reach the facility, inadequacy of essential resources such as equipment, commodities and infrastructure as well as human resources and bad language used by nurse/midwives.

Postnatal care (PNC) services: In the visited regions, the coverage was high within 24 to 48 hours post-delivery but reported to be low thereafter due to early discharge after 24 hours because of shortage of PNC rooms, lack of knowledge on the importance of PNC and majority of women fail to attend subsequent visits due to long distances to the facilities.

Prevention of mother-to-child transmission (PMTCT) of HIV: Coverage of HIV testing among pregnant women and for the exposed newborn, ARV prophylaxis to exposed infants and initiation of antiretroviral drugs (ARVs) for infected pregnant women were commendably high in all regions. The small space for ANC services and mixing with other services compromised privacy and confidentiality.

Reproductive cancers: Cervical cancer screening using visual inspection of the cervix with acetic acid (VIA) is practiced in all the regions visited. Selected staff working at the regional and district hospitals

and few of the health centers were trained to do the VIA screening and cryotherapy. Challenges for screening were mentioned to be poor community sensitization and misconception about the disease.

Gender-based violence (GBV) and violence against children (VAC): Across all surveyed regions, prevention of and response to violence against women, adolescents and children was at the rudimentary stage though it was reported that services on gender-based violence (GBV) and violence against children (VAC) were available in most of the health facilities. The main barriers on provision of services to GBV and VAC victims included few healthcare providers who have been trained on GBV and VAC service provision, fear of reporting GBV/VAC cases, lack of GBV kit and lack of one stop centers for GBV/VAC services.

Newborn and Child Health

Immunization coverage was reported to be high in all the surveyed regions. IMCI guidelines were available and utilized in most of the visited facilities. The main challenge mentioned was lack of neonatal intensive care which necessitated the use of Kangaroo Mother Care (KMC).

Adolescent health

In most of the visited regions, adolescents are not receiving quality care due to lack of infrastructure to accommodate youth and lack of trained staff to offer youth-friendly services. Social cultural barriers, pervasive stigma surrounding SRH of unmarried young people and parents' lack of knowledge/skills about SRH matters have been reported to hamper communication between parents/guardians and adolescents as well as access to care in some regions. School education programs incorporating sexual and reproductive health among adolescents are lacking in most of the visited regions.

Best practices on maternal and newborn care documented during qualitative study

1. CHMT established tele-consultation using mobile phones which were airtime charged using health facility funds. The phones have numbers of all key staff including members of the CHMT and doctors at the district hospital. Interview reports suggest a number of lives have been saved by using the system.
2. Provision of phones to community health workers to communicate with heath workers during emergencies saves maternal and neonatal lives.
3. Use of community health workers and/or community health volunteers to carry out health interventions and education at community level increases awareness and uptake of health services and preventive measures.

4. Regular in-service training and refresher courses to healthcare providers keep them updated on new advancements in RMNCAH services.

Recommendations

1. Trained community health workers have to be equipped with adequate skills and be employed by their respective councils. A clear scheme of service that will motivate to work for their communities should be designed. Council own source funds can be set aside for remuneration of employed CHWs. This would increase uptake of RMNCAH services and reduce some of the barriers, especially socio-cultural beliefs and misconceptions on some of the RMNCAH issues.
2. Networking of experienced retired, but not tired, HRH so as to use them in the provision of healthcare services within their locations of residence to cover up the shortage of health workers. These can be compensated only for their effort time through DHFF and facility own funds.
3. Harnessing of available ICT platforms in health can help reduce some of the existing challenges in the health sector such as use of e-learning for in-service training, telemedicine to reduce referral and save lives, tele-communication between CHWS and healthcare providers to cater for emergence cases requiring medical attention in hard-to reach areas and apps that are meant for health education and behaviour change at community level.

1 Background

Considering the vulnerability of pregnant mothers and children, in addition to HSSP IV, the government developed a more specific National One Plan II Strategic Plan (also called One Plan II) to improve Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) services in Tanzania for a period from 2016 to 2020. In 2016 the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) developed the One Plan II to guide the efforts of the government and the stakeholders working to improve reproductive maternal, newborn, child and adolescent health (MOHCDGEC 2016). This strategic document has been in use since June 2016 and its overall goal is to improve reproductive, maternal, new born, child and adolescent health in Tanzania in line with the National Development Vision 2025. In providing this strategic direction, identifying priority actions and measuring progress; the strategy is guided by the overall mission to promote, facilitate and support, in an integrated manner, the provision of comprehensive, high impact and cost-effective RMNCAH and nutrition services, along the continuum of care to men, women, newborn, children and adolescents. Development of HSSP IV and One Plan II strongly suggest the continued government commitment to the global and regional initiatives to improve RMNCAH care 2015-2030.

In order to attain the specified goal, the One Plan II focuses at three strategic approaches:

1. Strengthen Reproductive Maternal Newborn Child and Adolescent Health:
    i. Strengthen Maternal Health and Newborn Health services, including: Family Planning (FP); Focused Antenatal Care (FANC); Post Natal and Newborn care; and Emergency Obstetrics and Newborn Care (EmONC).
    ii. Strengthen and improve visibility of adolescent reproductive health services including strengthening the adolescent health programme, improving its visibility; and developing and implementing a comprehensive strategy for adolescent health.
    iii. Scale up and expand the coverage for Reproductive Health (RH) services, including: FP, Reproductive Cancers, Reproductive Gender (GBV and VAC), and Reproductive Health needs of the Elderly, Fistula, and male reproductive health including male involvement in reproductive health interventions.

2. Scale up the child health programme:

i. Scale up coverage of the Immunization and Vaccine Development program, care for the sick child and Emergency Triage Assessment and Treatment.
ii. Strengthen the implementation of the Integrated Management of Child Illnesses (IMCI) interventions.
iii. Scale up newborn, infant and young child feeding services, including promotion of early initiation of breast feeding, exclusive breastfeeding, and complementary feeding after 6 months.

3. Strengthen response to cross-cutting issues:
    1. Strengthen RMNCAH interventions through the implementation of the Annual One Plan II Operational Plans, and convening of annual RCH meetings.
    2. Improve the availability of RMNCAH and nutrition commodities (RMNCAH Lifesaving commodities, FP commodities, vaccines, therapeutic feeds, Vitamin A for U5 children, Iron-Folate supplements for pregnant women).
    3. Strengthen community involvement in RMNCAH and nutrition services.
    4. Provide comprehensive health promotion and education services in all RMNCAH programmes.
    5. Strengthen the RMNCAH Management Information System and Operational Research activities.

In order to maintain and further advance the significant progress made in the implementation of the HSSP IV and One Plan II, the MOHCDGEC and partners involved in RMNCAH noted the need to conduct a mid-term review (MTR) of HSSP IV and One Plan II. In this context, the Ministry is conducting a systematic review of the HSSP IV and One Plan II, to take stock of the progress and achievements to date, identify the priority areas that need to be strengthened and interventions that need to be scaled up nationally to achieve the objectives and targets, establish a baseline for all key MNH indicators and interventions, and develop a plan of action that will be implemented in the remaining period of the HSSP IV and One Plan II.

1.1 Justification

The mid-term review of the implementation of the HSSP IV and One Plan II is conducted in order to assess the extent to which the planned interventions are being implemented (coverage), determine the extent of services provision, identify existing gaps and contributing factors and the existing best practices. The ultimate goal of the One Plan II MTR is to inform specific recommendations on ways to improve or adapt best practices in different contexts by identifying both components that need strengthening and those contributing to desired behavior change outcomes.

1.2 Methodology

The One Plan II MTR has used both qualitative and quantitative data collection methods, and drawing from multiple data sources, to document important insights into *why* and *how* the implementation processes were done, challenges, and assess the extent to which the intervention was implemented as intended in 8 selected regions. The study interviewed the following people as indicated below:

Category	*Key Informants*
MOHCDGEC team	Minister, Deputy Minister, Acting Chief Accountant and Acting Health Quality Assurance Officer
Regional level	Members of the regional health management team in the selected regions. The list of interviewees included the regional RCH coordinators (Geita, Lindi, Tanga and Katavi).
District/ council level	Members of the council health management team in the selected councils. The list of interviewees included the district RCH coordinator (Geita, Lindi, Tanga and Katavi).
Health workers	Health workers (nurses and clinicians from the RCH clinic, labour ward, antenatal and postnatal and paediatric wards and community health workers) in all health facilities to be visited in Geita, Lindi, Tanga and Katavi.
RMNCAH users	Women of reproductive age attending health facilities in selected regions(Geita, Lindi, Tanga, Katavi, Dodoma, Kigoma, Dar es Salaam and Mbeya).

Data collection tools

In order to map the RMNACH service delivery and identify the implementation gaps, the consultants developed qualitative data collection tools (*see appendices 1-3*). These tools include guides for focus group discussions (FGD) for health care providers and RMNCAH service users and the in-depth interviews (IDIs) guides for high ranking officials at the MOHCDGEC, and members of the RHMT and CHMT. The tools were designed to assess service delivery and identify implementation gaps in the following RMNCAH thematic areas: emergency obstetric and neonatal care (EmONC), antenatal care (ANC), prevention of mother to child transmission of HIV (PMTCTC), postnatal care, child health, adolescent health, family planning services (FP), gender-based violence (GBV) and reproductive cancers.

These tools were designed to explore the extent to which these services are provided and the main challenges encountered during the implementation in Tanzania. The tools explored factors related with health sector infrastructure, medicines and medical supplies, leadership & governance, health financing

and human resources. The tools also explored the best practices in these areas and how the interviewees think the barriers/ inhibiting factors can be addressed.

Data Collection

Before data collection, a total of ten (10) assistant data collectors were oriented on the MTR objectives and outcomes, overview on the research principles, specifically on qualitative research methods, familiarized with interview guides, methodologies and research ethics. The training was conducted in early April 2019 for one day. All tools were circulated and discussed with the One Plan II and HSSP IV MTR teams on May 7th & 8th, 2019. The tools were piloted in Dar es Salaam and refined before being implemented in other seven regions in Tanzania.

1.3 **Data management and analysis**

Data analysis was done after each interview to develop meaningful results. Synthesis of the analysis was done and the field results were compared with the literature findings and the quantitative data. The results were shared with various stakeholders who were allowed to contribute on the key findings. All these steps were conducted in order to identify and recommend the priority areas and interventions that need to be implemented to achieve the One Plan II and HSSP IV RMNCAH-related objectives and targets.

Data analysis was manually and continuously done during the data collection period. After each in-depth interview and FGD, the moderator and note-taker immediately expanded notes followed by filling special debriefing form which served as initial analysis. The analysis started with familiarization of the data through reading the transcriptions several times in order to understand the context of the translated narratives. Thematic analysis was performed in order to come up with different themes. The themes were discussed within in the research teams and the transcripts were reviewed again as new themes emerged.

2 Results

Emergency Obstetric and Newborn Care (EmONC) progress has been made to ensure that health facilities have adequate equipment and supplies and large numbers of trained health workforce in EmONC. Basic Emergency Obstetric and Newborn Care (BEmONC) services were offered in all visited dispensaries in all surveyed regions though some signal functions were missing. The hospitals were found to provide Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services more than the health centers. The main constraints were infrastructure, few trained staff on EmONC and lack of blood transfusion services.

"We have BEmONC services in our dispensary and all seven signal functions are available but we have only one person trained. If she is not around it is a big problem...we cannot do anything." (Lindi)

"*MVA services are available including manual removal of placenta, anticonvulsants administration (Mgso4) assisted delivery with vacuum, neonatal resuscitation, CS and blood transfusion services in the facility..."(*Lindi, Geita)

"*EmONC services are available. We do MVA services. EmNOC job aid/guidelines are available; the challenge is there is no theatre and blood refrigerator so we refer serious cases to the hospital."* (Lindi, Geita)

" ...sometimes antibiotics are out of stock... sometimes no blood for transfusion...now the fridge is not working; it is on maintenance. So, if we need blood, we order from Kilwa district hospital (Lindi)

"Here we are giving CEmONC services, there is a theatre which is not ready for use now; if we have an emergency case that needs C/S or blood we refer but we are giving BEmONC services like magnesium sulphate, antibiotics, MVA and oxytocin..." (Geita)

In some regions, the lack of blood for transfusion was solved by communicating through WhatsApp groups (connecting all the health facilities in the region) for required blood as narrated below:

"When we don't have blood for cases requiring transfusion we communicate with other facilities through WhatsApp groups to get blood from facilities that have stock and this has helped to save lives." (Lindi, Geita)

2.1 Family Planning

The use of contraceptive methods is important to limit or space the number of children and substantially lower maternal and neonatal mortality (Dynes et al., 2018). Contraceptive prevalence rate (CPR) in Tanzania is low (Kaale and Muhanga, 2017). CPR among currently married women in Tanzania is 38%, of which 32% are using a modern method. CPR is low among adolescent women (both married and unmarried) compared to women in other age groups (MoHCDGEC, MoH, NBS, OCGS, ICF, 2016).

Family planning (FP) services were reported to be available in most of the facilities in the surveyed regions indicative of prioritization of the services in the country. However, utilization of the services was reported to be still low in almost all of the regions. Both short- and long-term modern FP methods were reported to be available in most of the regions. The most preferred methods across all surveyed regions were implants, intrauterine contraceptive device (IUCD) and injectable.

"*FP methods are available and the most preferred ones are implants, injectable and IUCD."*(Geita, Mbeya).

Barriers to access of FP services

One of the barriers to uptake of modern FP methods was fear of consequences (including infertility, cancer and intolerable side-effects or other health concerns related to contraceptive methods):

"...if you use family planning you will never get pregnant again... (Geita, Lindi, Tanga, Katavi)

"...they use of traditional FP methods... can cause cancer "…' can dry your eggs..." (Geita, Lindi, Dar es Salaam)

Other barriers were men's desire for large families; they belief that God determines family size; insufficient knowledge about benefits and tension between men and women responsibilities over reproduction:

" *There is poor male involvement in family planning because some of them forbid their wives to use family planning methods."; they don't allow women to use as they say FP dry eggs."* (Geita, Lindi, Kigoma).

"*Women fear to use family planning services without having permission from their husbands, because he is the one who is taking care of everything in the family."* (Geita).

"Religion is against using FP; it's is likened to killing a child..." (All regions).

Shortage of staff , lack of skills in in FP methods and lack of preferred FP commodities were also mentioned as factors hindering FP use;

"...maybe the need for FP among women in our community is there...but the skilled providers are few with multiple duties…. like offering ANC, PNC, PMTCT and also responsible for counseling women on FP services. Women cannot just be sitting there waiting …they are not sick" (All regions).

Health providers are trained in one type of FP only; so if a client wants a different method than that the provider is not trained on she has to go looking for it somewhere else." (Geita).

"*We lack long active FP method commodities. When the clients come, we counsel them to use what we have (Depo provera and pills)"* (Geita).

2.2 Antenatal care services

Majority of women (98%) do receive ANC services from a skilled health provider at once whereby a pregnant woman receives a package of interventions for the mother and child to promote positive behavior change which will help reducing maternal and neonatal deaths. However, only half of them attend the recommended four or more visits and 1 out of 4 women attend ANC during their first trimester (MoHCDGEC, MoH, NBS, OCGS, ICF, 2016; Bishanga et al., 2018; Konje et al., 2018) while 23% of women attend before 4 months of pregnancy (MoHCDGEC, MoH, NBS, OCGS, ICF, 2016) and 28% before 12 weeks (DHIS, 2018). This was also mentioned in most of the FGDs conducted in the 8 regions by both women and health workers. *"Lots of pregnant women visit ANC for the first time within 4-5 months of pregnancy".*

Socio-cultural beliefs, fear of HIV testing, poverty, and distance from health clinics were reported as barriers to early ANC utilization (Konje et al., 2018). This was also mentioned by participants in most of the regions:

*"Lots of pregnant women visit ANC for the first time within 4-5 months of pregnancy. They don't like to report early for fear of superstition .... that the baby will disappear inside her stomach." (*Lindi,Geita,Tanga,Katavi, Kigoma, Dodoma).

"... I booked late in my previous pregnancy and I didn't get any problem; why should I come earlier" (Kigoma, Lindi).

*"Distance challenges...there are villages that are far from health facilities (up to50Km) … women don't attend ANC regularly because of distance. It will cost them more than 20000Tsh round trip." (*Geita,Lindi, Kigoma, Dodoma)

"Male involvement is a challenge because they fear to be tested for HIV (All regions), a practice of some health care providers denying ANC services to pregnant women who attended without their male partners "...*The reason for few women attending ANC 4+ visits and few starting below 12 weeks is low men involvement in antenatal services which cause women to delay to get services because they are required to come with their partner especially at the first ANC visit."*(Geita) and also lack of awareness of the need for early booking *" We are not aware that we have to attend ANC earlier."* (Kigoma)

Limited understanding of the purpose of ANC, shortage of health care providers and supplies and drugs are some other common challenges affecting uptake of ANC services (Kearns et al., 2014; Konje et al., 2018). Most of the health facilities in the 8 regions never assessed BP, Hb, VDRL for reasons related with availability of required equipment and supplies (BP machines, cuvette, VDRL kits) *"…Hb ,glucose ,VDRL test are not available in our dispensary…"* (Dodoma, Dar es Salaam).. On the contrary, in Tanga region stock outs of essential commodities for ANC services were rarely experienced because they used own sources to procure these commodities from other sources.

“…Hb ,glucose ,VDRL test are not available in our dispensary…” (Dodoma, Dar es Salaam).

Shortage of skilled ANC providers in facilities providing ANC services has been documented. Less than half (46%) of the health facilities had at least one trained health worker on ANC(44% dispensaries and 65% health centers) (MoHCDGEC, 2017). This was also reported in all the 8 regions by health workers and ANC clients. Some of the ANC clients mentioned shortage of staff as one of the reasons discouraging them to attend:

".... *long waiting time is a disturbance and we decide not to visit the clinic.* (Lindi, Geita, Dar es Salaam, Kigoma, Dodoma)

".... human resource is still a challenge, we have few nurses." (All regions)

Inadequacy of the infrastructure for RCH services was reported in most places. Majority of the health facilities had small rooms which were used for provision of all types of RCH services (ANC, PMTCT, family planning). The small space for ANC services and mixing with other services compromised privacy and confidentiality as explained below:

"... few rooms which are congested; they share 1 room for all the services (delivery, antenatal and post-natal services).”(Katavi Lindi, Dodoma, Kigoma)

“There is no privacy as in one room you find more than one nurse doing different tasks and when you explain your problem they all hear you.” (Mbeya)

2.3 Delivery

Health facility delivery assisted by trained personnel has increased from 63% (in the MoHCDGEC, MoH, NBS, OCGS, ICF, 2016) to 80% **(** DHIS 2018). However, motivation to deliver at the health facility is also hampered by poor transportation, cost of delivery at hospitals, overcrowding and ill-treatment by hospital staff (Dhingra et al., 2014). In all the visited regions, women knew the importance of facility delivery assisted by skilled health provider and was mentioned to be common. However, motivation to deliver at the facility is hindered by long distance to the facility and the cost to reach the facility as narrated below:

"Previously they used to deliver at home due to long distance from the facility; after building this dispensary the number of deliveries at the facility has increased" (Lindi).

*" We have few rooms for providing all the services needed for ANC, PMTCT, delivery and postnatal services. Many women deliver at the facility…they are many...Katoro Health Center alone delivers around 600 to 700 women per month. We need more space in our facility." (*Geita).

In Kigoma clients mentioned that they have only one delivery room in their health facility. *"The challenge is we have only one labour room… more rooms are needed as the labour pains cannot wait for another client to finish…"*

"A woman came to our facility at gravida 6 … the previous deliveries were carried out at home. When asked the reason for not giving birth at the facility she said nurses have bad language." (Geita)

"Health facility delivery services at our facility are good but there is challenge of some nurses being harsh to women during delivery." (Geita, Lindi, Kigoma)

"If you don't have an ANC card, you can't deliver at the hospital; they will chase you, or they will be harsh to you, so it's better to deliver at home." (Geita)

In some regions telemedicine through WhatsApp groups was practiced whereby healthcare providers at lower level health facilities communicated with their counterparts at higher level health facilities in case of difficult cases thus minimizing the number of referral cases.

"*There was a mother who delivered by caesarean section; after 6 weeks the wound ruptured, we asked for help in telecommunication southern group, and they showed us how to provide care and later she was given referral, we was able to save life."* (Lindi)
"Even here in Sokoine RRH we have telemedicine, we have Whatsapp groups, we do consultations with other doctors." (Lindi)
This positive m-Health approach was also commended during key-informant interviews. *"Government should use ICT developments as important opportunity for innovations, e.g. telehealth, e-learning, teleconferences."* (MOHCDGEC)

For nurses, the bad language they are giving is associated with being harsh to their clients who are not cooperating during the final stage of delivery to avoid losing the baby in the process. *'… we are not harsh, some women are not cooperative so you have to make sure they deliver a healthy baby…yes.. Sometimes we are harsh but it is for their benefit* "(Geita)

Poor quality of maternal and newborn health services was also reported in rural districts of Tanzania (Baker et al., 2015). Baker et al. (2017) linked poor quality to uncertain or inadequacy of essential resources such as equipment and infrastructure as well as human resources which will limit capacity to provide care. These were also raised during the FGDs in almost all the regions as summarized below:

"...when you tell pregnant women to get prepared for delivery ... they disagree. They say it's a government dispensary so all equipment and supplies need to be there (gloves and syringes)." (Lindi)

Inadequacy of infrastructure for the labour wards, antenatal and postnatal care was reported in some facilities. *"There is no enough rooms for pregnant women and other services at our health facility*…"(Kigoma, Mbeya, Dodoma). Inadequacy of stocks of essential drugs and supplies for facility deliveries was reported in most of the surveyed regions. *"Sometimes you come and you don't get the prescribed drugs. They write for you to buy at the pharmacy; they tell you the drugs are out of stock."* (Dodoma,Kigoma ,Dar es Salaam).

*S*hortage of skilled staff was one of the key factors that affected quality of health facility delivery services in most places across the visited regions.

" *…when we arrive at the health facility, we queuing for getting a card for a very long time and then you make another queue for to see a doctor…one day I me here and I stayed for long time until I decided to go to a private hospital… they have few staff.*" (Dar es Salaam)

"Services are good…the only challenge I see here is inadequacy of medical staff, to the extent that one medical personnel is doing more than one task. This lead delaying of provision of health service to the patients..."(Kigoma)

2.4 Postnatal care services

Postnatal care (PNC) is the care given to the mother and her newborn baby immediately after the birth and for the first six weeks of life. In Tanzania, the majority (66%) of mothers and newborns (58%) are not receiving recommended postnatal care within 2 days after birth (MoHCDGEC, 2016). In the visited regions, the coverage was high within 24 to 48 hours post-delivery but reported to be low thereafter due to early discharge after 24 hours because of shortage of PNC rooms and majority of women fail to attend subsequent visits due to long distances to the facilities.

" ...We normally offer PNC within 24 hours after delivery and discharge them home due to shortage of rooms. After discharge the problem starts as many mothers fail to come after 48 hours after delivery and also between 3 to 7 days. The reason is the long distance they have to travel to the facility...." (Geita, Tanga)

"Good services are provided but the challenge is the shortage of rooms for postnatal care services" (Geita, Lindi Tanga, Dodoma, Kigoma).

"... lack of post-natal rooms, one bed is used by 2 to 3 mothers to sleep." (Lindi).

"... few rooms which are congested; they share 1 room for all services (delivery, antenatal and post-natal services)". (Lindi).

Lack of knowledge on the importance of PNC was also mentioned as a barrier for attending the required postnatal visits:

"Lack of understanding on the importance of postnatal services; when a woman feels she is doing well she doesn't see the reason to come back." (Lindi).

Traditional practices given after delivery may motivate women not to use the PNC offered at the health facilities as mentioned by some participants in one of the regions. *".. some tribes believe that after delivery they only need to massage the uterus by using either hot oil or hot water."(*Lindi).

2.5 Prevention of Mother to Child Transmission of HIV

Integrating sexual and reproductive health (SRH) and HIV services is crucial in improving maternal and child health as well as prevention of transmission of HIV from mother to child. Linkages between SRH

and HIV-related policies, national laws, operational plans and guidelines are generally evident in Tanzania (Mutalemwa et al., 2013). Promising results are also documented for the current Option B+ cascade (Gamell et al., 2017). This integration has been linked with increased health service utilization, notably of ante-natal care, universal HIV testing at the ANC, high rates of linkage to care, prevention of MTCT of HIV and some evidence of beneficial synergies between PMTCT programs and other health services especially maternal health care, STI prevention and early childhood immunization (Gamell et al., 2017; Mutabazi et al., 2017).

Coverage of HIV testing among pregnant women and for the exposed newborn, ARV prophylaxis to exposed infants and initiation of antiretroviral drugs (ARVs) for infected pregnant women were commendably high in all regions as narrated in one of the FGDs:

"The PMTCT services are provided at all health facility levels...mothers who come to clinics are counseled and tested and if found positive, they start ARVs." (Katavi, Lindi, Dar es Salaam, Tanga, Geita)

"… pregnant women are tested for HIV infection when they come to ANC to know if she is infected or not, so that early action can be taken to save her and her unborn child against HIV infection." (Kigoma)

2.6 Adolescent Health

Adolescence is a transition period whereby a child turns into adulthood. During this period, they are at risk of a broad range of health problems like early sexual debut, unwanted pregnancy and related complications, unsafe abortion, sexual abuse/violence, STIs and HIV/AIDS, and other sexual and reproductive health-related problems (Mmbaga et al., 2017; Abdul et al., 2018; MoHCDGEC, 2018; UNFPA, 2018). This was also mentioned to be prevalent in some of the regions visited:

*"Early pregnancy is still here, girls are getting pregnant as early as 9 -14 years … this is due to hardness of life.... they need money. They engage in risk behaviours earlier ...participate in sexual activities at tender age" (*Lindi).

"*Adolescent pregnancy is high (32%) in Geita as most of girls are married at young age due to ignorance and poverty ... special efforts are needed to offer ARH services in our health facilities."*(Geita).

*"…in Lindi ceremonial dances for initiation of girls when they are mature are common. These ceremonial dances may contribute to early pregnancies."(*Lindi).

In some regions, the community is against family planning for adolescents. So they are using it secretly
"*Adolescents in this community are not allowed to use family planning…so some girls and boys are using it secretly."*(Dodoma, Mbeya)

However, most of the facilities are not equipped to offer such services as they do not have skilled providers on sexual and reproductive health (SRH), are inaccessible to reproductive health services due

to lack of privacy, confidentiality, equipment and negative attitude from service providers (Mbeba et al., 2012). In most of the visited regions, adolescents are not receiving quality care due to lack of infrastructure to accommodate youth and lack of trained staff to offer youth-friendly services as narrated below:

"We lack rooms for adolescent-friendly services." (Geita, Dodoma, Kigoma, Lindi).

"We don't have staffs that are trained in AFRHS in our clinics. Also, adolescents have to share the same clinics with adults but they are not coming. They are shy…. elders will not understand them."(Lindi).

"No one is trained on how to offer ARH services but we are giving them general care if they come." (Geita, Kigoma, Dodoma)

Social cultural barriers, pervasive stigma surrounding SRH of unmarried young people and parents' lack of knowledge/skills about SRH matters have been reported to hamper communication between parents/guardians and adolescents as well as access to care (Ngilangwa et al., 2016; Nyblade et al., 2017). This was raised in some regions which were visited during the FGDs:

"...young adults, especially school children, when they go to the clinic for FP, they lose respect in the community, they are considered to be prostitutes..." (Geita, Dodoma)

"Somehow FP services for adolescents are available, but they fear their relatives, especially if they will know that they are using FP services."(Kigoma, Geita, Dodoma, Lindi)

*"The national guideline for FP encourages to give FP to all who are in need. But, community members are having a different opinion on that. If you give FP to adolescents, especially school children, they believe that they will start sexual activity earlier." (*Lindi)

"*No user-friendly services and when they come to ANC clinic, they are shy to be mixed with their elders so they don't come ...."* (Geita, Lindi)

School education programs incorporating sexual and reproductive health among adolescents have been proven to be effective (WHO, 2008; Kesterton and Cabral de Mello,2010, Mmbaga et al., 2017). However, this was not happening in most of the visited regions as narrated below:

*" Adolescents were used to be given RH education in primary schools. This included family planning education. We did not get community support from neither the community members nor politicians. We had to stop. This is no longer provided in schools." (*Lindi)

"...S*chool children are not allowed to use family planning because if you educate them it means they are allowed to practice sex…if they want, they can buy at the pharmacy but in a very secret way."(*Geita, Dodoma)

2.7 Reproductive Cancer

The burden of RH cancers in Tanzania is showing an upward trend (MoHCDGEC, MoH, NBS, OCGS, ICF, 2016), yet there is inadequate number of screening centres and inadequate knowledge of the disease(Mabelele et al., 2018). Insufficient training and staff shortages contribute to the limited accessibility of cervical cancer screening and treatment services as narrated by FGDs participants in some of the regions:

*"Most patients with advanced cancer go to tradition healers first. They believe that if cancer is radiated, you can't get better anymore. They say it's better to use traditional medicines for treating cancer." (*Geita)

"...when they get a health problem they go first to traditional healers." (Lindi)

'...To expose your private parts when you are not sick is not possible" (Lindi)

"We have severe shortage of medical staff especial those dealing with screening and treatment services for reproductive cancers."(Kigoma,Geita, Tanga)

*"We screen for cancers at district hospitals only. For other lower level facilities, we do through outreach services. The challenge we face is the shortage of gas needed for the procedure due to lack of gas cylinders for refilling and also money to buy the gas. Our partner who was supporting us (AGIE PIE) has moved out with his gas cylinders...." (*Geita)

Reproductive cancers affect both men and women. Cervical cancer screening using visual inspection of the cervix with acetic acid (VIA) is practiced in all the regions visited. Selected staff working at the regional and district hospitals and few of the health centers were trained to do the VIA screening and cryotherapy. Challenges for screening were mentioned to be poor community sensitization and misconception about the disease.

"Cancer services here are not given a priority like other services …. it is not integrated with other services during outreach." (Geita)

"HPV vaccine coverage is still low due to exiting belief that it causes infertility." (Geita)

"False beliefs; they believe that when someone gets this vaccine (HPV) she may not deliver."(Geita)

Some participants in the FGDs have not heard about cervical cancer screening. For example, in Dar es Salaam, in one of the FGDs, among all the participants only one participant had undergone screening for cervical cancer and the second one had only heard about the services but rest of the participants knew nothing at all.

2.8 Gender-based violence (GBV) and violence against children (VAC)

GBV/VAC is recognized as an important public health and social problem, with far reaching consequences for women's and children's physical and emotional health and social well-being. The number of reported rape cases is on the rise (Abeid et al., 2015). Rape of women and children is

considered a common but hidden phenomenon in Tanzania and has been associated with erosion of social norms, globalization, poverty, vulnerability of children, alcohol/drug abuse and poor parental care (Abeid et al., 2014). Across all surveyed regions, prevention of and response to violence against women, adolescents and children was at the rudimentary stage though it was reported that services on gender-based violence (GBV) and violence against children (VAC) were available in most of the health facilities.

The main barriers on provision of services to GBV and VAC victims included few healthcare providers who have been trained on GBV and VAC service provision and lack of one stop centers for GBV and VAC services.

"we are giving GBV services but we don't have one stop center because our buildings are few and few health workers are trained to handle these cases. Only one staff has been trained." (Geita)

*"we have 8 staff trained on how to handle GBV/VAC cases. They were trained by one of the NGOs .... the challenge is we don't have special rooms for GBV/VAC cases; they are seen at the OPD." (*Geita)

Lack of GBV kit in most of the health facilities visited in the surveyed regions and disintegrated services (health facility, police, civil societies, legal authorities), all of which are supposed to work together in the fight against GBV and VAC, were mentioned to be a challenge:

"…. there is a gender desk at the police station where GBV/VAC cases are referred. We have no guidelines and no training on this." (Lindi)

". …the victims think it is a disturbance to report to the police station." (Lindi_).

"Gender-based violence services are available and provided at the facility after the victim has reported to the police station and gets the PF3 form. "(Mbeya, Geita, Lindi).

Furthermore, most of GBV and VAC cases are not reported mostly because the perpetrators are either family members or close relatives and therefore resolved domestically as narrated below:

" … my sister's husband raped our 8-year old nice who was staying with them. But the case was resolved at home. Imagine if he was to be taken to prison who would feed the family? Who would have helped to take care of my sister with her newborn baby? …finally the case was resolved and ended at home."(Dodoma)

"*Many cases are hidden; they are not reported."* (Geita, Katavi, Mbeya, Lindi)

"*Women are beaten but they fear to tell the secret of the family for fear of the perpetrator who happens to be the husband." (Geita).*

"…when GBV/VAC case happens, it is taken to the ward leader and if one of the culprits is a family member, the case is resolved at family level to avoid shame in the family." (Mbeya, Kigoma, Lindi)

Also community sensitization was said to be low. *"…community is not aware of GBV/VAC; sensitization is low and cases are many especially in rural areas."* (All regions)

2.9 Newborn and Child Health

Child vaccination was mentioned to be available across all the FGDs and IMCI guidelines were available and utilized in most of the visited facilities. The main challenge mentioned was lack of neonatal intensive care which necessitated the use of Kangaroo Mother Care (KMC).

"... there is no neonatal intensive care unit (NICU), there is a room but there are no incubators … we are looking for support. The room is used for KMC." (Geita)

"…some of the services that are provided at our facility are vaccination for newborn and children under five years and checking their weight…" (Dodoma, Kigoma, Geita)

"Children's medical services are free but medicines/drugs are not available, the only available drug is panadol.." (Mbeya)

"We are using IMCI guidelines for treatment of under five children. The guidelines are very helpful to us..." (Lindi, Tanga, Katavi, Geita)

Best practices on maternal and newborn care documented during qualitative study

1. CHMT established tele-consultation using mobile phones which were airtime charged using health facility funds. The phones have numbers of all key staff including members of the CHMT and doctors at the district hospital. Interview reports suggest a number of lives have been saved by using the system.
2. Provision of phones to community health workers to communicate with heath workers during emergencies saves maternal and neonatal lives.
3. Use of community health workers and/or community health volunteers to carry out health interventions and education at community level increases awareness and uptake of health services and preventive measures.
4. Regular in-service training and refresher courses to healthcare providers keep them updated on new advancements in RMNCAH services.

3 SWOC Analysis from qualitative study

Strengths	Opportunities
• Availability of trained health workers on RMNCAH • Availability of infrastructure for RMNCAH services • Governance and leadership structures in place (HFGBs, CHMTs, RHMTs)	• Availability of trained CHWs in the community • DHFF • Availability of insurance schemes • Existing technological advancements in health, especially those harnessing ICT platforms
Weaknesses	**Challenges**
• Shortage of trained health workers on RMNCAH • Knowledge and skills on planning and leadership on facility governance • Inadequate mass media coverage on RMNCAH issues	• Shortage of financial resources • Lack of trained staff and one stop centres for GBV/VAC services • Inadequate infrastructure for provision of quality, user-friendly RMNCAH services • Existing socio-cultural beliefs and misconceptions on RMNCAH services

4 RECOMMENDATIONS

1. Trained community health workers have to be equipped with adequate skills and be employed by their respective councils. A clear scheme of service that will motivate to work for their communities should be designed. Council own source funds can be set aside for remuneration of employed CHWs. This would increase uptake of RMNCAH services and reduce some of the barriers, especially socio-cultural beliefs and misconceptions on some of the RMNCAH issues.
2. Networking of experienced retired, but not tired, HRH so as to use them in the provision of healthcare services within their locations of residence to cover up the shortage of health workers. These can be compensated only for their effort time through DHFF and facility own funds.
3. Harnessing of available ICT platforms in health can help reduce some of the existing challenges in the health sector such as use of e-learning for in-service training, telemedicine to reduce referral and save lives, tele-communication between CHWS and healthcare providers to cater for emergence cases requiring medical attention in hard-to reach areas and apps that are meant for health education and behaviour change at community level.

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Appendices

Appendix 1: FOCUS GROUP DISCUSSION GUIDE FOR MEMBERS OF RHMT AND CHMT

Region __________________________ District: _______________________

Date: ___________________________

Interviewers' self-introduction

Introduce yourself and the note-taker (include your names and from which institution they are involved).

Interview introduction

"Thank you for agreeing to participate. This interview is being conducted to get your valuable opinion about health care services in Tanzania. We are specifically interested in getting your perception, experiences, positives and negatives you are aware of, and recommendations you have on health care services. We hope to learn things that the government and other stakeholders can use to improve services."

"This discussion will be for about one hour. If it is okay with you, we will be tape-recording our conversation. The purpose is to make sure that we capture the thoughts, opinions, and ideas we hear from the group but at the same time be able to carry on an attentive conversation with you. We assure you that the information you give us is completely confidential, and we will not associate your name with anything you say in the focus group. We will be compiling a report containing all your comments without any reference to individuals. You may refuse to answer any question or withdraw from the study at anytime. We understand how important it is that this information is kept private and confidential."

Instructions to interviewers

Make sure you give people time to think before answering the questions and don't move too quickly. Use the probes to make sure that all issues are addressed, but move on when you feel you are starting to hear repetitive information.

Thematic Area/ construct	**Questions and Probes**
Engagement of	I would like to learn from you, how is your RHMT/ CHMT involved & engaged in

RHMT & CHMT in the implementation process of RMNCAH strategies	implementation of reproductive, maternal newborns children and adolescent health strategies? In Your opinion, were the goals and objectives clearly articulated? **Probes:** • Were the goals and targets realistic? • How do your RHMT/CHMT monitor implementation of RMNCAH strategies?
Emergency obstetric and neonatal care (EmONC)	In your opinion to what extent are the EmONC (basic and comprehensive) services being implemented (coverage) in your region/ district? **Probe:** • What are the achievements so far based on provision of full set of signal functions? • What are facilitating factors – including development partners' involvement etc? • What are the main challenges encountered during the implementation of EmONC in your region/ district? Explore factors related with o Infrastructure – explore adequacy of delivery beds, equipped theatre, blood refrigerators etc. o Medicines and medical supplies – for EmONC, Hb machine, BP machine etc. o Leadership & governance – audits for maternal and neonatal mortality audits o Health financing - what are the sources of funding for RMNCAH services? What are challenges related to funding RMNCAH – adequacy, processes? o Human resources – explore skills EmONC signal functions • How do you think the barriers/ inhibiting factors can be addressed? • Are you aware of any m-Health strategies (like WhatsApp groups) for maternal and child life saving teleconsultation? Are you also using it and how useful is the strategy? • Which best practices for EmONC are you aware of in Tanzania and in the region and how do you think can be scaled up?
Antenatal care services (ANC)	In your opinion to what extent are the ANC services being implemented (coverage) in your region/ district? **Probe:** • What are the achievements/ the coverage so far – proportion attending at

	least once and those who complete a minimum of four ANC visits? • To what extent are these services are of sufficient quality (in terms of assessment of Hb, BP, VDRL, HIV test, immunization, supplements- FeFol, mebendazole etc. • What are facilitating factors – including development partners' involvement etc? • What are the main challenges encountered during the implementation of ANC services in your region/ district? Explore factors related with infrastructure, medicines and medical supplies; leadership; health financing and human resources. • How do you think the barriers/ inhibiting factors can be addressed? • Which best practices for ANC services are you aware of in Tanzania and how do you think can be scaled up?
Prevention of Mother to Child Transmission of HIV (PMTCTC)	In your opinion to what extent are the PMTCTC services being implemented in your region/ district? **Probe:** • What are the achievements/ coverage made so far? • What are the facilitating factors – including development partners' involvement etc.? • What are the main challenges encountered during the implementation of PMTCT services? Explore factors related with infrastructure, medical supplies; health financing, leadership and human resources • Which best practices for PMTCT services are you aware of in Tanzania and in the region?
Postnatal care services	In your opinion to what extent are the postnatal care services being implemented (coverage) in your region/ district? **Probe:** • What are the achievements made so far based on immunization coverage? • What are the key health system gaps in implementing postnatal care services? Explore factors related with infrastructure, medicines and medical supplies; leadership and human resources • Which best practices for postnatal care are you aware of in Tanzania and in the region?
Child Health	In your opinion to what extent are the newborn and child health services being implemented in your region/ district? **Probe:** • What are the achievements made so far in-terms of management of children using IMCI principles in your region/ district? • What are facilitating factors – including development partners' involvement

	e.t.c? • What are the key health system gaps in implementing child health services? Explore factors related with infrastructure, supply chain – antimalarials, antibiotics, ORS and zinc; leadership, human resources – skills in IMCI services, availability of guidelines. • How do think the barriers/ inhibiting factors can be addressed?
Adolescent health	In your opinion to what extent are the adolescent health services being implemented in your region/ district? **Probe:** • How are the adolescent health services user friendly in your health facilities – timing, privacy, skilled providers? • What are facilitating factors? • What are the key health system gaps in implementing adolescent health services? Explore factors related with infrastructure, supply chain – contraception, MVA; service delivery – post-abortal care; human resources, socio-cultural factors. • How do you think the barriers/ inhibiting factors can be addressed? • Which best practices for adolescent health services are you aware of in Tanzania?

Family planning services (FP)	In your opinion to what extent are the FP services being implemented (coverage) in your region/ district? **Probe:** • What are the achievements made so far in-terms of coverage in your region/ district? • How are the FP services linked to antenatal and postnatal care services? • What are facilitating factors – including development partners' involvement etc.? • What are the key health system gaps in implementing FP services? Explore factors related with infrastructure, supply chain; leadership, human resources –skills in FP methods, ignorance of the community, socio-cultural factors. • How do you think the barriers/ inhibiting factors can be addressed? • Which best practices for FP services are you aware of in Tanzania and how can that be scaled up?
Gender based violence	Based on your experiences, to what extent are the gender-based violence (GBV) services being implemented (coverage) in your region/ district? **Probe:** • What are the achievements made so far in-terms of coverage in your region/ district? • How the GBV services are integrated into existing health services? • What are facilitating factors – including development partners' involvement etc.? • What are the key sectoral gaps in addressing GBV prevention and response? Explore factors related with the following key sectors MOHCDGEC, Ministry of Home Affairs (MOHA); Ministry of Justice and Constitutional Affairs (MOJCA); Prime Minister's Office Regional Authorities and Local Government; development partners; and civil society organizations (CSOs) and the community (ignorance, socio-cultural factors etc.) • How do you think the barriers/ inhibiting factors can be addressed? • Which best practices for GBV services are you aware of in Tanzania and how can that be scaled up?
Reproductive cancers	I would like also to learn from you, to what extent is the intervention for reproductive cancers being implemented in your region/ district? **Probe:** • What are the achievements made so far in-terms of coverage in your region/ district? • How is the intervention linked to RCH services? • What are facilitating factors – including development partners' involvement

	etc.? • What are the main challenges encountered during the implementation of reproductive cancers services? Explore factors related with infrastructure, supply chain; leadership, health financing, human resources –skills in screening, ignorance of the community, socio-cultural factors. • How could these factors be addressed? • Which best practices for reproductive cancers screening services are you aware of in Tanzania and how can that be scaled up?

5.1 Appendix 2: FOCUS GROUP DISCUSSION GUIDE FOR HEALTH CARE PROVIDERS

Targeted Populations: *Health Workers (nurses and clinicians from the RCH clinic, labour ward, antenatal and postnatal and paediatric wards and community health workers)*

Region ________________________ District: ___________________________

Health Facility: _________________ Date: _____________________________

Interviewers' self-introduction

Introduce yourself and the note-taker. The interviewers should include their names and from which institution they are involved.

Interview introduction

"Thank you for agreeing to participate. This interview is being conducted to get your valuable opinion about delivery services in Tanzania. We are specifically interested in getting your perception, experiences, positives and negatives you are aware of, and recommendations you have on delivery services. We hope to learn things that the government and other stakeholders can use to improve services."

"This discussion will be for about one hour. If it is okay with you, we will be tape-recording our conversation. The purpose is to make sure that we capture the thoughts, opinions, and ideas we hear from the group but at the same time be able to carry on an attentive conversation with you. We assure you that the information you give us is completely confidential, and we will not associate your name with anything you say in the focus group. We will be compiling a report containing all your comments without any reference to individuals. You may refuse to answer any question or withdraw from the study at anytime. We understand how important it is that this information is kept private and confidential."

Logistics and Ground Rules

"We understand that people have different background, knowledge and perception, and so,
O We will ask participants to respect each other's confidentiality.
O You may refuse to answer any question or withdraw from the study at anytime
O Stay with the group and please don't have side conversations
O Turn off cell phones if possible"

Instructions to interviewers

Make sure you give people time to think before answering the questions and don't move too quickly. Use the probes to make sure that all issues are addressed, but move on when you feel you are starting to hear repetitive information.

1. In your opinion to what extent are the ANC services being provided in your health facility?

   Probe:

   - *To what extent are these services of sufficient quality (in terms of assessment of Hb, BP, VDRL test, HIV test, immunization, supplements- FeFol, mebendazole etc.?*
   - *What are the main challenges encountered during the provision of ANC services in your health facilities?*
     - *Explore factors related with infrastructure, leadership; health financing and human resources.*
     - *Can you comment on availability of tests like Hb, BP that are supposed to be checked in each visit as well as the supplements – FeFol, SP, mebendazole?*
   - *What are the socio-cultural barriers (misconceptions, beliefs) contributing to inadequate utilization of ANC services characterized by few women attending ANC 4+ visits?*
   - *How do they think the barriers factors can be addressed?*
   - *Which best practices for ANC services are you aware of in Tanzania and how do you think can be scaled up?*

2. Does your health facility provide a full set of key interventions (signal functions) for emergency obstetric and neonatal care (EmONC)?

   Probe:

- *Availability of MVA services (for incomplete abortions), manual removal of placenta, anticonvulsants administration (MgSO4), assisted delivery with vacuum, neonatal resuscitation, CS and blood transfusion services in the facility. Probe for the reasons in case one of the services are not provided.*
- *Probe for availability of EmONC job aid/ guidelines, transport of emergency and audit of maternal and perinatal mortality audit in the facility.*
- *What are the main challenges encountered during the implementation of EmONC in your health facility? Explore factors related with*
  - *Infrastructure – adequacy of delivery beds, equipped theatre, blood refrigerators etc.*
  - *Medicines and medical supplies – for EmONC, Hb machine, BP machine etc.*
  - *Leadership & governance – follow up maternal and neonatal mortality audits' recommendations*
  - *Health financing – explore sufficiency and sources of funding for EmONC services?*
  - *Human resources – explore skills on EmONC signal functions*
- *Probe how they think the barriers/ inhibiting factors can be addressed.*
- *Are you aware of any m-Health strategies (like WhatsApp groups) for maternal and child life saving teleconsultation? Are you also using it and how useful is the strategy?*

3. Can you please tell me the existing link between HFs and CHWs in the community?
   PROBE:
   What is the role of CHWs in RMNCAH in the community, challenges they face if any!

4. In your opinion to what extent are the PMTCT services being implemented in your health facility?
   Probe:
   - *What are the achievements/ coverage made so far?*
   - *What are the facilitating factors – including development partners' involvement etc?*
   - *What are the main challenges encountered during the implementation of PMTCT services? Explore factors related with infrastructure, medical supplies; health financing, leadership and human resources*
   - *Which best practices for PMTCT services are you aware of in Tanzania?*

5. In your opinion, what are the factors contributing to health facility delivery services?
   Probe:
   - *Explore the social, cultural and economic factors in your community*
   - *Explore the factors related with quality of services in health facilities - disrespectful maternity care; corruption, attitude, beliefs of hospital delivery versus home delivery*
   - *Probe how they think the barriers/ inhibiting factors can be addressed.*

6. In your opinion to what extent are the newborn and child health services being provided in your health facility?

   Probe:
   - *What are the achievements made so far in-terms of management of children using IMCI principles in your health facility?*
   - *What are facilitating factors?*
   - *What are the key health system gaps in implementing child health services? Explore factors related with supply chain – antimalarials, antibiotics, vaccines, ORS, zinc; human resources – skills in IMCI services, availability of guidelines.*
   - *How do you think the barriers/ inhibiting factors can be addressed?*

7. In your opinion to what extent are the FP services being provided in your health facility?
   Probe:

- *How are the FP services linked to antenatal and postnatal care services?*
- *What are facilitating factors?*
- *What are the key health system gaps in implementing FP services? Explore factors related with infrastructure, supply chain- FP commodities; leadership, human resources –skills in FP methods,*
- *What are the community based factors – social, cultural and economic factors?*

- *What are the policy factors – FP for teenagers, school girls etc.?*
- *How do you think the barriers/ inhibiting factors can be addressed?*
- *Which best practices for FP services are you aware of in Tanzania and how can that be scaled up?*

8. Does your health facility provide gender-based violence (GBV) services?

   Probe:

   - *Are the GBV/VAC services integrated into existing health services?*
   - *Is there a one stop centre (OSC) within your HF? And how is it functioning according to the existing OSC guidelines?*
   - *What are the key sectoral gaps in addressing GBV prevention and response? Explore factors related with the following key sectors: MOHCDGEC, Ministry of Home Affairs; Ministry of Justice and Constitutional Affairs; Prime Minister's Office Regional Authorities and Local Government; development partners; and civil society organizations.*
   - *What are the community related factors - ignorance, social, cultural and economic factors?*
   - *Are there trained HWs to handle GBV victims?*
   - *Are there GBV guidelines in your health facility?*
   - *Probe how they think the barriers/ inhibiting factors can be addressed.*

9. I would like also to learn from you, to what extent are the interventions for reproductive cancers (cancers of cervix, prostate and breast) being provided in your health facility?

   Probe:

   - *How is the intervention (screening and treatment) linked to RCH services?*
   - *What are facilitating factors –development partners' involvement etc.?*
   - *What are the main challenges encountered during provision of reproductive cancers services? Explore factors related with infrastructure, supply chain; health financing – commodities, human resources –skills in screening, ignorance of the community, socio-cultural factors.*
   - *How could these factors be addressed?*
   - *Which best practices for reproductive cancers' screening services are you aware of in Tanzania and how can that be scaled up?*

Appendix 3: FOCUS GROUP DISCUSSION GUIDE FOR RMNCAH USERS

[PARTICIPANTS: PREGNANT WOMEN AND MOTHERS WITH CHILDREN UNDER 24 MONTHS]

Region ___________________________ **District: ____________________**

Health Facility: _____________________ **Date: ______________________**

Interviewers' self-introduction

Introduce yourself and the note-taker (include your names and from which institution they are involved).

Interview introduction

"Thank you for agreeing to participate. This interview is being conducted to get your valuable opinion about health care services in Tanzania. We are specifically interested in getting your perception, experiences, positives and negatives you are aware of, and recommendations you have on health care services. We hope to learn things that the government and other stakeholders can use to improve services."

"This discussion will be for about one hour. If it is okay with you, we will be tape-recording our conversation. The purpose is to make sure that we capture the thoughts, opinions, and ideas we hear from the group but at the same time be able to carry on an attentive conversation with you. We assure you that the information you give us is completely confidential, and we will not associate your name with anything you say in the focus group. We will be compiling a report containing all your comments without any reference to individuals. You may refuse to answer any question or withdraw from the study at anytime. We understand how important it is that this information is kept private and confidential."

Logistics and Ground Rules

"We understand that people have different background, knowledge and perception, and so,

- We will ask participants to respect each other's confidentiality.
- You may refuse to answer any question or withdraw from the study at anytime
- Stay with the group and please don't have side conversations
- Turn off cell phones if possible"

Instructions to interviewers

Make sure you give people time to think before answering the questions and don't move too quickly. Use the probes to make sure that all issues are addressed, but move on when you feel you are starting to hear repetitive information.

10. In your opinion to what extent are the ANC services being provided in your health facility?

    Probe:

    - *What is the importance of attending ANC care?*
    - *To what extent are these services of sufficient quality (in terms of assessment of Hb, BP, VDRL test, HIV test, immunization, supplements- FeFol, mebendazole etc.?*
    - *What are the main challenges encountered during the provision of ANC services in your health facility?*
        - *Explore factors related with infrastructure like lack of privacy and human resources – attitude, practices etc.*
        - *Can you comment on availability of tests like Hb that are supposed to be checked in each visit as well as the supplements – FeFol, SP and mebendazole?*
    - *What are the social, cultural and economic barriers (misconceptions, beliefs) contributing to utilization of ANC services? Explore why just few women attending ANC 4+ visits and few start ANC below 12 weeks of pregnancy?*
    - *How do they think the barriers factors can be addressed?*

11. In your community, to what extent do pregnant women seek delivery services at the health facility?

    Probe:

    - *Are health delivery services available on 24 hours seven days a week?*
    - *What is the motivation of health facility delivery versus home delivery?*
    - *To what extent are the health facility delivery services of sufficient quality in this facility?*
        - *Explore the factors related with quality of services in health facilities - disrespectful maternity care (privacy, confidentiality, information, consent, bad language etc.); corruption, community expectations and attitude towards the health facility delivery*
    - *Explore the social (who decides where give birth?), cultural (what are existing cultural and myths towards health facility delivery) and economic (transport - means and cost, distance to the health facility) factors in your community.*
    - *Probe how they think the barriers/ inhibiting factors can be addressed.*

12. In your community, to what extent do pregnant women practice birth preparedness and readiness to complications?

    Probe:

    - *In your opinion, what are some serious health problems that can occur during pregnancy, labour and childbirth that could endanger the life of a pregnant woman?*
    - *In your opinion, what are some things a woman can do to prepare for birth? - Identify mode of transport, Identify skilled provider, save money, essential commodities for delivery, etc.*
    - *Where and why would you advise a pregnant woman to go if she develops danger signs?*

13. In your opinion to what extent are the newborn and child health services being provided in your health facility?

Probe:

- *What is the community perception regarding the causes of newborn and child death?*
- *In your opinion, what is the importance of child vaccination?*
- *What are the key health system gaps in provision of newborn and child health services? Explore factors related with:*
    - Supply chain – warmers, resuscitation gargets, antimalarials, antibiotics, vaccines, ORS, zinc.
    - Human resources – attitude and competences of care providers.
- *How do you think the barriers/ inhibiting factors can be addressed?*

14. Can you tell me the availability of family planning (FP) services in your community?

Probe:

- *Who provides FP services in your community? And which types? What are the most preferred methods of FP in your community and why?*
- *What are the advantages and disadvantages of using FP methods?*
- *What are the key health system gaps in provision of FP services? Explore factors related with infrastructure, supply chain- FP commodities; human resources –skills in FP methods,*
- *What are the community based factors – social (religious etc.), cultural and economic factors?*
- *Are FP services readily available for adolescents including school and out of school girls/ boys?*
- *How do you think the barriers/ inhibiting factors can be addressed?*

15. To what extent are gender-based violence (GBV)/ violence against children (VAC) services available in your settings?

Probe:

- *What is the general perception of your community on GBV/VAC?*
- *How does the community deal with GBV/VAC in the community?*
- *What are the key sectoral gaps in addressing GBV prevention and response? Explore factors related with the following key sectors:*
    - *MOHCDGEC – access to services for GBV/VAC victims,*
    - *Ministry of Home Affairs – police (gender desk) services*
    - *Ministry of Justice and Constitutional Affairs - access to legal advice and counselling*
    - *Community leaders – access to legal advice and counselling*
    - *Civil society organizations – access to legal advice and counselling*
- *What are the community related factors - social - ignorance, cultural and economic factors?*
- *Probe how they think the barriers/ inhibiting factors can be addressed.*

16. I would like also to learn from you, to what extent are the screening and treatment services for reproductive cancers (cancers of cervix, prostate and breast) being provided in your health facility?

Probe:

- *What are the main challenges encountered during provision of reproductive cancers services? Explore factors related with availability of services, human resources –skills in screening, ignorance of the community, misconceptions and wrong beliefs etc. How could these factors be addressed?*