2015:4 Sida Decentralised Evaluation

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External evaluation of the Amref Health Africa Project on Sexual Reproductive Health Rights for the Young People (Tuitetee – Lets Fight For It), 2010- 2015

Final Report

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Commissioned by the Embassy of Sweden in Zambia

Date of final report: January 2015

Published by Citat 2015

Art. no. Sida61834en

urn:nbn:se:sida-61834en

This publication can be downloaded from: http://www.sida.se/publications

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Abbreviations and Acronyms

Amref	African Health Africa
ARHSP	Adolescent Reproductive Health Service Programme
ASRH	Adolescent Sexual and Reproductive Health
ARV	Anti Retro Viral (drugs)
DAC	Development Assistance Committee
CCHP	Council Comprehensive Health Plan
CEDAW	Convention on the Elimination of all forms of discrimination against women
CSOs	Civil Society Organizations
CSW	Commercial Sex Workers
DMO	District Medical Officer
DSW	Deutsche Stiftung Weltbevoelkerung
EAC	East African community
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FP	Family Planning
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
HRBA	Human Rights Based Approach
ICDP	International Child Development Programs
IEC	Information, Education and communication
IDU	Intravenous Drug Users
LGBT	Lesbians, Gay, Bisexual and Transgender
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Rate
MOHSW	Ministry of Health and Social Welfare
MOEVT	Ministry of Education and Vocational Training
MOLYD	Ministry of Labour and Youth Development
MSM	Men having Sex with Men
NGO	Non Governmental Organization

OECD/ DAC	Organization of Economic Cooperation and Development/ Development assistance Committee
PLHIV	People Living with Human Immunodeficiency Virus
RCH	Reproductive and Child Health
RFSU	The Swedish Association for Sexual Education (Riksförbundet för Sexuell Upplysning)
SADC	Southern African Development Community
SEK	Swedish Krona
Sida	Swedish International Development Cooperation Agency
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health Rights
STI	Sexually transmitted Infections
TAT	Technical Advisory Team
TZS	Tanzanian Shilling
VCT	Voluntary Counselling for HIV and Testing
USD	United States Dollar
YFSRH	Youth friendly Sexual and Reproductive Health
YPLHIV	Young People Living with Human Immunodeficiency Virus

Preface

This end-of-project evaluation of the Swedish support to the Amref Health Africa Project on Sexual Reproductive Health Rights for the Young People (Tuitetee – Lets Fight For It), 2010- 2015 was commissioned by the Embassy of Sweden in Tanzania, through Sida's framework agreement for reviews and evaluations.

Indevelop carried out the evaluation from November 2014 to January 2015. The independent evaluation team included Bernt Andersson, Team Leader and member of Indevelop's Core Team of Professional Evaluators, Shamshad Rehmatullah as Human rights and Evaluation expert, and Ian Christoplos who provided Quality Assurance. Sarah Gharbi was the Project Manager with overall responsibility for managing the implementation and the evaluation process.

This report was circulated in draft form to the Embassy of Sweden in Tanzania and Amref Health Africa and their comments have been incorporated into the final report.

Executive Summary

Introduction
This is an end-of-project evaluation of the Swedish support to the Amref Health Africa Project on Sexual Reproductive Health Rights (SRHR) for the Young People (Tuitetee – Lets Fight For It), 2010-2015. The current project is one of a multitude of projects, studies, surveys and interventions to improve Adolescent or Youth Friendly Reproductive Health services in Tanzania during the last 15 years.

The project is implemented by Amref Health Africa. Initially the project was to run for three years from December 2010 to October 2013, but has been extended up to September 2015 to provide space for a phase-out period and enhance sustainability. The project is closely aligned to the plan for implementation of the National Adolescent Reproductive Health Strategy for 2011-2015.

The overall objective of the project is to promote Sexual and Reproductive Health and Rights and access to sexual and reproductive health services among 100 000 young people in the Iringa and Dar es Salaam regions. The project is working with four major strategic components to achieve the overall objective:

- Advocacy and Policy
- Youth Friendly Sexual and Reproductive Health (YFSRH) services (strengthening of two youth friendly model service centres, one in Iringa and one in Dar es Salaam),
- Capacity Building (for supporting and setting up youth friendly services, directed to peer educators in and out of school, district planners, health providers, school teachers and community based civil society organizations (CSOs)),
- Health Systems Strengthening (supporting the health system regarding service provision, human resources, information system and leadership and governance).

The project is targeting young people in two municipalities of Kinondoni and Ilala in Dar es Salaam and one in Iringa region.

The purpose of the evaluation was to review and analyse the project's relevance, effectiveness, efficiency, sustainability and impact and identify possible lessons

learned, and recommendations for modification/improvements in design and methodologies used[1]. The evaluation adopted a human rights based approach.

The data collection phase took place in November 2014 during approximately three weeks of field work in Dar es Salaam and Iringa. The preliminary findings were presented and discussed with the Embassy in Dar es Salaam and Amref Health Africa in a de-briefing meeting in Dar es Salaam at the end of the data collection phase.

Findings

The evaluation has found that the strategic components of the project design are logical and well conceived and correspond to Tanzanian policies for youth friendly sexual and reproductive health services. The results framework has served the project well in monitoring project activities and for the annual progress reports. However, the project would have benefitted from some more work in defining and formulating the outputs and outcomes of the project.

The project applies a human rights perspective as it is non-discriminatory in taking into account the needs of special groups such as vulnerable groups (young people living with HIV, the deaf) and key populations (men having sex with men, commercial sex workers, and lesbians), both girls and boys. The project interventions have been participatory as the rights holders and the wider community such as parents, teachers, community leaders and health service providers have been involved in the project activities. Capacity of duty bearers has been built to be accountable to the rights holders in terms of provision of youth friendly services, albeit with some challenges of resource constraints. Although services are provided, accountability to young people as rights holders is not evident from the documents and from interviews.

The specific objectives have been largely achieved. The target for awareness raising will probably be reached within the extended project period. The number of visits to YFSRH services has increased, which is an indicator of demand for services.

The municipality councils in Iringa, Kinondoni and Ilala have increased their own resources for provision of friendly sexual reproductive health services for young people. The target of providing youth friendly SRH services in at least 30% of the existing health facilities has only been reached in Iringa municipality. Overall, the achievement is 9% of health facilities in the three targeted municipalities providing

[1] Amref TOR for final evaluation TUITETEE 29 September

YFSRH services. The services in the government health facilities do not fully meet the standards set by the Ministry of Health and Social Welfare[2].

Capacity building has been conducted for the provision of services as well as on raising awareness on sexual and reproductive health and rights. The target for number of service providers, peer educators and school teachers trained has been largely achieved. Training packages have been developed and used. Organizational capacity building of youth led CSOs has been conducted with good results.

The overall objective of the project has been reached. The awareness and demand for YFSRH services has increased and the target of reaching 100 000 young people has been exceeded in each of the three last years. It should however be noted that there are approximately one million young people in the three targeted municipalities.

The project was found to be highly relevant for the rights holders and addressed the identified problems related to SRHR of young people and specific needs of vulnerable groups such as young people living with HIV, the deaf and of the key population groups mentioned above, through the youth led organizations composed of and/or representing these groups. By successfully implementing technical assistance, capacity building and models of youth friendly services, the project has been highly relevant also for the duty bearers.

The evaluators found that the project design was highly relevant in relation to the Tanzanian policies and strategies concerning sexual and reproductive health, specifically for adolescents. The implementation of the project built on the national strategies and guidelines and the national curriculum were used for the training. The project design and implementation have also been in line with applicable Swedish strategies for development cooperation and in particular regarding the cooperation with Tanzania.

As for the gender relevance, the project proposal and the in-depth Assessment Memo by the Embassy of Sweden assess the general context of the situation of SRHR in Tanzania from a gender and rights perspective. The baseline study has a gender analysis. Apart from the baseline, there is no other document providing a comprehensive analysis of women's practical needs and gender interest, or how to promote girls/women participation in health programs. The project objectives are not gender specific. Despite that , the project interventions have ensured equal gender representation in activities and access to YFSRH services. Gender disaggregated data for beneficiaries reached is provided but inconsistent.

[2] Standards for Adolescent Friendly Reproductive Health Services. Ministry of Health 2005

Regarding the spending, the individual budget allocations are assessed as relevant in relation to the designated activity as per the costed activities in the work plans. The trainings have been carried out in a cost-effective way. Institutional arrangements and project management were found to be lean and efficient.

Positive impact reported by the rights holders include improved access to YFSRH services and living a healthier life, protecting oneself and avoiding risk behaviour were consistently reported by young people.

Through the efforts of the project and in collaboration with the municipal councils, there were at the time of the evaluation, 31 health facilities in the three municipalities providing youth friendly sexual and reproductive health services. Capacity building through advocacy and planning meetings has created an awareness among municipality officers of the need to provide YFSRH services.

The project had a sustainable impact in changing awareness, behaviour and care seeking of a considerable number of young people in the three targeted municipalities. Structures to continue the activities in those municipalities or to scale up the activities to other municipalities are not deemed to be sufficient. Service provision at the current level, quantitatively and qualitatively, may continue for some time, but is not deemed to be sustainable without further support, in spite of the considerable capacity building by the project at municipality and health facility level, on how to plan, budget, set up, run and support the services. Limited funding from the national budget will prevent the expansion of services to other health facilities.

The training created sustainable impact on the persons trained as well as in developing training packages, but financial conditions for continued training are currently lacking at the municipal level.

Although there is a plan for scaling up of youth friendly services in the National Adolescent Reproductive Health Strategy for 2011-2015, progress is slow. And the decreasing health budget is not likely to promote progress for a national scale-up of YFSRH services. The prevailing challenges together with poor track record of implementing youth friendly services during the last decade and lack of financial resources lead the evaluators to believe that there will be no scale-up of the services within (or beyond) the targeted municipalities.

Recommendations

- Activities regarding increasing quality, accountability and sustainability are included in the Project Exit Plan and it is strongly recommended to Amref Health Africa that all activities detailed in the Exit plan that can possibly be implemented until the end of the project, in fact are implemented, and that implementation is closely monitored by Amref,
- Future Swedish funding and Amref Health Africa programs should have gender specific goals and objectives and distinguish between girls and boys. Their

different needs should be analysed as well as power relations between girls and boys, such as power to negotiate safe sex, economic dependency and patriarchal attitudes,

- The supported municipalities should make every effort to continue to provide the YFSRH services and scale-up to all their health facilities,
- The government of Tanzania has all the knowledge, policies, strategies and guidelines necessary for a nationwide scaling up of youth friendly SRH services. It is recommended that the government prioritize resource allocation to accelerate the implementation of the National Adolescent Reproductive Health strategy for 2011-2015,
- Wider learning within Amref Health Africa should be enhanced through documentation of best practices, lessons learned and success stories from the project as suggested in the Exit plan. These documentation should be widely distributed by Amref Health Africa to all stakeholders of SRHR in Tanzania and elsewhere,
- The Amref Health Africa internal knowledge management system should be strengthened to be less vulnerable to turn over of staff,
- Future advocacy and programming for YFSRH services by the Embassy and Amref Health Africa should continue to support the current and future National Adolescent Reproductive Health Strategies,
- The Embassy of Sweden should seek ways to continue to support young people through youth led organizations, in the project supported municipalities and elsewhere within the programming of support to the new priority area of entrepreneurship.

1 Introduction

1.1 BACKGROUND

In Tanzania, young people face significant sexual reproductive health challenges such as limited access to youth friendly services including information on sexuality and family planning. This has led youth into risky sexual behaviours resulting in high prevalence of sexually transmitted infections (STIs) and HIV prevalence, early pregnancy and vulnerability to delivery complications resulting in high rates of death and disability. The National Demographic Survey of 2010[3], shows that maternal mortality ratio (MMR) is still high at 454/100 000 live births. A total of 23% of women aged 15-19 have started childbearing, while 44% of them were either mothers or are pregnant with their first child by the age of 19.

Having a sexual orientation other than the heterosexual norm is not accepted in Tanzanian societies. Lesbian, Gay, Bisexual and Transgender (LGBT) people are not in a position to discuss their sexual orientation openly. People with a diverse sexual orientation are at risk of Gender Based Violence (GBV). Homosexuality and Men having sex with men (MSM) is a criminal act in Tanzania according to Section 154 of the Penal Code. Similarly, the health system is not responsive to the needs of LGBT persons. Health workers are not trained on these issues and people may be afraid that their privacy is not kept. LGBT issues are not discussed within the education system. As a result, LGBT people live a life within the heterosexual norms while having other sexual relationships in secret. This contributes to HIV/AIDS and sexually transmitted infections (STIs). Overall, 5.1% of Tanzanians age 15-49 are HIV-positive. HIV prevalence is higher among women (6.2%) than among men (3.8%). Stigma and discrimination against youth living with HIV and AIDS deprives them of their basic right to sexual and reproductive health and rights (SRHR) services.

Tanzania's government has ratified international and regional conventions promoting Adolescent Sexual Reproductive Health Rights (ASRHR).[4] Within the international and regional context, Tanzania has taken several steps towards enabling policies and

[3] Tanzania Demographic and Health Survey 2010. National Bureau of statistics. March 27, 2012
[4] Convention on the right of the child (UNICEF 1990), UN Convention on the Elimination of all forms of discrimination against women (CEDAW), International Child Development (ICDP) Program of Action (1994), and the Southern African Development Community (SADC) Protocol (Article 17) on child and adolescent health.

strategies in establishing friendly SRH services for the youth. SRHR is one of the key issues in the new Tanzanian Draft Constitution 2014. However, accessing these rights for the youth is a big challenge. The main constraints towards attaining SRHR are lack of education and awareness of SRHR, harmful cultural practices such as early marriages, female genital mutilation (FGM), low education levels and low income (especially among girls) that leads to risky sexual behaviour. There are limited numbers of health providers that are trained in provision of adolescent sexual and reproductive health (ASRH), as well as a limited number of health centres that provide safe and confidential services to the youth.

The current project is one of a multitude of projects, studies, surveys and interventions to improve ASRH services during the last 15 years. Some references of evidence are given in the footnote[5].

1.2 THE PROJECT

The Sexual Reproductive Health Rights for the Young People (Tuitetee) project is being implemented by Amref Health Africa from December 2010 to end of September 2015. Initially the project was to run for three years from December 2010 to October 2013, but has been extended to provide space for a phase-out period and enhance sustainability. The project is closely aligned to the plan for implementation of the National Adolescent Reproductive Health Strategy for 2011-2015.

The overall objective of the project is to promote Sexual and Reproductive Health and Rights and access to sexual and reproductive health (SRH) services among 100 000 young people in Iringa and Dar es Salaam regions. The project is working with four major strategic components to achieve the overall objective:

- Advocacy and Policy (for SRHR and YFSRH services)
- Youth Friendly Services (strengthening of two youth friendly SRH model service centres, one in Iringa and one in Dar es Salaam),
- Capacity Building (for supporting and setting up youth friendly services, directed to peer educators, district planners, health providers, school teachers and CSOs),

[5] Integrating Youth-Friendly Sexual and Reproductive Health Services in Public Health Facilities: A Success Story and Lessons Learned in Tanzania. Pathfinder 2005; Report on assessment of availability and accessibility of adolescent and reproductive health services in mainland Tanzania. A Health Facility Based Assessment. Final Report. October 2008, MOHSW; Case study. DFID Research: Support to the Tanzanian government with adolescent sexual and reproductive health. Department for International Development. 4 February 2011; Standardizing and scaling up quality adolescent friendly health services in Tanzania. Venkatraman Chandra-Mouli et al. BMC Public Health 2013, 13:579 . Published: 14 June 2013.

- Health Systems Strengthening (supporting the health system regarding service provision, human resources, information system and leadership and governance).

The project is targeting young people (girls and boys) aged 10-24 years in the Iringa (Iringa Municipality) and Dar es Salaam regions (Ilala and Kinondoni Municipalities). These include the vulnerable groups (Young people living with HIV, orphans, youth with disabilities) and the "key populations"[6] or risk groups. The Project also works closely with ministries and departments dealing with youth related issues and other stakeholders such as parents, health providers, communities and teachers. The specific objectives of the project are[7]:

1. Young people (10-24 years old) in Tanzania realised their sexual and reproductive health rights and exercised it by demanding for quality and friendly sexual reproductive health services.
2. Municipality councils in Iringa, Kinondoni and Ilala increase resources for provision of friendly sexual reproductive health services for young people in at least 30% of the existing health facilities.
3. Government, non-governmental institutions and individuals in Tanzania with access to technical support for instituting programmes for managing SRH needs of the young people.

Sida is supporting the project with Swedish kronor (SEK) 43 million (approximately USD 6.5 million) for the period 2010-2013 and an additional amount of SEK 9 million for extension of the project until end of September 2015.

1.3 THE EVALUATION

The purpose of the evaluation was to review and analyse the project's relevance, effectiveness, efficiency, sustainability and impact and identify possible lessons learned, and recommendations for modification/improvements in design and methodologies used[8]. According to the ToR, the evaluation is:

1. To measure the achievement and outcomes and to identify how SRHR project design have contributed to overall impact in promoting human rights among young people in Tanzania especially on access and utilization of SRH

[6] The term "key populations" is used in the project proposal and includes commercial sex workers, men having sex with men and injecting drug users

[7] Amref TOR for final evaluation TUITETEE 29 September

[8] Amref TOR for final evaluation TUITETEE 29 September

services, as per project proposals, available baseline information and developed results frameworks;

2. To ascertain the extent to which the goals and objectives of the project have been met, challenges observed and how they were solved.

3. To come up with recommendations on the project in terms of scaling up and suggesting ways of sustaining the project interventions.

4. Identify lessons learnt and explore potential for sustainability and scale-up of developed practices and services by Government of Tanzania at national and district level through enabling policy and economic environment.

5. Provide recommendations for improving program quality and program accountability to beneficiaries (especially young people) and contribute to wider learning within Amref Health Africa.

6. Provide information for future advocacy and programming in the area of young people's sexual and reproductive health and rights.

The evaluators have employed the OECD/DAC Evaluation Criteria in order to assess the results (output, outcome, and impact), effectiveness, efficiency, relevance and sustainability of the programme, along with the institutional arrangements. In accordance with Swedish development cooperation policies, gender mainstreaming was assessed as a cross-cutting issue.

The evaluation adopted a human rights based approach. The evaluation was conducted in a transparent manner in that young people, peer educators, sub grantees, youth led organizations, the three municipal councils and the two youth centres were involved during the evaluation through focus group discussions (FGDs), interviews, and exit surveys, whereby the objectives of the evaluation were explained by the evaluation team. The evaluators adhered to the principle of non-discrimination by including vulnerable rights holders (young people living with HIV, the deaf) and risk groups (men having sex with men, lesbians, commercial sex workers and injecting drug users) in the interviews and group discussions.

The evaluation assessed the extent to which the project design and implementation have been participatory in the sense that stakeholders have been able to participate in the design, implementation and monitoring of the intervention. The targeted group of young people, boys and girls in the project municipalities are the right holders in this project. They have the right to supportive environment, access to information, education and friendly health services, protection from all forms of exploitation, sexual abuse, assault and harassment, parent and community support, participate in planning, implementation and monitoring of Sexual and Reproductive Health and Rights (SRHR) programs. The evaluation assessed to what extent they have been heard during the project implementation and the evaluation has included methods that ensure that they are heard in the evaluation through exit surveys and focus group discussions. The number of rights holders heard was however limited due to the limited

scope of the evaluation. The duty bearers in this project are the government officials at central and municipal level together with the health facility staff. The evaluation assessed the capacity building efforts directed to the duty bearers and its effects on their capacities to shoulder their responsibilities.

The evaluation questions are detailed in Annex 2 of the Inception Report. An important task for the evaluators was the collection of information from young people. A survey from a randomly selected sample from the 100 000 young people would have been the ideal method, but was not feasible due to the time frame of the evaluation. Instead, an exit survey was conducted at each of the two model health facilities in Iringa and Dar es Salaam and in two additional government health centres in each targeted municipality. The exit surveys for government facilities had to be done following introduction and approval from the municipalities and the officer in charge at the health facilities. The facilities providing YFSRH services, visited by the evaluators, selected on the basis of proximity, was therefore also selected for the exit surveys. All visitors to the YFSRH services during 2-3 days were interviewed by local research assistants. The total number of respondents was 294.

Focus group discussions with young people were conducted with students in primary and secondary schools in each of the three municipalities of Iringa, Ilala and Kinondoni .The national consultant and the local research assistants conducted the focus group discussions. The teachers were also interviewed.

Semi-structured interviews were conducted with the district medical officer and the coordinator of reproductive health in all three municipalities. 2-3 health facilities in each municipality were visited, selected by the project. At each facility, the available doctors, nurses and clinical officers providing YFSRH services were interviewed in a group session. The evaluators also interviewed project staff, Amref Health Africa officials and the program officer at the Embassy of Sweden in Tanzania.

The data collection phase took place in November 2014 during approximately three weeks of field work in Dar es Salaam and Iringa. The preliminary findings were presented and discussed with the Embassy in Dar es Salaam and Amref Health Africa in a de-briefing meeting in Dar es Salaam at the end of the data collection phase.

1.4 LIMITATIONS

The Terms of Reference are very much forward looking (according to four of the six expectations listed on page 6 of the ToR). The evaluation has addressed the forward looking evaluation questions within the scope provided by the evaluation, but could not engage in extensive information gathering and analyses of, e.g., the extent of commitments from central government to maintain and scale up this type of programme in the future.

Several of the meetings that the evaluation team had requested, included those with bilateral and multilateral donors and ministries, could not be arranged during the time

of the field visit, although the evaluators extended their availability for an additional period of two weeks. The main reason being that the relevant people were not available.

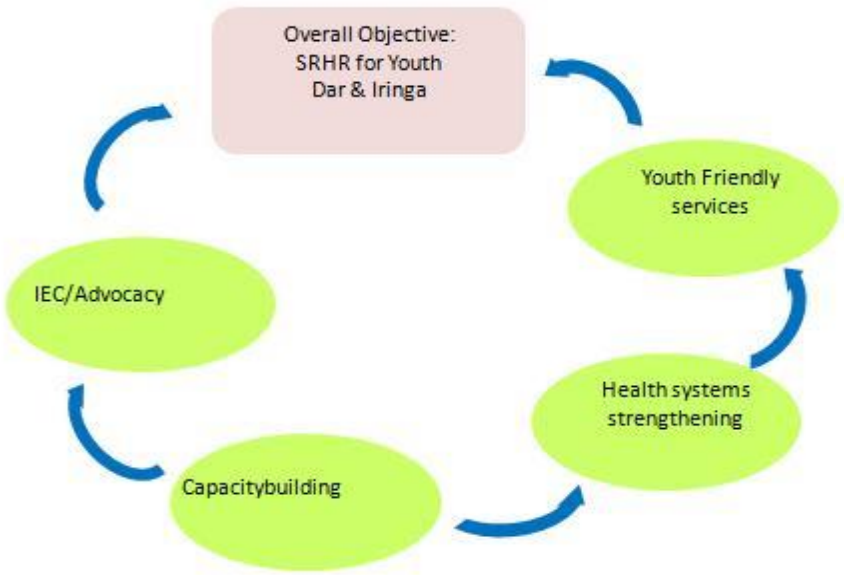
The overall time frame for the evaluation limited to some extent the team's ability to conduct focus group discussions and/or interviews with all sub-groups of beneficiaries and stakeholders.

2 Findings and Analysis

2.1 PROGRAM DESIGN

The project strategy
The project has defined four strategic components to achieve its overall objective as shown in the following figure.

Figure 1: Project strategies



The four strategic components of the programme, as described above, give an insight into the intended *theory of change* of the project. Better sexual and reproductive health for young people will be achieved through advocacy interventions directed to them as rights holders and by providing youth friendly SRH services. Capacity building will be provided for health service providers and planners as duty bearers to increase quality and access to the youth friendly SRH services. Capacity building will also be provided on advocacy to strengthen this capacity among stakeholders and CSOs. To increase sustainability, health systems will be strengthened both at the service provision level and at the level of planning and development. The institutional framework will be strengthened through policy analysis and development.

The Results Framework
Specific objective one deals primarily with the information, education, communication (IEC) and advocacy activities. The objective is that "young people (10-24 years old) in Tanzania will have realised their sexual and reproductive health rights and exercised them by demanding for quality and friendly sexual reproductive health ser-

vices". This objective also includes a component of support to revising Tanzanian policies on SRHR.

Specific objective two is about improvements of the youth friendly services at the two model centres and at government health facilities, including outreach activities, road shows, debates and edutainment (music/dancing, sports, drama, community theatres). This specific objective also includes a training component of municipality structures in provision of quality, friendly and sustainable SRH services for young people. Also included in this specific objective are activities related to the strategic component of health systems strengthening, mainly support to integrate youth friendly services in existing health facilities.

Specific objective three is primarily concerned with the capacity building strategic component by developing training programmes regarding youth friendly SRH services, both for the demand side (training of peer educators, school teachers and CSOs to build awareness among young people) and for the supply of services (district planners and health providers).

The overall objective is summarizing the specific objectives one and two about creating awareness and providing youth friendly sexual and reproductive health (YFSRH) services.

There are two outcomes defined under each specific objective. A great number of activities are detailed under each specific objective. A number of additional outcomes are added in the Indicator Reference Sheet and outputs are referred to in the progress reports.

A total number of 22 indicators are defined by the project[9]. The indicators are described in detail including definition, calculation method and source of information. The evaluators have made some re-arrangements of the indicators to fit more logically to the objectives and outcomes of the project.

Human Rights Based Approach

The project design builds on human rights principles, building the capacity of the rights holders to demand their SRHR, and of duty bearers for provision and to be accountable to the rights holders. The problem statement and rationale for the project clearly states that the main focus of the proposed project is on the SRHR of young people, numerating all the rights associated with SRHR. The project proposal provides a stakeholder analysis showing main stakeholders and their focus, which in-

[9] Amref -CDC II Indicator Reference sheet 2012-2013

cludes 10-24 years old young people including the most vulnerable (YPLHIV and disabled youth) and what the project document refers to as key population groups (commercial sex workers, men having sex with men and injecting drug users). Stakeholders also include health care providers, health managers, planners and policy makers and communities and parents including guardians, teachers and local leaders.

According to the project proposal Amref Health Africa made a number of consultations with the National Coordinator for Adolescent Sexual and Reproductive Health Services at the Ministry of Health and Social Welfare (MOHSW); contacted municipalities in Kinondoni and Iringa; discussed with medical officers in charge for Mwanayamala and Iringa hospitals to ensure they are part of development of the project design and/or the program. The project also involved relevant stakeholders in the start-up workshop to orient all partners, councils, regional and national officials on the project components and implementation strategies.

There is evidence of engagement and participation of stakeholders during the project intervention stage in terms of capacity building through workshops, trainings, IEC materials development, and lobby with policy makers for allocation of funds for SRH services for youth. Discussion forums were held in communities with parents, community leaders, community development officers, health care providers, youth and teachers. Youth and communities were involved in the outreach activities.

The baseline assessment revealed that the health facilities in the three municipalities had limited mechanisms of ensuring involvement of young people in the provision of reproductive health services that are friendly as per their own perception. The rights of adolescents to monitor the quality of ASRH services provided in the three municipalities was limited and health facilities assessed did not allow adolescents participation in monitoring the quality of the ASRH services provided. They were however involved in the development of information-, education- and communication material that was later produced and distributed.

Summary

The strategic components of the design of the project are logical and well conceived and are lined to and follow Tanzanian policies for youth friendly SRH services. The theory of change is logical, clear and easy to understand and seems to have been very useful in defining the project specific objectives and outcomes.

The results framework has served the project well in monitoring project activities and for the annual progress reports. However, not enough work seems to have been done to better define and formulate objectives, outputs and outcomes of the project, including gender specific objectives.

The project is non-discriminatory as it takes into account the needs of vulnerable groups (young people living with HIV, the deaf) and risk groups (commercial sex workers, men having sex with men, injecting drug users), both girls and boys. The project interventions have been participatory where stakeholders and the wider community such as parents, teachers, community leaders and health service providers

have been involved in the project activities. Capacity of duty bearers has been built to be accountable to the rights holders in terms of provision of YFSRH services.

2.2 EFFECTIVENESS

2.2.1 Specific Objective 1: Young people (10-24 old) in Tanzania realised their sexual and reproductive health rights and exercised it by demanding for quality and friendly sexual reproductive health services

Specific objective 1 deals primarily with the IEC and policy component and is focused on mobilization of young people to understand their sexual and reproductive health and rights and participate in discussions and sessions of sharing information and experiences. The project works with a number of IEC activities like open forums, youth group discussions, entertainment, sports events, etc. to reach young people.

The baseline study[10] found that youth in the three municipalities (Ilala, Kinondoni and Iringa) had incomplete information and knowledge on how to protect themselves from STIs and HIV/AIDS. It also showed that most youth know or consider use of condoms as a main way a girl or a boy can protect themselves from contracting STI and HIV/AIDS. Being faithful was not considered to be a favourite way of protection.

Insufficient information and knowledge can be explained by the fact that youth do not have enough sources of correct SRH information in the communities. Findings from youth interviewed indicated that there were no places in their community that young people could visit and talk and find information about relationships, sex, contraception, sexually transmitted infection, HIV/AIDS, etc.

Outcome 1.1 Increase realization of SRHR among young people
This outcome is focused on IEC activities and the project started in 2011 with consultative meetings to identify and develop IEC material. The consultative meetings included government officials, teachers, health workers CSOs and young people. An advocacy strategy was developed. Materials were then produced and distributed at various events, including calendars, posters, t-shirts, caps, school bags, leaflets and brochures. At the youth centres, discussion forums were held with young people, parents and young people with disabilities. The project is collaborating with youth CSOs to advocate for SRHR and participated in sports events and youth days. The activities of the CSOs receiving grants from Amref Health Africa are described more in detail

[10] Baseline Assessment Report Ilala, Kinondoni and Iringa Municipalities. October 2011

under objective 3. The indicators in the table below measure the achievement of this outcome. Some of the original targets have been revised by the project after the mid-term evaluation in 2012 and some again in 2013. The original target is shown within parenthesis in the table below.

Table 1: Indicators and achievements for Outcome 1.1

Indicator	Baseline	Achieved September 2014	Revised Target	Achievement (%)
Number of young people reached with correct SRHR messages through edutainment during Bonanza, health talk and forums	0	281 942	(100 000) 275 266	102.4
Percent of young people with correct knowledge on SRHR and responsibilities	0	No data	90%	No data
Number of young people reached by trained peer educators on SRHR	0	60 443	(26 469) 52 449	115.2
Number of IEC materials developed, tested, produced and distributed	0	1 753 422	(1 684 468) 2 323 859	75.5
Number of AEJAT[11] awards supported (Journalism award)	0	2	3	66.7
Number of TV/radio sessions on SRHR conducted and aired	0	16	(18) 22	72.7

The indicators show good achievements and the project seems to be on track to reach the targets of the indicators. In the mid-term evaluation, data for the first indicator in the table above was disaggregated with specific information about numbers of deaf people, MSM, YPLHIV and CSW reached (total 1 721). The project data base has not recorded information about this since the log frame did not specify that this should be done.

The major factors influencing the achievement of the outcome is the outreach activities, the wide distribution of IEC materials, training of peer educators in schools through direct training of primary and secondary school pupils and teachers, and out of school youth through youth led organizations and sub-grantees. Collaboration with

[11] Annual Excellence Journalism Award Tanzania

the media has raised awareness and educated the youth and communities through printed and electronic media.

There have been some communication challenges with the deaf although some service providers have been trained on sign language. Since SRHR education is not part of the school curriculum, there have been challenges of finding space and time to teach the pupils. Commonly encountered challenges by peer educators were reported to be related to the retention of peers and high turnover rate, lack of maturity, skills, and knowledge to respond to challenges from their peers or the community, inadequate IEC materials and poor linkage with health services.

This has been tackled by the project by providing some incentives to the peer educators, improving the supply of IEC materials and condoms, and involving peer educators in project planning, implementation and mobilization of young people. Meetings with key stakeholders – parents, teachers, health workers, and religious leaders – have also contributed to supporting peer educators activities.

Outcome 1.2 Increased demand among young people for SRH services
The baseline study found, although the number of respondents is small, that about half (41%) of young people visiting health facilities in the past three months for SRH services did not wish to return to the same health facilities because of lack of privacy at the facility (83%), mistreatment by staff (53%), and too embarrassing (97%). Other reasons included time and distance. These factors have been addressed by the project, primarily through training of staff and by increasing the number of health facilities offering YFSRH services. There has been some follow-up of about young peoples' perception of the services during the supervisions, but this has not been part of the project's M&E system and information has not been systematically collected and analysed.

One of the purposes of the IEC activities directed to young people is to encourage them to demand and use SRH services. An increased demand for these services is an indicator of effectiveness of the IEC work. The project monitoring and evaluation (M&E) system collects quantitative data by age groups and sex for the number of visits to YFSRH services at health facilities and at outreach. The following table shows the number of visits to the YFSRH services in the supported health facilities.

Table 2: Number of visits at YFSRH services per year

Municipality	Oct 2011- Sept 2012			Oct 2012 - Sept 2013			Oct 2013 - Sept 2014			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Mwanan-yamala	978	2137	3115	2089	3533	5622	3563	4883	8446	6630	10553	17183
Kinondoni	10866	26470	37336	25338	57203	82541	35859	78196	114055	72063	161869	233932
Ilala	9046	12687	21733	13668	21464	35132	32085	20460	52545	54799	54611	109410
Umati	21695	17591	39286	16681	16187	32868	15896	11650	27546	54272	45428	99700

Municipality	Oct 2011- Sept 2012			Oct 2012 - Sept 2013			Oct 2013 - Sept 2014			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Iringa	23171	24059	47230	28308	40016	68324	25009	36429	61438	76488	100504	176992
Total	**65756**	**82944**	**148700**	**86084**	**138403**	**224487**	**112412**	**151618**	**264030**	**264252**	**372965**	**637217**

The table shows an increase from 2011/2012 to 2013/2014 for both males and females (the number of women accessing SRHS outweighs that of men). There are two main explanations to the increase, the awareness and demand created and the availability of youth friendly services, a clear indication that the project strategy has worked. In the project document, the indicator for this outcome is percent of young people utilizing SRHR services, with a baseline of 19% and a target of 60%. This is analysed in Chapter 2.2.4 as part of the achievement of the overall objective. Please note that all activities related to the support and conducting the SRH services fall under Objective 2 below.

The health facilities' information systems do not capture whether patients belong to the key population groups as defined above. However, interviews conducted with these groups and with service providers consistently show that they do utilize the services and that they are welcomed. The challenges for the provision of YFSRH services are analysed in the next chapter.

Working with media

From the outset Amref Health Africa organized a project orientation for about 92 media people in Dar es Salaam and Iringa for purposes of collaboration with the media in public awareness rising on SRHR issues, advocacy and behaviour change in the project areas. The media people included news editors, writers, photographers, presenters and programmers from blogs, radio, television and newspapers and magazines, The objective was to build capacity of journalists on SRHR issues and on reporting of SRH issues in the media.

The Media Council of Tanzania introduced a special category for adolescent reproductive health in the Annual Excellence Journalism Award Tanzania (AEJAT). Two best writers in print and electronic media are awarded each year. A media orientation workshop in supporting annual excellence in journalism awards of Tanzania 2012/13 was organized on 17 December, 2012 and a special training workshop in reporting on SRHR issues was conducted for the journalists on 17 December, 2013. Training of media people and keeping the SRHR for young people as a standalone category in the annual journalist's award worked as an incentive for journalists to write about and cover SRHR issues/news.

The media also reported from education events, bonanzas[12], etc. organized by the project. For example, on 9 June, 2012 Ebony FM covered the bonanza in Iringa; Mtanzania (Swahili daily) reported on the bonanza in the paper on 21 June, 2012. Amref and UMATI team had an one hour session on SHRH issues on 12 August, 2012 on Ebony FM. In 2013, Amref Health Africa conducted 3 live discussions on radio and television and 4 recorded discussions for advocacy agendas that the project is striving to achieve. Additionally there were a number of television sessions in 2013 and 2014.

There has been an increased number of journalists writing about SRHR issues for young people. More than 5 articles were picked for the 2012 award reported on SRHR issues. More than 25 articles featured in various newspapers and more than 10 sessions on SRHR were reported on television and radio in Iringa and Dar es Salaam. Issues covered and discussions included policies affecting young people, the situation of ASRH in Tanzania, reporting methodologies and ethics[13].

Policy documents reviewed

Messages and key information from young people was used to identify policies that should be developed or reformed with support from the project. According to the project document, key policy issues should be identified, an advocacy agenda identified and the project should work with MOHSW and others to ultimately change the policies. The indicator tracking sheet has some indicators that measures some of the activities of the advocacy plan for reviewing policies as included in the table below.

Table 3: Indicators for the activities regarding policy documents reviewed

Indicator	Baseline	Achieved September 2014	Target[14]	Achievement (%)
Number of policy brief forums conducted	0	8	6	114.3
Number of people participating in lobbying sessions for young people inclusion in community council health planning	0	562	100	562

[12] A ”bonanza” in Tanzania mostly refers to a sports event that creates an opportunity to meet and have fun

[13] Annual Progress Reports and Newspaper articles

[14] These are the original targets

Number of policy guidelines reviewed	0	1	3	33.3

One policy is in the process of being reviewed with support from the project. Support is provided to the MOHSW on the review of the National Policy Guideline on Reproductive and Child Health. A consultant was selected to conduct the actual work of updating the policy under coordination by the MOHSW Reproductive and Child Health Unit. A proposal from the consultant is currently being reviewed by the ministry.

Summary

Specific objective number 1 has been largely achieved. The indicators of Outcome 1.1 indicate that the outcome on awareness raising will probably be reached within the extended project period. It is shown that the number of visits to YFSRH services has increased, indicating that Outcome 1.2 on the demand for YFSRH services has also been reached. However only one of three policy reviews is being conducted.

2.2.2 Specific Objective 2: Municipality councils in Iringa, Kinondoni and Ilala increase resources for provision of friendly sexual reproductive health services for young people in at least 30% of the existing health facilities

Specific objective number two is defined in the Project document as providing sexual and reproductive health services at the model youth centres and at least 30% of the existing health facilities in those municipalities. Two outcomes have been defined, one about increased resource allocation for SRH services in the municipalities and one about strengthening the services at the two model centres.

Activities related to non-clinical youth friendly services, such as Information, Education and Communication (IEC) activities directed to young people, road shows, using a road show van, and other edutainment activities are reported under this objective in the progress reports. The evaluators find that these activities contribute mostly to Specific objective 1 and Outcome 1.2 which is increased demand among young people for SRH services. The IEC activities are therefore evaluated under Outcome 1.2 above.

The other group of activities reported under Specific objective 2 is youth friendly services, both the services provided at government health facilities (Outcome 2.1) and at the model youth centres (Outcome 2.2).

Outcome 2.1 Increased resource allocation for SRH services for the young people in municipalities

Main activities for achieving this outcome have been advocacy meetings with municipal officers and youth organizations and participation in health planning meetings for the development of Council Comprehensive Health Plans (CCHP). Resource alloca-

tion is measured by the project as budget allocations for YFSRH services by the municipalities. This is reported by the project to have increased in the budget 2014/2015 (from zero before the project) to TZS 20 million in Iringa, to TZS 21 million in Kinondoni, and it remained at TZS 4.5 million in Ilala.[15]

Officials of the three municipalities confirmed that the budget for providing YFSRH services has increased. The actual release of funds is often less than the budget, but the figures on actual spending could not be provided. The increase of resources is evident as there is a substantive increase in the number of government health facilities providing YFSRH services. The evaluators also learned that costs for human resources have increased when services to youth are provided after normal opening hours at the health facilities. Since the costs for human resources are not included in the ministry of health budget, no figures could be provided. The following indicators are defined to measure the activities for achievement of this outcome in relation to the original targets.

Table 4: Indicators for Outcome 2.1

Indicator	Baseline	Achieved September 2014	Target	Achievement (%)
Number of consultation meetings for resource allocation conducted	0	16	9	177.8
Number of advocacy meeting to advocate for deployment of social workers	0	7	7	100

Both of the two indicators measure activities and not the outcomes and are not clear proxy indicators for measuring the outcome. However as shown above, the three municipalities have increased resources allocated to providing YFSRH services.

The many consultation and advocacy meetings, involving young people, and their participation in the council comprehensive health planning meetings, mobilized by the project, were cited by project staff and district medical officers (DMOs) as having contributed to the awareness and resource mobilization for youth friendly services. A challenge hindering the implementation in more heath facilities was the budget limitations.

[15] Amref Proposal for cost extension

Outcome 2.2 Two model centres strengthened for offering quality youth friendly SRH services according to national standards[16]

Two model youth centres one in Dar es Salaam and one in Iringa, were renovated and furnished in 2011. The centres are providing youth friendly SRH services and other SRH related activities as well as providing sports facilities and have a resource centre with computers. Non-clinical services or outreach services include IEC activities, road shows, debates and edutainment and are intertwined with the advocacy activities under Objective 1. Clinical services include STI-management, voluntary counselling and HIV testing (VCT); family planning services (FP) and referral services. The services are under the responsibility of the Mwananyamala Hospital and Iringa Regional Hospital and their staff. The model centres also provide psychosocial counselling.

Table 5: Indicator for Outcome 2.2

Indicator	Baseline	Achieved September 2014	Revised Target	Achievement (%)
Number of model centres renovated and providing SRHR services to young people including vulnerable young people (activity indicator)	0	2	2	100

This indicator is defined to be an activity indicator in the project log frame. The indicator is input focused and is not really useful as an indicator. Although the project does collect data for the services provided, both for the quantity (i.e. what population they serve, disaggregated for male and females, as an indicator for outcome 1.2 – see Table 2) and the quality (i.e. to what extent they are youth friendly) of services through the supervisions – see the following pages.

Problems with Umati Youth Centre in Iringa were not captured by the indicator. The report from the supportive supervision in November 2014 reports that YFSRH services are dormant with the exception of the information resource centre. All the health care providers trained or oriented by the project have left the centre. The only clinical officer working at the centre has not been trained, although he has been there for 3 years. The supervision report concludes that the centre is not at all functioning as a model for YFSRH services in the municipality. The problems were explained by Amref Health Africa as stemming from the absence of a coordinator at the centre for

[16] Standards for Adolescent Friendly Reproductive Health Services. Ministry of Health 2005

the last 6 months. The situation at Umati youth centre demonstrates poor commitment from Umati as a duty bearer to provide the services. The central management of Umati was not available for an interview by the evaluators.

The definition of specific objective number 2 includes that 30% of government health facilities should provide YFSRH services. This has been calculated by the evaluators. There are a total of 344 operational government health facilities in the three municipalities targeted by the project[17].

Table 6: Percentage of government health facilities providing YFSRH services 2014

Project municipalities	**Total number of operational government health facilities**	**Health facilities with YFSRH services**	**%**
Ilala	187	9	5
Kinondoni	143	11	8
Iringa	14	11	79
Total	**344**	**31**	**9**

About 9% of government health facilities provide YFSRH services supported by the project. In Iringa the project is supporting almost all of the government health facilities (79%). The percentages in Ilala and Kinondoni fall both far short of the target of 30%.

Quality of YFSRH services
Key Standards as defined by the Ministry of Health[18] are:

1. All adolescents are able to obtain sexual and reproductive health information and advice relevant to their needs, circumstances and stage of development.
2. All adolescents are able to obtain sexual and reproductive health services that include preventive, promotive, rehabilitative and curative services that are appropriate to their needs.
3. All adolescents are informed of their rights on sexual and reproductive health information and services whereby these rights are observed by all service providers and significant others.
4. Service providers in all delivery points have the required knowledge, skills and positive attitudes to provide sexual and reproductive health services to adolescents effectively and in a friendly manner.

[17] MOHSW Online Health Facility Registry. December 2014
[18] Standards for Adolescent Friendly Reproductive Health Services. Ministry of Health 2005

5. Policies and management systems are in place in all service delivery points in order to support the provision of adolescent friendly sexual and reproductive health services.
6. All service delivery points are organized for the provision of adolescent friendly reproductive health services as perceived by adolescents themselves.
7. Mechanisms to enhance community and parental support are in place to ensure adolescents have access to sexual and reproductive health services.

For each of the standards, criteria have been defined and have been used for the supportive supervision tool that the project developed and used for supervision of the health facilities receiving support from the project. Some important criteria for well-functioning YFSRH services are that the services are provided by specifically trained staff and separately from other services, providing privacy and confidentiality for young people. STI medicines, HIV test kits and family planning commodities should be available and there should be IEC material to read and to take home. The health facility should be conducting regular outreach to the community and have good working relations to the trained peer educators. The supervision reports show that:

- Many health facilities do not have separate rooms and/or waiting areas for youth friendly services, nor do they provide privacy and confidentiality
- There is often a shortage of service providers that have been trained in YFSRH services because of transfers, although normally there is at least one trained provider
- STI medicines and HIV test kits are not always available due to inadequate supply
- IEC material is most often available, although not always for taking home
- Outreach services are not regularly conducted at several health facilities, in some instances due to lack of funds
- Most health facilities have good links to peer educators

In summary, the supervision reports reveal that the management and staff of the health facilities are aware of the demand for YFSRH services and are struggling to provide the services, within the financial, logistical and organizational limitations of the public health system. The Mwananyamala model youth centre is distinguished in providing YFSRH services in accordance to all the criteria. Factors contributing the good results at Mwananyamala are the location of the project office there, the financing from the project and the close supervision and collaboration and interaction between the youth centre and the project staff.

An exit survey was conducted by the evaluation team in order to provide another indication of the quality of the youth friendly services. The survey was conducted at the two youth centres and at two government health facilities providing youth friendly services in each targeted municipality. The results of the survey are summarized in the following table.

Table 7: Summary of results from the exit survey

Questions	**Agree** (%)	
	Females	Males
I am satisfied and I achieved the purpose with my visit here today.	98.3	96.6
The staff was very friendly and respected me.	98.3	96.6
I did not wait a long time before I was attended to by a nurse/clinical officer	96.6	95.0
They responded to my questions so that I clearly understood	100.0	95.0
I have good access to reproductive health services when I need it.	82.9	84.9
I have good knowledge of sexual and reproductive health issues	89.1	90.8
I understand and use contraceptive methods that prevent HIV and STDs	83.4	87.4

The table shows a very high degree of satisfaction with services, for most questions above 90%. The only notable difference between females and males is the responses to the fourth question about understanding the service providers. Females agreed to 100% and males to 95%, although satisfaction is very high for both females and males.

Summary

The municipality councils in Iringa, Kinondoni and Ilala have increased their own resources for provision of friendly sexual reproductive health services for young people. The services are provided in 2 Youth centres, strengthened and managed by the project and in 11 health facilities in Iringa (80% of the existing health facilities) , in 11 health facilities in Kinondoni (8% of the existing health facilities) and in 9 health facilities in Ilala (5% of the existing health facilities). The target of providing youth friendly SRH services in at least 30% of the existing health facilities has only been reached in Iringa municipality. Overall, the achievement is 9% of health facilities in the three targeted municipalities providing YFSRH services. The services in the government health facilities do not fully meet the standards set by the Ministry of Health and Social welfare.

2.2.3 Specific Objective 3: Government, non-governmental institutions and individuals in Tanzania with access to technical support for instituting programmes for managing SRH needs of the young people

Specific objective number three is about providing skills to health care providers and about developing training programs for peer educators, district planners, health providers, school teachers and CSOs. The 2013 Progress report is mainly about the

grants from Amref Health Africa to nine CSOs and their activities. The Progress reports 2013 also report on capacity building activities directed to target groups (youth led CSOs, teachers, parents, in and out of school youth, marginalized youth including commercial sex workers, men having sex with men, homeless youth and orphans). Training packages are reported to have been developed and tested, to be used for training of social workers, service providers, school teachers and CSOs.

Outcome 3.1 Increased numbers of health care providers skilled in provision of quality and friendly SRH services to young people aged 10-24 years

The main activities during 2011 – 2014 have been to train service providers, nurses and clinical officers, as well as school teachers and peer educators, in the provision of youth friendly sexual and reproductive health services. The following indicators have been defined in the Indicator tracking sheet, to measure activities and outputs for this outcome:

Table 8: Indicators for Outcome 3.1

Indicator	Baseline	Achieved September 2014	Original Target	Achievement
Percent health care providers trained and have knowledge and skills on SRHR programs and YFS, disaggregated by cadre and sex[19]	0	172	150	115%
Percent peer educators trained and have knowledge and skills on SRHR programs and YFS, disaggregated by cadre and sex[20]	0	591	800/600[21]	74 %/99 %
Number of school teachers trained and have knowledge and skills on SRHR programs and YFS, disaggregated by cadre and sex	0	251	250	100%
Number of health care providers (medical) addressing SRHR who	0	172	229	75 %

[19] The project reports the number of trained providers and the percentage in relation to the target.
[20] The project reports the absolute numbers
[21] Target was revised to 600 in 2013

Indicator	Baseline	Achieved September 2014	Original Target	Achievement
are skilled and knowledgeable				
Number of service providers (non-medical) who are skilled and knowledgeable	0	484	238/539[22]	203 %/90%

The original targets for the training were considered to be not fully realistic and were revised in 2013. The targeted number of trained peer educators and school teachers has been reached and 75 % of the target for medical service providers has been reached.

Outcome 3.2 Institutionalized training program made available along a calendar year to cover various packages addressing friendly services for young people and vulnerable group's particularly young people living with HIV and young people with hearing disabilities.
The following indicators have been defined in the Indicator tracking sheet, to measure the achievement of this outcome:

Table 9: Indicators for Outcome 3.2

Indicator	Baseline	Achieved September 2014	Target	Achievement (%)
Number of institutionalized training packages developed	0	3	3	100
Number of youth led organizations and CSOs trained on organizational development	0	39	40	98
Number of local organizations (sub-grantees) supported to address SRHR services for young people	0	8	9	112
Number of Council Health Management Team members, District planners, health facility in-charge oriented on SRHR, TFS and rights based approach	0	136	130	104

[22] Target was revised to 539 in 2013

The three training packages developed are a Youth Centre Counselling Training Manual, a Parent Child Communication Guide and a manual on Comprehensive Sexual Education for Young People. Training material such as power point presentations and hand-outs has been prepared for each of the manuals/guides. The development has been a combined effort with Ministry of Health and Social Welfare (MOHSW) and Ministry of Education and Vocational Training (MOEVT) and builds on the national curriculum for YFSRH. The materials have been used in the various training activities conducted by national trainers and supported by the project, i.e. training of peer educators, training of school teachers and training of health care providers. Experiences from using the material have been used to revise it and it has now been approved by MOHSW and is available for national trainers from all organizations. All targets for the indicators have been reached.

The evaluators were given access to a study[23] that assessed organizational capacity competence of civil society organizations (CSOs) within the project areas. A total of 9 organizations based in Ilala, Kinondoni and Iringa Municipal councils (all of them sub-grantees and part of the project) were assessed using an organizational assessment capacity tool designed by Amref Health Africa Tanzania.

The project provided training and mentorship to the organizations in the areas of governance, financial management or managerial processes (such as monitoring and evaluation), leadership and good governance, advocacy skills, proper planning, organizational structure and entrepreneurship skills.

The study found that all organizations have moved from one level of competence to another. Three CBOs (International Youth Development Programme, NYP+ and TAYOPA) moved from development or emerging stage to expanding stage, three other CBOs (CHAVITA, Adolescent Psychosocial Consultancy and ST. CAMILLUS) made outstanding movement from development or emerging to sustainability stage. Kiota Women Health Development has moved from the development or emerging stage to sustainability or mature stage.

The evaluators visited several of the CSOs (Adolescent Psychosocial Consultancy, International Youth Development Programme, CHAVITA, and Matumaini Group) who stated that they had greatly benefitted from the capacity building provided by the project.

[23] Assessment of organizational capacity competence: A case of selected community based organizations in Dar es Salaam. By Rita Mbeba

The extent to which the training packages have been institutionalized is analysed in Chapter 2.6 about sustainability.

Summary
Capacity building has been conducted for the provision of services as well as on raising awareness on sexual and reproductive health and rights. The outcome about number of service providers, peer educators and school teachers trained has been largely achieved. Training packages have been developed and used. Organizational capacity building of youth led CSOs have been conducted with good results. The objective has been achieved.

2.2.4 Overall objective: To promote the realization of Sexual and Reproductive Health and Rights and access to SRH services among 100 000 young people in Iringa and Dar es Salaam regions

The overall objective is interpreted by the evaluators as (i) being aware of and (ii) having access to YFSRH services. There are a total of 1 073 000 young people in the three municipalities[24] so the target of 100 000 young people is equivalent of reaching about 10% of the young people. Specific objective 1 covers the awareness building activities and it was found that this objective will likely be reached within the extended project period. The number of visits to YFSRH services shows an increase, indicating that the target about demand for YFSRH services also has been reached.

Specific objective 2 covers the YFSRH services. Data on the number of people visiting the health facilities providing YFSRH services has been provided by the project M&E system. The following table shows the young population and the number of new patients visiting the YFSRH services in the supported health facilities.

Table 10: Number of people reached by YFSRH services per year

Municipality	Population 10-24 years	June 2011-Sept 2011	Oct 2011-Sept 2012	Oct 2012 - Sept 2013	Oct 2013 - Sept 2014	Total
Kinondoni	400 551	1 753	29 934	64 346	93 600	**189 633**
Ilala	592 795	32	18 097	20 411	19 489	**58 029**
Iringa	79 643	0	62 936	75 848	56 069	**194 853**

[24] Population Distribution by Age and Sex. National Bureau of Statistics Ministry of Finance Dar es Salaam and Office of Chief Government Statistician President's Office, Finance, Economy and Development Planning Zanzibar. September, 2013

Total	1 072 989	**1 785**	**110 967**	**160 605**	**169 158**	**442 515**

The table shows that the target of reaching 100 000 young people with YFSRH services was exceeded in each of the three last years.

Additionally, through outreach activities, the project and the supported health facilities have reached about 2 000 young people every year, mostly for VCT and tens of thousands of youth with information about SRHR issues.

There is no data collected on an aggregated level on the access to services for people from key population groups or for the disabled, although the information from Amref Health Africa is that this is included in the data compiled by providers. It may be difficult to indicate this in the official registers due to stigma and legal issues around some of these groups. Interviews with service providers at the visited health facilities and interviews with key population groups did not indicate any discrimination against them. On the contrary, the persons interviewed from these groups informed the evaluators that they were welcomed and the support they got changed their lives for the better. However, due to lack of service providers with the knowledge of sign language, it has proven it difficult to get someone to translate the problems of the deaf people visiting health centres, which is discrimination and has posed a great challenge for this group in realizing their SRHRs.

Summary
The overall objective of the project has been reached. The awareness and demand for YFSRH services has increased and the target of reaching 100 000 young people with YFSRH services has been exceeded in each of the three last years.

2.3 RELEVANCE

2.3.1 Relevance for the rights holders

The evaluation has assessed if the project has been relevant to the specific needs of the primary beneficiaries in the project area, particularly the defined subgroups of beneficiaries of the project, YPLHIV and young people with hearing disabilities and people belonging to risk groups, or key population groups as they are defined by the project (see definition in footnote 6). This was done through review of studies and reports about the needs of young people in relation to SRHR, through FGDs with young people, exit surveys at health facilities and interviews with the Network of young people living with HIV (NYP+), TAYOPA, and young people from the deaf association (CHAVITA).

The problem statement in the project proposal mentions a number of problems facing young people in urban Tanzania. Young people are often exposed to unwanted sex (coerced or a result of physical/sexual violence), unsafe sex (without a condom to protect against HIV infection and STIs), unprotected sex (without contraceptives to prevent pregnancy), violence, unplanned and unwanted pregnancy, HIV infection and

STIs, unsafe abortion, drug abuse and other risk behaviour. The project proposal specifically mentions the following problems affecting young people that the project will address:

- Young people lack adequate knowledge and skills on sexual and reproductive health and prevention of HIV & STIs, and those who become HIV positive cannot afford timely and adequate health care services
- Women start childbearing early (15-19 years) often resulting in school drop-outs and unsafe abortion
- Acceptance of family planning is high, but use of contraceptives among young people is still low
- HIV prevalence among young people range between 0.8% among the younger ones (15-17yrs) to 4.6% for those aged 23-24 years. Young women aged 23-24 years are more than ten times as likely to be HIV-positive than young women aged 15-17
- There is little attention to sexual reproductive health needs of young people living with HIV and AIDS, and also among young people who are disabled
- Previously, young people used to receive guidance and sexual reproductive health through traditional extended families systems. As these structures are almost non-existent, many young people resort to peers and the internet as sources of sexual information

According to the baseline, non-clinical referral services like legal support services, life skills, career counselling, microfinance and entrepreneurship support are much needed by young people visiting the YFSRH service units, especially those with problems related to drug and substance abuse, GBV victims and those living with HIV/AIDS, orphans and vulnerable young people, including the disabled.

The baseline study findings further showed that 33% of health facilities assessed reported that adolescents cannot be seen without the consent of their parents or guardians. Furthermore, the rights for adolescents to monitor the quality of ASRH services provided in the three municipalities, was limited. The baseline study findings showed that 83% of the health facilities assessed did not allow adolescents participation in monitoring the quality of the ASRHS provided. Realization of ASRH rights to disabled and youth living with HIV/AIDS in the three municipalities was also limited. Young people with disabilities faced several challenges when visiting a health facility for SRHS. The findings further showed that, parents, teachers and communities' members at large were not aware of ASRH rights, and the national policy provisions for such.

The evaluation findings in November 2014 shows that not much has changed. From interviews with service providers and focus group discussions with youth Peer Educators it was evident that requiring parental consent before a young adolescent gets SRH services is still practiced and there is still little if any participation in monitoring the services. The interviews with deaf people revealed that service providers not knowing sign language is still a problem.

There was also inadequate capacities, facilities and national support framework, including the legal framework to allow efficient referral mechanisms to young people in need of non-clinical services in all three municipalities of Iringa, Ilala and Kinondoni. For example, in 2010 a total of 418 GBV cases were reported to Police in Kinondoni Municipal only, but at the end of the year there was no evidence of prosecution completed and justice accessed by the victims.

Many of the problems related above are addressed by the project. The project also addressed specific needs of the special groups such as young people living with HIV, risk groups and the deaf through the youth led organizations composed of or representing these groups. People from risk groups were provided with education on STIs and safe sex as well as entrepreneurship training, which influenced life style changes due to being economically independent and less reliant on commercial sex. There is however a lack of direct collaboration with either Human Rights or Women Rights CSOs for providing legal aid to GBV victims.

Summary
The project was highly relevant for the right holders and addressed the identified problems related to SRHR of young people and specific needs of vulnerable groups such as young people living with HIV and the deaf as well as risk groups or key population groups through the youth led organizations composed of or representing these groups.

2.3.2 Relevance for the stakeholders

There are two different groups of stakeholders identified in the project document and assessed by the evaluation :

- district planners, health facility managers and health providers (duty bearers)
- peer educators, school teachers and CSOs (mix of both rights holders and duty bearers)

The evaluators have used progress reports and interviews with the stakeholders as the sources of information for assessment of relevance.

For the first group, involved in the supply of YFSRH services, lack of capacity and skills for supporting and setting up youth friendly services in municipalities was identified in the project proposal as a big challenge in instituting and sustaining youth friendly sexual and reproductive health services in Tanzania. This has been tackled by the project by providing technical assistance and training in setting up, running and supervising as well as providing models supported by the project for youth friendly SRH services. According to the assessment in Chapter 2.3 and 2.4 above, the technical assistance, training and service provision by the project has been successfully implemented.

A problem for young people is the lack of knowledge and awareness about SRHR issues as described in the project document and detailed in the baseline study. Capacity building and technical assistance comprised of specialized training programmes have therefore also targeted peer educators, school teachers and CSOs aimed at building awareness and knowledge about SRHR issues and supporting YFSRH services for the young people. According to the assessment in Chapter 2.1 and 2.4 above, the capacity building by the project, directed to this group has been successfully implemented.

Summary
By successfully implementing technical assistance, capacity building and models of youth friendly services, the project has been highly relevant for the two groups of stakeholders.

2.3.3 Relevance in relation to Tanzanian policies and strategies

The evaluation analysed the relevance in relation to Tanzanian policies and strategies through document reviews and interviews, particularly the following:

- The National Policy Guidelines on Reproductive and Child Health (May 2003) categorically provides that in relation to accessibility of information, education and services to adolescents, health institutions and provider of health services shall not restrict or deny access to SRH information, education, and appropriate services to adolescents. All adolescent boys and girls shall have the right to protection from all forms of exploitation, sexual abuse, assault and harassment and there should be parent and community support to adolescent sexual and reproductive health.

- The National Strategy on Gender Development (NSGD) highlights the major issues of concern to gender equality, presents challenges and provides guidance on the interventions and identifies the roles of various actors and the coordination mechanisms to facilitate the participation and linkages of the various actors.

- MOHSW Standards of Adolescent Friendly Reproductive Health Facilities outlines the minimum standards of care that should guide the delivery of quality adolescent friendly reproductive health services in the country as the benchmark for the assessment, guidance and provision of quality adolescent friendly reproductive health services.

- MOHSW is implementing the Adolescence and Reproductive Health Services Program (ARHSP) under the Reproductive Health Child Unit (RHCU) and the program focuses on increasing access to HIV and sexual and reproduction health information and services to youth.

- The National Roadmap Strategic Plan to Accelerate Reduction of Maternal, New born and Child Deaths in Tanzania- 2008-2015 recognizes that high percent of adolescent are sexually active and practice unsafe sex. Consequently, a majority of them are highly vulnerable to SRH problems including adolescent pregnancy and early child bearing, the complications arising from unsafe abortions, and STI including HIV/AIDS.[25]

- The National Youth Development Policy 2007 has captured issues of concern for young people such as youth economic empowerment, employment, youth promotions, youth participation, HIV/AIDS, gender, arts and culture, adolescent reproductive health, and family life issues. It identifies five problems affecting youth as STIs/HIV/AIDS, Mental Health, Poor Nutrition, Harmful Traditional Practices, and Childbearing at an early age. The policy requires MOHSW to ensure that youth friendly health services are accessible to young people, reproductive health education is included in school curriculum and health services are made available to young mothers.

The project proposal lists a number of policy and strategy documents that existed for establishing adolescent friendly SRH services for the young people, including the ones mentioned above and additionally, the National Curriculum for Service Providers on Adolescent Reproductive Health and the Health Sector Strategic Plan III (2009-2015).

Summary
The evaluators found that the project design was highly relevant in relation to the Tanzanian policies and strategies concerning sexual and reproductive health, specifically for adolescents. The implementation of the project built on the strategies and national guidelines and national curriculum were used for the training.

2.3.4 Relevance in relation to Swedish policies and strategies

In the Assessment memo in 2010, the Embassy concluded that the project is in line with the Swedish Policy on Sexual and Reproductive Health and Rights as well as The Right to a Future, the Policy for Sweden's International HIV and AIDS Efforts. Furthermore, the project was found to be in line with Sweden's Perspectives of Poverty, that emphasises that it is vital that the ultimate stakeholders (namely the poor) are given the opportunity to participate and influence directly or indirectly, through decision making assemblies, the process of change in their societies.

[25] National Adolescent Health and Development Strategy 2004-2008

The Embassy also noted in 2010 that conclusions of the midterm review of the Swedish Co-operation Strategy for Tanzania 2006-2011 stated that Sweden should maintain and strengthen capacity for policy dialogue and support in the subsector of Human Rights, including Sexual and Reproductive Health and Rights. Furthermore, the then Swedish development co-operation policy thematic priority of gender and women's role in development focuses on 1) women's participation in politics, 2) women as economic actors 3) sexual and reproductive health and rights, including HIV and AIDS and 4) women and security, gender based violence and human trafficking.

The evaluation agrees with those assessments and has found that the implementation of the project has also been in line with those Swedish strategies.

Summary
The project design and implementation have been in line with applicable Swedish strategies for development cooperation and in particular regarding the cooperation with Tanzania.

2.3.5 Gender relevance

The Embassy´s in-depth assessment of the Project proposal
The Embassy of Sweden's in-depth assessment memo assessed the project from a gender perspective and highlighted the fact that the greatest stumbling block to SRHR is the patriarchal attitude of men towards the reproductive rights of women. A proper analysis of the male/female power construct with regard to challenges for women's SRHR is made. Accordingly, it was concluded that effective and successful prevention efforts require that respect for human rights is strengthened and gender equality is increased, and that a broad approach is needed to reach the entire population i.e. adults, young people and children.

The main conclusions by the Embassy were that the proposed project addresses key areas that intend to enhance both the gender and SRHR perspective. The project places emphasis on the fact that the existing high prevalence of HIV/AIDS among young people in developing countries, with women having a higher prevalence than men, due to their biological makeup, makes it important to widen the scope of SRHR. In this case gender relations and sexual education become important elements of behaviour and social change.

The baseline study
Amref Health Africa conducted a baseline study for the project and the report includes a gender analysis. Gender issues are addressed in the baseline in terms of intergenerational relations/sex partners, early marriages, unwanted pregnancies/unsafe illegal abortions, teenage pregnancies, sexual assault and harassment. The findings show no differences between girls and boys. Different forms of rape were reported from many of the studied communities. Sexual assault of school children (boys and girls) was also reported as another serious problem in the three municipalities.

Other issues/challenges that were found specific to girls were misconception about the efficacy of family planning methods and that it can cause infertility, as well as communication challenges whereby parents find sexual issues sensitive to discuss with their children. In Iringa, girls are married at a young age to prevent the family from shame in case she becomes pregnant. Such marriages end up exposing young girls to abusive acts and SRH problems**.** There are also challenges of parents who do not want their children (especially girls) to get SRHR education for fear that this would make them 'loose'.

The evaluation's assessment of the Amref project proposal
In the Amref Health Africa project proposal, the background and context sections identifies SRH issues that mainly affected girls (sexual abuse, GBV, prostitution, trafficking etc.) which resulted in negative SRH outcomes such as unwanted pregnancies, unsafe abortions, obstetric complications, STIs, and HIV/AIDS. With an unsupportive environment and inadequate access to appropriate services, maternal mortality, mortality due to unsafe abortion, AIDS and suicide were found to be some of the fatal outcomes among abused and exploited young girls and women.

Gender equality is however not clearly integrated in goals and objectives in the project proposal. The proposal refers to the SRHR of the youth, not distinguishing between young boys and girls. The problem statement and rationale refers to young people exposed to unwanted/unsafe sex that lead to SRH challenges but lacks gender analysis as well as an analysis of power relations between girls and boys when it comes to SRH, such as power to negotiate safe sex, economic dependency, patriarchal attitudes, etc. Throughout the project proposal, objectives and specific objectives are neutral, referring to "young people" instead of boys and girls.

Gender is referred to in a separate paragraph as a cross cutting and guiding principle in the project. Gender analysis was part of the baseline assessment. However, attention to the findings in the baseline is not evidenced in the project interventions, as explained in the following paragraphs. There were no specific gender programming but there were several ways of ensuring gender sensitivity on data collection and reporting. The project proposal proposed to use a participatory approach and include a wide range of female and male stakeholders at the government level and from the CSOs including women organizations and gender equality experts. The barriers for women's participation in the health programs were proposed to be identified and strategies developed to address them. Women's practical needs and strategic interests were proposed to be identified and opportunities would be identified. The measurable targets and expected results and indicators were proposed to be established as a milestone to measure the project performance addressing gender in the project intervention after gender analysis.

Gender relevance of the implementation of the project
There is evidence of gender balanced participation of beneficiaries in various activities and those who received SRH services, as reported in annual reports. Most training reports reflect a gender balance of participants, however, no analysis of gender

power relations in decision making on SRHR is made. This is crucial, especially in view of the gender dimension in relation to HIV/AIDS.

There is no evidence of identification of barriers for women's participation and strategies to address them in any of the narrative reports. Neither the narrative reports nor interviews with key informants (project staff) and Municipal Councils in Dar es Salaam and Iringa could get information on identified women's practical needs and strategic interests. The Indicator Tracking Tool updated November 2014 is not consistent on gender disaggregated data.

Information about empowerment of girls in terms of protection against unwanted (teenage) pregnancies for in and out of school girls has been consistently reported by many informants as an improvement that could be attributed to the project . This is empowering in the sense that girls can continue uninterrupted schooling which is security for their better future.

Summary
The project proposal and the in-depth assessment memo by the Embassy of Sweden assesses the general context of the situation of SRHR in Tanzania from a gender and human rights perspective. The baseline has a gender analysis. Apart from the baseline, the project intervention does not seem to have made an effort to make a comprehensive analysis of women's practical needs and gender interest, and girls'/women's participation in health programs. Gender equality is not integrated in the formulation of the project objectives, but the project interventions ensure that there is an equal gender representation in activities and access to SRHR. Gender disaggregated data for beneficiaries reached is provided but inconsistent.

2.4 EFFICIENCY

2.4.1 Efficiency in budget allocations

Well justified budget allocations
The project was initially planned for implementation from December 2010 to December 2013 with a budget of SEK 43 million (USD 6 534 100). It was amended in April 2013 with a no-cost extension, to be aligned with the Amref Health Africa budget year, with an activity period until September 2014. It was amended a second time in April 2014 until September 2015, with an additional amount of SEK 9 million (USD 1 367 780).

Table 11: Budget and actual project costs 2010-2015 (USD with exchange rate SEK 6.58 = USD 1)

	Dec 2010-Sep 2011	**Oct 2011-Sep 2012**	**Oct 2012-Dec 2013**	**Jan -Dec 2014**	**2015**	**Total**
Initial	2 127 000	1 824 000	2 583 100	0	0	6 534 100

	Dec 2010-Sep 2011	**Oct 2011-Sep 2012**	**Oct 2012-Dec 2013**	**Jan -Dec 2014**	**2015**	**Total**
budget						
Revised budget	2 127 000	1 824 000	2 431 000	1 443 769	75 988	7 902 736
Actual Budgeted	2 864 068		3 148 856	1 025 798	N/A	
Spent	1 293 123		2 123 058	N/A	N/A	
Balance	1 573 448		1 025 798	N/A	N/A	

The annual review meetings that should take place in October or November each year have been regularly delayed until February the following year to give sufficient time for Amref Health Africa to prepare narrative and financial reports, for auditing of the financial report and give time for the Embassy to review the reports. This has delayed disbursements from the Embassy to Amref Health Africa and funds have been regularly received with a 6 months delay in relation to the Annual activity plans starting in October each year. This has caused delays in implementation of some activities although Amref has been able to finance critical activities with its own resources until the Swedish funds arrive.

Table 12: Budget and spending per category for the three first years of the project (1000 USD)

	2010/11		2011/12		2012/13		2013/14	
	Budget	Spent	Budget	Spent	Budget	Spent	Budget	Spent
Project staff	333	143	345	345	552	328	633	364
Interventions	1 240	445	750	750	1 059	870	653	397
Equipment	537	335	178	178	367	75	307	25
Other costs	165	55	113	113	281	141	249	127
Sub-grants	235	155	178	178	455	455	255	141
Overhead	351	158	210	210	432	251	293	137
Total	2 864	1 293	1 777	1 777	3 148	2 025	2 392	1 193

During the four years, actual spending was just over 6.3 million US dollar, about 78% of the budget, leaving about USD 1.5 million for the last year of the project. According to the narrative reports, the project is on track to achieve the objectives during the extension period of the project.

Table 13: Spending per specific objective

	2010/11	2011/12	2012/13	2013/14	Total for 4 years	%
Objective 1	96 847	146 193	350 290	187 362	780 692	32
Objective 2	59 199	72 285	174 879	107 332	413 695	17
Objective 3	239 135	443 590	268 971	87 374	1 039 070	42

M&E	49 919	88 435	76 327	15 141	229 822	9
Total interventions	**445 100**	**750 503**	**870 467**	**397 209**	**2 463 279**	**100**

Resources are allocated to key population groups, mainly through support to CSOs representing and involving them, through direct support, training of peer educators and by encouraging them to avail of the youth friendly SRH services. It has however not been possible to calculate the amounts of resources allocated to key population groups or marginalized groups like out-of-school children, but they constitute a considerable part of the intervention.

Comparative analysis of training costs
The evaluation has looked specifically at training costs. Almost half of the budget for interventions goes to specific objective 3. Included in objective 3 is the training of 591 peer educators during the first and second year that cost USD 342 000, giving an average cost of USD 579 per trained peer educator. Refreshment training in 2013 cost USD 67 000. Training of health care providers was done during the second and third year when 172 providers were trained at a cost of USD 137 000 (USD 797 per trained provider). Training of teachers, took place during the first and second year with a total of 251 teacher trained at a cost of USD 16 200. The average cost per trained teacher was USD 65. It is assessed that the capacity development activities of the project compare with those of other programmes based on the evaluators' general knowledge.

Summary
Regarding the well argued spending; the individual budget allocations are assessed as relevant in relation to the designated activity as per the costed activities in the work plans. The trainings have been carried out in a cost-effective way.

2.4.2 Institutional arrangements and project management

The project office based in the Mwananyamala youth centre consists of a small management team, are working well with each other and work as an efficient team. The internal structure seems to be conducive to efficient and effective project implementation, although the project M&E officer and the project manager that had been in the project from the beginning, left the project last year and new staff was recruited. The turn-over of staff seems to have negatively affected the knowledge management of the project - and Amref Health Africa Tanzania, in the sense that that knowledge had not been effectively transferred to new staff. The changes of staff did however not seem to have significantly affected the implementation.

There has been a steering committee with annual meetings. According to the project proposal, the steering committee should include representatives from the three concerned government ministries (MOHSW, MOEVT and MOLYD) together with implementing partners, stakeholders and local government representatives. The steering committee was thus supposed to provide avenue for advocating and coordinating

YFSRH services with the government ministries. According to progress reports, the central ministry representatives did seldom participate in steering committee meetings.

The project has primarily interacted with the three targeted municipalities, the subgrantees and the MOHSW. The project played a role as a secretary to the technical advisory team (TAT) with representative from MOHSW in reviewing the National Policy Guideline on Reproductive Health Services. Apart from that, there has been less than anticipated interaction with the central level of other ministries like the MOEVT and the MOLYD, and with other organisations. The programme officer at the Amref Health Africa office in Tanzania has had the responsibility to oversee the project while the project office in Mwananyamala has been focusing on project implementation activities.

The role of Amref Health Africa have also been to work with other organizations, the German development Foundation[26] (DSW), the East African community (EAC), the WAMA foundation[27] and others in advocating for more funding in the area of SRHR. Amref is an active member of the SRH CSOs coalition to advocate for more funding by World Bank and European Union to areas of SRH for young people. Amref had a common dissemination meeting with the Swedish Association for Sexuality Education (RSFU), both being programs funded by the Embassy of Sweden. At policy level there is a technical working group at MOHSW comprising of all development partners. Each organization including Amref presents its plan for the coming year to the MOHSW. The ministry thereafter comes up with a road map including activities and budget.

RSFU exchanges some of ICT materials with Amref. Both work with youth but in different regions and RFSU focus is on engaging men. There is no overlap as both are engaged in different geographic locations and targeting a different group.

Summary
Institutional arrangements and project management was found to be lean and efficient.

[26] DSW (Deutsche Stiftung Weltbevoelkerung) is an international development and advocacy organisation, focusing on achieving universal access to sexual and reproductive health and rights

[27] Wanawake Na Maendeleo (WAMA) Foundation is a NGO founded by the Tanzanian First Lady, Mama Salma Kikwete in October 2006. The main goal of the organization is to improve the life standard of women, girls and other vulnerable children through promoting them to access to education, health service: adolescent and sexual reproductive, maternal and infant, and capacity building for economic empowerment.

2.5 IMPACT

The evaluators had a limited opportunity to assess the project's long-term impact because it is too soon (activities are still on-going) and because a rigorous impact assessment could not be undertaken within the scope of the evaluation. The evaluation team has to the extent possible looked at plausible and perceived impact on the right holders (young people in the targeted municipalities, including key population groups, and their CSOs) and the duty bearers (municipality officials and service providers).

The evaluation benefitted from the fact that there was a baseline study in 2011. Data from the baseline study has been used for the project indicators and data on the indicators have been continuously collected by the project. Information for assessing the impact has also been collected through semi-structured interviews with project officials, municipality officials, service providers, risk groups and CSOs as well as focus group discussions with primary and secondary school students and exit interviews with visitors to youth friendly SRH services. A table about the findings on impact from the interviews is attached as Annex 5.

2.5.1 Impact on right holders

In response to the open questions at the exit surveys at health facilities, young people reported that they feel good and it is helpful knowing how to protect themselves from HIV and unintended pregnancies. The education encouraged them to achieve their goals and it gave confidence, especially after knowing their HIV status. They reported that they learnt about reproductive health and were able to educate others also. They reported that the education has helped them to change and take precaution in avoiding diseases and that they have learnt methods for family planning and reported that they and their partner take care of each other and prevent themselves and their partners from sexually transmitted diseases. One respondent said:

"I feel good because when you get reproductive health, it helps and you can have objective in life and you know that life in Tanzania without HIV/AIDS is possible."

In several interviews with service providers, a reduction in teenage pregnancies was reported, as well as decreasing number of pregnant teenage girls seen at health facilities. Health facilities also saw a reduction of STIs, and increased number of young people utilizing the SRH services which improves their sexual and reproductive health. Health data in Iringa show a reduction from 7 pregnancies of primary school students 2012 reduced to 2 in 2013[28].

[28] Interview with the District Medical Officer of Iringa municipality

Visited schools have not seen any teenage pregnancies since SRH education was introduced. Pupils do not succumb to pressure from others. At focus group discussions in schools, students said that they know where to get help and advice. Behavioural changes reported include pupils being careful about indulging in sexual activities. Even those who are boyfriend and girlfriend say that they respect each other and they focus on the goal of education and try to pursue their studies. Knowledge among students regarding how to avoid teenage pregnancies, how to say no and protect themselves from sexual harassment and gender based violence including rape, sexual advancement by their teachers, was mentioned as an impact from the project. Boys are aware of dangerous behaviours and the need to avoid places that could lead to sexual infections such as drinking, going to discos, mingling with other groups that have bad habits.

Young people from key population groups reported in a group discussion with the evaluators that they have changed to practice safe sex and have less sexual partners. They have developed knowledge and awareness on how to be more acceptable in their communities and get jobs. They are no longer depending on sex work to earn their living. Their health has improved due to Anti Retro Viral drugs (ARVs) and a healthier lifestyle. They now knew how to demand SRH services and recognize that it is their right. They have gained knowledge about SRH and family planning.[29]

Summary
Positive impacts in living a healthier life, protecting oneself and avoiding risk behaviour were consistently reported by young people.

2.5.2 Impact regarding YFSRH services as the responsibility of duty bearers

The primary source of data regarding the project's impact on service provision came from the supportive supervision reports, progress reports and the visits by the evaluators to a few health facilities and in-depth interviews with service providers and with the District Medical Officers.

Through the efforts of the project and in collaboration with the municipal councils, there were at the time of the evaluation, 31 health facilities in the three municipalities providing youth friendly sexual and reproductive health services. The services do not fulfil all the criteria in the government standards for provision of YFSRH services, but much needed services are regularly provided in spite of the challenges.

[29] LGBT Voice in Tanzania, interviewed on18 November

The shortcomings are described in Chapter 2.2.2 above. In summary, the supervision reports and the interviews at the health facilities visited by the evaluators reveal that many health facilities does not have separate rooms and/or waiting areas for youth friendly services, nor do they always provide privacy and confidentiality. STI medicines and HIV test kits are not always available although IEC material is most often available. Outreach services are not regularly conducted at several health facilities, in some instances due to lack of funds.

The impact of the capacity building on the municipality officers as duty bearers is above all an increased awareness of the need for YFSRH services, demonstrated in the interviews with District Medical Officers and Reproductive Health Coordinators in the three municipalities and demonstrated in the inclusion of YFSRH services in the Comprehensive Council Health Plans.

Summary
Through the efforts of the project and in collaboration with the municipal councils, there were at the time of the evaluation, 31 health facilities in the three municipalities are providing youth friendly sexual and reproductive health services. The capacity building through advocacy and planning meetings has created an awareness among duty bearers of the need to provide youth friendly SRH services. It has also created knowledge and skills on how to plan, manage and supervise the services.

2.6 SUSTAINABILITY

2.6.1 Sustainability considerations in the design and implementation of the project

The issue of creating sustainability has been considered from the outset of the project. The project proposal mentions several issues that are important for sustainability, the involvement of government structures, capacity building of municipality officers and local youth led organizations, as well as the continued use of youth centres and health facilities. The project document further says that Amref will work with the MOHSW, the MOEVT and the MOLYD to strategically set up regular programs for skills transfer and technical assistance with special training programs for peer educators, district planners, health providers, school teachers and CSOs for support of the YFSRH services.

Initially the project was to run for three years from December 2010 to October 2013. To gear the activities towards sustaining them within communities, the project felt there was a need of addressing gaps and ensuring by the end of the project that results are sustained by the government partners and other key stakeholders. The project was therefore granted an extension of one more year ending in September 2014. Given the cost extension by Sida, the project planned to increase the prospect of sustainability through interventions addressing the following gaps found during the initial three year implementation period:

- The gradual decrease in National health budget from 11% in 2011, to 9% in 2012 and 8% in 2013 has been a draw back in setting out the council ceiling budget and therefore limiting the SRHR budget increment.

- The reallocation of YFS trained health service providers affects the continuity of provision of YFS in health facilities thus need to scale up knowledge and skills on YFS among health providers
- Inadequate provision of equipment and medical supplies for example, STI medicine, HIV test kits and family planning supplies, screens and curtains, examination beds, etc. in health facilities and during SRH outreach services.
- Communication barriers between parents and young people in SRHR issues
- The economic status of young people remain at stake as many youth led organizations lack funding opportunities which could enable them to start and run businesses such as craft making, tie dying, tailoring, jewellery making, and bakeries.
- Sustaining the stand alone youth centres when the project comes to an end

The activities during extension period included:

- Continued training and retraining of health service providers on provision of quality YFSRH services in health facilities and ensuring the services are well monitored,
- Increase awareness on SRHR among youth, vulnerable groups and key population groups and continue the lobbying for increased resource allocation for SRH services in all municipal
- Support the Ministry of Health in reviewing the national policy guideline for Reproductive and Child Health to incorporate the SRHR issues focusing on youth.

A follow-up of the activities during the one-year cost extension is annexed as Annex 3 . Many of the planned activities during the cost extension are being attended to by the project. Several of the identified gaps can however not be effectively addressed by the project, but are the responsibilities of the authorities, such as the budget decrease, the reallocation of trained staff and the inadequate provision of medical supplies and drugs. It does not seem likely that the considerable gaps in sustainability can be effectively addressed during a one year extension.

2.6.2 Sustainability of project achievements

From a sustainability point of view, it seems to be most important that service providers and youth led organizations are well prepared to continue to function after the project has ended. The evaluation has looked specifically at the sustainability for the achievements within each of the specific objectives of the project.

Sustainability of awareness building for sustained demand for YFSRH services

Advocacy and information activities directed to young people through the variety of interventions by the project may be deemed to be sustainable if they have resulted in changed behaviour and regular utilization of health services. Positive impact was noted in young people benefitting from the project reported living a healthier life, protecting oneself and avoiding risk behaviour were consistently reported by young people. The major factors promoting awareness are the outreach activities, the wide dis-

tribution of IEC materials, training of peer educators in schools through direct training of primary and secondary school pupils and teachers, and out of school youth through youth led organizations and sub-grantees. Collaboration with the media has raised awareness and educated the youth and communities through print and electronic media.

Although health providers have been trained by the project to conduct outreach, lack of funding will likely limit outreach activities and production of IEC material when the project ends. There is no system in place to train new peer educators. Amref has shared the potential supporters of media award through the technical working group.

Regarding the youth led organizations, several important activities were conducted to increase sustainability. Youth led organizations were trained on organizational development, result based management, monitoring and evaluation, basic leadership and governance; strategic planning, internal control, advocacy and proposal writing in May 2014. Young people from youth led organisations in Iringa and DSM have been trained on entrepreneurship and livelihood skills in April and June 2014. Training on the job orientation in Small Scale Business Management, Bookkeeping and Revolving Fund management to CSOs and sub-grantees was conducted in August and September 2014. However, for the proposed capacity assessment of youth led organizations for developing income generating activities and proposals and linking them with funding institutions, no budget was allocated due to limited resources during the last year of the project.

The project has managed to increase the capacity of the CSOs. When the project ends, the CSOs benefitting from support reported that they will do their best to continue their work, reaching more young people, including vulnerable groups and risk groups, although they will have difficulties finding new funding.

Considering that there are about one million young people living in the three targeted municipalities, the scale of influence is limited.

At the national policy level, a sustainable impact from the project may be the review the National Policy Guidelines on Reproductive and Child Health that has been supported by the project, but not yet finalized. Otherwise there have been interaction with the MOHSW but limited interaction with the MOEVT and the MOLYD, limiting the creation of a sustainable impact at national level of understanding and developing youth friendly sexual and reproductive health services in Tanzania.

Sustainability of youth friendly service provision for sexual and reproductive health
The project has demonstrated how youth friendly SRH services can be set up and run in 2 model youth centres and 29 government health facilities and how the services can be supported, further developed and sustained through regular supportive supervision and how youth can be reached through outreach activities. Capacity has been built within the municipality structures on how to plan, budget, set up, run and support the services. But the extent to which such pilot efforts lead to sustainable adoption of

these models can be questioned. The project is working with consultants to define the business plan after a needs assessment to see the best way to sustain the Mwananyamala youth centre beyond the project support.

There were at the time of the evaluation, 31 health facilities in the three municipalities providing youth friendly sexual and reproductive health services. Regarding the service providers, the project continued training more care providers and conducting supportive supervision to health facilities and providing IEC materials, equipment and supplies.

The evaluators' assessment is that the health facilities currently providing YFSRH services will continue to function at the current level of service provision, both quantitatively and qualitatively. Due to budget constraints there will probably be limited outreach services – which are currently supported and funded by the project.

The sustainability of the youth friendly services is severely hampered by the decreasing budget at national and local levels. The national health budget has decreased from a share of the total national budget of 11% in 2011, to 9% in 2012 and 8% in 2013. This has already resulted in inadequate provision of equipment and medical supplies, STI medicines, HIV test kits, and family planning supplies[30].

Sustainability of training programs
Three training packages have been developed by the project, a Youth Centre Counselling Training Manual, a Parent Child Communication Guide and a manual on Comprehensive Sexual Education for Young People. The training materials have been used in the various training activities conducted by national trainers and supported by the project, i.e. training of peer educators, training of school teachers and training of health care providers. The training has produced sustainable results in capacitating individuals. Experiences from using the material have been used to revise it and it has now been approved by MOHSW and is available for national trainers from all organizations.

The development of the training packages is perhaps the strongest example of sustainable results of the project. The packages can be used by the national trainers but financing for conducting continued training is limited, since there is very little money budgeted for trainings at the municipality level.

The project also provided training and mentorship to youth organizations in the areas of governance, financial management or managerial processes (such as monitoring

[30] Proposal for cost extension. Amref.

and evaluation), leadership and good governance, advocacy skills, proper planning, organizational structure and entrepreneurship skills. The training was successful in increasing the organizational capacity of the organizations to sustain their activities after the termination of support from the project, although sustainability will be hampered by financial constraints.

Many of the challenges have been recognized by the project and activities to increase the possibility of continuation of services after the project ends are defined in the project exit plan[31], which has 18 activities and implementation was ongoing at the time of the evaluation with most activities not yet fully implemented. Some of the activities under the responsibility of the project will most likely be implemented, such as ensuring that all planned trainings are completed, that records are properly archived, that best practice, lessons learned and success stories are documented and that peer educators and sub-grantees plan are shared with the respective wards. It will be more difficult to implement the ones that require a strong ownership and resources by the municipalities, like maintenance of the services, sustaining the reporting and monitoring system of peer educators, monitoring and supporting sustainability of life skills interventions in schools, incorporating supervision of youth friendly services into the regular supervision plan and providing continued support to the youth led CSOs by the municipalities.

Summary

The project had a sustainable impact in changing awareness, behaviour and care seeking of a considerable number of young people in the three targeted municipalities, but structures were not created to continue the activities in those municipalities or to scale up the activities to other municipalities.

Service provision at the current level, quantitatively and qualitatively, may continue for some time, but is not deemed to be sustainable without further support, in spite of the considerable capacity building by the project at municipality and health facility level, on how to plan, budget, set up, run and support the services. Limited funding from the national budget will prevent the expansion of services to other health facilities.

The training created sustainable impact on the persons trained as well as in developing training packages, but financial conditions for continued training are currently lacking.

[31] Project Phase Exit Plan. Prepared by the Project team. Dated 30 April 2014.

2.6.3 Scaling up of youth friendly SRH services within the three targeted municipalities

Interviews with the District Medical Officers in the three project supported municipalities revealed that scaling up of YFSRH services in those municipalities face several challenges, like training of new staff, adapting the infrastructure of health facilities and supply of equipment, medical supplies and drugs. The municipalities will be struggling with maintaining and improving the existing youth friendly services and without further support within the national plan to scale up the services, there will most likely be no expansion.

Summary

The prevailing challenges together with poor track record of implementing youth friendly services during the last more than ten years and lack of financial resources lead the evaluators to believe that there will be no scale-up of the services within the targeted municipalities.

2.6.4 Scaling up of youth friendly SRH services at national level

The Health Sector Strategic Plan III[32], covering the period 2009-2015, has a strategy for improving maternal, neonatal and child health (Strategy 7). The strategy does not explicitly mention YFSRH services or any particular efforts to reach young people although HIV/AIDS and reproductive health are some of the priorities in the strategy. Financing requirements for implementation of the Strategic plan are calculated to annual increases of the health sector budget by at least 10%. This sharply contrasts the actual decreases during the project implementation period, decreasing the possibilities of the Strategic plan being implemented. However, at the time, when the project was designed, Tanzania had experienced a long period of real GDP growth of about 7%, since 2005 and a predicted continued growth at or above that level for the next 5 years until 2016. The Health sector had grown by an average of 8% during that period and was predicted to continue to grow at about 8%.[33]

The Health Sector Performance Profile Report 2011 reported that nominal per capita spending on the public health sector increased from TZS 13 375 in 2006/07 to 21 716 in 2010/11. This represents an increase by more than 75%. Even in real terms, the per capita public health expenditures increased from about USD 7 in 2005/06 to USD 9.62 in 2009/10. The estimate for 2010/11 was USD 10.55. The public health expenditures as a percentage of GDP increased from 2.7% in 2005/06 to 3.2% in 2009/10. [34]

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[32] Health Sector Strategic Plan 2009 – 2015 (HSSP III), on “Partnership for delivering the Millennium Development Goals”

[33] Guidelines for the preparation of Annual plan and Budget for 2012/2013. Ministry of Finance and The President’s Office Planning Commission, February, 2012

[34] Health Sector Performance Profile Report 2011. Ministry of Health and Social Welfare, Policy and Planning Department, Monitoring and Evaluation Section

Somewhat disturbing was the fact that the means of increasing the fiscal space changed from 2008/09. There had been no increase in the share of GDP raised in domestic revenue since 2007/08 and fiscal space has been created by increasing government borrowing. The budgeted per capita spending for health increases, but it is financed largely through aid and mostly from Global Fund resources.[35]

The assumption by the project in 2010, that the government at central level and the local governments at municipal level would be able to increase resources to scale up YFSRH services appear to have been largely realistic at that time.

The National Standards for Adolescent Friendly Reproductive Health Services[36] provide guidance on "what do to" in the area of adolescent friendly reproductive health services and on "how to do it" using methods and tools that are user friendly.

The goal of the National Adolescent Reproductive Health Strategy for 2011-2015[37] strategy is to improve reproductive health of all adolescents in Tanzania. The strategy seeks to enhance delivery of adolescent sexual and reproductive health interventions in line with the National Standards for Adolescent Friendly Reproductive Health Services. One of the outputs of the strategy is to scale up adolescent friendly SRH in Public, private, FBOs and NGO service delivery points, to increase the number of health facilities providing adolescent friendly SRH services from 30% to 80 % by 2015. This would be done through disseminating the National Standards for Adolescent Friendly Reproductive Health Services, reviewing/developing/ adapting, and printing training materials, training of human resources and setting up of youth friendly SRH services in more health facilities. Other parts of the strategy refers to strengthening of the policy environment, expand the demand for SRH services and life skills knowledge by adolescents. The strategy provides no cost estimates for its implementation. MOHSW has the responsibility to lead the implementation of the plan and ascertain that set targets are met by 2015.

The Amref project is directly supporting the implementation of the strategy by the review of SRHR policies, expanding the demand for SRH services and life skills knowledge by adolescents and supporting the setting up of youth friendly SRH services in three municipalities.

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[35] United Republic of Tanzania Public Expenditure Review 2010. Prepared by the Members of Macro Group of the Tanzania PER Working Group. Document of the World Bank September 2011

[36] National Standards for Adolescent Friendly Reproductive Health Services. Reproductive and Child Health Section. Directorate of Preventive Services. Ministry of Health 2005

[37] Adolescent Reproductive Health Strategy 2011 – 2015. MOHSW. February 2011

The information that the evaluators have indicates that the implementation of the National Adolescent Reproductive Health Strategy has been slow, reflecting the scarcity of financial resources during the strategy period. This is supported by a study[38] that found that, none of the 38 facilities in Mtwara district has designated areas for provision of youth friendly services (YFS) since services provided were adult centred.

Summary
Although there is a plan for scaling up youth friendly services in the National Adolescent Reproductive Health Strategy for 2011-2015, progress is slow. And the decreasing health budget is likely to prevent a national scale-up of youth friendly SRH services.

2.7 CHALLENGES AND MITIGATION

There have been a number of reported challenges to the project. Many of them have been overcome, when solutions have been within the control of the project. Others, that require resources from the municipalities have continued. Challenges mentioned when visiting youth led organizations, municipalities and health facilities are reported in annex 5. Some major challenges are listed below.

- One challenge to the project has been to reach the targeted number of people with both awareness building and with services. This has been complicated by the frequent lack of medical supplies and drugs in the supported government health facilities, like in most health facilities in Tanzania. Amref has supplied STI drugs to improve the situation.
- The reallocation of trained service providers, often to health facilities outside the targeted municipalities, has been a challenge. The project has encouraged trained staff to do on-the-job training of their colleagues to overcome this challenge to some degree.
- The usual opening hours of health facilities, closing around 3 pm, has made it difficult for young people to visit the facilities after school. Many facilities have managed to extend opening hours to attend to young people. This also had the advantage of separating young people from adults, who come earlier.
- Separation of young people from regular adult visitors to health centres has been another challenge that has been overcome in several health facilities by providing support for small infrastructure works.

[38] Barriers to sexual reproductive health services and rights among young people in Mtwara district, Tanzania: a qualitative study. Rita Moses Mbeba et al. The Pan African Medical Journal Published: 26/12/2012.

- It has also in many instances been a challenge to encourage or facilitate communication between young people and their parents, particularly when the child is gay or lesbian. Social counselling has played a great role in making parents understand and accept the situation.
- Traditional norms around sexuality and the perception that use of contraceptives is linked to a "loose sexual behaviour", specifically for young girls, have created difficulties in advocating for protection from HIV, STIs and unwanted pregnancies.
- The youth led organizations have been very receptive in responding to training opportunities and improving their range of activities and expanding their reaching more young people. The challenge for them has been to find some funding, at least to cover their most basic costs, like transport, somewhere to be and some incentives for their members and peer educators.
- It has been a challenge to find income-generating activities for the youth led organizations, so that they can be self-sustainable to some extent. The project has initiated soap manufacturing, catering services, manufacturing of nutrition flour, craft making etc.
- For the project, high staff turnover has been a challenge, particularly towards the end of the project, when several project staff left the project, like in many other projects.

3 Conclusions

3.1 PROJECT DESIGN

The strategic components of the design of the project are logical and well conceived and are lined to and follow Tanzanian policies for youth friendly SRH services. The theory of change is logical, clear and easy to understand and seems to have been very useful in defining the project specific objectives and outcomes.

The results framework has served the project well in monitoring project activities and for the annual progress reports. However, the project would have benefitted from some more work in defining and formulating the outputs and outcomes of the project.

The project is non-discriminatory as it takes into account the needs of vulnerable groups (young people living with HIV, the deaf) and key population groups (commercial sex workers, men having sex with men, injecting drug users), both girls and boys. The project interventions have been participatory where stakeholders and the wider community such as parents, teachers, community leaders and health service providers have been involved in the project activities. Capacity of duty bearers has been built to be accountable to the rights holders in terms of provision of YFSRH services. Accountability to stakeholders, such as primary and secondary beneficiaries is not evident from the documents and from interviews.

3.2 PROJECT IMPLEMENTATION

The specific objectives have been largely achieved. The targets for awareness raising has been reached or will be reached within the extended project period. The number of visits to YFSRH services has increased, indicating that the target for the demand for YFSRH services has also been reached.

The municipality councils in Iringa, Kinondoni and Ilala have increased their own resources for provision of friendly sexual reproductive health services for young people. The target of providing youth friendly SRH services in at least 30% of the existing health facilities has only been reached in Iringa municipality. Overall, the achievement is 9% of health facilities in the three targeted municipalities providing YFSRH services. The services in the government health facilities do not fully meet the standards set by the Ministry of Health and Social welfare.

Capacity building has been conducted for the provision of services as well as on raising awareness on sexual and reproductive health and rights. The target for number of service providers, peer educators and school teachers trained has been largely

achieved. Training packages have been developed and used. Organizational capacity building of youth led CSOs have been conducted with good results.

The overall objective of the project has been reached. The awareness and demand for YFSRH services has increased and the target of reaching 100 000 young people with YFSRH services has been exceeded in each of the three last years. It should however be noted that the total number of young people in the three targeted municipalities are about one million.

3.3 IMPACT AND SUSTAINABILITY

Positive impact in access to SRH services, living a healthier life, protecting oneself and avoiding risk behaviour were consistently reported by young people.

Through the efforts of the project and in collaboration with the municipal councils, there were at the time of the evaluation, 31 health facilities in the three municipalities providing youth friendly sexual and reproductive health services. The capacity building through advocacy and planning meetings has created and awareness among municipality officers of the need to provide YFSRH services.

The project had a sustainable impact in changing awareness, behaviour and care seeking of a considerable number of young people in the three targeted municipalities. Structures to continue the activities in those municipalities or to scale up the activities to other municipalities are not deemed to be sufficient.

Service provision at the current level, quantitatively and qualitatively, may continue for some time, but is not deemed to be sustainable without further support, in spite of the considerable capacity building by the project at municipality and health facility level, on how to plan, budget, set up, run and support the services. Limited funding from the national budget will prevent the expansion of services to other health facilities.

The training created sustainable impact on the persons trained as well as in developing training packages, but financial conditions for continued training are currently lacking.

Although there is a plan for scaling up youth friendly services in the National Adolescent Reproductive Health Strategy for 2011- 2015, progress is slow. And the decreasing health budget is not likely to promote progress for a national scale-up of youth friendly SRH services. The prevailing challenges together with poor track record of implementing youth friendly services during the last decade and lack of financial resources lead the evaluators to believe that there will be no scale-up of the services within (or beyond) the targeted municipalities.

4 Recommendations

The ToR for the evaluation states that the evaluation shall give recommendations on the project in terms of:

- improving program quality and program accountability to beneficiaries (especially young people)
- sustaining the project interventions
- scaling up of youth friendly SRH service
- wider learning within Amref Health Africa
- future advocacy and programming in the area of young people´s sexual and reproductive health and rights

The evaluators recommend the following:

Recommendations

- Activities regarding increasing quality, accountability and sustainability are included in the Project Exit Plan and it is strongly recommended to Amref Health Africa that all activities detailed in the Exit plan that can possibly be implemented until the end of the project, in fact are implemented, and that implementation is closely monitored by Amref,
- Future Swedish funding and Amref Health Africa programs should have gender specific goals and objectives and distinguish between girls and boys. Their different needs should be analysed as well as power relations between girls and boys, such as power to negotiate safe sex, economic dependency and patriarchal attitudes,
- The supported municipalities should make every effort to continue to provide the YFSRH services and scale-up to all their health facilities,
- The government of Tanzania has all the knowledge, policies, strategies and guidelines necessary for a nationwide scaling up of youth friendly SRH services. It is recommended that the government prioritize resources allocation to accelerate the implementation of the National Adolescent Reproductive Health strategy for 2011-2015,
- Wider learning within Amref Health Africa should be enhanced through documentation of best practices, lessons learned and success stories from the project as suggested in the Exit plan. These documentation should be widely distributed by Amref Health Africa to all stakeholders of SRHR in Tanzania and elsewhere.
- The Amref Health Africa internal knowledge management system should be strengthened to be less vulnerable to turn over of staff,

- Future advocacy and programming for YFSRH services by the Embassy and Amref Health Africa should continue to support of the current and future National Adolescent Reproductive Health Strategies,
- The Embassy of Sweden should seek ways to continue to support young people through youth led organizations, in the project municipalities and elsewhere within the programming of support to the new priority area of entrepreneurship.

Annex 1 – Terms of reference

TERMS OF REFERENCE FOR THE EXTERNAL EVALUATION OF THE AMREF HEALTH AFRICA PROJECT ON SEXUAL REPRODUCTIVE HEALTH RIGHTS FOR THE YOUNG PEOPLE, (*TUITETEE- LETS FIGHT FOR IT*), 2010- 2015

A. BACKGROUND

Amref Health Africa is a non-government organization which was founded in 1957. Its headquarters is based in Nairobi, and has country offices in Kenya, Tanzania, Uganda, Senegal, South-Africa, Southern Sudan and Ethiopia. Amref Health Africa focuses on transforming communities by improving the health of women and children based on three health systems building blocks: Human Resources for Health, Community Systems Strengthening and Health Management Information Systems, with a strong focus on evidence-based advocacy, operational research and policy change. Amref Health Africa's programs are guided by seven strategic directions which focus on the health of women and children as primary beneficiaries.

The Embassy of Sweden is planning to hire an External Consultant (s) to undertake the final Evaluation of the Sida/ Embassy of Sweden funded Amref Health Africa project namely the Sexual and Reproductive Health and Rights for the Young People Project *("Tuitetee"- Lets Fight for It*!) (2010-2015),in October 2014. Back ground information on the project is provided below.

The Sexual and Reproductive Health and Rights for the Young People Project ("Tuitetee")

This is a 4 year project that is being implemented from December 2010 to 31st September 2015. Initially the project was to run for three years from December 2010 to October 2013, but has been extended to provide space for a constructive phase-out stage and enhance sustainability. The overall project goal is to promote human rights among young people in Tanzania that are hampered by poor access and utilization of SRH services resulting into sexual-related illnesses, dependency and/or premature deaths. The specific objectives of the project are:

- Young people (10 – 24 old) in Tanzania realised their sexual and reproductive health rights and exercised it by demanding for quality and friendly sexual reproductive health services.
- Municipality councils in Iringa, Kinondoni and Ilala increase resources for provision of friendly sexual reproductive health services for young people in at least 30% of the existing health facilities.

- Government, non-governmental institutions and individuals in Tanzania with access to technical support for instituting programmes for managing SRH needs of the young people.

The Sexual Reproductive Health and Rights Project is targeting young people (girls and boys) aged 10-24 years in Iringa (Iringa Municipality) and Dar Es Salaam regions (Ilala and Kinondoni Municipalities). These include the vulnerable groups (Young people LHIV, orphans, youth with disabilities) and the key populations (CSW, MSM, IDU). The Project also works closely with ministries and departments dealing with youth related issues and other secondary beneficiaries such as parents, health providers, communities and teachers. The project also sub-grants 8 civil society organizations (NYP+, TAYOPA, UMATI, CHAVITA, KIWOHEDE, CAMILLUS, IYDP and APCS) and works closely with ministries and departments dealing with youth related issues and other secondary beneficiaries such as parents, communities and teachers.

B. PROGRAMME CONTEXT

Universal Access to Comprehensive Sexual and Reproductive Health Services remains a strong emphasis towards improving health of women and men in Africa. With almost half the world's population under the age of 25, young people's sexual and reproductive health and rights (SRHR) are of the utmost priority. It is shown that, developing countries which invest to young people could see economic growth surge. In Tanzania over a third of the Population is under the age of 24 years; 17% of the population is aged 15-24; over 40% of the total population being children below the age of 15 years. Yet young people aged 10-24 face many significant challenges. Maternal mortality is still high (454/100000 live births) – majority being young mothers. Young people use family planning to prevent pregnancy less frequently than their elder peers and there are more youth dying from pregnancy – related causes. In addition youth account for over 60% of the new HIV Infections.

Sexual Reproductive Health Rights in Tanzania are a basic need for young people. Access to SRH information, youth-friendly services, right to know and make choices are all well reflected in a number of policies targeting youth reproductive health welfare however Tanzania continues to face the burden of teenage pregnancies with about 29% of rural girls aged 15–19 years already have given birth. Youth-friendly sexual reproductive health services are scarce, mostly inaccessible and not adequately integrated into sustainable health plans.

It is also noted that, services currently provided to young people are not right based leaving out key populations such as MSM, IDUs and CSWs that form an important part in the prevention of new HIV infections leading to high HIV prevalence and high rates of poverty and inequality among young people. This equally applies to other marginalized groups such as institutionalized young people in juvenile homes, orphanage centers and disabled vocational schools. Even with knowledge of how to protect oneself from infection, such information may not always be usable in daily situations of economic and social disadvantage that characterize the lives of many young people and women in poor countries.

Relative economic disadvantage is found to significantly increase the likelihood of a variety of unsafe sexual behaviours and experiences. Low socioeconomic status not only increases female odds of exchanging sex for money or goods, it also raises fe-

male chances of experiencing coerced sex, and male and female odds of having multiple sexual partners, it lowers female chances of secondary abstinence and female and male age at sexual debut, condom use at last sex, and communication with most recent sexual partner about sensitive topics.
Amref Health Africa with the support from the Embassy of Sweden/Sida has been implementing the Sexual reproductive health and rights (SRHR) project which is addressing the above stated challenges which are facing youth in communities. The SRHR project works in line with Amref Health Africa strategic Direction number one: "Making pregnancy safe and expanding reproductive health". Its focus area is supporting reproductive health and rights. This project also works in line with Amref Health Africa strategic direction number 6 on "Developing a strong research and innovation base to contribute to health improvement". The focus of this strategic direction is "Strengthening Amref Health Africa's research agenda and capacity" and "Strengthening Amref Health Africa's advocacy agenda".

C. THE RATIONALE AND APPROACH FOR THE EXTERNAL EVALUATION

The external evaluation is therefore an opportunity for reviewing the project's approaches, strategies and accomplishments for the implementation period 2010 - 2014, as well as challenges faced and how the challenges have been solved during the stated period. The evaluation will measure the achievements of the project against the set outcomes and related indicators, as well as record lessons learnt and make recommendations. The evaluation attempts to determine, as systematically and objectively as possible, the relevance, value for money (efficiency, effectiveness and economy), impact, results, innovations, risks and sustainability of the project.

Purpose of the External Evaluation

The External Evaluation will assess the achievements and impact made by the Sexual Reproductive Health and Rights Project during its 4 years (2010- 2014) of implementation. Overall, the evaluation will assess the approaches and strategies for relevance, effectiveness, efficiency, outcome, impact, project performance and sustainability.
The purpose of the evaluation is to review and analyse the projects relevance, effectiveness, efficiency, sustainability and impact and evaluate the project results, achievement of objectives and project impacts/outcomes and effects with a focus on the youth sexual and reproductive health and rights and structure of the project, the project rationale in line with the developed result frameworks and identify possible lessons learned, and recommendations for modification/improvements in design and methodologies used.
The evaluation is expected to generate relevant findings, lessons, and recommendations which will inform future programme design in the area of youth sexual and reproductive health and rights and which will be shared with key stakeholders at the national and district level,

This is an external end-of-term evaluation and it is expected to:

7. To measure the achievement and outcomes and to identify how SRHR project design have contributed to overall impact in promoting human rights among

young people in Tanzania especially on access and utilization of SRH services, as per project proposals, available baseline information and developed results frameworks;

8. To ascertain the extent to which the goals and objectives of the project have been met, challenges observed and how they were solved.
9. To come up with recommendations on the project in terms of scaling up and suggesting ways of sustaining the project interventions.
10. Identify lessons learnt and explore potential for sustainability and scale-up of developed practices and services by Government of Tanzania at national and district level through enabling policy and economic environment.
11. Provide recommendations for improving program quality and program accountability to beneficiaries (especially young people) and contribute to wider learning within Amref Health Africa.
12. Provide information for future advocacy and programming in the area of Young people Sexual and reproductive health and rights.

Specific Questions of the Evaluation

1. What was the project's overall impact in relation to its outcome/ purpose and how can this be compared to what was expected? What were the key results against the outcomes and how was this compared with the targets set in the logical framework? How effective was the project's overall strategy?

2. What are the gaps, challenges and opportunities observed in the implementation of the SRHR project from 2010 to 2014?

3. What are the key best practices and lessons learnt from the project that can be used in future plans? How can the good practices be replicated and sustained?

The Consultant(s) will use the five criteria set out by the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD) to conduct the final evaluation. The five evaluation criteria are: Relevance; Effectiveness; Efficiency; Impact and Sustainability. For each of the criteria, the Consultant(s) will get specific information on the project's performance from beneficiaries, partners and stakeholders.

Below is the specific information that should be collected under each criterion. The Consultant(s) will examine the extent to which the projects are suited to the priorities of the target groups along the following lines:

Relevance

1. Have the activities and outputs of the projects been consistent with the overall goals and attainment of its objectives?
2. Were the activities and outputs of the projects consistent with the impacts and effects?
3. Was the overall project objective relevant to the specific needs of the population in the project area?

Effectiveness:

1. To what extent were the objectives achieved/are likely to be achieved in the project timeframe?
2. What were the major factors influencing the achievement or non- achievement of the objectives?

3. To what extent are unplanned positive effects contributing to results produced / services provided?
4. Have all planned target groups access to or are using project results available so far?
5. Are there any factors which prevent target groups accessing the results/services?
6. To what extent has the project adapted or is able to adapt to changing external conditions (risks and assumptions) in order to ensure benefits for the target groups?

Efficiency

1. Were activities cost efficient?
2. Were projects' resources managed in a transparent and accountable manner?
3. How flexible were the projects in adapting to changing needs?
4. How did the project co-ordinate with other similar interventions to encourage synergy and avoid overlaps?

Impact:

The Consultant(s) will examine if the project demonstrated impact, i.e. positive and negative changes produced by project interventions, directly or indirectly, intended or unintended. The examination will also be concerned with the positive and negative impact of external factors. The following will be explored:

1. What has happened as a result of the projects?
2. What real difference have the projects made to beneficiaries?
3. How many people (beneficiaries, partners or stakeholders) have been affected?
4. Have there been/ will there be any unplanned positive impacts on the planned target groups or other non-targeted communities arising from the project? How did this affect the impact?
5. Did the project take timely measures for mitigating the unplanned negative impacts? What was the result?

Sustainability:

The Consultant(s) will examine if the project has factored in sustainability when working with beneficiaries, partners and stakeholders. The following will be explored:

1. Have the projects resulted in leveraging of knowledge and interventions to ensure sustainable impact for young people at scale?
2. How far is the project embedded in local structures?
3. Are the relevant authorities able to afford maintenance or replacement of the services introduced by the project?
4. Were project partner's capacities being properly built (technically, financially and managerially) for continuing to deliver the project's benefits/services?
5. What support has been provided from the relevant national, sector al and budgetary policies?
6. Is there a financial/ economic phase-out strategy? If so, how likely is it to be implemented beyond the project life?
7. What are the other major factors that have influenced the achievement and non-achievement of sustainability of the projects?

Replicability and scale
The Consultant(s) will examine if and to what extent are the approaches, services and interventions replicable across Tanzania and in other contexts?

D. SCOPE OF THE EVALUATION

The evaluation will examine the results achieved by the project. It will explore policy and programmatic changes achieved by the project both in Dar es Salaam and Iringa regions as well as impact on targets i.e. young people from the perspective of available structures to address young people sexual and reproductive health rights targeted by the project. The evaluation will include in-depth discussions with young people, and government officials, implementing partners, journalists, communities and other relevant key stakeholders. It will also incorporate the findings from the various reports reviews and project documents. It is expected that the evaluation will cover project locations in Iringa, Ilala and Kinondoni districts.

E. SCOPE OF THE ASSIGNMENT

The Evaluators are expected to:

1. Provide an inception report highlighting understanding of the TORs for the external evaluation proposed methodology and plan for execution framework including the tools for data collection and detailed evaluation work-plan. This may include working with project team to refine the evaluation design and sharpen the methodology and tools to be used including questions.
2. The consultants will review and analyse existing project documents provided by Amref Health Africa programme team and management and manage the field data collection, analysis and report writing.
3. Evaluate overall impact in relation to the project design and approaches applied, given that it operates as one actor among many actors trying to achieve the same ultimate goal. Assess as to whether the project contributed in a meaningful way to the achievement of overall vision.
4. Assess the overall achievement and effectiveness of SRHR project in relation to stated objectives, outcomes and impact. Provide reasons for achievement or non-achievement of the objectives.
5. Assess the added value of the project interventions to Tanzania conducted through its catalytic role in promoting young people's sexual and reproductive health and rights specifically the youth between 10 -24 years, vulnerable groups and key populations.
6. Identify the best practices and lessons learnt from the project that can be replicated and/or scaled up elsewhere.
7. Provide explanations on the cost effectiveness and efficiency of the project.
8. Make recommendations, conclusion and how to sustain the project interventions
9. Debriefing Amref Health Africa, Embassy of Sweden, incorporate feedback and update the report.
10. Submit final report with the analysis and conclusions of the evaluation process.

Amref Health Africa is responsible to:

1. Provide relevant project documents (proposals, reports, monitoring and evaluation plans, project deliverables etc.)
2. Provide list and set appointments with key respondents, collaborators, implementing partners, Government officials and other stakeholders who the Consultant (s) agrees with Amref Health Africa to meet and interview.
3. The project team will be available for an interview, guiding the consultant(s) to meet key stakeholders, acquire documents created by the project or elsewhere but relevant to the consultancy and other support to enable the consultant(s) to get required information.
4. Inform the external evaluator about the programme's operations and objectives, characteristics of the target population, and the benefits that programme expects from the evaluation.
5. Provide feedback to the evaluators throughout the evaluation period
6. Provide information to all sub-grantees and other partners before and after the evaluation process.
7. Plan for consultative and debriefing sessions with the evaluators at various times during the evaluation and at its conclusion.
8. Amref Health Africa will review the inception note and draft evaluation report.

F. EVALUATION DESIGN AND METHODOLOGY

Methodology

The consultant will design a methodology that is suitable and acceptable for conducting scientific enquiry, using relevant evaluation methods and techniques. However, this may be discussed and agreed by the evaluator and Amref Health Africa with the aim of ensuring that every possible source of important document is consulted. The evaluation shall be carried out through analysis of available project documents and other documents considered necessary by the Consultant. To ensure the methodology is participatory, interviews shall be carried out with, but not limited to project beneficiaries, representatives of the organization, strategic partners, and other relevant stakeholders.

The evaluation shall be carried out based on a gender and rights perspective, i.e. analysis made and findings presented shall consider the involvement of males and females as well as their communities.

This evaluation will involve methodological triangulation of both qualitative (In-depth interviews and focus group discussions) and quantitative (Interviews) approaches. The consultant will prepare or adopt appropriate tools, which cover the key areas identified in the scope of work and key tasks of the Evaluation. These methods include:

- Conducting focus group discussions with project beneficiaries such as youth (10-24 years), key populations, vulnerable groups, parents, teachers and community members.

- Conduct exit interviews with project beneficiaries (Youth between 10-24 years) who are utilizing youth friendly services in health facilities within project areas.
- Conduct of semi-structured in-depth interviews with district and regional representatives, key partners, sub-grantees, government officials,
- Desk review of secondary data at project, district, regional and national level.

The Consultant(s) will produce a methodological framework to evaluate the project before commencing the final evaluation. The methodological framework is a document which will show the sample design and data collection methods that will be used. The data collection tools that will be used should also be stipulated in the methodological framework. In the document the Consultant (s) will also explain how they will involve young people during the evaluation. The methodological framework will also state the data analysis software that will be used. A timeline showing activities should be attached at the end of the document.

Stakeholder Involvement

The evaluator shall visit the field areas and meet the beneficiaries in their various categories and other stakeholders. He/she shall apply participatory methods to gather information useful for the analysis and final assessment. Stakeholders who will be involved will include:

1. Young people including key population and vulnerable groups
2. Amref Health Africa Staff
3. Ministry of Health and Social Welfare
4. Ministry of Education and Vocational Training
5. Ministry of Information, Youth, Culture and Spots
6. Multilateral and Bilateral development partners working on young people's sexual and reproductive health and rights
7. Local Government Authorities of Ilala, Kinondoni and Iringa Municipalities
8. CSOs Sub-granted by the project
9. Beneficiaries in the field.
10. Any other Government agencies and stakeholders as may be discussed with Amref Health Africa.

Geography Coverage

The evaluation will be conducted in project areas in Ilala, Kinondoni and Iringa Municipal councils.

G. PROFILE OF THE CONSULTANTS

To ease the procurement process Sida's Evaluation Framework Agreement will be used. A team of consultants (international and local), not exceeding three (3) not affiliated or representing the organization in anyway, to carry out the external evaluation. In terms of team composition, the consultants are expected to have the following key qualifications.

The International consultant should have the following qualifications:

1. Postgraduate qualification (Masters degree or above) in a relevant field
2. An evaluation specialist with expertise in monitoring and evaluation methodologies including Results Based Management Frameworks

3. Must have significant experience working in developing countries, preferably East Africa.
4. Excellent research and analytical skills, in both qualitative and quantitative methodologies
5. Excellent writing skills in English; and
6. Previous experience of similar assignments is an added advantage

The local consultant must have the following skills and knowledge:

1. Minimum of a Bachelor's degree in public health, development studies, social sciences, organizational development or any other related disciplines.
2. Demonstrated experience in evaluating sexual reproductive health and development programmes
3. Knowledge and demonstrated experience in monitoring and evaluation methodologies including Results based management frameworks.
4. Excellent research and analytical skills, in both qualitative and quantitative methodologies.
5. Sound experience in institutional development assessments
6. Clear understanding of expected role of civil society in development process
7. Sound experience in conducting project end term evaluations of Adolescent Sexual and Reproductive Health programmes would be an added advantage

Both consultants are expected to have a sound background and good knowledge of the following areas

1. Program monitoring and evaluation
2. Participatory methodologies
3. Organizational development
4. Financial Management
5. English Language proficiency
6. Computer skills especially the use of statistical analysis software packages for qualitative and quantitative data analysis

H. TIMEFRAME

The consultants shall prepare and submit a preliminary work-plan and budget for the end term evaluation. He /She shall accomplish the work within an agreed timeframe of not more than **60 days** (approximately eight weeks) including weekends, public holidays and travel time. This will involve travels to various areas (within the 3 Municipal Councils of Iringa, Ilala and Kinondoni), to consult and interview various people, conduct desk reviews, analysis, preparation of a draft report, discussions with stakeholders for feedback on draft and preparation of the final report.

A brief inception report shall be submitted to Amref Health Africa and Embassy of Sweden before commencing the field work. Immediately after completing field work, a debriefing meeting will be held between Amref Health Africa, the evaluator, Embassy of Sweden and any other relevant stakeholders to validate the key findings.

The Consultant(s) will submit draft reports to Amref Health Africa and Embassy of Sweden for review and feedback five weeks after commencing the evaluation. The

Consultant(s) will submit a consolidated final evaluation report two weeks after receiving feedback and inputs from the Embassy and Amref Health Africa.

The Final Evaluation report shall be submitted **for approval by the Embassy of Sweden**, not later than **15th January 2015**.

I. REPORTING AND EXPECTED OUTCOMES

The report shall present the methodology, main findings, discussion and conclusions, and include recommendations essential for future development. The evaluation report shall be written in English and shall have the following structure:

1. Executive Summary- Summary of the end-of-funding evaluation with emphasis on main findings
2. Assessed interventions- description of the assessed interventions, its purpose, logic, history, organization, stakeholders and other relevant information
3. Lessons Learnt - general conclusions including a reflection on the project's response to the midterm evaluation
4. Recommendations
5. The evaluation report shall not exceed 40 pages, excluding annexes.

The consultants will provide a debriefing on the highlights of the findings after completion of field work and before a draft report is submitted. The draft report will be submitted to the Embassy of Sweden electronically and in 2 hardcopies no later than **12th December 2014**. It must also be submitted to Amref Health Africa electronically, by that same date.

Within two weeks after receiving the Embassy's and Amref Health Africa's comments on the **Draft report**, a final version shall be submitted to the Embassy, again electronically and in 2 hardcopies not later than **15th January 2015**. The **End of Funding Evaluation Report** must be presented in a way that enables publication without further editing.

J. CONTACT PERSONS

Embassy of Sweden: Joyce Tesha, Programme Officer, email: joyce.tesha@gov.se

Amref Health Africa: Dr Festus Ilako, Country Director, email: festus.ilako@amref.org

Amref Health Africa: Dr Rita Noronha, Deputy Country Director, email: rita.noronha@amref.org

K. ADDITIONAL RESOURCES AND REFERENCES

There are several useful information sources for the evaluator. These include:

i. Approved project proposal and monitoring protocols
ii. Mid Term Review reports

iii. Programme implementation reports e.g. Annual reports, context reports, policy briefs, annual reports form sub-grantees and Financial audit reports
iv. Project evaluation reports i.e. baseline, midterm and operational research reports
v. Monitoring tools and data base information
vi. Documentation reports i.e. case studies
vii. Reproductive health policy documents and guidelines from the Ministry of Health (specifically from the Department of Reproductive Health).
viii. National NPG- RCH policy
ix. National Health Sector Strategic Plans
x. Amref Health Africa business plan
xi. List of participants from various areas trained within project area
xii. Training materials /curriculums developed
xiii. List of items procured

Annex 2 – Inception Report

1. Assessment of Scope of the Evaluation

This report elaborates on the proposal previously submitted to the Embassy of Sweden in Dar es Salaam and the Amref Health Africa (Amref). The report is based on a desk review of the programme documentation. The team will further develop the evaluation questions and align data collection processes ahead of the field visits.

1.1 BACKGROUND AND CONTEXT

Adolescents have the right to supportive environment, access to information, education and friendly health services, protection from all forms of exploitation, sexual abuse, assault and harassment, parent and community support, participate in planning, implementation and monitoring of Sexual and Reproductive Health and Rights (SRHR) programs.

Youth according to the United Nations' definition are people between 15 to 24 years of age, however, each region might have their own definition of youth. In Tanzania youth is defined as young men and women from the age group of 15 to 35[39] and they comprise 35.1 % of the population. These young people face many significant sexual reproductive health challenges such as limited access to youth friendly services including information on growth, sexuality and family planning. This has led youth into risky sexual behaviours resulting in high STI and HIV prevalence, and early pregnancy and vulnerability to delivery complications resulting into high rates of death and disability. The National Demographic survey of 2012, shows that maternal mortality ratio (MMR) is still high at 454/100 000 live births. A total of 23% of women aged 15-19 have started childbearing, while 44% of them were either mothers or are pregnant with their first child by the age of 19.

Having a sexual orientation other than the heterosexual norm is not accepted in Tanzanian societies. Lesbians, Gay, Bisexual and Transgender (LGBT) people are not in a position to discuss their sexual orientation openly. People with a diverse sexual orientation are at risk of Sexual and Gender Based Violence (SGBV). Homosexuality and Men having Sex with Men (MSM) is a criminal act in Tanzania according to Section 154 of the Penal Code. Similarly, the health system is not responsive to the needs of LGBT. Health workers are not trained on these issues and people may be afraid that their privacy is not kept. LGBT issues are not discussed within the education

[39] National Youth Development Policy 200, Ministry of Labour and Youth Development

system. As a result, LGBT live a life within the heterosexual norms while having other sexual relationships in secret. This contributes to HIV/AIDS and STIs. Overall, 5.1% of Tanzanians age 15-49 are HIV-positive. HIV prevalence is higher among women (6.2%) than among men (3.8%). Stigma and discrimination against youth living with HIV and AIDS deprives them of their basic right to SRHR services.

Tanzania's government has ratified international and regional conventions promoting Adolescent Sexual Reproductive Health Rights (ASRHR) (Convention on the right of the child (UNICEF 1990), UN Convention on the Elimination of all forms of discrimination against women (CEDAW), International Child Development (ICDP) Program of Action (1994), and the Southern African Development Community (SADC) Protocol (Article 17) on child and adolescent health). Within the international and regional context, Tanzania has taken several steps towards enabling policies and strategies in establishing friendly SRH for the youth. SRHR is one of the key issues in the new Tanzanian Draft Constitution 2014. However, accessing these rights for the youth is a big challenge in Tanzania. The main constraints towards attaining SRHR are a lack of education and awareness of SRHR, a changing context of traditional socialization process where youth learn the norms about sexual behaviour, harmful cultural practices such as early marriages, female genital mutilation (FGM), a low education level and low income (especially among girls) that leads to risky sexual behaviour, a limited number of health providers that are trained in provision of ASRH, as well as a limited number of health service centres that provide safe and confidential facilities to the youth.

1.2 THE PROGRAMME

This is a 4 and a half year project which is being implemented from December 2010 to 31st September 2015. Initially the project was to run for three years from December 2010 to October 2013, but it has been extended to provide space for a constructive phase-out stage and enhance sustainability.

The overall objective of the project is to promote the realization of SRHR and access to SRH services among 100 000 young people in Iringa and Dar es Salaam regions. The project is working with four major strategic components to achieve the overall objective:

- Youth Friendly Services (two youth friendly SRH model service centres will be strengthened, one in Iringa and one in Dar es Salaam),
- Capacity Building (for supporting and setting up youth friendly services, directed to peer educators, district planners, health providers, school teachers and CSOs),
- Advocacy and Policy (for SRHR and youth friendly services)
- Health systems Strengthening (supporting the health system regarding service provision, human resources, information system and leadership and governance).

The Sexual Reproductive Health and Rights Project is targeting young people (girls and boys) aged 10-24 years in Iringa (Iringa Municipality) and Dar es Salaam regions

(Ilala and Kinondoni Municipalities). These include the vulnerable groups (Young PLHIV, orphans, and youth with disabilities i.e. the deaf) and key populations (CSW, MSM, lesbians). The Project also works closely with ministries and departments dealing with youth related issues and other secondary beneficiaries such as parents, health providers, communities and teachers. The specific objectives of the project are[40]:

4. Young people (10 – 24 years old) in Tanzania realised their sexual and reproductive health rights and exercised it by demanding for quality and friendly sexual reproductive health services.
5. Municipality councils in Iringa, Kinondoni and Ilala increase resources for provision of friendly sexual reproductive health services for young people in at least 30% of the existing health facilities.
6. Government, non-governmental institutions and individuals in Tanzania with access to technical support for instituting programmes for managing SRH needs of the young people.

Specific objective1 deals primarily with the Advocacy and Policy component and is focused on mobilization of young people to understand their SRHR and participate in discussions and sessions of sharing experiences. The project works with open forums, youth groups and bonanzas to reach young people and identify policies that should be developed or reformed. Messages and key information from young people are used in policy dialogue by the project, by working with the MOHSW in reviewing policy documents in collaboration with the Youth SRHR Forum.

Specific objective number one refers to young people realizing their sexual and reproductive health rights. It is understood by the evaluators that this means that they have come to gain knowledge on their sexual and reproductive rights. The activities under this objective are mainly about advocacy, policy dialogue and sensitization of young people. Specific objective one would then refer to the demand side of the demand-supply equation. On the other hand, the health services provided are reported under Specific objective one in the Progress report for 2013.

Specific objective 2 deals with the first component of Youth Friendly Services. Improvements of the youth friendly services at the two model centres fall under this specific objective, including outreach activities, road shows, debates and edutainment (music/dancing, sports, drama, community theatres). Within this specific objective, the project also advocates for resource allocation for youth friendly SRH services, including sensitizing health programmers and planners, and also advocates for recruitment of social welfare cadres specialized in youth counselling to health centres.

[40] Amref ToR for final evaluation TUITETEE 29 September

This specific objective also includes a training component of municipality structures in provision of quality, friendly and sustainable SRH services for young people (responding to the second component of Capacity building). Also in this specific objective are activities related to the fourth strategic component of Health Systems Strengthening, mainly support to MOHSW to integrate youth friendly services in existing health facilities.

Specific objective number two is defined in the Project document as providing sexual and reproductive health services at the three model centres and at least 30% of the existing health facilities in those municipalities. Two outcomes for this objective have been defined, one is about strengthening the services at the two model centres and the second is about increased resource allocation for SRH services in the municipalities.

Activities are grouped under non-clinical youth friendly services, where we find Information, Education and Communication (IEC) activities directed to young people, road shows, using a movie van, and other edutainment activities. The other group is clinical youth friendly services where we find the SRH services of the three model centres as well as training and information activities directed to health planners, ministries, Council Health Management teams and community health committees in the three municipalities. In the Progress report for 2013, only the non-clinical activities are reported under Specific objective two, while the clinical activities are reported under Specific objective one. No training activities directed to health planners, ministries, Council Health Management teams and community health committees in the three municipalities are reported under Specific objective two in the 2013 Progress report.

Specific objective 3 is primarily concerned with the Capacity Building component by developing training programmes regarding youth friendly SRH services for peer educators, district planners, health providers, school teachers and CSOs. Development of governance, leadership and supervision skills is also part of this specific objective.

The 2013 Progress report is partly about the grants from Amref to nine CSOs and their activities. The Progress report 2013 also reports on capacity building activities directed to target groups (youth led CSOs, teachers, parents, in and out of school youth, marginalized youth including commercial sex workers, men having sex with men, homeless youth and orphans). Training packages are also reported to have been developed and tested, to be used for training of social workers, service providers, school teachers and CSOs.

There are two outcomes defined under each specific objective. Outputs and indicators have been defined in Project Management Framework (PMF) M&E plan. A great number of activities are detailed under each specific objective. Project achievements per project objective and expected result (outcome) are described in the Amref Proposal for Extension of the project until September 2015.

A number of additional outcomes are added in the Indicator Reference Sheet; outputs are defined in the Project Management Framework M&E plan and referred to in the Progress reports. The theory of change for the project will be analysed as part of the evaluation, based on the Project document, the Indicator Reference Sheet, the Project Management Framework M&E plan and discussions with Amref. The theory of change will attempt to clarify if the activity focus of the progress reports has overshadowed the intended outcomes in relations between rights holders and duty bearers. The analysis of the theory of change may also strive to determine the nature of capacity development supported by the project, including that of strengthening the capacities of rights holders to demand appropriate services, strengthening the capacities of duty bearers to provide services (both the individual capacities of staff, and the functioning of their organisations) and the enabling policy environment for these capacities to be developed and sustained.

The four strategic components of the programme, as described in the Project Proposal, do give an insight into the intended theory of change of the project. Better sexual and reproductive health for young people will be achieved through advocacy interventions directed to them as rights holders and by providing youth friendly SRH services. Capacity building will be provided for health service providers and planners as duty bearers to increase quality and access to the youth friendly SRH services. Capacity building will also be provided on advocacy to strengthen this capacity among stakeholders and CSOs. To increase sustainability, health systems will be strengthened both at the service provision level and at the level of policy and planning. The institutional framework will be strengthened through policy analysis and development.

The progress reports refer to and follow up on the baseline study from 2011[41] which provided baseline data for the project indicators.

1.4EVALUATION PURPOSE AND OBJECTIVES

"The purpose of the evaluation is to review and analyse the project's relevance, effectiveness, efficiency, sustainability and impact and evaluate the project results, achievement of objectives and project impacts/outcomes and effects with a focus on the youth sexual and reproductive health and rights and structure of the project, the project rationale in line with the developed result frameworks and identify possible lessons learned, and recommendations for modification/improvements in design and methodologies used"[42]. According to the ToR, the evaluation is:

[41] Baseline Assessment Report Ilala, Kinondoni and Iringa Municipalities. October 2011

[42] Amref ToR for final evaluation TUITETEE 29 September

13. To measure the achievement and outcomes and to identify how SRHR project design has contributed to overall impact in promoting human rights among young people in Tanzania especially on access and utilization of SRH services, as per project proposals, available baseline information and developed results frameworks;

14. To ascertain the extent to which the goals and objectives of the project have been met, challenges observed and how they were solved.

15. To come up with recommendations on the project in terms of scaling up and suggesting ways of sustaining the project interventions.

16. Identify lessons learnt and explore potential for sustainability and scale-up of developed practices and services by Government of Tanzania at national and district level through enabling policy and economic environment.

17. Provide recommendations for improving program quality and program accountability to beneficiaries (especially young people) and contribute to wider learning within Amref Health Africa.

18. Provide information for future advocacy and programming in the area of Young people Sexual and reproductive health and rights.

The evaluators will employ the OECD/DAC Evaluation Criteria in order to assess the results (output, outcome, and impact), effectiveness, efficiency, relevance and sustainability of the programme, along with the institutional arrangements. In accordance with Swedish development cooperation policies, gender mainstreaming will also be assessed as a cross-cutting issue, as well as human rights..

2. Relevance and Evaluability of Evaluation Questions

The tasks or expectations of the evaluation are listed in the ToR (page 6). The following table gives input on how each of these will be taken care of by the evaluation.

Expectations of the evaluation	
1. To measure the achievement and outcomes and to identify how SRHR project design have contributed to overall impact in promoting human rights among young people in Tanzania especially on access and utilization of SRH services, as per project proposals, available baseline information and developed results frameworks;	Achievements and outcomes will be assessed as part of the effectiveness of the project according to chapter 2.1 below.
2. To ascertain the extent to which the goals and objectives of the project have been met, challenges observed and how they were	This is also part of the Effectiveness part of the evaluation (see chapter 2.1 below).

solved.	
3. To come up with recommendations on the project in terms of scaling up and suggesting ways of sustaining the project interventions.	Recommendations will be based on the relevance to programs and policies as well as actual planning and availability of resources by government at central and municipality level that impacts on sustainability of program activities (see chapter 2.2 Relevance and chapter 2.5 Sustainability below).
4. Identify lessons learnt and explore potential for sustainability and scale-up of developed practices and services by Government of Tanzania at national and district level through enabling policy and economic environment.	Lessons learnt will be analysed through interviews with project officials, from the progress reports, from Focus Group Discussions (FGDs), what resources are available at the 3 health centres and what National government policies and current economic environment support future sustainability The potential for scaling-up and sustainability as described above will also take into account the extent of enabling policies.
5. Provide recommendations for improving program quality and program accountability to beneficiaries (especially young people) and contribute to wider learning within Amref.	The effectiveness assessment will analyse both quantitative and qualitative aspects of the Youth friendly services provided. The assessment of accountability to beneficiaries is part of the HRBA of the evaluation described in chapter 3.
6. Provide information for future advocacy and programming in the area of Young people Sexual and reproductive health and rights.	Recommendations for future advocacy will be based on the assessment of effectiveness of current advocacy activities. Recommendations for future programming are part of issue number 3 above.

The following evaluation questions from the ToR will be assessed by the evaluation:

2.1 EFFECTIVENESS

"The extent to which the development intervention's objectives were achieved, or are expected to be achieved, taking into account their relative importance"

The following questions from the ToR will be assessed:

7. To what extent were the objectives achieved/are likely to be achieved in the project timeframe?
8. What were the major factors influencing the achievement or non- achievement of the objectives?
9. To what extent are unplanned positive effects contributing to results produced / services provided?
10. Have all planned target groups access to or are using project results available so far?
11. Are there any factors which prevent target groups accessing the results/services?
12. To what extent has the project adapted or is able to adapt to changing external conditions (risks and assumptions) in order to ensure benefits for the target groups?

The assessment of effectiveness will be based on a review of the activities being implemented, according to the Project Document and Annual Plans. Most of the information about activities is available from the progress reports. The assessment of activities being implemented will help the evaluators respond to the question whether the activities were effective.

The indicators values will provide important information on the achievements. The evaluation will assess the indicators, the calculations and the values which have been arrived at. The assessment of achievements will be complemented by the questions defined in the evaluation framework in Annex 2.

These questions will be assessed through the exit interviews and focus group discussions in these municipalities (the details, the number of health facilities where interviews will be done and the number of respondents will be discussed with Amref and the Embassy).

2.2 RELEVANCE

"The extent to which the objectives of a development intervention are consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' policies"

The following questions from the ToR will be assessed:

4. Have the activities and outputs of the projects been consistent with the overall goals and attainment of its objectives?
5. Were the activities and outputs of the projects consistent with the impacts and effects?
6. Was the overall project objective relevant to the specific needs of the population in the project area?

The evaluation will assess if the activities have been relevant for the achievements of the overall objective, the specific objectives and outcomes of the project.

The evaluation will also assess if the project has been relevant to the specific needs of the primary beneficiaries in the project area, particularly the defined subgroups of beneficiaries of the project, young PLHIV and young people with hearing disabilities. This will be done through a review of analysis and reports on the needs of young people in relation to SRHR, through focus group interviews with young people, exit interviews at health facilities and interviews with the Network of young people living with HIV (NYP+), TANOPA, and young people from the deaf association (CHAVITA).

Evaluators will also assess the relevance for secondary beneficiaries receiving training and information about implementing youth friendly SRH services. The secondary beneficiaries are identified in the project document as peer educators, district planners, health providers, health facility managers, school teachers and CSOs. Progress reports and interviews with secondary beneficiaries will be the sources of information.

Finally, through document reviews and interviews, the evaluation will analyse the relevance to government stakeholders (MOHSW, MOEVT and municipal governments), for development partners (UNFPA and donors) and for other stakeholders, like parents, teachers and community members, as well as in relation to Tanzanian policies and strategies and Swedish development cooperation strategies and policies, including the relevance in regards to the point of view of gender.

The project document will also be analysed in relation to gender issues according to Sida's Manual for Gender mainstreaming[43] and according to the OECD/DAC evaluation criteria of integrating gender equality in an evaluation. Particularly, the team will look for any dialogue between Sida and the partners on gender issues, if any gender analysis has been done and if there have been any attempts in the project to specifically identify and address gender issues. The evaluation will assess whether the programme has contributed to increasing gender equality, in what way and to which extent. It will specifically look for signs that the programme has empowered women to demand their rights.

[43]Gender equality in practice. Sida. March 2009

2.3 EFFICIENCY

"The extent to which the costs of a development intervention can be justified by its results, taking alternatives into account"

The following questions from the ToR will be assessed:

5. Were activities cost efficient?
6. Were projects' resources managed in a transparent and accountable manner?
7. How flexible were the projects in adapting to changing needs?
8. How did the project co-ordinate with other similar interventions to encourage synergy and avoid overlaps?

Depending on financial data available, cost-efficiency analysis will be done, reviewing the costs for achieving some of the results.

The evaluation will also assess if projects' resources were managed in a transparent and accountable manner, through review of financial reports to Sida and the Amref system of reviewing the financial reports of sub-grantees. To apply a human rights-based approach in the evaluation, the team will also assess the extent to which the allocation of resources to targeted groups takes into account the most marginalized and the adequacy of resources provided for addressing human rights concerns in the intervention.

The flexibility in adapting to changing needs is understood as the changing needs of the beneficiaries. If their needs in fact have changed during the project period this will be established through interviews with beneficiaries and in interviews with Amref, and through documentation of changing needs. The next step will be to assess if the project has adopted –and how – to the changed needs, through interviews and assessing the annual work plans. The baseline study will also provide information about the needs at that time to be compared to what the needs of the beneficiaries are as expressed through FGDs and exit interviews as well as progress reports.

The question about coordination will be assessed based on the mapping of similar initiatives through interviews with project officials at Amref, municipal councils and development partners and in the project sites.

2.4 IMPACT

"The totality of the effects of a development intervention, positive and negative, intended and unintended"

The following questions from the TOR will be assessed:

6. What has happened as a result of the projects?
7. What real difference have the projects made to beneficiaries?
8. How many people (beneficiaries, partners or stakeholders) have been affected?

9. Have there been/ will there be any unplanned positive impacts on the planned target groups or other non-targeted communities arising from the project? How did/will this affect the impact?
10. Did the project take timely measures for mitigating the unplanned negative impacts? What was the result?

The evaluation will be greatly assisted by the fact that there was a baseline study in 2011 and that data on the indicators have been continuously collected by the project. Since the project has a well defined target group, there are also some possibilities for the evaluation to get some indications of impact related to the expected outcomes, through surveys and focus group discussions with samples from the target group, including its sub-groups. The evaluation will however not be able to do a full impact evaluation which would require substantially more time and resources. The project will not be ending until September 2015, so there could still be some impact that will not appear at the time of the evaluation.

The evaluation will apply a HRBA by assessing the nature of the capacity development supported by the project, including that of strengthening the capacities of rights holders to demand appropriate services, strengthening the capacities of duty bearers to provide services (both the individual capacities of staff, and the functioning of their organisations) and the enabling policy environment for these capacities to be developed and sustained. This will be done through focus group discussions with young people and through interviews with project officials, municipal officials and other stakeholders, as well as through review of progress reports and any other research documents that will be availed to the evaluators.

2.5 SUSTAINABILITY

"The continuation or longevity of benefits from a development intervention after the cessation of development assistance"

The following questions from the ToR will be assessed:

8. Have the projects resulted in leveraging of knowledge and interventions to ensure sustainable impact for young people at scale?
9. How far is the project embedded in local structures?
10. Are the relevant authorities able to afford maintenance or replacement of the services introduced by the project?
11. Were project partner's capacities being properly built (technically, financially and managerially) for continuing to deliver the project's benefits/services?
12. What support has been provided from the relevant national, sectoral and budgetary policies?
13. Is there a financial/ economic phase-out strategy? If so, how likely is it to be implemented beyond the project life?
14. What are the other major factors that have influenced the achievement and non-achievement of sustainability of the projects?

Advocacy and information activities directed to young people through variety of interventions by the project may be deemed to be sustainable if they have resulted in changed behaviour and utilization of health services. This will be analysed based on the corresponding indicators from the progress reports and complemented by the FDGs.

The evaluation will also assess the prospects for sustainability in relation to the structures that have been strengthened and promoted by IEC activities and other organized ways of communicating with young people, either through the health facilities or through the supported CSOs (question 2 and 3).

The sustainability of existing youth friendly SRH services will also be assessed by reviewing the sustainability of the capacity building results at individual, organizational and institutional levels (question 4), and financial sustainability (question 5 and 6). Sustainability will to the extent possible be assessed through interviews with council officials, for the 30 % of health centres that have been capacitated to offer youth friendly SRH services (if this has been achieved). Please see the Evaluation framework in Annex 2.

We understand that question 6 about a phase-out strategy refers to the project and the existence or non-existence of this strategy. This will be assessed based on interviews with Amref officials and documents of the phase-out strategy.

Question number 7 will be analysed through interviews with Amref project officials, municipal officials and sub-grantees.

3. Proposed Approach and Methodology

3.1 APPROACH

The evaluation will adopt a human rights based approach. The evaluation will assess the extent to which the project design and implementation have been participatory in the sense that stakeholders have been able to participate in the design, implementation and monitoring of the intervention. In addition, the evaluation will assess whether stakeholders of the intervention have been consulted and participated in decisions about what will be evaluated and how the evaluation will be undertaken. The evaluation will assess if the intervention has adequately identified the capacities of duty bearers and rights holders and if increased capacity has had the effect of duty bearers meeting their obligations and rights-holders exercising their rights. The principle of non-discrimination promotes equality and rejects discrimination in all forms, the evaluation will be responsive to non-discrimination and determine which groups are subject to discrimination and whether they are receiving the support they need.

The right holders in this project are the beneficiaries. The evaluation will assess to what extent they have been heard during the project implementation and the evaluation will include methods that ensures that they are heard in the evaluation through exit interviews and focus group discussions. The number of beneficiaries heard will be limited due to the limited scope of the evaluation.

The duty bearers in this project are the government officials at central and municipal level together with the health facility staff. The evaluation will assess the capacity building efforts directed to the duty bearers and its effects.

The project document will be analysed in relation to gender issues according to Sida's Manual for Gender mainstreaming, as well as through review of progress reports and any other research documents that will be availed to the evaluators (see Chapter 2.2).

The evaluation will make use of mixed evaluation methods, using both quantitative and qualitative methods. The former, i.e. data from progress reports and M&E systems both for the project and the municipal councils, will give credible information about the extent of results for particular groups of stakeholders, while the latter can assist in explaining how those results are achieved. Qualitative methods also allow for the voice of the marginalised to be heard.

The team will gather information through a desk study of documents received from Amref and the Embassy of Sweden in Dar es Salaam, meetings with relevant staff members at Amref and the Embassy in Dar es Salaam, and interviews during field visits, with young people, decision makers, district planners, health care providers, CSOs and stakeholders (parents, teachers, and community members), as well as UNFPA and other DPs engaged with SRHR programs in Tanzania. The evaluation framework in Annex 2 details the evaluation questions. The evaluation of the effectiveness of the programme will be mainly based on document review and complemented by interviews of Amref, implementing partners and beneficiaries. The evaluation of the relevance of the programme, both at its inception and at present, will be assessed based on both document review and interviews with young people, decision

makers, district planners, health care providers, CSOs and stakeholders (parents, teachers, community members).

To evaluate the outputs and short- and medium-term outcomes of the programme on the target groups, the evaluators will conduct interviews with Amref, implementing partners, community organisations working with the poor and marginalised, in particular working with young people and through focus group discussions with young people at the project model youth friendly health facilities.

The evaluation will emphasize on a participatory and consultative approach in line with human rights based principles. At the start of meetings and interviews, the evaluators will highlight the purpose of the evaluations and its potential as a tool for learning and improvement and will seek to establish an open tone that encourages respondents to express their views with candour. The evaluators will stress their independence from any donor or other stakeholder organisation and that the final assessment and findings will be those of the team.

3.2 DATA COLLECTION, SOURCES OF INFORMATION AND ANALYSIS

A combination of quantitative and qualitative methods will be used for the collection of data and information, including:

- Desk review of documents, plans, minutes and reports;
- Analysis of primary and secondary data from the M&E system, from programme sites and implementing organisations, plans, budgets and reports and of relevant databases and information systems;
- Formal and informal individual and group interviews, using semi-structured discussion guidelines with informants to obtain a wide range of informants' perceptions.

Collection of information from different beneficiaries and stakeholders are summarized in the following table.

Groups	**Methods**	**Purpose**
Young people (to be further detailed per age groups and sub-groups)	Exit interviews Focus groups	Effectiveness (use of services, youth friendliness) Relevance (responding to needs) Impact (change of knowledge, attitudes and behaviour)
Decision makers, district planners, health care providers MOHSW and MYD	Semi-structured interviews	Effectiveness (training, information) Impact (outcomes in terms of capacity development) Sustainability (capacity building, structures, capacity/commitments to cover recurrent costs) Relevance (of training and information)
CSOs	Interviews Reports	Effectiveness (achievements) Relevance (to their needs, to needs of their

		beneficiaries) Impact (capacity building of CSOs) Sustainability (capacity building, structures, financially)
Development partners, bilateral and multilateral (UNFPA, UNICEF)	Interviews	Relevance (similar projects)
Stakeholders (parents, teachers, community members)	Interviews Group discussions	Relevance (needs of communities and schools, etc.)

The evaluation methodology will be largely qualitative and will not seek to replicate the data already collected from Amref's progress reports and other programme documents. The evaluation questions are detailed in Annex 2.

Different sampling methods may be used and will be determined when developing the detailed plan for the field work. It will be important to allow for the identification of 'key informants', representing the target groups and relevant stakeholders, and for visiting relevant institutions and organisations.

An important task for the evaluators will be the collection of information from young people. A survey from a randomly selected sample from the 100 000 young people would have been the ideal method but is not feasible due to the time frame of the evaluation. Instead, we suggest, as indicated in the ToR, that we use exit interviews and focus group discussions. The following table provide preliminary details about exit interviews, focus group discussions and semi-structured interviews.

Method	**Target**	**Number of interviews, groups, participants**
Exit interviews	Young people visiting youth friendly SRH services	The target is 30-60 interviews at each of the model youth centres and another 30-60 in total at the other health facilities[44].
Focus groups	Young people in the municipalities,	1-2 focus groups will be conducted in each municipality with young people 15-24 years, females and males possibly

[44] Since interviewees cannot be randomly selected, the desired number of interviews cannot be scientifically calculated using statistical formulas.

Method	Target	Number of interviews, groups, participants
		separately.
Semi-structured interviews	Beneficiaries (teachers, parents, in and out of school youth, marginalized youth including commercial sex workers, men having sex with men, homeless youth and orphans).	Group interviews, probably small groups and individual interviews will be used, depending on the possibilities and sensitivity of meeting some of the beneficiaries. This will be discussed and agreed with Amref. A detailed time schedule will be developed in collaboration with Amref
Semi-structured interviews	Health centre management, clinicians and other staff. Municipal Director, Municipal Health Secretary, district medical Officer, Municipal Planning Officer, Members of Council Health Management Team (CHMT), Members of Council Management Team (CMT), Members of Community Health Committee. Responsible officers at the Ministry level towards whom advocacy is targeted	Group interviews and individual interviews will be used depending on the availability of officials at the municipal administration and at the model health centres. A detailed time schedule will be developed in collaboration with Amref

Exit surveys will be conducted at each of the two model health facilities in Iringa and Dar es Salaam and possibly at other health facilities in the same municipalities providing youth friendly SRH services.

Focus group discussions with young people will be conducted in each of the three municipalities of Iringa, Ilala and Kinondoni. The number of focus groups and the composition and selection of participants will be further discussed and agreed on with Amref. The sub-granted CSOs and Amref are expected to facilitate the organization of the focus group sessions by making participants available and providing space.

The data collection phase will involve approximately two and a half weeks of field work, during which the two team members will visit Dar es Salaam and the three project municipalities respectively in Ilala, Kinondoni and Iringa.

At the outset, respondents will be informed about the purpose of the evaluation, and that opinions expressed will be treated sensitively. Senior officials and those in positions of authority will be asked whether they do not mind being quoted, but for the most part, quotes will not be attributed to particular individuals. Judgments and views expressed will be those of the authors interpreted from information received from

respondents. If matters of particular sensitivity arise, complete confidentiality will need to be given to sources, and such matters will be raised with the Embassy in the first instance. It will be important to the evaluation process to establish conditions that encourage open and frank dialogue, as this is essential to the sharing of ideas.

The evaluation team will present and discuss the preliminary findings with the Embassy in Dar es Salaam, Amref and stakeholders in a de-briefing workshop in Dar es Salaam at the end of the data collection phase.

After the field work, the evaluation team will proceed with the data analysis and reporting.
In order to ensure the reliability of the data, reduce the potential for bias and obtain a more 'holistic' view of the programme's implementation and outcomes, different forms of triangulation will be used, comparing a variety of data from different sources (*data triangulation*) and using different methods (*methodological triangulation*).

3.3 WORK PLAN

The evaluation will be carried out in three phases, inception, in-country missions and analysis and reporting phase.

Inception Phase (20 – 29 October)

This phase primarily entails a desk review of programme documentation that has been made available to the team (listed in Annex 6) and drafting of the Inception Report, including review and comments by the Embassy of Sweden and Amref. The Draft Inception report is to be submitted on 29October.

In-Country Mission (12- 28 November)

At the end of the inception phase, the evaluators will conduct the in-country missions to Tanzania and the three project sites, meet with and interview relevant program officials at the Embassy in Dar es Salaam, Amref and implementing partners as well as beneficiaries and stakeholders. The trip will begin with briefing meeting with the Embassy and with Amref. A wrap-up meeting will be held at the end of the field mission.

Analysis and Report Drafting (1 – 12 December)

Following the field visits, the team will analyse the information gathered and draft the Evaluation Report.

3.4 THE USE OF THE EVALUATION

The ToR states that the evaluation is expected to generate relevant findings, lessons, and recommendations which will inform future programme design in the area of youth sexual and reproductive health and rights and which will be shared with key stakeholders at the national and district level,

The evaluation shall identify lessons learnt and explore potential for sustainability and scale-up of developed practices and services by Government of Tanzania at national and district level through enabling policy and economic environment and provide recommendations for improving programme quality and programme accountability to beneficiaries (especially young people) and contribute to wider learning within Amref Health Africa.

3.5 LIMITATIONS

The ToR are very much forward looking (according to four of the six expectations listed on page 6 of the ToR), and it is uncertain how the backward looking analysis of the evaluation will provide sufficient evidence to address these expectations in an evidence based manner. We will address the forward looking evaluation questions within the scope provided by the evaluation, but we do not expect to engage in extensive information gathering and analyses of, e.g., the extent of commitments from central government to maintain and scale up this type of programme in the future.

The project site visits will be critical to understanding the multi-dimensional nature of the programme's interventions. The overall time frame for the evaluation will limit the team's ability to conduct focus group discussions and/or interviews with all subgroups of beneficiaries and stakeholders. The presented schedule is however deemed to generate sufficient information to respond to the evaluation questions.

The time frame for the evaluation does not allow for randomized surveys to be undertaken by the evaluation, i.e. for the exit interviews of visitors to youth friendly services or for the focus group discussions. The convenience sampling method[45] that will be used is deemed to provide good-enough data for the evaluation purposes.

As noted in Section 2, the team will not be able to conduct a full impact evaluation.

The scope of the evaluation limits the extent on how participatory the evaluation can be and how much the evaluation can actually capture the voices of rights holders. The evaluation has however been framed within a HRBA, and will look at accountability, participation, transparency and non-discrimination.

Related to the issue of evaluation criteria, is the inherent difficulty of assessing impact and sustainability. For this project, this challenge is compounded by the recent nature of the assistance to be evaluated and that the project is still ongoing.

[45] Non-probability sampling technique where subjects are selected because of their convenient accessibility

4. Other issues

4.1 QUALITY ASSURANCE

Quality Assurance (QA) and back-stopping will be provided by Indevelop: Ian Christoplos will provide Quality Assurance and technical support; Katarina Norderstål (Project Administrator) will provide logistics and administration support; Sarah Gharbi (Project Manager) will provide management and co-ordination and will liaise with the Embassy. The evaluation will comply with Sida's Evaluation Guidelines 2010.

4.2 FIELD TEAM

The field team will comprise Bernt Andersson and Shamshad Rehmatullah. The team will work together on all aspects of the evaluation, but each team member will have specific responsibilities for different sets of the evaluation questions. The team will also include some local research assistants, with main responsibilities to implement and summarize the exit surveys, and f taking notes at the focus group discussions them.

The field team members will adopt a flexible approach, which will require them to work independently at times in order to consult with as wide a range of stakeholders as possible. However findings will be shared and agreed, through continuous dialogue between team members and this will ensure that conclusions reached are considered, well founded, and arrived at through consensus of judgements.

Annex 3 – Follow-up of the cost extension for the Amref Tuitetee project

Planned activities for financial year October 2013 to September 2014:	**Achieved:**
Capacity building:	
Train youth led organizations on organizational development, result based management, monitoring and evaluation, basic leadership and governance; strategic planning, Internal control, advocacy, communication, basic library Skills and proposal writing.	Youth led organizations were trained on organizational development, result based management, monitoring and evaluation, basic leadership and governance; strategic planning, Internal control, advocacy and proposal writing in May 2014.
Train youth led organizations on entrepreneurship and livelihood skills	Young people from youth led organizations in Iringa and DSM have been trained on entrepreneurship and livelihood skills in April and June 2014
On job orientation in Small Scale Business Management, Bookkeeping and Revolving Fund management and linking them with microfinance	On job orientation in Small Scale Business Management, Bookkeeping and Revolving Fund management to CSOs and sub-grantees was conducted in August and September 2014.
Train health providers, teachers, sub-grantees and youth led organizations on SRH right based approach, life skills, sexuality and basic youth counselling skills.	Training for health care workers, school teachers and young people from sub grantees on life skills comprehensive sexuality, youth centred counselling and right based SRH in Iringa and DSM was conducted in November 2013 and June 2014.
Advertise and recruit students for training using institutionalized training packages.	Not yet conducted. Will be done after roll out of the institutionalized training packages
To develop a training manual/ guide for right based YFS.	Due to limited resources the components of right based YFS were fused in the comprehensive sexuality education and youth centred counselling manual.
Conduct supportive supervisions to sub grantees and youth led organizations	Supportive supervisions to sub grantees was conducted in September 2014 Supportive supervisions to youth led organizations were conducted in No-

	vember 2014.
To orient gate keepers i.e. parents/guardians, teachers, community leaders; health care providers and social welfare on parent- child communication, youth centred counselling and comprehensive right based sexuality training	Orientation was done to health care workers engaged in YFS, School teachers engaged in youth counselling, social workers, community development officers and young people from sub grantees from Iringa and DSM. The training was conducted at Mwananyamala Youth Centre in November 2013
To sub grant organizations that have contributed in reaching young people with SRHR	CSOs have contributed in reaching young people with SRHR information and services. The 8 sub grantees have signed MOU with Amref Health Africa in July 2014 to implement activities from July to December 2014. These funds are provided to sub grantees on quarterly basis.
To conduct capacity assessment of youth led organizations for IGA and link them with funding institutions.	No budget was allocated to conduct this assessment. The final approved budget did not include this activity due to limited resources.
Youth Friendly Services	
Continue to support the two model youth centres and health facilities in promotion and provision of YF SRH	The two models are supported by the project. The MYC is well operating however Mtwivila youth centre has been lagging behind due to challenges in the management and operation systems of UMATI.
To continue training and retraining health providers on provision of Youth Friendly Sexual Reproductive Health (YFSRH) services in health facilities and monitor progress for its sustainability	Training and mentorship of health providers on provision of Youth Friendly Sexual Reproductive Health (YFSRH) services in health facilities was conducted in July 2014 and sustainability plans were established.
Provision of equipment and supplies supporting provision of YFS.	STI drugs and male condoms use demonstration penile models were procured and distributed to health facilities providing YFS in the project area in Iringa and DSM between July and November 2014.
Continue providing SRH and psychosocial outreach services to young people including the marginalized and key populations	SRH and psychosocial outreach services were provided to marginalize young people including those in retention home, children's home. These included Yombo college for disabled and elderly home in DSM and children's homes in Iringa.

	These activities were conducted in November 2013, May and July 2014.
Health System Strengthening	
To train and mentor 30 Health Care Providers on YF SRH services from existing (especially those which staff have been shifted to other facilities) and new health facilities to be supported.	Training and mentorship for health care providers on YFS to fill the gap caused by staff reallocation was conducted in Iringa, Ilala and Kinondoni using available national YFS TOTs in each municipality in March, May and June 2014.
To facilitate supervisions to health facilities providing YFSRH	Supportive supervision has taken place in Iringa in November and planned in Ilala and Kinondoni in December.
Distribution of IEC materials to health facilities and youth centres providing YFS	IEC materials with important SRH messages Have been developed and distributed to health facilities, Schools and CSOs and other partners on quarterly basis. School teachers, in school and out of school peer educators have been oriented on how to prepare BCC materials suitable to the target population, using appropriate methods and messages In September 2014.
Continue to improve HMIS in collaboration with Municipals and data collection on SRH services	The project has continued to improve HMIS in health facilities providing YFS in Iringa and DSM in collaboration with Municipal officials responsible for data collection, process and utilization during YFS supportive supervision in December 2013 and November 2014.
Advocacy and policy analysis	
Maintain good relationship with municipal councils and continue advocating for resources increase in areas relating to SRHR (Plan to review the planned activities verses budgets allocated for the next financial year after the ceiling budget approval to see how significant the change is).	Good relationship with municipal councils has been maintained and the project has conducted a series of consultative meetings with relevant Municipal officials and Word Development Committee members in November 2013 and September 2014
Documentation of lessons learnt and best practices	Documentation of lessons learnt and best practice was conducted in Iringa for health facilities, in school and out of school peer educators in February 2014.
Development of an exit plan and ensure its implementation to sustain the interventions.	Sub grantees were facilitated to prepare and implement sustainability

	plans in July 2014 In September 2014, all sub-grantees provided updates on the implementation of their exit plans.
Support the MOHSW on the review of the National policy guideline on Reproductive and Child Health.	A consultant has been selected to conduct the actual work of updating the policy under coordination by the MOHSW-RCH unit.
Continue supporting the AJAET 2013 and conducting a master class with media practitioners on the good quality reporting of SRH news.	The project supported the Annual excellence of journalism awards of 2014 conducted in March 2014.
Continue supporting youth CSO and Networks to organize and participates in national and international advocacy events to spearhead SRHR advocacy and YFS.	Youth led CSOs and networks from Iringa and DSM oriented on youth participation in advocacy and decision making forums at different levels in July and August 2014
Preparation of policy brief and symposium to share findings, lessons learnt and challenges on SRH policies and research findings.	Planned to be done from February to March 2015.
Develop Business plan for Mwananyamala Youth Center	In the process of hiring a consultant.

Annex 4 – Project Management Framework/M&E plan

Results	Indicator	Indicator definition	Base-line (%)	MTE (%)	Target set in the beginning of the project 2011	New Targets set after the mid-term evalua-tion 2012	New Targets by 2015	Data source	Data collec-tion method	Frequen-cy of report-ing	Responsibil-ity for reporting
Impact											
Universal Access to Sexual Reproductive Health among young people (10-24 years) in Dar es salaam and Iringa	% of young people in Dar es Salaam and Iringa Regions realized sexual reproductive health rights and access to SRH services		0	122%	100%(reachin g 100,000 young people)	161,945 (100%)		Baseline survey report; Evaluation report; Pro-ject final report	Field sur-veys	Mid term and End term	Project Man-ager and M&E
Outcome											
Realization of sexual reproductive rights and increased demand for youth friendly SRH ser-vices.	% of young people utilizing SRHR services.	Young people utilizing ASRHR service will include categorized by age ranging 10-14, 15-19, 20-24 years, by sex (male and female) by key population (MSM, lesbi-ans, CSW) Vulnerable groups (deaf, YLWHIV, OVC, GBV, remand home) and type of ser-vices(STI, FP, HIV testing, coun-selling and condom provision, psychosocial etc.)	19%	42%	33%	60%	60%	Project reports, Evaluation report, data-base	Questioners, Interviews , FGD, and case studies	Annually, Mid term and End term	Project Man-ager and M&E

Increase number of young people with correct Knowledge, Attitude and Practises (KAP) on SRH rights	% of young people with correct knowledge on SRH Rights and responsibilities.	Young people are able to mention six rights out of ten as per National standards curriculum by sex (male and female) and by key population (MSM, lesbians, CSW) Vulnerable groups (deaf, YLWHIV, OVC, GBV, remand home).	0	80%	33%	90%	90%	Project reports, evaluation reports, Database	Questioners, Interviews , FGD, and case studies	Annually, Mid term and End term	Project Manager and M&E
Knowledgeable and skilled individuals addressing youth friendly services and their needs	% health care providers trained and have knowledge and skills on SRHR program to YFS disaggregated by cadre and sex.	Health care providers are clinical personnel in health facilities trained to provide youth friendly sexual reproductive health services.	0	79%(118/150)	100%	100%	100%	monthly, quarterly and annual reports	supervision report reviews	quarterly	Project Manager and M&E
	% peer educators trained and have knowledge and skills on SRHR program to YFS disaggregated by cadre and sex.	Peer health educators are young people (in and out of school) aged 10-24 years who have received peer health education according to the national health peer educator curriculum.	0	113%(563/500)	100%	100% (300 peer health educators)	100%(563 peer health educators)	Project reports, evaluation reports, Database	supervision report reviews	Quarterly	Project Manager and M&E
	% school teachers trained and have knowledge and skills on SRHR program to YFS disaggregated by cadre and sex.	Primary and secondary school teachers who have received SRHR and YFS skills using the national curriculum	0	86% (215/250)	100%	100%	100%	monthly, quarterly and annual reports	supervision report reviews	Quarterly	Project Manager and M&E
Outputs (Objective 1)	***Young people (10-24 years old) in Dar es Salaam and Iringa realized their sexual reproductive health rights and exercised it by demanding for quality and friendly SRHS***										
Youth (including MSM, Sexual Workers, PLHIV, Deaf, Youth in remand homes, IDUs and OVC) reached with SRH messages through edutainment during Bonanzas, health talks and	# of youth (10 – 24 yrs.) reached with correct SRHR messages through edutainment during BONANZA, health talk and youth forums		0	**122,053 (206 - deaf, 56 - MSM, 1171 - PLHIV, 288 - OVC , 120,332 Other youth)**	100 000	161,945 (100%)		Project evaluation reports and field survey	Questioners, Interviews , FGD, and case studies	Annually, Mid term and End term	Project Manager and M&E

youth forums											
Peer educators promoting Sexual Reproductive Health Rights among youth	# Peer educators trained and promoting Sexual Reproductive Health Rights among youth		0	563	500	800		Project reports	Project review	Quarterly	Project Manager and M&E
	# of youth reached by trained peer educators on SRHR messages		0	26 469	26 469	39 704		Project database	Review	Quarterly	Project Manager and M&E
Outputs (Objective 2) Municipality Councils in Iringa, Kinondoni and Ilala with increased resources for provision of friendly sexual reproductive health services for young people in at least 30% of the existing health facilities in the municipalities											
Reviewed National Policy guideline on reproductive and child health addressing ASRHR	# of policy guidelines reviewed		0	1	2	3		Project reports	Project review	Quarterly	Project Manager and M&E
Conduct Advocate meetings for deployment of social welfare cadres	Advocacy meeting conducted		0	4	1	2		Project reports	Project review	Quarterly	Project Manager and M&E
Supporting EJAAT 2012 in awarding of best writer and photographer on SRHR for young people,	EJAT 2012 Supported		0	1	1	2		Project reports	Project review	Quarterly	Project Manager and M&E
Conduct Youth SRHR Discussion sessions on TV	Tv sessions conducted		0	10	10	18		Project reports	Project review	Quarterly	Project Manager and M&E

Conduct Youth SRHR Radio Discussion sessions	Radio sessions conducted		0	0	8	8		Project reports	Project review	Quarterly	Project Manager and M&E
Lobby for young people consultation during WDC Planning sessions and follow up	Young people involved n WDC planning sessions		0	24	24	48		Project reports	Project review	Quarterly	Project Manager and M&E
Preparation of policy brief targeting national policies on adolescent reproductive health rights and YFS.	Policy brief conducted		0	3	3	6		Project reports	Project review	Quarterly	Project Manager and M&E
Conduct consultative meetings Advocating for resource allocation for Y/ASRH services at all levels (Ministries and Local Government structures – in Midterm Expenditure Frameworks and CCHPs).	PMO RALG, POPC,MOF engaged in Consultation meetings for resources allocation		0	3	3	6		Project reports	Project review	Quarterly	Project Manager and M&E
Outputs (Objective 3) Government, Non-governmental institutions and Individuals in Tanzania access technical support for instituting programmes for managing SRH needs of the young People											
IEC and BCC materials with correct messages on ASRHR developed, tested, produced distributed to young people	# IEC and BCC materials distributed directly to youth	IEC materials messages on ASRHR developed, tested, produced and shared to young people (CSOs and schools), LGA, key population, vulnerable groups, HFs, partners, resource centres and events.	0	1 684 468	2 000 000	5 000 000	2 000 000	Project monthly, Quarterly and annual reports.	Project database.	Quarterly and annually.	Project Manager and M&E

Local organizations (NYP+, TAYOPA, CHAVITA, KI-WOHEDE, IYDP, MEWATA, St Camillius, UMATI and APCS engaged in addressing SRHR services for youth	# of supported local organizations addressing SRHR services for the young people.	Local organizations subgranted by the project to address SRHR services for youth include NYP+, TAYOPA, CHAVITA, KI-WOHEDE, IYDP, MEWATA, St Camillius, UMATI and APCS.	0	6	9	8	8	Project monthly, Quarterly and annual reports.	Project review	Quarterly and annually.	Project Manager and M&E
District Planners, CHMTs and Health facilities managers oriented, trained and supported in planning, priority setting and resource allocation	# of CHMT members oriented on youth friendly SRH services and rights	CHMT members include DMO,RCHCO,DACC,DSWO,DHS , DHO,DMC,DTbCO. District planners means; Heads of departments which includes primary and secondary education, Youth, social welfare, planning and community development.	0	136	136	136	136	Training reports	Attendance register.	Annually.	Project Manager and M&E
Institutionalized packages utilized in building the capacity of individuals for youth related issues	number of training programme package institutionalized and made available in AMREF, project implementing partners and CSOs calendar year 2012/2013 addressing YFSRH for young and vulnerable people	Institutionalized training packages are training manuals which include Youth centred counselling, Parent child communication, right based sexuality education and organisational development.	2	3	4	4	3	Previous manuals, references and project reports	Secondary data review.	Quarterly and annually.	Project Manager and M&E
Skilled and knowledgeable health care providers addressing SRHR	Number of service providers (medical) recruited and trained to provide friendly SRH services for the young people	Health care providers are clinical personnel in health facilities trained to provide youth friendly sexual reproductive health services.	20	118	150	229	195	MTE, Project monthly, Quarterly and annual reports.	Project document review.	Monthly.	Project Manager and M&E

skilled and knowledgeable individuals addressing SRHR	Number of service providers (non-medical) recruited and trained on life skills, right based approach and youth friendly SRH services for the young people	Non medical service provide include teachers, CSO's and partners.	-	435 (129 teachers,152 CSO/Partners, 154 media people)	193	238	539	MTE, Project monthly, Quarterly and annual reports.	Project document review.	Monthly.	Project Manager and M&E
2 model centres renovated and providing SRHR services	number of model centres renovated and providing SRHR services to young people including vulnerable youth	Model centres are youth centres providing comprehensive sexual reproductive health services including psychosocial counselling.	2	2	2	2	2	Project documents.	Project document review.	Monthly, Quarterly and annually.	Project Manager and M&E
Youth led organisation and CSO's with skills and knowledge on organisational development, result based management, monitoring and evaluation, entrepreneurship, basic leadership and governance; strategic planning, internal control, advocacy and proposal writing.	# of youth led organisation and CSO's trained on organisational development, result based management, monitoring and evaluation, entrepreneurship, basic leadership and governance; strategic planning, internal control, advocacy and proposal writing.	Youth led organisation and CSO's include Tandale Youth development centre, UNA,YOP,Positive change foundation, St camillus, Mzizi cultural troup, Ruaha Youth group, Mkwawa Youth group, Ngome youth development association,Kikosi kazi jamii, Matumaini youth group,Ngao youth group, CHAKUVIKIUTA, NYP+ and Kaengesa Youth group.	0	0		15	15	Project monthly, Quarterly and annual reports.	Project document review.	Monthly, Quarterly and annually.	Project Manager and M&E

Annex 5 – Table of impact and challenges assessed by the evaluation

Organizations visited by the evaluation	**Ultimate beneficiaries**	**Input from the Tuitetee project**	**Impact for beneficiaries**	Challenges
Dar es Salaam				
LGBT Voice in Tanzania	LGBT people, IDU, CSW	Amref provided YFSRHS, SRH education. 40 PEs trained. Free SRH services. Majority are PLWHAs. HIV testing and voluntary counselling. Training in entrepreneurship and IGAs start-up such as decorations, catering, etc.	Behaviour changes to safe sex, less sexual partners, how to behave in public and more acceptable in communities and get jobs. No longer depending on sex work to earn their living. Improved health due to ARVs. Demanding for SRH services, recognize that it is their right.	Stigma and discrimination in communities still a challenge Parents do not accept the fact that their children are MSM/Lesbian.
AWVT/TOPECD	The deaf youth in Ilala and Kinondoni Municipalities	Mobilized youth aged between 15 and 24 years. Amref organized bonanzas where the deaf participated for the first time where they got SRH education. Two weeks training on SRH for the group members in Morogoro. 75 deaf people supported by Amref. Support to conducted debate by deaf 8 deaf PE s	Gained knowledge about SRH and family planning.	Not easy to send information to deaf people they need pictures , DVDs and CDs Ignorance about HIV and AIDS and SRHR Counsellors have challenges with deaf people There are only 2 counsellors who are deaf people members; however, they cannot attend the HC every day due to financial constraints.

Organizations visited by the evaluation	Ultimate beneficiaries	Input from the Tuitetee project	Impact for beneficiaries	Challenges
				No sign language in hospitals or interpreters for deaf Gender issues –when deaf women go for labour there is communication barrier with the nurse/birth attendant. A deaf woman lost a child during labour due to communication challenges. # Of pregnancies among deaf women high due to sexual abuse and rapes. Negative perception that if an HIV+ person has sex with a deaf woman he will be cured.
Positive Change Foundation	MSM, IDU, CSW	Amref provided HIV and AIDS education and entrepreneurship. SRHR education from Amref. SRHR for youth to fight against HIV/AIDS. More than 600 have been reached. Leadership, financial management, M &E, documentation skills and write activity reports. Amref sponsored Anabasis Netball team. Organize meetings with Amref support. When Amref organizes bonanzas they pro-	Capacity of the leadership is built: they now have Administrative policy, financial policy, procurement policy, cash book. Payment voucher Write activity reports (documentation) Members demand for YFS at the Anabasis dispensary. Members are invited by the municipal council to participate in the municipal work plan preparation. Acquired skills to work with key population. How to communicate with them. And how to train youth on SRHR Pressurized the municipal to provide YF SRH services	Some parents do not want their young girls to get sex education because they think that they are being taught to become loose sexually Financial constraints. The group has been working with Amref for the past 3 years, but they never received any financial support. The leadership is working in risky areas with IDUs

Organizations visited by the evaluation	**Ultimate beneficiaries**	**Input from the Tuitetee project**	**Impact for beneficiaries**	Challenges
		vide transport. IEC materials, T-shirts and condoms for distribution. So far 18 PE s trained(12 are active)	at the district HC. The budget allocation has increased Youth groups are getting material support to call meetings and conduct HIV education Extra staff at the HC in Anabasis Reduction in teenage pregnancies # of teenage girls at dispensary decreasing Increase in the use of condoms (the group is distributing condoms) higher demand for condoms # of HSP at dispensary increased The HC have set aside special time for youth to ensure confidentiality, availability and affordability Community recognizes what the group is doing. More parents appreciate our work When there is sexual harassment (sexual assault) we refer to WLAC and Human Rights Organization The Secretary was trained as PE and now she is voluntary for the Human Rights organizations outreach program on SRHR	Lack of motivation and incentive from Amref Only when we participate in trainings we get allowances It is a challenge to work as a youth organization
Adolescent Psychosocial Consultancy services (APCS)	Young people in schools and out-of-schools needing psychosocial help	Sub granted by Amref. Counsellors paid by APCS	Youths reached: 2013: 372 M/399F; 2014 1866M/1952F Working with PE s and helped girls who were raped and MSM that need psychosocial counselling. GBV in families (family violence) deal with	Early marriages, infrastructures, older men seducing girls, including elder men seducing young boys

Organizations visited by the evaluation	**Ultimate beneficiaries**	**Input from the Tuitetee project**	**Impact for beneficiaries**	Challenges
			parents who are violent with their children. A case of a 5 year old that was sexually abused by an older man hard core criminal. The case was reported to the Oyster bay Gender Desk and the culprit was brought to court.	
International Youth Development Programme (IYDP)	Young people out of school and street children	SRH education to out of school young people. Trained PE s, helped vulnerable children. 15 orphans supported in Kinondoni area. Tuitetee Football cup tournament.	4684 (gender disaggregated) youth have been reached.	Delayed funds to conduct RSHR activities
Binti Mussa Secondary School	700 Students (50% girls)	Peer Educators (P E s) trained by Amref. HIV testing.	No teenage pregnancies since SRH education was introduced. Form 4 students did very in 2013 as compared to earlier years Pupils do not succumb to peer pressure. They know where to get help and advice. Behavioural changes 100% pupils are careful about indulging in sexual activities. Even those who are boyfriend and girlfriend say that they respect each other and they focus on the goal of education and try to pursue their studies.	The pupils said that since they got the training there has been no follow up from Amref. One of the challenges for the pupils is that teachers do not take this issue seriously. They do not get any encouragement from them.
Mnazi Mmoja Healthe Centre, Ilala	Young people needing SRH services	Trainings, refresher training, STI treatment, IEC materials. Supportive supervision. Outreach services in schools and communities.	Not many teenage pregnancies.	Working environment is congested Overstretched government budget cannot provide YFS
Magomeni Health	Young people need-	2 YFS providers trained by Amref. ICT mate-	Prevention of teenage pregnancies (no data though).	Budgetary constraints.

Organizations visited by the evaluation	**Ultimate beneficiaries**	**Input from the Tuitetee project**	**Impact for beneficiaries**	Challenges
Centre, Kinondoni	ing SRH services	rials. STI medicines, antibiotics, and penal models	More visits from the deaf as our staff members are trained in sign language	
Hananasif HC	Young people needing SRH services	Tuitetee provides training and ICT materials. Support Supervision and STI supplies. Ward communities benefitted from the project on awareness creation on SRHR of young people.	Increase of youth demanding YFS. Impact on girls is different attendance increased. Behaviour change more condom use and safe sex. Follow up on GBV? Just started in 2014 where GBV cases are referred to the social welfare department and one stop centre at the police station.	shortage of space no special space set aside for YFS. Services integrated. Provided to all. Lack of audiovisual facilities to make centre attractive to youth, Sometimes stock outs of HIV Test kits.
Mwananyamala Youth Centre	Young people needing SRH information and services	Secondary school text books for reference by school children, internet facilities, ICT materials		
Iringa				
Ipogolo Health Centre, Iringa	Young people needing SRH services	Small infrastructure renovation, training of staff in YFSRH services, IEC-material, some drugs, support to outreach activities, supportive supervision	Reduction of teenage pregnancies, reduction of STIs, and increased number of beneficiaries utilize the SRH services which improves their sexual and reproductive health. Health Information system show reduction from 7 pregnancies of primary school students 2012 reduced to 2 in 2013 (in all of Iringa)	
Umati Youth Centre	Young people needing SRH information and services	Amref sub grantee. Amref did renovation of the office, provided furniture, and the resource centre where there are computers etc.		None of the current staff are trained on YFS. High staff turnover lack of continuity.

Organizations visited by the evaluation	**Ultimate beneficiaries**	**Input from the Tuitetee project**	**Impact for beneficiaries**	Challenges
Kisera Primary School, Iringa	866 pupils (426 boys/440 girls). Average age is 14-15 yrs.	Training of peer educators among students, training of teachers	Knowledge among students how to avoid teenage pregnancies, to protect oneself and how to say no to sexual harassment and GBV (rape) sexual advancement by their teachers, etc. Boys are aware of dangerous behaviours and that need to avoid places that could lead to Sexual infections such as drinking, going to discos, mingling with other groups that have bad habits. Pupils educate each other's (in school and outside school). A rape incident in the school whereby they took the case to the one stop centre at the police station and to women's rights NGO TARWOL that provides legal aid to women and girls.	Getting the space and time to teach the pupils. SRH education is not part of the school curriculum. Need to INSTITUTIONALIZE SHRH in the school curriculum.
Mtivilwe Secondary School, Iringa	1 500 secondary school students	Training of peer educators among students, training of teachers, IEC material, life skills training and understanding the changes within you from a child to an adult.	Reduction of students pregnancies, less "bad behaviour" (smoking, sexual relations)	School timetable does not allow delivering SRHR education. The Ministry of Education has no policy for syllabus on SRH for YOUTH.
Mzizi Cultural troup	Young people and Key populations, drug and alcohol abusers, bar-maids,	Training of peer educators among the members, training in entrepreneurship, remuneration when the entertainment group performs	Healthier and more productive life Youth demanding their right to confidentiality and received treatment in confidence.	Timing is a challenge- often those who need to be trained are at their work, and when they are free to come in the afternoon, the trainers are

Organizations visited by the evaluation	**Ultimate beneficiaries**	**Input from the Tuitetee project**	**Impact for beneficiaries**	Challenges
	"boda-boda" drivers			mostly busy with their own work.

Annex 6 – Schedule for field work

Day	Activity
Wednesday 12 November	Internal consultant meeting
Thursday 13 November	Meeting with project staff at Mwananyamala Youth Centre
Friday 14 November	Meeting with project staff at Mwananyamala Youth Centre
Monday 17 November	Amref, meeting with John George, Programme manager Positive Change Foundation AWVT/TOPECD Organization of DEAF people
Tuesday 18 November	Amref, meeting with Rita Noronha, Deputy country director APCS Kinondoni (Psychosocial Counselling) LGBT Voice in Tanzania International Youth Development Programme
Wednesday 19 November	Secondary School, Ilala Mongozo Primary School, Kinondoni
Thursday 20 November	Project staff in Iringa Iringa municipality, meetings with DMO and RH coordinator Ngome Health Centre, Iringa Ipogolo Health Centre, Iringa
Friday 21 November	Mtwivila Secondary and Kihesa Primary school, Iringa Mzizi Cultural performance group Iringa municipality, meeting with the Youth development officer and Social welfare officer Umati Youth Centre, Iringa
Saturday 22 November	Travel from Iringa to Dar es Salaam
Monday 24 November	Grace Magembe, Regional Medical Officer, and former Tuite-tee Program Manager
Tuesday 25 November	Kinondoni Municipality, meetings with DMO and RH coordinator Magomene Health Centre, Kinondoni Hananisif Dispensary, Kinondoni Matumani group Embassy of Sweden, meeting with Joyce Tesha, Programme officer
Wednesday 26 November	Ilala Municipality, meetings with DMO and RH coordinator Mnazi Mmoja Municipal Hospital, Ilala Kiwalani Dispensary, Ilala Municipality
Thursday 27 November	Internal work
Friday 28 November	Internal work, preparing preliminary conclusions and debriefing
Tuesday 2 December	Debriefing Embassy of Sweden and Amref

Annex 7 – Questionnaire for Exit survey

Health facility:

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A. MULTIPLE CHOICE QUESTIONS

Age:		Sex:	Male	Female	Number of visits here this year	

1. I am satisfied and I achieved the purpose with my visit here today.

I totally agree	I agree	I neither agree or disagree	I disagree	I totally disagree

2. The staff was very friendly and respected me.

I totally agree	I agree	I neither agree or disagree	I disagree	I totally disagree

3. I did not wait a long time before I was attended to by a nurse/clinical officer.

I totally agree	I agree	I neither agree or disagree	I disagree	I totally disagree

4. They responded to my questions so that I clearly understood.

I totally agree	I agree	I neither agree or disagree	I disagree	I totally disagree

5. I have good access to reproductive health services when I need it.

I totally agree	I agree	I neither agree or disagree	I disagree	I totally disagree

6. I have good knowledge of sexual and reproductive health issues

I totally agree	I agree	I neither agree	I disagree	I totally disagree

		or disagree		

7. I understand and use contraceptive methods that prevent HIV and STDs

I totally agree	I agree	I neither agree or disagree	I disagree	I totally disagree

B. OPEN QUESTIONS

1. What is the best thing with this health centre?

2. Are you missing any services here that they are not provided?

3. What has it meant to you, that you have access to this SRH services?

Annex 8 – People interviewed

Amref and the Project offices in Dar es Salaam and Iringa
John Georg, Program Manager RMNCH
Rita Mbeba, Project Manager, Dar es Salaam
Rose Mtanangu, Project Officer, Dar es Salaam
Rita Nornha, Deputy Country Director¨
Proched Innocente, Project Liaison Officer, Iringa
Stella Jambo, Project Assistant, Iringa
Mercy Kawala, M&E Officer, Dar es Salaam
Kassimu Komungoma, Training Officer, Dar es Salaam, Lucy Lugome, Psychosocial officer, Dar es salaam

The Embassy of Sweden, Dar es Salaam
Joyce O. Tesha, Programme Officer, Gender, Child and Youth rights

Ministry of Health and Social Welfare
Grace Magembe, Regional Medical Officer, and former Tuitetee Program Manager

International Youth Development Programme
Flora S. Kalinga, Executive Director

Matumaini Group (CBO)
Maulo David Kilfane, Peer Educator
An Selma Laurent, Peer Educator
Onesmo John, Director
Prosper Paul, Human Resource Officer
Sawadi Shabani Program Manager
Pesper Kanist, Peer Educator
Penina Nkinga, Project Officer
Stella Ngeru, Accountant

Positive changes foundation at Ananasifu ward- Kinondoni municipality-Youth Led Organization
Khadija Hamisi- Secretary
Mary Stephano
Sharmia Yusuf
Saidi Nasoro (member)
Salum Khatibu (chairperson)

AWVT/TOPECD Organization of DEAF people
Francis Mbisso-Director
Teresia Nkwerra- member

Husna Jumanne- member
Wilhard Nyoni- Deputy/Assistant chairperson
Makunja Makunja- treasurer
Juma Abduly- PR officer
Habib Mkurute- interpreter

APCS Kinondoni (Psychosocial Counselling)
Josephat Thadeo- Accountant
Dr Zaynab Mkocho= Counsellor
Noel Simon- MEO
Liptano Salinyomba- Counsellor

Magomeni HC:
Dr Zuhura Majapa- HCF in charge and also a National Trainer for adolescent

Hananisif Dispensary (HC)
Dr Christian Katanga- Clinician

ILALA Municipality:
Dr Mary Sobai- DRCH Coordinator;
Dr Mwanahamisi Hassan- Program Coordinator

Mnazi Mmoja Municipal Hospital:
Dr F Kwai in Charge;
Farida Shemkande in charge of YFS Canter

KIWALANI Dispensary, Ilala Municipality
Stephen Mapunda- Clinician Officer;
Catherine Muya-HF in charge; Kadoyo Juma –Clinician Officer

Municipality of Iringa
Mew Alexander, Municipal Officer of Health
Sezaria Andrew, SRH Coordinator

Ipogolo Health Centre, Iringa
Mary Makundi, Officer in Charge
Pelagia Mwalongo, Health Care Provider
Catherine Lupembe, Health Care Provider

Umati Youth Centre, Iringa
Eison Kabuka, Officer in Charge

Mtwivile Secondary School, Iringa
Sapali Mshana – Swahili teacher (4 yrs. in school)
Eva Chaula- Civics teacher (2 yrs. in school)
Asha Swetta- Swahili teacher (4 yrs. in school) also trained in SRH

Annex 9 – Documents reviewed

- Adolescent Reproductive Health Strategy 2011 – 2015. MOHSW February 2011
- Amref Proposal for cost extension
- Adolescent Reproductive Health Training Curriculum for Peer Educators. Reproductive and Child Health section. MOHSW August 15, 2012,
- Advocacy Strategy. Amref Young People Sexual and Reproductive Health Rights Project 2012-2015. David Makala November 2011
- Annual progress reports 2010/2011, 2011/2012, 2012/2013
- Assessment of Marginalized Young People's Access to Sexual and Reproductive Health and Rights Education and Information in Selected Districts in Tanzania. Research Report submitted to Amref by Dr Kitila Mkumbo. March 2014
- Assessment of Organizational Capacity Competence: A case of selected community based organizations in Dar es Salaam. By Rita Mbebwa
- Baseline Assessment Report Ilala, Kinondoni and Iringa Municipalities. October 2011. Makawia Aimtonga Amani
- Barriers to sexual reproductive health services and rights among young people in Mtwara district, Tanzania. Rita Moses Mbeba et al. The Pan African Medical Journal. Published: 26/12/2012.
- 'Better Health for Africa'. Amref Business Plan October 2011 – September 2014. Amref
- Case study DFID Research. Support to the Tanzanian government with adolescent sexual and reproductive health. Department for International Development 4 February 2011
- Convention on the right of the child. UNICEF 1990
- Consultancy to facilitate the development of Mwananyamala young people Centre business plan. Amref
- Financial reports. Tuitetee project 2010/2011, 2011/2012, 2012/2013
- Guidelines for the preparation of Annual plan and Budget for 2012/2013. Ministry of Finance and The President's Office Planning Commission, February, 2012
- Health Sector Performance Profile Report 2011. Ministry of Health and Social Welfare, Policy and Planning Department, Monitoring and Evaluation Section
- Health Sector Strategic Plan 2009 – 2015 (HSSP III), on "Partnership for delivering the Millennium Development Goals"
- Health Sector Strategic Plan III July 2009 – June 2015. MOHSW
- Indepth Assessment of the Amref Tanzania Project on Sexual and Reproductive Health Rights for Young People 2010-2013. Embassy of Sweden in Tanzania 2 December 2010

- Indicator Reference sheet 2012-2013. Amref
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- International Child Development (ICDP) Program of Action. 1994TOR for final evaluation TUITETEE. Amref 29 September
- Knowledge, attitude and Practice (KAP) related to sexual and reproductive health among youth in Ilala, Iringa and Kinondoni municipalities. Kitila Mkumbo, Department of Educational Psychology and Curriculum Studies, University of Dar es Salaam. November 2011
- Mid-Term Evaluation of the Project on Sexual and Reproductive Health Rights for Young People. Process Consultants & Facilitators March 2013
- Minutes of Annual review meetings 2012, 2013, 2014
- National Adolescent Reproductive Health Strategy 2011-2015. MOHSW February 2011
- National Policy Guidelines on Reproductive and Child Health. MOHSW May 2003
- National Standards for Adolescent Friendly Reproductive Health Services. Reproductive and Child Health Section. Directorate of Preventive Services. Ministry of Health 2005
- National Standards in Peer Education for Young People. Reproductive and Child Health Section, Directorate of Preventive Health Services, MOHSW 2008,
- Online Health Facility Registry. MOHSW December 2014
- Population Distribution by Age and Sex. National Bureau of Statistics Ministry of Finance Dar es Salaam and Office of Chief Government Statistician President's Office, Finance, Economy and Development Planning Zanzibar. September, 2013
- Project Proposal Project on Sexual and Reproductive Health Rights for Young People. Dec 2010- Dec 2013. Submitted by Amref in Tanzania 16th November 2010
- Proposal for cost extension Sexual Reproductive Health Rights for the Young People Project Afya ya uzazi ni haki ya kijana, Tuitetee. Amref
- Project Phase Exit Plan. Prepared by the Project team. Dated 30 April 2014.
- Putting African communities first. Enhancing Capacity and Participation to Close the Gap in Health Systems. Amref Strategy 2007 – 2017
- Report on assessment of availability and accessibility of adolescent and reproductive health services in mainland Tanzania. A Health Facility Based Assessment. Final Report. October 2008 MOHSW
- Southern African Development Community (SADC) Protocol (Article 17) on child and adolescent health
- Standards for Adolescent Friendly Reproductive Health Services. Reproductive and Child Health Section, Directorate of Preventive Services, Ministry of Health Tanzania 2005

- Standardizing and scaling up quality adolescent friendly health services in Tanzania. Venkatraman Chandra-Mouli et al. BMC Public Health 13:579
- Supportive supervision reports Iringa, Ilala, Kinondoni2013 and 2014
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- The National Youth Development Policy. MOLYD 2007
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- United Republic of Tanzania Public Expenditure Review 2010. Prepared by the Members of Macro Group of the Tanzania PER Working Group. Document of the World Bank September 2011

External evaluation of the Amref Health Africa Project on Sexual Reproductive Health Rights for the Young People (Tuitetee – Lets Fight For It), 2010- 2015

This was an end-of-project evaluation carried out from November 2014 to January 2015. The overall objective of the project was to promote Sexual and Reproductive Health and Rights and access to sexual and reproductive health services among 100 000 young people in Iringa and Dar es Salaam regions. The evaluation found that the overall objective had been reached. The project had a sustainable impact in changing awareness, behaviour and care seeking of a considerable number of young people in the three targeted municipalities. Service provision at the current level, quantitatively and qualitatively, may continue for some time, but will not be sustainable without further support, in spite of the considerable capacity building by the project at municipality and health facility level, on how to plan, budget, set up, run and support the services. Limited funding from the national budget will likely prevent the expansion of services to other health facilities.

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