OMB Clearance Request

A Sustainability Assessment of Community-based Interventions in Northwestern Tanzania

Supporting Statement A

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Project Officer:

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A. Justification

1. Circumstances Making the Collection of Information Necessary

Empowerment and capacity building have been promoted by the Bamako Initiative as integral steps in making Primary Health Care (PHC) services universally available. These Health Sector Reform programs within Ministries of health, including Tanzania, have built on the Bamako Initiative since the early 1990s, drawing attention to the potential for community engagement in health services and health governance through mechanisms such as Community Health Funds. In many contexts, community-focused approaches have been used to promote maternal and infant health, and community well-being.

In Tanzania, a community-based approach to improve maternal and newborn health (MNH) and reduce preventable maternal and perinatal deaths was implemented by CARE (also known as Cooperative for Assistance and Relief Everywhere, Inc.) with CDC support from 1997-2002, called the Community-Based Reproductive Health Program (CBRHP). The CDC staff was involved in providing technical support to CARE-Tanzania.

No OMB number is available from the previous work done with CARE-Tanzania on the CBRHP because the funding for the project came from the Woodruff Foundation, a private source of funding in which no taxpayer money was involved and therefore did not need OMB clearance. In addition, the CDC staff provided technical assistance to the Country office in which the projects were funded and implemented, such was the case with CARE-Tanzania.

This approach used a community-based surveillance system to identify preventable deaths during pregnancy, during the perinatal and newborn period, and developed a community mobilization program utilizing community volunteers to assist women and families with obstetrical emergencies to get to functioning health facilities. Specifically the initiative focused on increasing capacity (e.g., involving women, responding to needs of pregnant women, decision making by consensus) of community members to identify and participate in decisions and strategies for providing health care services, and supporting prevention and health education through village health workers (VHWs). The CDC technical assistance was specifically provided in community mobilization activities and on-going assessment of these activities.

Evaluation of this effort showed that the community members used the services successfully and supported their volunteers, but only a handful of these communities had programs in place that were functional at the end of the project in 2002.

Since the end of project activities, the long-term sustainability of CBRHP community-level efforts has not been assessed. An opportunity to apply for grants through the CDC-Georgia State University Initiative (GSU) was presented to CDC staff and GSU faculty, purpose of which was to foster collaboration between these institutions. This applicant's grant was successful in obtaining funds to conduct a sustainability assessment.

Assessment of sustainability is critical for promoting community mobilization within the health care sector in resource poor settings such as northwestern Tanzania and places where CARE, CDC, and other organizations work. Little data exist on the issue of long-term viability of community efforts and this project will inform the discussion about sustainability of health-focused programs. This will be one of the few projects that will examine long-term impact of programs in which CDC has provided technical assistance in collaboration with CARE-Tanzania at the community level. Data from this project will be useful for future programming efforts at CDC and organizations we work with in the future.

This data collection is authorized under Section 301 of the Public Health Service Act (42 U.S.C 241), see Appendix A.

2. Purpose and Use of the Information Collection

The aim of our proposal is for a multi-partner collaboration between CDC, GSU, and CARE to do a follow-up examination of the community mobilization approach used by the CBRHP from 1997 to 2002, to learn about the acceptance, relevance and sustainability of this approach in rural Tanzania. We want to identify successful/sustainable approaches in community mobilization and to identify reasons for lack of success, and incorporate these ideas and methodologies into CARE Tanzania's health sector programs and strategies. Lessons learned from this project will be applicable to future public health programs and research in which long-term sustainability is an explicit consideration.

The CDC staff in collaboration with their partners, share the findings of this assessment with others by making presentations and developing manuscripts for publication in the scientific literature.

3. Use of Improved Information Technology and Burden Reduction

We recognize that use of technology could facilitate data collection, processing, and use; however it is difficult in this context to use computers for data collection purposes. This data collection will not involve the use of sophisticated automated, electronic, or technological collection techniques because this type of technology and people trained to use these technological tools are not available in the rural environment where the villages are located. We do plan to use tape-recorders for focus group interviews.

The brief paper survey will be administered by trained field staff and then entered into a computer system at the headquarters in Dar-es-salaam. Focus group interviews will be transcribed and translated into English and transcripts will be formatted for analysis.

4. Efforts to Identify Duplication and Use of Similar Information

There are no similar data available which could be used to evaluate the long-term sustainability of Community Based Reproductive Health Program (CBRHP) in Tanzania. Literature searches (e.g., Social Science Index, PubMED, CORES Website, and published

articles/books) have yielded a handful of studies focusing on sustainable programs and these are not done within the context of rural Tanzania or community context. There are no known data available that assess the sustainability of CDC-CARE efforts. Our proposal is one of the few projects that will explore the potential impact of programs implemented by CDC in collaboration with other agencies, particularly, programs that work at the community level.

5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this study.

6. Consequences of Collecting the Information Less Frequently

This data collection is a one time study and the majority of respondents will be interviewed only once. Village leaders will be interviewed once and facility staff will be interviewed twice, based on their availability to participate in individual and/or group interviews. These data will provide information about long-term consequences of working in communities on specific programs and this information will be useful for informing program that are intended to produce long-term/sustained change. Without these data, we will continue to work with assumptions without evidence about sustainability of public health efforts.

There are no legal obstacles to reduce the burden.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

There are no special circumstances and this request fully complies with the regulation 5 CFR 1320.5.

8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside The Agency

A. 60-day notice published in Federal Register on February 17, 2006, Volume 71, Number 33, Pages 8586-8587 (see attachment in Appendix B.). Responses to these comments were provided in a letter and that letter appears in Appendix C.

Comments from Ms. Jean Public were the only ones received in relation to the notice and these are provided verbatim below:

> sorry, i think priority should be given by cdc efforts to wiping out ill health in baltimore, newark nj and other pockets of poverty in america. the bush administration has pushed poor people in america to new lows since he focuses on helping rich people. i do not think that cdc has enough budget or time to focus on both and i think american cities deserve priority.
> we should be helping american citizens and when we find illegal immigrants here, we should be sending them to their own home countries to get any help they need there.

the cdc is overextended. it has no funding nor time effort or employees to do the world. it should concentrate on straightening out america first.

b. sachau
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florham park nj 07932

B. We have consulted with CARE-Atlanta staff who are involved in other such initiatives to seek their advice and with the Georgia State, a co-partner in this assessment of the ongoing public health effort. CARE-Tanzania staff and Tanzania Health Ministry staff have also provided consultation, they support this project recognizing its importance to their public health efforts and also recognizing such information is not available through other means. Below is a list of individuals consulted in developing this project:

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District Medical Officer
Missungwi District
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Dr. Kaniki
District Medical Officer (Acting)
Kwimba District
Ministry of Health

Mr. Samson Kagwe
Community Development Officer
District Economist
Kwimba District

9. Explanation of Any Payment or Gift to Respondents

There will be no payment or gift to respondents.

10. Assurance of Confidentiality Provided to Respondents

The CDC Privacy Officer has reviewed this submission and determined that the Privacy Act is not applicable. Respondents will be speaking from their roles in the village (resident, leader, health worker, or health facility staff member), not as individuals. Respondents will not be asked for any personal health information nor will any personal identifiers be maintained in study records. The unit of assessment is the village, not the individual. The appropriate village representatives will be identified by local CARE-Tanzania staff and village health workers.

However, because the identity of each respondent may be known to the interviewer during the interview or focus group, procedures to maximize respondent comfort have been implemented. These include obtaining consent from village leadership as well as consent for individual respondents, and informing respondents that the interviewer or focus group moderator will not record their name in the interview notes.

Maternal health indicator data for each village will be abstracted by project staff from the existing records kept by the Zonal Medical Records Office. No personal identifiers are on these records.

Identifiable information will not be collected from individual respondents. All data collected will be treated in a secure manner and will not be disclosed, unless otherwise compelled by law. The data that will be collected will be maintained in locked cabinets and once entered into the computer will be maintained in a password protected files. The data will be accessed by authorized personnel at CARE, CDC, and GSU.

CDC has determined that this activity does not require IRB review approval.

11. Justification for Sensitive Questions

Respondents will not be asked sensitive questions. The same or similar questions were asked in the initial follow up surveys conducted by CARE-Tanzania during the earlier phases of CBRHP.

12. Estimates of Annualized Burden Hours and Costs

A. Estimated Annualized Burden to Respondents

There are several forms that will be used to conduct this assessment. First, we have a Community Assessment Survey (Appendix D) that is designed to collect information from the 20 villages and 10 persons per village representing various aspects of the village life. Participants will be asked these questions and it is expected that it will take approximately 1 hour to do this activity. Second, key informant interviews, 2 per village, will be conducted with village leaders using the key informant interview guide (Appendix E). It is expected that it will take about 45 minutes to conduct these interviews. The key informants are people in leadership positions at the village (e.g., Village Chairman) and are the decision makers. Third, group interviews will be conducted with the village health workers using the VHW open-ended interview guide (Appendix F) and these are expected to take ½ hour each. Fourth, a short discussion is planned with the facility staff and the content of this discussion is open and it is expected that about each health facility staff will be consulted for about ½ hour on two occasions once before the assessment and once after to debrief them on the process, a common courtesy observed in these communities. A discussion guide with health facility staff will be used (Appendix G). All the data forms will be revised with input from our partners, including the Ministry of Health staff.

The hour burden was estimated from consultation with project staff who is involved in conducting similar activities in Tanzania and with direct review of the data collection instrument and based on staff experience with similar efforts. The staff at CARE-Tanzania is involved in conducting multiple surveys in village similar to the target areas and their previous experiences with conducting surveys and qualitative data collection at the community level provided guidance to the investigators.

Table A .12-1: Estimated Annualized Burden Hours

Type of Respondent	Form	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
Villagers	Community assessment Survey	200	1	1	200
Leaders	Key-informant interview guide	40	1	45/60	30
Village Health Workers	Village health worker open ended interview-guide	44	1	30/60	22
Facility Staff	Facility staff guide (1 pre-assessment and 1 post-assessment)	15	2	30/60	15
Total		299			267

B. Estimated Annualized Cost to Respondents

We consulted the World Fact Book: (http://www.cia.gov/cia/publications/factbook/geos/tz.html) to learn that the per capita income in Tanzania is $700.00 per year. These estimates are derived from a broad range of work experiences and we've applied this to estimate the costs in Table B. Most of the people in the community are farmers. We took the 700 per capita income and divided it by 12 to estimate monthly income and from that daily and hourly income to come up with a figure of about $0.36 per hour for the farmers, then we multiplied that estimate to come up with $0.50 per hour for the leaders as they usually have more land and income. The VHW's are usually farmer we used the $0.36 per hour estimate for them. In terms of the facility staff, we know that they are paid approximately $1000 per annum, so using their income scale we come up with a cost of approximately $0.55 per hour.

Table A. 12-2: Estimated Annualized Costs to Respondents

Type of Respondent	Total Burden (in Hours)	Hourly Wage Rate	Total Respondent Costs
Villagers	200	$0.36	$72
Leaders	30	$0.50	$15
Village Health Workers	22	$0.36	$7.92
Facility staff	15	$0.55	$8.25
Total			$103.17

13. Estimates of Other Total Annual Cost Burden to Respondents and Record Keepers

No additional cost to respondents.

14. Annualized Cost to the Federal Government

The project is fully funded by the CDC-GSU Initiative and the costs incurred are those of investigator time and those who are consulted on a regular basis. Method used to estimate the cost to the Federal Government was the hourly wage, of the CDC-employees involved with the project, multiplied by the number of hours the investigator is expected to spend on the project activities in the field and then back at the office examining data and writing up reports.

Table A. 14: Estimated Annualized Costs to the Government

Individual time	Grade	Time	Cost incurred ($)
Indu Ahluwalia, PhD Epidemiologist	13	400 hours	$18,396
Tom Schmid, PhD Senior Evaluator	14	8 hours	$ 446
Ms. Suzianne Garner	14	80 hours	$ 4,004
Travel to Tanzania			$7740
Administrative/Research Costs			$4850
Total			$35,436

For the purposes of conducting this assessment, the investigators at CDC were awarded a grant totaling $29, 980 for a period of two years. These funds are in addition to the estimated costs presented in Table A.14.

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

Project Time Schedule

Activity	Time Schedule
Assessment/data collection	One month after OMB approval
Transcribing qualitative data	Three months after OMB approval
Data analysis/synthesis	Six to seven months after OMB approval
Presentations/report writing	Eight to ten months after OMB approval
Papers submitted for publications	Twelve to eighteen months after OMB approval

17. Reason Display of OMB Expiration Date is Inappropriate

Display of OMB expiration date is not inappropriate.

18. Exceptions to Certification for Paperwork Reduction Act Submissions