The Mama na Mtoto Experience

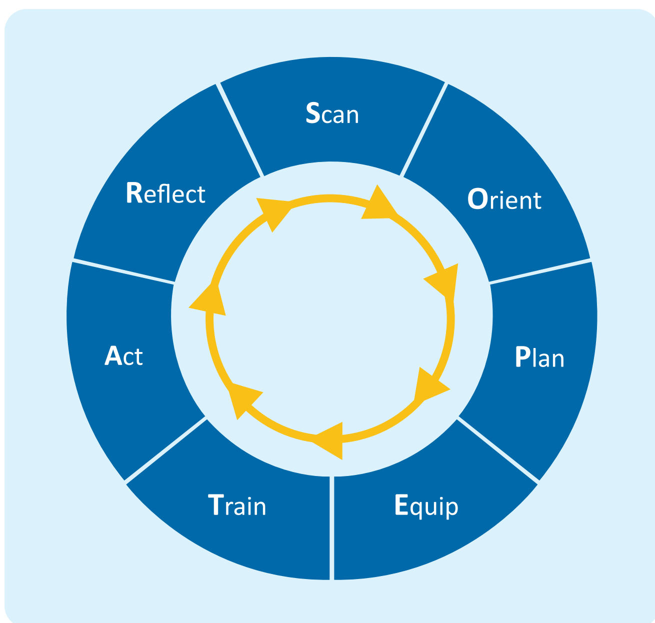
Project Implementation

Background

From 2016-2020, Mama na Mtoto partners worked together in Lake Zone, Tanzania, to reduce maternal and newborn mortality through comprehensive community and facility-based maternal, newborn, and child health (MNCH) programming. Mama na Mtoto developed, implemented, and evaluated a package of interventions in Misungwi and Kwimba Districts. Activities aimed to strengthen existing government health systems through activities at the district, health facility, and community levels. Core activities involved operationalizing district-led networks of community health workers (CHWs) to encourage healthy practices and increase use of MNCH services (*demand side*). At the same time, the project promoted district and health facility capacity to provide quality MNCH services including antenatal care, delivery, and postnatal care (*service side*).

Intervention

During the intervention, Mama na Mtoto facilitated district-led activities including meetings, equipment provision, facility upgrades, training, mentorship, and technical assistance. Activities were delivered in a specific sequence and purposeful way (SCAN, ORIENT, PLAN, EQUIP, TRAIN, ACT, and REFLECT), designed to promote quality implementation incorporating partner experiences and recognized best practices. Districts set their own MNCH priorities. Hands-on simulation-based clinical workshops refreshed basic emergency obstetric and newborn care (BEmONC) skills of health workers. District health managers and facility in-charges participated in leadership training and led facility-based quality improvement, supervisory, and planning initiatives. Training and mentorship on data management and use promoted Health Management Information Systems (HMIS) capacity. Orientations and MNCH-planning reinvigorated Health Facility Governance Committees. Training, supervision, and mentorship encouraged strong networks of volunteer CHWs who conducted home visits, assessed and triaged pregnant mothers and newborns, provided health education, and mobilized their own groups and communities for innovation, health, and income-generating activities.



1,000,000 people living in catchment communities

Implementation in **2 districts**

107 rural health facilities equipped

Major infrastructure upgrade to **4** health facilities

1,664 CHWs trained

850 facility governance committee members oriented

1,556 hamlets with CHWs

479 health providers trained

75,356 health facility deliveries during project period

Best Practices

Foundational Factors for System-Wide Health Improvement

Embeddedness: Align with programs and policy; Cascade activities from district to facility to community levels; Promote district leadership for all activities; Leverage existing structures and systems

Comprehensive: Use a whole system approach; Implement district-wide

Self-Reliance: Foster local solutions to local needs; Be resourceful and "use what you have"; Apply participatory facilitation

Collective Action: Ensure meaningful, all-level, and broad engagement; Promote a shared and unified goal; Cultivate constructive relationships and teamwork

Transparency: Clearly communicate expectations and roles

Engage District Leaders

Implement Throughout Entire District, Not Piecemeal: Promotes ownership and sustainability

Promote District Leadership: In planning, conducting, and monitoring all activities

Align with Pre-Existing District Structures and Processes: Incorporate planning timelines and tools, HMIS processes, and supportive supervision guidelines

Invest in Leadership Capacity Development: Foster readiness amongst Council Health Management Team members and health facility in-charges

Strengthen Supportive Supervision: Build capacity for constructive and positive supervision visits and programming

Strengthen Health Facilities

Use Hands-On Simulation Training: Use scenarios and lifelike mannequins to provide clinicians refresher training and encourage practice of emergency skills, thus promoting competency, confidence, teamwork, and positive facility culture

Employ Peer-to-Peer Learning: Train and provide tools for clinicians and staff to serve as mentors and partners, sharing knowledge, skills, and debriefing with confidence

Strengthen Facility Services Broadly: Invest in infrastructure, equipment, supplies, training, community linkage, and governance committees to reduce risk of gaps

Provide Clinical Mentorship: Use local mentors to support primary health providers through positive and focused visits and feedback

Use a Quality Improvement Approach: Promote creation of simple and focused facility action plans that reflect on available data and take a "use what you have" approach

Promote Healthy Communities

Ensure Transparent and Broad CHW Selection: Engage local community leaders and health facility staff; Ensure clear expectations, basing criteria on national guidelines and added community priorities

Encourage CHW Income-Generating Activities: Provide tools to CHW teams to promote savings/loans groups or small businesses which may keep volunteers motivated and together

Prime Facilities for Increased Service Use: Equip and prepare facilities to manage increased demand for services (e.g. antenatal care, deliveries) once CHWs are mobilized

High-Density CHWs: A high ratio of CHWs (i.e. one per hamlet) allows CHWs to reach all households and facilitate a manageable volunteer workload

District-Wide Networks: CHWs across a whole district (not piecemeal) enables a district-led network ready for district and community action

CHW Teams: Organize CHWs into teams that report together to a health facility-based supervisor providing peer support to strengthen linkages with facilities

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