Context: The maternal mortality ratio for Tanzania is one of the highest in the world at 556/100,000 (Tanzania DHS, 2016). The Mara Region of Tanzania has a high non-facility birth rate at over sixty percent. Barriers to accessing rural health care facilities for antenatal care and delivery include lack of human resources, lack of supplies, large distances and cost and lack of transport, lack of knowledge of the risks of non-facility births, cultural beliefs about avoiding care, unofficial costs of delivering at facilities (to buy supplies), negative attitudes of health providers, and women’s low status in the family limiting their decision-making power.

Research Purpose: To increase maternal health through improving access to health care facilities by enhancing the role of community health workers to deliver multiple interventions.

Methods: Phase 1: Community and Policy Maker consultations on the barriers for women to access health care services at delivery. Phase 2: Community and Policy Maker consultations on possible solutions Health Care Provider Workshops to improve attitudes towards women. Phase 3: Multiple Baseline Trial introducing 3 interventions sequentially over 3 month periods in 4 divisions of Rorya District. The 3 Delays:

Delay 1: Gender issues limiting women’s value and power
Delay 2: Socio-cultural Barriers and Taboos preventing access to care in health facilities
Delay 3: Costs of Facility Delivery

Interventions: GENDER AND SOCIO-CULTURAL COMMUNITY DISCUSSIONS (CHW led village discussions)
TRANSPORT INTERVENTION (provides free transport for delivery)
CHW HEALTH EDUCATION AND DELIVERY OF BIRTH KITS WITH MISOPROSTOL
HEALTH CARE PROVIDER WORKSHOPS (to address negative health care provider attitudes towards women)

The 3 Delays: Factors delaying access to care:

1. Gender issues limiting women’s value and power
2. Socio-cultural Barriers and Taboos preventing access to care in health facilities
3. Costs of Facility Delivery (to buy supplies)

Factors delaying access to care:

1. M-health quantitative data on baseline use of family planning methods and uptake of methods, works flows of CHWs and stock monitoring of family planning items.
2. Qualitative data will be from focus groups with women, men, CHWs, nurses and policy makers.