**Proposal for Maternal and Child Healthcare Programme Effectiveness Evaluation: John Taolo Gaetsewe (JTG) District in Northern Cape Department of Health**

**Northern Cape Department of Health**

**Research and Development Unit**

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**Acronyms**

CARMMA Campaign on the Accelerated Reduction of Maternal Mortality in Africa DCSTs District Clinical Specialist Team National Committee on Confidential

DHIS District Health Information System

DHS Demographic and Health Surveys

HIV Human Immunodeficiency Virus

HST Health System Trust

JTG John Taolo Gaetsewe

MCH Maternal and Child Health

MDGs Millennium Development Goals

NDoH National Department of Health

MRC Medical Research Council

NCCEMD Enquiry into Maternal Deaths

SDH Social Determinants of Health

UNDP United Nations Development Programme

UNICEF United Nations Children's Fund

WHO World Health Organization

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**Proposal for Maternal and Child Healthcare Programme Effectiveness Evaluation: John Taolo Gaetsewe (JTG) District in Northern Cape Department of Health**

1. **Executive Summary**

Under the Millennium Development Goals (MDGs), adopted by the international community in 2000, countries committed to accelerate the reduction of maternal and child mortalities. The MDGs 4 and 5, in particular, stated to reduce child and maternal mortality by 2/3 and 3/4 respectively between 1990 and 2015. South Africa is one of the signatory countries committed towards reaching the MDGs by 30 September 2015. In South Africa, to achieve these goals, strengthening of the entire health system has been considered as one of the vital steps to provide high quality and accessible healthcare services to these more vulnerable groups of the society. Consequently several bold steps in order to improve maternal and child health outcomes have been taken, and it is also reported that, since the MDGs, the average health status of these groups have been showing improvement. However, according to the Demographic and Health Surveys (DHS) report, while the average health status of the population as indicated by life expectancy at birth has been generally improving, there are some important exceptions. For instance, in John Taolo Gaetsewe (JTG) district, the maternal and child mortality rates are unacceptably higher than that of the national averages. Yet, to date there has not been a systematic study that aims to identify the root causes of the challenges and to make recommendations on appropriate programme based intervention strategies tailored to the district’s specific challenges.

To close the gap and improve maternal and child health outcomes, the Research and Development directorate together with relevant programme units of the department and stakeholders envisaged to conduct a facility-based survey to evaluate the effectiveness of maternal and child health of programme in John Taolo Gaestsewe district. The primary objective is to assess and identify the root causes for high maternal and child mortality incidences, and to make recommendation on ways for better health outcomes in the district. To this end, research questionnaires for different respondent groups in the district have been developed. To administer the questionnaire, 383 sample respondent mothers attending six- weeks immunization services for their infant’s will be consecutively sampled at each facility using a random probability proportional to size sampling technique based on the number of children who used the six-weeks immunization services in 2013/14 financial year. The interview will assist to evaluate their knowledge, attitude and practices related to safe pregnancy and child care, as well as assessing service utilization rates and their satisfaction level with the antenatal care, delivery and postnatal care services (six-weeks) they received in public health facilities. In addition to this, focus group discussions will be held. For each focus group discussion key informants will be selected from women who have not accessed reproductive health care, women who have experienced abortion and teenage pregnancies, health care service providers and traditional birth attendants. Observation on particular activities will be done by physicians and nurses, who are part of the study team.

The outcome of the study will assist the department to have a better understanding of the factors which are responsible for the high rates of maternal and child mortality and the key problem areas within the health system and subsequently improve the maternal and child health outcomes, achievement of national and provincial targets as well as reducing avoidable health disparities in the district. The estimated period for conducting the proposed research is about six months, starting from September 2014. Financial support for the study, Forty Nine Thousand Rand (R49, 000) is obtained from Priority Health Program Chief Directorate budget of comprehensive HIV/AIDS grant fund.

1. **Background of the Research**

Given the persistently high maternal and child morbidity and mortality rates in many developing countries, including South Africa, improving the health status of these socioeconomically more vulnerable groups of the society has been Government’s top priority agenda in the past two decades (Evance, et al. 2013; UNICEF, 2008; WHO, 1997). Globally, maternal and child health issue is one of the major concerns as reflected in the Millennium Development Goals (MDGs) declaration as indicated by various global and national commitments and targets (UNDP, 2000; Beltman, Stekelenburg & van Roosemalen, 2010). The commitments include taking several bold policy steps and implementation of improvement strategies at all levels. Internationally, maternal and child mortality figures are important indicators that have been used for comparing country’s level of socio-economic development as well as to examine whether a country’s health system is responsive to the health needs of various groups of the population. Regrettably, every year many mothers and babies continue to die due to complications related to pregnancy and delivery (Evance, et al 2013); and socio-economic related avoidable health inequalities still exist (Worku and Woldesenbet, 2012; Goga et al.2012; Levenal et al., 2014).

The United Nations Children Fund (UNICEF) 2013 report indicates that despite the many encouraging and conducive policies, strategies and high coverage of maternal and child health services, every year, 4,300 mothers die due to complications of pregnancy, delivery and postpartum, 20,000 babies are stillborn and another 23,000 die in their first month of life in South Africa. In total, 75,000 children do not make it to their fifth birthday (UNICEF, 2013). However, it was reported that the mortality rate was not uniform in all provinces and health facilities. For instance, performance the Health System Trust (2013) report indicate that mortality figures in John Taolo Gaetsewe district are unacceptably higher compared to other districts within the province as well as compared with the National averages. Studies indicate that maternal and child deaths are caused by numerous factors (Levenal, et al, 2014; Bradshaw, 2012; WHO 2000; Herman et al, 1987). This include factors attributable to pregnancy, delivery, poor quality and access to health services, culture, health system and socio economic factors. As a result maternal and child mortality vary from one place to another depending on prevailing factors.

In South Africa, the delivery and management of health services has been devolved to local (district) levels. District health management is responsible for developing district’s health plans and allocation of available budgets to priority areas. John Taolo Gaetsewe district is one of the five districts in the Northern Cape Province which is sub divided into three local municipalities namely Gamagara, Ga-Segoyana and Joe Morolong. The estimated population in the district is 224 799 with the majority being blacks. Afrikaans, English and Tswana is the main three languages spoken with Tswana being the most spoken language (more 80% of the population) while Afrikaans being the second most spoken with English being the least spoken language. The district comprises of three local municipalities and 186 town and settlements of which the majority (80%) are villages, thus making the district mostly rural. Of the three local municipalities Joe Morolong is the most underdeveloped area in terms of infrastructure, roads and residential housing. The JTG district economy is based on mining and agriculture. Mining includes manganese and iron ore. Mixed farming such as cattle and sheep is the common type of agricultural activity. There is high level of unemployment and low level of education and income opportunities. There are three hospitals in the district, two public hospitals both located in Ga-Segoyana local municipality and the other private hospital Medi-clinic in Kathu (Gamagara Municipality). There are 5 Community Health Centres, 38 clinics and 5 mobile clinics distributed throughout the entire district. The district has high teenage pregnancies rate (18.7%), which is the highest in the province, high facility mortality rate (19.4%) and highest facility mortality rate under five year rate (8.5%) in 2012/13 financial year (NCDOH report 2012/13).

This study hypothesised that poor socio-economic conditions coupled with poorly functioning health system building blocks to adequately and effectively implement the maternal and child health programme is one of the causes responsible for higher maternal and child mortality rates in the district. Hence, improving the existing situation requires evidence based intervention strategies that are informed by research outputs. This study argues that through identifying service delivery gaps such as the unmet maternal and child health needs, barriers and constraints in the use of health services and then implementing improvement strategies, it is possible to reverse the current undesirable maternal and child health outcomes in the JTG district. Exploring the effective functioning of six main building blocks of the health system, such as human resources (to provide quality healthcare services and skilled attendance); financing of the health system (to adequately allocate financial resources to needed services); health services (to ensure quality and accessible maternal and neonatal health services across all levels of care, including family planning); management of the health sector (implementation of national guidelines, policy and regulatory mechanisms, and partnerships with the private sector); infrastructure and technologies (obstetric instruments, emergency referral centres linked to primary care providers, obstetric ambulances) are essential components of the evaluation programme.

However, to date there has not been a systematic study that aims to identify the root causes of the challenges and to make recommendations on appropriate programme based intervention strategies tailored to the district’s specific challenges. The Research and Development directorate together with a team of experts from different programme units of the department such as Priority Health Programme (maternal health coordinator), Policy and Planning, Health Informatics as well as District Clinical Specialist Team (DCST) members in John Taolo Gaetsewe district and stakeholders will work together to conduct maternal and child healthcare programme effectiveness evaluation study in JTG district. The study outcome is critical for better understanding of the major causes of maternal, newborns and child mortalities and to make recommendations on ways to accelerating the reduction of maternal and child health in the district.

1. **Statement of the Problem**

The government of the South Africa has placed health, in general, and maternal and child health in particular, as a high priority in its service transformation plan and the Health Minister’s Negotiation Service Delivery Agreement (NSDA). Accordingly, the country has taken several bold steps to strengthening the entire health system in order to provide high quality and accessible health services. This has been recognised as a vital step in improving the maternal and child health outcomes in the country (NDoH, 2008). Based on this, the national Department of Health (NDoH) launched the widely endorsed strategies for promoting safe childbirth, skilled birth attendance, and timely referral for emergency care and improving the functioning healthcare system as reflected in South African's maternal and child health policy. The National Department of Health 2007 guideline for maternal care for clinics, community health centres and district hospitals indicates that maternal healthcare is one of the priority reproductive health issues that have been identified as requiring urgent attention in the country (NDoH, 2008). In 2001 South Africa started implementing a programme to prevent HIV transmission from mother-to-child. The launch of the Campaign on the Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in 2012, introduction of the District Clinical Specialist Team (DCSTs) to support districts in clinical guidance to existing staff in health facilities and commissioning of different studies on maternal and child health are some of the steps that has since been taken.

Furthermore, government’s commitment to improve maternal health is demonstrated by making maternal deaths a notifiable condition and by the formation of the National Committee on Confidential Enquiry into Maternal Deaths (NCCEMD). According to the 10th Interim report on the maternal death report in South Africa, the institutional MMR (iMMR) decreased from 176.22/100000 live births in 2008-2010 to 159.14/100000 live births in 2011 and 146.71 in 2012. Much of this reduction was mainly due to the reduction in deaths associated with non-pregnancy related infections (71.29/100000 live births in 2008-2010 to 56.32/100000 live births in 2011 and 50.21/100000 live births in 2012). The figures show the iMMR has decreased in 2011 and further in 2012 when compared with the 2008-2010 report. However, it was reported that the rate of decline was not uniform in all provinces and health facilities. For instance, the iMMR decreased for district, regional and tertiary hospitals but increased in respect of Community Health Centres for 2011 and 2012 combined (NDOH, 2013). The report also indicates that the decrease was mostly attributed to deaths due to non-pregnancy related infections, the vast majority of whom are HIV infected, while mortality due to bleeding during or after caesarean section which is rapidly increasing.

Performance reports indicate that mortality figures in John Taolo Gaetsewe district are unacceptably higher compared to other districts within the province as well as compared with the National averages. The JTG maternal mortality in facility ratio was the highest provincially at 260.5 per 100 000 live births, and much higher than the national ratio of 132. 9 per 100,000 live births. The still birth in facility rate was the highest in the Province at 28.4 per 1000 births. The inpatient early neonatal death rate increase from 5.0 per 1000 live births in 2011 /2012 to 8.2 per 1000 live births in 2012/2013 (HST, 2012/2013). Even though the non-availability of vital statistics based on good quality medical certification of the causes of death are extremely challenging (Evance, et al., 2013; Bradshaw, 2012), the reported figures for JTG district remain extremely worrying and calls for urgent attention. Yet, to date there has not been a systematic study that aims to identify the root causes of the challenges. Based on this concern and to improve maternal and child health outcomes in the district, the Research and Development directorate together with relevant programme units of the department and stakeholders proposed this research to conduct maternal and child health of programme effectiveness evaluation, particular to look at the factors that contribute to high maternal and child mortality in John Taolo Gaestsewe district.

# Objectives of the Research

* 1. **Aim**

The overall aim of this study is to conduct facility-based survey to evaluate the effectiveness of maternal and child health of programme, in particular to look at the factors that contribute to high maternal and child mortalities in John Taolo Gaetsewe district and make recommendations on ways to address the challenges and achieve better maternal and child health outcomes in the district.

* 1. **Specific Objectives**

The specific objectives of this study are:

* + 1. To assess and identify the immediate and broader root causes of high maternal and child mortality rates in John Taolo Gaetsewe district;
		2. To explore barriers to reproductive health services particularly among high reproductive health risk groups (adolescents, mothers presenting themselves late for reproductive health services, mothers who plan to deliver at home etc);
		3. To assess utilization rates of reproductive health, family planning and maternal and child health services;
		4. To explore health system challenges that hinder the provision of quality reproductive health, family planning and maternal and child health services; and
		5. To make recommendations on ways to address the challenges and improve maternal and child health outcomes in the district.
1. **Research Questions**

To achieve the research objectives, identifying the root causes and recommending innovative improvement strategies for maternal and child health programme within a policy context is therefore imperative. This in turn requires systematic data gathering and analysis to answer the following pertinent research questions which include but is not limited to:

* + 1. What are the factors responsible for variations in utilization of reproductive health services as some mothers did not receive while others did receive it?
		2. Who are high reproductive health risk group and why?
		3. What are health system challenges and constraints in providing quality and accessible health services and achieve better maternal and child health outcomes in the district?
		4. What characterises or explains mothers and infants who died during pregnancy and childbirth?
1. **Research Methods and Materials**
	1. **Research Method and Design**

A cross-sectional facility based survey among mothers who will present at their local healthcare facility for their infant’s for six-weeks immunisation (1st DTP dose) visit will be conducted at all public health facilities in John Gatesewe district. This research methodology is chosen as immunization up take at six-weeks is >99% in South Africa (WHO, 2011; Goga, et al.2012) making six–weeks immunization point an ideal catchment point for information gathering.

The research design for this study is both descriptive and high level satirical analysis of cases to explain and draw conclusions. Both qualitative and quantitative data collecting methods will be used for data gathering to answer the research questions. Accordingly the data collection methods in this research include secondary data (facility based data on maternal and child services and if possible, retrospective case review of deceased patients); in-depth interviews on health service utilization and reproduction health knowledge, attitude and practices will be collected from sample respondent mothers who are visiting Public Health Facilities for six-weeks for their infants first DPT immunisation between September and December 2014, exit interviews for mothers who have abortions or experienced a miscarriage; direct observation during antenatal care visit, delivery and post natal care; service review on supply side problems; facility assessment (inventory on condition of facilities) healthcare workers, focus group discussions (traditional births, high productive health risk groups such as teenage pregnancy and mother who do not access services).

In addition, data will be collected from different sources that include performance of health systems, the supply side constraints, the demand side unmet needs, and on the quality and accessibility of services. Data collection on health system will be organized around 6 key health system indicators drawn from WHO health system building blocks and monitoring and evaluation framework. Health facility factors include finance, human resources, equipment and supplies, treatment protocols, and essential drugs, vaccines and the infrastructure available for service delivery and governance issues. In addition to this, as maternal and child health outcomes are influenced by numerous factors that are outside the control of the health system, the study will gather information on the broader context in which maternal and health programs operate.

* + 1. **Research Population and Sample**

All women of reproductive age (refers to women aged 15–49 years) in JTG district are research population from which the sample is drown. Census 2011 used to estimate women with reproductive age in JTG and the estimated figure is about 72,000. The six-week immunisation and reproductive health utilization rate data from the 2012/13 District Health Information System (DHIS) used to quantify the number of sample mothers that could be expected within facilities over a study period of time and valid district level reproductive age mothers could be ascertained.

* + 1. **Sampling Techniques and Sample Size for Facility based Survey**

For the facility based survey a precision based sample size is calculated taking into account the expected annual utilization of reproductive health services, a design effect of 2 to account for clustering within facilities and a precision level of 2-3%; and 95% confidence level. When we put the confidence level and the confidence interval together with the estimated 72,000 study population provided a convenient sample of 383 mothers in total to assess and evaluate the effectiveness of maternal and child health programme in JTG district. All public health facilities in the district will be included and mothers attending six-week immunization services for the infants will be consecutively sampled from each facility. A random probability proportional to size sampling technique will be used based on the number of children who attended the six week immunization services in 2013/14 financial year.

* 1. **Data Collection, Instruments and Sources**
		1. **Data Sources**

Data will be gathered using a questionnaire adapted from validated tools (Zaruhi Mkrtchyan, 2007; Goga et al., 2012). The questionnaire include information on maternal reproductive knowledge, attitude and practice, socio-economic status, antenatal care, delivery and postnatal visits (six-weeks), facility performances and constraints in provision of maternal and child health services. The fieldwork for data collection will take place from September to December 2014. Data collectors will be recruited from the Community Health Care Workers. They will be responsible for clinical, socio-economic data collection, community mobilizing for group discussion and conducting of interviews. The data collectors will be provided a two-day training session in which they will familiarize with the content of the data collection instruments and the research methodology and logistics.

The following data collection methods will be used to gather the necessary information for the study.

1. **Secondary data analysis**: written materials and other documents from organizational, clinical or program records, memoranda and correspondence; official publications and reports will be reviewed. Accordingly, district level data on the maternal and child health report for the past three years will be reviewed. In addition to this, the study will include reviews of routine surveillance data; program plans and financial records; training records and list of staff trained. Program reviews will also include activities at the community level such as the availability of trained CHWs.

**2.Mother’s survey:** Mothers who are present at public health facilities for six-week immunization for the infant’s 1st DTP dose between September-December 2014 will be interviewed using a standardized questionnaire addressing women’s knowledge of maternal and child health issues and their practice. Abortion and Miscarriage at admission / exit.

**3. Exit interview:** Exit interviews will be conducted in respect of women who experience an abortion or miscarriage. This will help to obtain feedback on health worker performance and facility conditions which are important indicators that will assist to address the identified challenges and gaps in the maternal and child health programme. The interview duration will be a maximum of 30 minutes; the interview will be conducted at the facility.

**4. Direct observation of services**: A checklist of routine actions used to measure the performance of the provider during an ordinary antenatal care visit, labour/delivery and postnatal care (six-week) visit.

**5. Service review:** In each of the selected facilities, facility manager; heads of maternal and child health services, staff will be interviewed to supplement the information obtained from secondary data. Service review will include: human resource issues include availability of trained personnel, quality of training programmes and quality of follow up after training; availability of key resources and management systems; an uninterrupted supply of laboratory and other supplies; functioning management systems, a system for the collection of routine data is necessary to monitor programme performance, and 7/24 availability of maternal and child health services.

**7. Facility assessment:** routine health information on reproductive health performance from facility records will be collected. This data includes service statistics such as the number of cases seen per category; number of maternal and child deaths at the facility; number of pregnancies and births; number of vaccinations given and the number of outreach visits conducted. In addition to this, physical structure, supplies, equipment will be assessed using a checklist developed based on WHO guideline. Data will be collected through quality assessment reports, observation and interview with healthcare workers.

**8. Focus group discussion:** Ten focus group discussions will be held in different communities in JTG district. 2-3 focus group discussions will be held for each group with 12-15 people at a time. For each focus group discussion, key informants will be selected from the following ‘groups. The aim is to understand barriers not use effectively use of health facilities within their catchment areas.

(i) Women who fully or partially missed reproductive health services

The first focus group discussion will be for women who have missed one or more of the antenatal services due to many reasons. These participants will be selected from a facility based survey and from facility records.

(ii) High risk reproductive health groups

The second focus group participants include high risk reproductive health groups (adolescents, mothers who plan to give birth at home, late presenters to reproductive health, and those who plan to give delivery at home. In addition women who have unplanned pregnancies and women with a history of abortion will be included.

(iii) Traditional birth attendants.

The third focus group discussion participants will be traditional birth attendants. The aim of these focus group discussions is to understand the level of linkage between TBAs and health facility including gaps.

(iv) Health care service providers

The fourth focus group include health service providers, with particular emphasis on the supply side challenges. Participants will be selected to participate in group discussions with the assistance of Community Health Workers (CHW) and data capturers.

* + 1. **Instruments and Target Groups**

Table 1 presents a list and brief description of the instruments used in the study. All instruments are provided in the Appendix (Section 1-9).

**Table 1: Instruments and Target Groups**

|  |  |  |
| --- | --- | --- |
| **Instrument** | **Details of the instrument** | **Target group** |
| Facility document review  | Facility based maternal and child health services performance reports and documents | All facilities providing maternal and child care  |
| Mothers interview | A standardized questionnaire exploring women’ perceptions of the quality of services and their knowledge of and practices in antenatal, postpartum and infant care  | 383 mothers who present to health facilities for their infant’s six-week immunization (1st DTP dose) visit. |
| Post-abortion client exitinterview | Prior to discharge from the facility questionnaire exploring providers’ performance on family planning counselling after abortion | 10 women who underwent abortion  |
| Observation antenatal care visits | A checklist to assess or measure the performance of healthcare workers during 25 postnatal care visits | Healthcare workers |
| Observation of deliveries  | A checklist to assess or measure the performance of healthcare workers during 10 deliveries  | Healthcare workers |
| Observation postnatal care (six-weeks) visits | A checklist to assess or measure the performance of healthcare workers during 25 postnatal care visits | Healthcare workers |
| Inventory | A standardized checklist reviewing the standard minimal equipment, optional equipment, written guidelines, infrastructure, and medical supplies at the facility. | Health care facility |
| Service review | A standardized questionnaire exploring provider performance factors, with a particular focus on supply side problems  | 40 staff (nurses, midwives, GP and physicians)  |
| Focus group discussion with communities  | Focus group discussion points to explore client’s challenges and barriers to utilization of services, socioeconomic conditions, linkages, and provision of maternal and child care services.  | 10 Focus group discussion with traditional birth attendants, high reproductive health risk groups and service providers  |

* 1. **Data Entry, Management, Statistical Analysis and Interpretation**

After the data has been collected it will be entered into STATA Software for statistical analysis and interpretation of results. The study will use STATA version 13. Data cleaning will be performed to ensure data accuracy and find and correct any outliers. When needed data from different sources will be combined for further analysis.

Data analysis will include primarily descriptive statistics, (frequencies and percentages), Chisquired test of association, odds ratios statistical techniques, multilevel analysis and correlation testing. Where appropriate, data will be disaggregated by different attributable characteristics socio-economic status of respondents, by type of health facility district hospital, CHCs, Clinics, home deliveries, knowledge, attitude and practice of sample mothers. If necessary, for multilevel analysis of data, the department may require a statistician analysis support.

The outcome of the study will assist to design improvement plan for maternal and child health programme outcomes in the JTG district. In order to effectively execute the objectives of the project, the under-mentioned team members will be involved in the planning, execution and evaluation stages as well as the capturing and analysing of the data. Table two below shows different programme Units of the department that will be part of the planned Maternal and Child health programme evaluation study in JTG district.

1. **List of Research Team Members**

**Table 2: List of team members on the study maternal and child health programme evaluation in JTG district**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name**  | **Programme**  | **Project responsibility**  | **Tasks** |
| Ms Ipeleng Tihankana | Office of the Premier (Monitoring and Evaluation Unit) | Co-investigator | * Custodian of the Provincial Monitoring and Evaluation
* Have responsibilities similar to that of a PI on the project;
* Technically support the evaluation research;
* Support the final report writing on the project and publications
 |
| Mr I Barki  | Office of the Premier (Monitoring and Evaluation Unit) | Co-investigator | * Custodian of the Provincial Monitoring and Evaluation
* Have responsibilities similar to that of a PI on the project;
* Technically support the evaluation research;
* Support the final report writing on the project and publications
 |
| Mr Phemelo Matome | Stat SA | Research Team  | * Technically support the evaluation project
 |
| Dr Eshetu Worku  | Research and Development  | Principal Investigator | * Serves as the primary individual responsible for designing, the scientific integrity and administrative management of the study
* Liaise with all relevant role players in all aspects of the project and co-ordinate its implementation
* Liaise with the funder (HIV/AIDS Directorate) of the Project
* Write the final report on the Project and publications
 |
| Ms P Poloholo | Priority Programme | Co-principal Investigator | * Have responsibilities similar to that of a PI on the project;
* Support financially the research;
* Support the final report writing on the project and publications
 |
| Ms. Nyati-Mokotso | Maternal and Child Health programme  | Co-principal Investigator | * Have responsibilities similar to that of a PI on the project;
* Ensures that procedures used questionnaires are appropriate to answer the research questions;
* Arrange sources to provide information to the study
* Support the final report writing on the project and publications
 |
| Dr Ifebuzor | DCST  | Co-investigator | * Collaborate closely with the principal & co-investigators;
* Review clinical and technical issues including direct observations;
* Advise on the procedures that will be used are consistent with the MCH policies and guidelines
 |
| Mr. B Mashute  | Research and Development | Co- investigator | * Collaborate closely with the principal and co-principal investigators;
* Responsible for certain day-to-day management of the project;
* Supervise data capturers;
 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name**  | **Programme**  | **Project responsibility**  | **Tasks** |
| Ms Y Nowell | Research and Development | Administrative Support | * Synchronization of the administrative and logistical activities of the project
* Acquire information from Health Facilities
* Maintain records of informed consent
* Collating and capturing of the data
 |
| Ma M Kaotsane | GTG district health manager | Co-investigator  | * Collaborate closely with the principal and co-principal investigators
* Arrange sources to provide information critical to the study;
* Assist in recruitment of data collectors and research participants;
* Provide support to data capturers and study group members
 |
| Mr L Wababa | Policy and planning  | Co-investigator | * Collaborate closely with the principal and co-investigators;
* Ensures the quality and integrity of data;
* Assist in supervision of data collectors data, filling informed consent forms
* Provide routine data necessary to crosscheck and monitor programme performance.
 |
| Ms P Ndlovu  | Health Information  | Co-investigator | * Collaborate closely with the principal & co-investigators;
* Ensures the quality and integrity of data;
* Assist in supervision of data collectors data, filling informed consent forms
* Provide routine data necessary to crosscheck and monitor programme performance
 |

# 8. Ethical Consideration

The study will be conducted after the Northern Cape Provincial Health Research and Ethics Committee (PHREC) has approved the research proposal. Formal permission to conduct the research will be requested from the District Health manager. Questionnaires are written in English to be easily understood by respondents. Interview of the study will be conducted by Principal Investigators (PI), team of researchers from different programme units and data collectors. Respondents for the study will be randomly selected by the PI or his research assistants and data collectors. The consent form is written in English and Tswana Language. The research team will obtain verbal informed consent from each study participant (both provider and client) prior to interview or observation. Prior to obtaining verbal consent participants will be informed about the study’s objectives, the benefits and possible risks of their participation in the study, and the voluntary nature of their participation. The interviewers’ will introduce themselves and the study purpose verbally and a copy of the participant information sheet will be given to the participant for her/ his record. The informed consent is brief and highlights the purpose of the study and why the research participants and selected. After the participant understands the purpose of the study, expectation from the research, the protection of privacy of information, and the long and short term benefits, he/she will be requested to sign informed consent for the study. If the respondent feels discomfort he/she can withdraw from study. A maximum of 1 hour will be taken to complete the questionnaire. There will be also appropriate handling of the research findings (e.g. anonymous storage of data). This will insure that the study participants will not experience psychological, social, physical or economic harm. The study will pursue the same ethical procedures for focus group discussion. The PIs and the research team will provide full information about the purpose and uses of participant’s contributions about the expectations of the group and topic. Participants will not be pressurised to speak and encouraged keeping confidential what they hear during the meeting. The consent forms in English and Tswana Language are provided in Appendix (Section 1-8).

# 9. About the Research and Development Directorate

This project will be conducted by the Research and Development Directorate of the Provincial Department of Health together with a team of experts from different programme Units of the Department. The directorate is strongly dedicated to health related research and health policy relevant issues. In the past three years, the unit has provided a good number of operational research outputs and research experience is one of the strengths of this application. The current research areas at the Unit include, equity in health and health care, unit costing of delivery of health care, pharmaceutical expenditure experiences, universal health care financing, Prevalence and service utilization challenges among Men who have Sex with Men (MSM); Out sourcing vs Insourcing. The Unit is keen in working in partnership with national and international funding partners to build on the existing research capacity and came up with policy recommendations to address the health related problems of the Province. In this research, the Research and Development Directorate will develop questionnaires and discussion points for research participants, facilitate all logistical arrangements to conduct the research and write a summary report to the funding unit, HIV/AIDS, TB, and STI grant fund manager.

There will be no conflict of interest. The professional judgment concerning a research will not be unduly influenced by an interest such as personal, academic, political or financial gain.

Individual participants will only be given refreshments and meals during the group discussion session.

# 10. Significance of the Research and Expected Result

The information obtained from this maternal and child health programme evaluation in JTG district will be used to assess the quality of maternal and child health services in JTG district. The study is very important and it will help us to understand the current status of the maternal and child care in in the district and provide recommendations for its improvement. As a result we expect accessible and quality maternal and child health services will be improved irrespective of the socioeconomic status. Improvement in public health facilities not only benefits the poorest women to use services because of access but also empower in reproductive health issues.

1. **Budgetary Consideration and Time Framework**

## Budget

The HIV Conditional grant will be funding this project. Forty Nine Thousand Rand (R49, 000) is obtained from Priority Health Program Chief Directorate budget of comprehensive HIV/AIDS grant fund.

* 1. **Time Framework**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Activity  | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
| April | May | June | July | August | Sept  | Oct | Nov | Dec | Jan | Feb | March |
| Revision of proposal  |  |  |  |  |  |  |  |  |  |  |  |  |
| Finalization of method |  |  |  |  |  |  |  |  |  |  |  |  |
| Training of field assistances |  |  |  |  |  |  |  |  |  |  |  |  |
| Data collection |  |  |  |  |  |  |  |  |  |  |  |  |
| Data entry  |  |  |  |  |  |  |  |  |  |  |  |  |
| Analysis of data |  |  |  |  |  |  |  |  |  |  |  |  |
| Report writing |  |  |  |  |  |  |  |  |  |  |  |  |
| Report Submission  |  |  |  |  |  |  |  |  |  |  |  |  |
| Writing articles |  |  |  |  |  |  |  |  |  |  |  |  |
| Publication  |  |  |  |  |  |  |  |  |  |  |  |  |

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1. **Annexes**
	1. **Questionnaire**
	2. **Consent Form**