

**PROCESS EVALUATION OF ADOLESCENT AND YOUTH
SEXUAL REPRODUCTIVE HEALTH (AYSRH) PROGRAMME
ON UTILISATION OF SEXUAL REPRODUCTIVE HEALTH
SERVICES**

CASE STUDY OF KINONDONI MUNICIPALITY

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ON UTILISATION OF SEXUAL AND REPRODUCTIVE
HEALTH SERVICES
CASE STUDY OF KINONDONI MUNICIPALITY**

By

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**A dissertation Submitted to School of Public Administration and Management
in Partial Fulfillment of the Required Award of Master of Science in Health
Monitoring and Evaluation (MSc. HME) of Mzumbe University**

2019

CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled ***Process Evaluation of Adolescent and Youth Sexual Reproductive Health (AYSRH) Programme on Utilisation of Sexual and Reproductive Health Services - Case Study of Kinondoni Municipality*** in partial fulfillment of the requirements for award of a Master degree in Health Monitoring and Evaluation of Mzumbe University.

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DECLARATION

I, Winfrida Leonard Muhoja, declare that this dissertation is my original work and that it has not been presented and will not be presented to any other university for a similar or any other degree award.

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DEDICATION

This dissertation is dedicated to my mother Liberata Biseko, my father Leonard Muhoja and my uncle Aaron Muhoja whom without them, I wouldn't reach this milestone in life.

ABBREVIATIONS AND ACRONYMS

AY	Adolescent-Youth
AYSRH	Adolescent-Youth Sexual Reproductive Health
CSE	Comprehensive Sexual Education
CPR	Contraceptive Prevalence Rate
FP	Family Planning
HIV	Human Immunodeficiency Virus
RMNCAH	Reproductive, Maternal, Newborn, Child & Adolescent Health
SRH	Sexual Reproductive Health
STIs	Sexual Transmission Infections
TCI	The Challenge Initiative
UNFPA	United Nations Population Fund
WHO	World Health Organisation
YFHS	Youth Friendly Health Services
UNESCO	United Nations Educational, Scientific and Cultural Organisation

ABSTRACT

Different stakeholders have been investing in the adolescent and youth programme to help them by providing sexual reproductive health services including the challenge initiative (TCI) on Tupange Pamoja under Jhpiego in Dar es Salaam. It was believed that Adolescent and Youth Sexual Reproductive Health (AYSRH) services would contribute to the rise of Contraceptive Prevalence Rate (CPR). Study conducted in Kinondoni Municipality which showed significant rise of CPR from 11% in 2017 to 13.5% in 2018 after implementation of Tupange Pamoja and AYSRH programs. The objectives of this study were to examine how AYSRH program was implemented, what were the factors facilitated and impinging attainment of outcomes and what were the best practices on attainment of program outcomes.

The study adopted a case study design. Health managers were purposively selected based on involvement in designing, planning and implementing programme. Convenient sampling selected on duty trained health care providers (HCP), and young people attended services, made total of 19 respondents. Data were collected through documentary review (Reports and guidelines), in-depth interviews to health managers, HCPs and young people, observations in health facilities. Analyses of interviews were conducted by importing transcriptions in ATLAS ti. 7 by coding themes as per objectives, thus, output report generated for report writing. Content analysis conducted for documentary review.

Results indicated that, process involved municipal council on designing, planning and implementing programme with technical support from jhpiego organization. Commitment of budgeting for services and supplies of AYSRH and capacity building were major factors for the improving utilization of young people services. Major factors impinge the attainment of outcomes were bureaucracy, late report submission and unavailability of condoms. Best practices were program design at council level, community dialogues, data management and services sign boards.

Major conclusion was that, implementation of demand generation, advocacy, services and supplies increased number of young people using SRH services.

Municipal medical officer's office should train more providers, to make sure health facilities budget for audio and visual materials, recognize peer educators' role and manage to have enough stock of supplies and commodities especially condoms. MoHCDEC should provide guidelines addressing both adolescent and youth issues.

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OPERATIONAL DEFINITIONS

Sexual Reproductive Health (SRH)

Sexual Reproductive Health (SRH) includes those activities that address any of the following: puberty, pregnancy prevention, HIV, sexually transmitted infections (STIs), gender, SRH soft skills, abstinence, access to contraceptives, and HIV/STI testing (Rutherford, 2017).

Adolescent

WHO defines as adolescents as individuals of 10-19 year age group. In this period of life, individual is no longer a child but not yet an adult. Adolescence is a journey which an individual passes through physical and psychological changes, experiencing social expectations and perceptions. It is a time when physical growth is accompanied by sexual maturation which might lead to relationship intimacy (MOHSW, 2006).

Youth

World Health Organisation (WHO) defines youth as people who are at the age of 15-24, and young people include both adolescent and youth which cover the age range of 10-24 years (UNESCO, 2017).

Access to SRH

World Health Organisation explains Africa region access to sexual reproductive health (SRH) Services as “Accelerating Universal Access to Sexual and Reproductive Health”. It focuses on five thematic areas: (i) Maternal and newborn health (ii) Family planning (iii) Harmful practices, including female genital mutilation (FGM) (iv) preventing unsafe abortion, sexually transmitted infections (STIs), HIV/AIDS (v) Cervical cancer (WHO, 2013).

CHAPTER ONE

INTRODUCTION

1.1 Background

Adolescents and youth sexual reproductive health (AYSRH) has been critical area which needs to be addressed with quick scalable and sustainable proven approaches on provision of services (TCI-U, 2018). That was the reason for The Challenge Initiative (TCI) expanding its programmes to The Challenge Initiative - Youth by including proven AYSRH approaches in service delivery, demand generation and advocacy. This resulted in development of proven young people sexual reproductive health toolkits (Advocacy, Demand Generation, Services and Supplies) to support implementation of AYSRH approaches in cities that include the component of youth in family planning or reproductive health programmes (TCI-U, 2018).

In East Africa, Urban Reproductive Health Initiative (URHI) – Tupange Project in Kenya have shown significant contribution of young people in improving family planning contraceptive prevalence rate (CPR) in urban cities (TCI-U, 2018). The project was implemented in five urban cities including Nairobi, Kisumu, Mombasa, Machakos and Kakamega. Prior to the project implementation, Contraceptive Prevalence Rate (CPR) of the cities scaled up from 45% to 58% over the project implementation period (2010-2014). Though the project was not specifically targeted to adolescents and youth, evidence shows that they attended for family planning services which consequently led to increase of CPR (MLE, 2014). Such experience led to the replications of the project in other East Africa countries namely Tanzania and Uganda (MLE, 2014).

Before The Challenge Initiative, Tuitetee project was initiated by AMREF to promote sexual reproductive health rights for young people in Ilala, Kinondoni and Iringa municipalities from 2010-2015. The project focused on four strategies such as advocacy and policy, strengthening two youth friendly model service centres in Dar es Salaam and Iringa. Another strategy was capacity building aimed at supporting and set up youth friendly services, involve peer educators in and out of school, district

planners, health providers, school teachers and community based civil society organisations. Also it based on strengthening health systems by supporting service provision, human resources, information system, leadership and governance (Andersson, Rehmatullah, & Christoplos, 2015).

The project managed to achieve on creating awareness and demand to more than 100,000 targeted young people in each year of implementation, building capacity on services provision. Only Iringa municipality managed to reach target of 30% on providing youth friendly services in existed health facilities (Andersson, Rehmatullah, & Christoplos, 2015).

Though the project had impact in changing awareness, behavior, and care seeking, but service provision was not sustainable because of limited national government funding which prevented expansion of services to other health facilities other than those were in project. Training created a sustainable impact to trained persons but fund for continued training were not planned at municipal level (AIR, 2017).

To address the above problem, The Challenge Initiative (TCI) introduced Tupange Pamoja project on family planning at Dar es Salaam region in Ilala, Kigamboni, Kinondoni, Temeke and Ubungo municipal councils in 2018, because the region had lower Contraceptive Prevalence Rate (CPR) by 11.3% in 2018 and raised to 16.8% in 2019 with a goal of reaching 20% in 2020 (DHIS2, 2019).

In 2017, Kinondoni Municipality had only 4.8% (15-19 ages) and 28% (20-24 ages) of never married women using modern family planning services. On married women, only 13.3% (15-19 ages) and 28% (20-24 ages) of them was using modern family planning methods. And there was 12.8% (15-19 ages) and 21.4% (20-24 ages) unmet need married women (Kinondoni-MC, 2017).

Together with the above discrepancy there were only 67 facilities providing family planning among 185 total facilities in Kinondoni municipality, with only 5 youth friendly facilities to provide AYSRH services. On health care providers only 12 staff were providing friendly youth services with 0 staff trained on AYSRH in past 5 years,

also only 4 AYSRH champions, 0 number of community health workers (CHWs) and community-based distributors (CBDs) (Kinondoni-MC, 2018).

The reasons associated to low uptake of modern contraceptives and access to FP among adolescents and youth include inadequate facilities, inadequate trained and competent staff to provide AYSRH services, youth have no correct knowledge of pregnancy prevention and use of modern contraceptives and they do not know where to go for youth friendly counselling and services, another problem is provider's bias, lack of confidentiality and privacy, also limited methods of choice and social or peer pressure (Kinondoni-MC, 2017).

In effort to address the above problems in Kinondoni, Adolescent and Youth Reproductive Health (AYSRH) programme started its implementation in the municipality. The aim was to improve access to, and utilisation of Adolescents - Youth Sexual Reproductive Health (AYSRH) services and women of reproductive age. This was believed to scale up family planning and have additional women and girls with voluntary family planning services over the next three to five years (TCI-U, 2018). The program have shown significant contribution on increasing number of young people utilising sexual reproductive health services including family planning which resulted to rise of contraceptive prevalence rate.

1.2 Statement of the problem

In Kinondoni Municipality contraceptive prevalence rate (CPR) was only 11% in 2017, this include young people and adults. It had lower percentage of never married adolescent (15-19 years) who use modern family planning by 4.8% and married by only 13.3%. There was only 28% of never married and married youth (20-24 years) using modern contraceptives, but this time AYSRH programme was not started its implementation (DHIS2, 2018).

When AYSRH programme was introduced, the CPR figure raised up to 13.5% (2018) before completion of financial year 2018/19 of programme implementation (DHIS2, 2018). This time, AY accessed family planning by 31% in 2018, with uptake of contraception by 69% (Kinondoni-MC, 2017). There was no clear information on how AYSRH programme improved utilisation of sexual reproductive health services

among adolescent and youth, which led to the increase CPR in Kinondoni Municipality.

1.3 Objectives

The main objective of this study was to evaluate implementation of Adolescent and Youth Sexual Reproductive Health programme on improving utilisation of sexual reproductive health services in Kinondoni Municipality.

1.3.1 Specific Objectives

- i. To examine implementation process of AYSRH programme in Kinondoni Municipality
- ii. To examine factors facilitating attainment of AYSRH programme intended outcomes on utilisation of sexual reproductive health services among adolescent-youth in Kinondoni Municipality
- iii. To examine the factors impinging attainment of AYSRH programme intended outcomes on utilisation of sexual reproductive health services among adolescent-youth in Kinondoni Municipality
- iv. Establish best practices influencing attainment of AYSRH programme outcomes towards utilisation of sexual reproductive health services among adolescents-youth in Kinondoni Municipality

1.4 Evaluation Questions

How implementation of Adolescent and Youth Sexual Reproductive Health programme improved utilisation of sexual reproductive health services in Kinondoni Municipality

1.4.1 Specific Evaluation Question

- i. How AYSRH programme was implemented in Kinondoni Municipality?
- ii. What were the factors facilitating attainment of AYSRH programme intended outcomes on utilisation of sexual reproductive health services among adolescent-youth in Kinondoni Municipality?
- iii. What were the factors impinging attainment of AYSRH programme intended outcomes on utilisation of sexual reproductive health services among adolescent-youth in Kinondoni Municipality?

- iv. What are the best practices influencing attainment of AYSRH programme outcomes towards utilisation of sexual reproductive health services among adolescents-youth in Kinondoni Municipality?

1.5 Significance of the Study

This evaluation study provided evidence based information showing how AYSRH programme contributed to the scale up of CPR by percent of AY who utilised family planning services in and out of facilities. It generated essential information to programme implementers on the best practices that should be taken into account on improving AYSRH programme, impinging factors that might affect utilisation of the services and what factors facilitate attainment of AYSRH programme objectives. Also, generated inputs to guidelines preparation might help the implementation of the programme.

1.6 Description of the Programme to be evaluated

Adolescent and Youth Sexual Reproductive Health programme under the challenge initiative (TCI) project was initiated in Tanzania (Dar es Salaam) in 2018 and is being implemented by considering the designed toolkits which are (i) Advocacy (ii) Demand generation (iii) Services and Supply. Kinondoni Municipality designed the programme interventions according to the need of its context with the technical support from Jhpiego on how to include the mentioned toolkit in the programme for implementation (Kinondoni-MC, 2018). These are also strategic priorities of National Adolescent Health and Development Strategy 2018-2022 of MoHCDGEC, which need to be implemented in adolescents' program, they include (i) demand (ii) supply (iii) enablers (MoHCDGEC, 2018)

Demand seeks to understand social-cultural and economic trends in the country and their influence on health outcomes with disease burden for adolescents. Supply assesses health services and other needed support to address adolescents' health and development needs effectively. Enablers focus on policies and legislations, financing, data systems including access to information and coordination that create the right environment and provide relevant tools to support adolescent health and development (MoHCDGEC, 2018).

1.6.1 Programme Stakeholders

The Ministry of Health Community Development Gender Elderly and Children (MoHCDGEC) is a stakeholder by providing policy/guideline on concrete areas of focus to address reproductive health challenges faced in Tanzania. The ministry provides guidelines for training guidelines of trainers of trainees (TOT) on provision of services for.

Jphiego organisation, provide technical support on programme design, planning, implementation, monitoring and evaluate the programme implementation in council. Makes follow up on the use of fund to see if it has reached the objectives in each year of implementation. Links the council and funders, and provides funds for implemented activities.

Council Health Management Team (CHMT), are programme designers and implementers at council level. Members conduct supervision of AYSRH services in health facilities and out of facilities. The team conducts monitoring and evaluation of programme activities. They develop a plan and activities of AYSRH implementation which are included in Comprehensive Council Health Plan (CCHP) in each year if the council is qualifying for more fund in a given year.

Health care providers are essential stakeholders who provide services in health facilities and out of facilities. They are supposed to provide friendly sexual reproductive health services to adolescent and youth to increase utilisation of SRH services. They were trained and supervised by CHMT to make sure they provide the intended services as the programme requires. They are also supposed to provide education to beneficiaries on the use SRH services. Therefore, they have a great role to increase number of young people in SRH.

AYSRH programme beneficiaries, these are adolescents and youth who are expected to have information on SRH and utilise services in health facilities and out of facilities. Utilisation of AYSRH services believed to increase the CPR of Kinondoni Municipality. Therefore, advocacy, demand generation, services and supply were important in the implementation to make sure that these stakeholders benefit for the intended services.

Table 1.1: Stakeholders Assessment and Engagement Matrix

Stakeholder	Role in the programme	Interest or perspective on evaluation	Role on the evaluation	Means of communication	Level importance (H, M, L)
MoHCDGEC	Develop guidelines and strategies				M
	Provide national trainers	Increased CPR	User of final report for programme improvement	Email	
Jhpiego organization	Programme designer and technical supporter	Increased AYSRH services utilisation	Provide framework for evaluation	Power point presentation in their feedback meeting	H
	Provide fund for implementation	Knowing the improvement or hindrances of the programme implementation	User of final report for programme improvement	Email	
	Monitoring and evaluation, Conduct training				
Council Health Management Team (CHMT)	Programme designer, planning, implementers, monitoring and evaluation	Availability of financial resource for programme implementation	Provide guidelines plan and reports document for evaluation	Presentation in Council Health Management Team (CHMT) Meeting	H
	Health facilities owners and supervisors	Increased AYSRH utilisation	Support evaluators	Email	
	Conduct training	Tracking programme implementation	User of final report for improving implementation		
Health Care Providers	Provide friendly services to Adolescent-Youth	Increase number of Adolescent-Youth utilising services	Provide information on programme implementation, User of final evaluation report	Meetings	H
Adolescent-Youth	AYSRH programme beneficiaries	Utilise friendly AYSRH services in facilities and out of facilities	Provide information on programme implementation	Feedback Meetings with peer Groups Printed and meeting	H

Source: Researcher (2018)

1.6.2 Expected Programme Effects/Objectives

The objective of AYSRH programme is to have young people who use sexual reproductive health services and increase the contraceptive prevalence rate in Kinondoni Municipality in Dar es Salaam region. The expected outcomes are:-

- i. Increased number of family planning (FP) acceptors from FP/sexual reproductive integration service areas
- ii. Improved method mix
- iii. Total Adolescent –Youth served from integration service areas
- iv. Increased funding and support for SRH targeting the adolescents and youths
- v. Increased awareness on AYSRH services
- vi. Change in behaviour among target population
- vii. Increased number of stakeholder forums held

1.6.3 Major Strategies

Strategies of implementing adolescent and youth reproductive health services are based on advocacy, demand generation, services and supply toolkits designed by The Challenge Initiative (TCI) which presents evidence-based interventions for increasing young people's access to, and utilisation of sexual and reproductive health services.

Advocacy (Enabling Environment)

Advocacy focuses on supporting FP from people who are key influential (men, husbands, family members, political, social, religious leaders) and encourages using FP. Supportive FP policies should be in place at national and local level and the use of FP data. FP Social Acceptability: includes Social or community norms and expectations which support adoption and continuation of FP, also FP services should be visible in the marketplace. Champions actively promote and ensure continued access to quality FP services and contraceptives. On limited negative factors: There should be no clear negative forces acting as barriers to the access of FP (this may be location specific).

Services and Supplies

In services and supplies, youth are supposed to be able to access and choose from among all modern FP methods including long acting reversible contraceptives (LARCs), in their community directly, through outreach, or referral. There should be multiple options for supply so that youth can choose where to get contraceptives either in the public, NGO, or private sector. Convenient access for youth on having easy access to service delivery points, including public, private, and NGO in close geographic proximity and open at hours when youth need them.

Youth Friendly Services requires all aspects to be youth-friendly including private area for counseling, age-appropriate materials, unbiased providers regardless of age or marital status, confidential and supportive facilities. It also needs trained or quality service providers, performing youth friendly service standards, delivering both long acting reversible contraceptives and short-term methods. On serving underserved markets includes provision of services in underserved markets, youth friendly service delivery through outreach, community health workers, community based distributors, and other community based services.

The services should be affordable in price for all or free of charge. Contraceptive supply stock should not be stock-outs or old stock in all locations (clinics, health facilities) and adequately reported in HMIS. FP Service supposed to be integrated with other related health areas such as women's health, children's health, obstetric or gynecology practices; midwives post-partum, HIV/AIDS and others. Multi-sectoral collaboration in AYSRH services are linked with organisations focused on education, legal aid, financial literacy and other related urban youth services and programmes where accessing health may be secondary to safety or economic security.

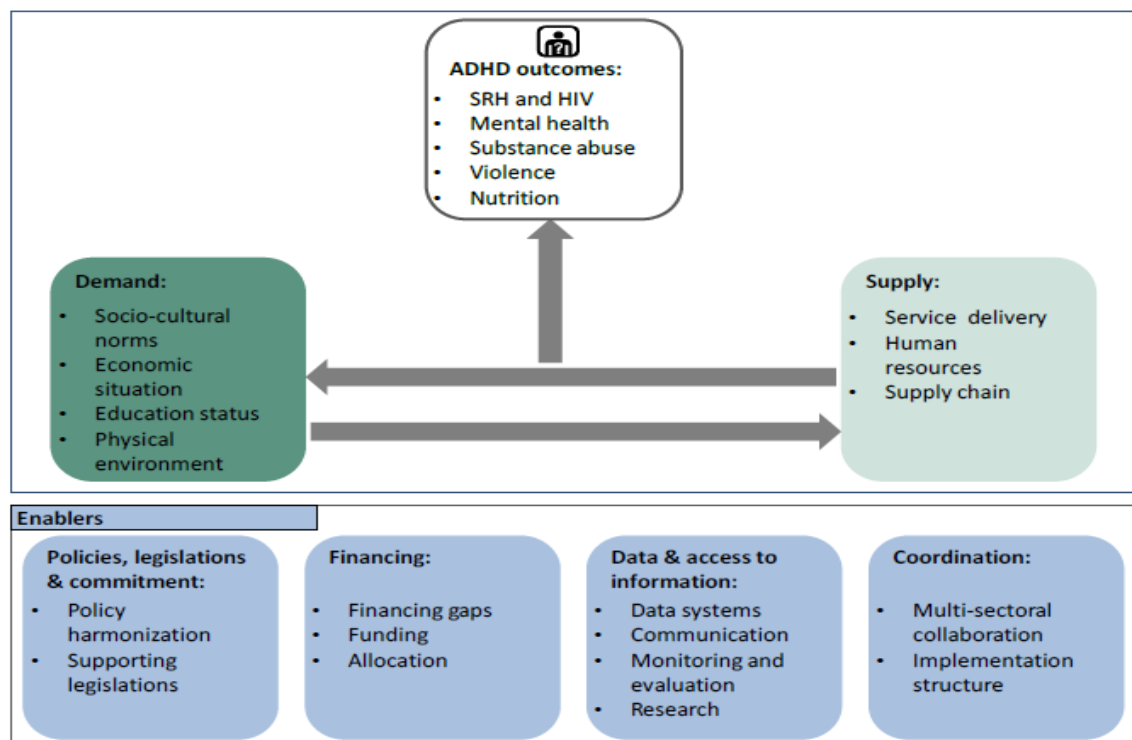
Demand Generation

Youth (age 15-24) supposed to have correct knowledge of pregnancy prevention, know about modern contraceptive methods, and know where to go for youth friendly counseling and services. Methods include male or female condoms, diaphragm, pills, injectables,

spermicides, patch, IUD, implants, sterilisation). AYSRH social acceptability in schools have to teach comprehensive SRH education, community or youth groups provide SRH support, norms and expectations support ASYRH interventions including FP. Champions promote AYSRH to youth and others champions publicly, actively and ensure continued access to AYSRH in schools, community organisations and health services.

Couples supposed to have FP knowledge, accurate information about specific methods and know where to go for contraceptives and services. On attitudes and values, families are supposed to value and seek out FP for delaying, spacing and limiting; choosing the best methods for their desired goals. Also, they should have communication about FP, being confident in the method they choose and tell others. FP norms beliefs: Couples have to believe their neighbors practice FP and that it is common and accepted to do so.

Figure 1.1: Framework of assessing adolescent health development in Tanzania



Source: MoHCDGEC (2018)

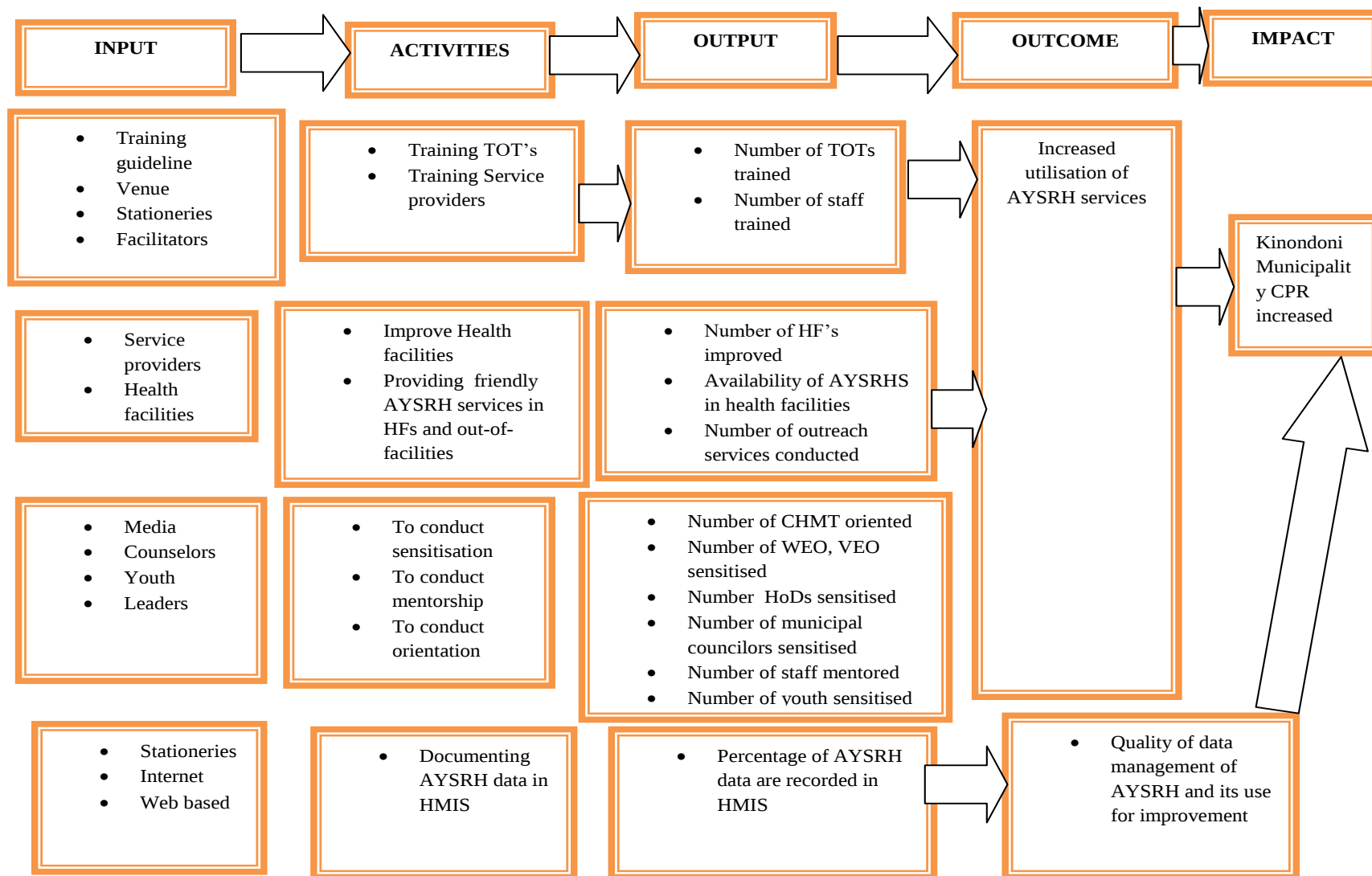
1.6.4 Programme activities and resources

Implementation of the activities depends on ceiling amount that has been provided by Bill and Melinda Gates foundation for Kinondoni Municipality under Jphiego Organisation and included in 2018/19 Comprehensive Council Health Plan. The following activities are the ones which are on continuing implementation (CCHP, 2018).

- To conduct 2 weeks training on AYSRH to 30 Health care providers from 10 Public Health Facility by June 2019
- To conduct whole site orientation to 200 Health care provider from 10 Public health facilities on AYSRH by June 2019
- To conduct 3 days orientation to 30 CHMT members on AYSRH by June 2019
- To conduct mentorship to 30 HCP from 10 Public and health facilities quarterly on ARSH including proper documentation in HMIS book by June 2019
- To conduct 3 days ASRH integrated outreach services to 6 distant communities quarterly by June 2019
- To conduct 5 days in-reaches for AYSRH in one public health facilities monthly by June 2019.
- Conduct 5 days AYSRH support supervision to 10 public health facilities providing AYSRH
- Conduct monthly PIT meetings for CHMT and other implementing partners
- To conduct one day sensitisation meeting to 30 municipal head of departments (CMT)members bi-annually by June 2019
- Conduct one-day sensitisation meeting to 116 WEOs and VEOs members on AYSRH by June 2019.
- To conduct one day sensitisation meeting to 40 Municipal Councilors on AYSRH by June 2019

1.6.5 Programme Logic Model

Figure 1.2: Programme Logic Model



Source: Constructed by researcher (2018)

CHAPTER TWO

LITERATURE REVIEW

2.1 Young People Population and Associated Challenges

Worldwide, there are 1.2 billion number of young people aged 10-24 years which is 16% of the global population (UN, 2018). The World Youth Report explains the 2030 agenda and youth development which examines the mutually supportive roles of the new agenda and youth development efforts. The report aimed to offer member states and other stakeholder's information and analysis to help them in addressing youth issues, assessing policy gaps and develop policy responses (UN, 2018).

In developing countries, young people (10-14 years) estimated to be 545 million, 346 million in Asia and Oceania, 143 million in Africa, 56 million in Latin America and Caribbean. This age group experience rapid changes related to physical, social, emotional and cognitive. This is the time of laying foundation for healthy and fulfilling sexual and reproductive lives (Guttmacher, 2017).

Female adolescent at age of 10-14 estimated to give 777,000 births in 2016, among them 58% were in Africa, 28% in Asia and 14% in Latin America and the Caribbean, where one third of those births were unplanned. Evidence shows older adolescents in developing countries face barriers associated with structural, cultural and legal barriers to SRH information and services. These barriers include inability to afford services, negative attitudes among providers, breaches of confidentiality and privacy, lack of knowledge on services and where to find them, stigma and taboos around sexuality, and laws that prevent adolescents' obtaining the information and services they need (Guttmacher, 2017).

Young people around the world suffer from challenges associated to be adolescence. Adolescence experience changes to their bodies that make them susceptibilities to human rights abuses, particularly on sexuality, marriage and childbearing. Millions of girls are found themselves into unwanted sex or marriage subjecting them into risk of unwanted pregnancies, unsafe abortions, sexually transmitted infections (STIs) and HIV, and risks of early pregnancies (UNFPA, 2017).

Though young people face the above challenges, but they also face barriers to reproductive health information and care. Even those who are able to find accurate information about their health and rights may be unable to access the services needed to protect their health. Adolescents' sexual and reproductive health must be supported to overcome these barriers by providing access to comprehensive sexuality education, services to prevent, diagnose and treat sexual transmitted infections (STIs), and counseling on family planning. The barriers can also be addressed by empowering youth to know and exercise their rights including the right to delay marriage and the right to refuse unwanted sexual advances (UNFPA, 2017).

In Tanzania there are 12 million adolescent which is 23% of the population, and still young people specific health care needs are overlooked. Though there is good progress on reducing HIV related infections, but mortality has not decreased where the age group with highest new infections is 20-24 years. Many young people have already engaged in sexual activity at the age of 18 and are vulnerable to sexual and reproductive health problems such as teenage pregnancy and early child bearing (estimated 1 girl among 4 girls), complications from unsafe abortions. These problems lead them at higher risk of maternal mortality and morbidity (UNICEF, 2017)

Despite those challenges there are girls who are aware of the benefits and wish to access contraception but are restricted by laws and policies regarding provision of contraception based on age or marital status, health-care provider bias or lack of willingness to acknowledge adolescents sexual and reproductive health needs (WHO, 2018).

2.2 Policies, Guidelines and Strategies on Implementing AYSRH in Tanzania

Tanzania health policy, guidelines and strategies supports implementation of sexual and reproductive health services to young people. National Policy Guidelines for Reproductive and Child Health Services (URT/MoH, 2003) of MoH give directions and facilitate effective implementation of reproductive and child health interventions. The guidelines authorise the integration of HIV and AIDS services into family planning and reproductive health in the context health education provision. The document has stipulated that all people shall have the right to information, education

and communication on issues relating to sexually transmitted infections (STIs), HIV and AIDS. It stated that government shall have to facilitate public, voluntary agencies, non-governmental organisations (NGOs) and private institutions incorporate STIs, HIV and AIDS issues in the curricula for young people in and out of school settings (Mutalemwa, 2013).

The National Adolescent Reproductive Health Strategy (2010-2015) of MoH, aims at strengthening policy, legal and community environment for sexual and reproductive health information, services and life skills. This strategy seeks to advance health system responses to adolescent health needs and provide a platform to link with other sectors dealing with adolescents and young people (UNICEF, 2011).

The National Life Skills Education Framework aims at improving knowledge, and promotes attitudes and skills, that will make possible adolescent making decisions on sexual issues. Both strategies need adequate resources, trained teachers and supportive environment that is responsive to the needs of adolescents. The Ministry of Health and Social Welfare recognises that reproductive health services are basic human right for all people including adolescents (UNICEF, 2011).

National Youth Development Policy (2007) provides direction to youth, partners and other stakeholders on youth development issues and identifying adolescent reproductive health as a policy focus but does not provide strategies help to implement the issues (UNICEF, 2011). National Adolescent Health and Development Strategy 2018-2022 (2018) provides six priority objectives around various components that need action immediately to address adolescents' challenges in implementing adolescent interventions and how to implement them. The priority objectives are (i) demand (ii) supply (iii) policies, legislations and commitments (iv) financing (v) data and access to information (vi) coordination (MoHCDGEC, 2018).

Priority objectives aim to improve accessibility of sexual reproductive health services at all levels by decreasing barriers, raising awareness and demand for adolescent and youth to utilise sexual reproductive health services.

2.3 Accessibility to Sexual Reproductive Health

Africa has been shown below performance on universal access to sexual and reproductive health on millennium development goal 5. It was expected that maternal mortality ratio needed to decline at rate of 5.5% but in Africa was only 2.7% rate from 1990 to 2010. HIV epidemic had negative impact on maternal death by 10% in 2010. Contraceptive prevalence rate (CPR) in 1990 was 12% and rose to 24% in 2010 while unmet need for family planning was high at 26.5% in 1990 and remained at 25% in 2010. Adolescent aged 15-19 birth rate remained high at 117 per 1000 women aged 15-19 years as compared to 50 per 1000 of global estimate in 2010 (WHO, 2013).

Constraints to improve maternal and child health care were caused by inadequate access to, and inequitable distribution of high-quality maternal and child health care, inadequate financial resources, insufficient skilled human and institutional capacity, weak information systems for tracking progress made and weak community involvement and participation (WHO, 2013).

On improving targets which were not achieved in millennium development goals 5a and 5b UNFPA developed strategic plan 2018-21. It focuses on sexual and reproductive health aiming at contributing achieving of 2030 Agenda and respond to the Global Strategy for Women's, Children's and Adolescents' Health 2016-2030. The strategy also will contribute directly on achieving Sustainable Development Goal 3 on maternal mortality, skilled birth attendance, met need for family planning, adolescent birth rates and HIV incidence (UNFPA, 2017).

Prior to the above efforts, the study conducted by Denno et al (2014) suggests that, programmes which promote access to and uptake of adolescent sexual and reproductive health services are most effective when there is adolescent friendly facility approaches combined with community acceptance and demand generation activities (Denno, Hoopes, & Chandra-Mouli, 2014).

The study conducted in Dar es Salaam, examined the gaps in access to SRHR communication among marginalized youth. The study observed that access to SRH rights information is high but decreases when it is disaggregated across different age groups. It suggested that, there is a need of expanding approaches for reaching specific

groups of young people depending on their needs and circumstances (Ngilangwa, 2016).

2.4 Demand generation and Advocacy for SRH Services to Young People

In order to generate demand, adolescents need information about the availability of services through different channels, which include youth groups, parents, the media and schools. The information must be detailed about the availability of the services (when and where), information about the reasons (why) young people should use the services, and information to alleviate their anxieties about using them (WHO, 2009).

Though, giving only information and knowledge to adolescents is not enough, for adolescents to use reproductive health services remains a sensitive issue in many communities. Therefore, it is important to contact and inform gate-keepers such as parents, religious and community leaders on the importance of young people reproductive health services. Community acceptance of young people reproductive health services is important in determining the uptake of these services. Young people are most likely to use youth-friendly services in communities that demonstrate most awareness and approval. Also, to have supportive social environment is important on resulting higher utilisation rates (WHO, 2009).

A study conducted in Bulawayo, Zimbabwe found that young people do not use the existing health services because of lack of knowledge about existing services, stigmatization, bias of adults and neglecting young people's sexual and reproductive health needs by service providers and policy makers. The study also found out that peer pressure, unwelcoming atmosphere, waiting times, poor attitudes of staff, negative associations with STDs, prostitution and loose sexual morals, and cultural taboos in discussing matters of sexuality prevent the young from utilising the existing health services (Obong'o & Zani, 2014).

2.4.1 Comprehensive Sexual Education (CSE) to Adolescents and Youth

In creating demand to young people CSE is essential to help young people possess knowledge, skills, attitudes and values to empower them on self-determination and well informed decisions, to realise their health, well-being and dignity. Young people will develop and enjoy respect with fulfilling relationships, being responsible,

satisfying and having healthy sexual lives when they are educated comprehensively (Rutgers, 2018).

CSE provides broader understanding to young people about their lives, to equip them with knowledge and life skills on making informed decisions. This helps them to enjoy their sexuality, mitigate vulnerabilities, protects their health well-being and rights. CSE can be conducted in different contexts such as schools, vocational centers and youth clubs. This includes practical information on how and where to access services. Some programmes link CSE with institutions providing services through peer educators who refer classmates to certain clinics, or health providers might ask to visit schools to raise awareness of youth-friendly services. This education is more of helping young people take their personal wishes and decisions into realities for their lives, and one way of doing it is connecting with services (TCI-U, 2018).

Studies demonstrated that, in Africa, America and Hispania, CSE programmes which are effective for all ages, races, ethnicities, socioeconomic groups and geographic areas are reducing the rates of sexual activity, sexual risk behavior such as number of partners and unprotected sex, also reduce sexual transmitted Infections and adolescent pregnancy rates among 15-19 years old. Community-centered initiatives on interventions about adolescent pregnancy preventions and reproductive methods like long-acting reversible contraception have contribution on reducing pregnancy rates among the mentioned continents (Committee, 2016)

2.5 Services and Supplies

Adolescent services can be delivered through different channels. In health facilities are provided in hospitals and clinics. Out of facilities includes schools, community-based services and youth center. All services provided to adolescent and youth should be offered friendly as WHO recommended (MoHCDGEC, 2018).

2.5.1 Youth Friendly Services

WHO identified adolescent-friendly health services should be accessible for all adolescents to obtain health services that are available. Services should be acceptable for all adolescent who are willing to obtain health services that are available. They

have to be equitable to all adolescents not just selected groups, have to be appropriate (right and needed by adolescent). Effective focus on the right health services are provided in the right way and make a positive contribution to their health (WHO, 2012).

According to WHO (2002), the procedures of providing services to must be confidential on clients' registration, retrieval and storage records, short waiting time, attend clients with or without appointments. Health care providers supposed to be competent, using adequate time with clients, being non-judgmental, providing information and help clients to make choices for their needs. Staff need to understand and treat clients with equal care and respect, motivated and supported. Health facilities should have safe environment, convenient location and working hours, maintaining privacy and avoiding stigma. Community involvement and dialogue outreach and peer to peer services to increase cover age and accessibility. Provision of services should be appropriate, comprehensive and effective (MoHCDGEC, 2018).

In providing sexual reproductive services to young people it is important to practice empathy and supportive attitudes. Training skilled SRH providers they must be tailored with enhanced focus on attitudes and norms, engagement and involvement of youth. Providers can be youth friendly enjoying working with them, counseling in private areas and assuring confidentiality. The use of simple language and open-ended questions is very crucial (TCI-U, 2018)

2.5.2 Integrated and Expansion of Service Package

Sexual reproductive health services should be offered with other services which needed by youth, they include treatment and care for menstrual hygiene, anemia, mental health, substance use, injury, non-communicable diseases, HIV, post-abortion care and maternal health. It is very important to have broad range of contraceptive options both short and long-acting reversible methods for young people. These interventions have shown contribution on increasing access of contraception to young people in variety contexts (TCI-U, 2018).

Rutgers (2016) specified essential services that meet the most urgent needs of youth population. The comprehensive package of services includes contraception counseling

and provision, HIV testing, STI counseling and testing, prescribing appropriate medications and health products, pregnancy testing, maternal health services, abortion-related services and post-abortion care and referral (Rutgers, 2016).

The study conducted in Uganda at Mbarara municipality, suggested that HIV and SRH services for young people is still a challenge in areas with high HIV prevalence. There is a need to refocus efforts to promote integrated services among the young people at the health facility and policy level. The integration will help increase of service utilisation, promote HIV testing and improve risk reduction behaviour among young people (Akatukaswa, 2019).

2.6 Factors Facilitating Sexual Reproductive Health Outcomes

Tanzania and Mozambique experience lower contraceptive prevalence rates with low uptake of effective and long acting methods compared with other countries. In these countries girls start their first sexual intercourse at median age of 16.1(Mozambique) and 17.2 in (Tanzania), this signify that adolescent and young girls require access to sexual reproductive information and services before these ages. Despite that, there is low utilization of SRH services in both countries. In Tanzania only 8.3% (15-19 years) and 15.1% (20-24 years) of young people used modern contraceptive with unmet need by 18% (15-19 years) and 22% (20-24 years). In Mozambique only 8.3% (15-19 years) and 28% (20-24 years) of young people used modern contraceptives with unmet need by 10.8% (15-19) and 17.7% (20-24) (Pathfinder, 2017).

Some factors associate to the utilisation of sexual reproductive health services. The study conducted in Ethiopia, observed that students who discussed with health workers, young people with history of sexually transmitted infections (STIs) symptoms previously, those experienced sex ever and exposed to information from school teachers were found to be better utilised sexual and reproductive health services (Binu, 2018).

Another study conducted in Harar town, East Ethiopia revealed that utilisation of youth friendly services increased due to information obtained about youth related services from different sources and having knowledge about the services. It also suggested that efforts should be made by all relevant stakes on creating conducive environment for

youth through training service providers, particularly for those who work in the government institutions, and strengthening of the awareness creation strategies among the youth to increase the utilisation of the services (Motuma, 2016)

According to study conducted in Ghana, concluded that, major factors on utilisation of reproductive health services determined by sex, age, formal education, and religion. Major factors inhibiting utilisation of reproductive health services among youth was about feeling shy to confront health service providers, cost of reproductive health services (monetary), gender of health service providers, religious beliefs of young people, and fear of maltreatment by health service providers (Addo, 2015).

CHAPTER THREE

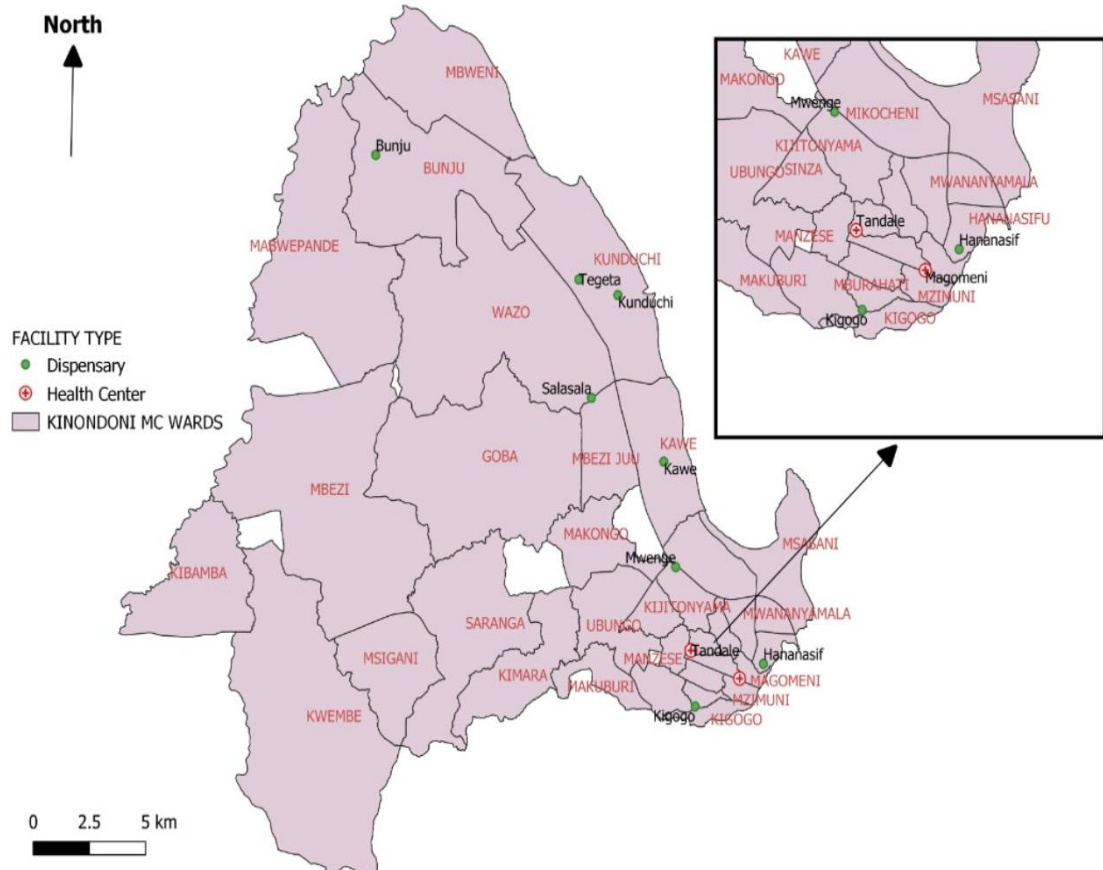
EVALUATION METHODS

3.1 Study Area

This study was conducted in Kinondoni Municipality. Kinondoni Municipality is located in northern part of the region with an area of 321 km². The population of

Kinondoni was estimated to be 1,255,849 in 2017, with women of reproductive age (WRA) 791,550 including women ages (15-24) were 82,645 and (20-24) were 93,765 who made 22.2% of WRA that are youth . The council has a total of 572 health care workers out of 852 required. Currently the council is facing a shortage of 280 health workers of various health cadres equivalent to 33% deficit. The council is divided into 2 division, 20 wards and 106 streets with 26 government health facilities and 181 private health facilities. The selection was based on the implementation of AY access to FP by from 28% (2017) to 31% (2018) with uptake of contraceptives by 69% as a result contributed to the increase of Contraceptive Prevalence Rate (CPR) from 11% (2017) to 13.5% (2018), this was at the mid financial year 2018/19 during implementation of Adolescent and Youth Sexual Reproductive Health programme.

Figure 3.1: Health Facilities Map



3.2 Evaluation Period

Evaluation started in December 2018 to July 2019. The researcher took some important data for developing research proposal from Kinondoni Municipality. Data collection started on May after proposal approval from Mzumbe University, and data analysis conducted on June 2019 followed by report writing through July 2019.

3.3 Evaluation Approach

Process evaluation approach was conducted in this study which conducted when the programme is on implementation period with aim of improving the programme. This approach allow to examine how implementation was being conducted, examine factors facilitated attainment of intended outcome, examine factors impinged attainment of intended outcomes, and establish best practices influencing attainment of Adolescent Youth Sexual Reproductive Health programme towards utilisation of services. The

information generated from this study informs programme implementers on alternative delivery process to improve the implementation performance in realising intended objectives.

3.4 Evaluation Design

Case study design used to examine the implementation of Adolescent Youth Sexual Reproductive Health programme in Kinondoni Municipality. The design was employed to evaluate different situations in the process of realising programme outcomes. Case study has ability to deal with different source of evidence such as documents, which helped to examine activities status through implementation reports and service provision guidelines. It allowed interviews and observations which were useful to explore in-depth information on how the programme process was being conducted. This allowed generating information from different units of analysis.

3.5 Focus of Evaluation and Dimension

This study focused on evaluating the process on implementing AYSRH toolkits in Kinondoni Municipality. The evaluation focused on examining how the following aspects of the project are being implemented:-

- AYSRH services and supply toolkit which involves adolescent youth – friendly services, integration and expansion of service package, and out-of-facility service delivery
- AYSRH demand generation toolkit that include social and behavior change for youth sexual and reproductive health, comprehensive sexuality education (CSE), gender transformation, and digital health.
- AYSRH advocacy which contains accountability and positive legal environment
- Data management and use in the programme

3.6 Indicators/Variables

This study was designed to evaluate AYSRH implementation process, factors influencing programme implementation, impinging the programme implementation and establish best practices influencing attainment of programme objectives.

3.7 Population and Sampling

3.7.1 Target Population

Target population of this study was AYSRH programme implementers at management and facility levels to determine process of programme implementation, facilitating and impinging factors to attain program outcomes and best practices. Adolescent and youth targeted to determine friendly youth services in health facilities in Kinondoni Municipality.

3.7.2 Source of Population/Sampling Frame

The source of population were health staff from Kinondoni Council, Jphiego AYSRH staff in the programme implementation, adolescent and youth aged 10-24 years in Kinondoni district.

3.7.3 Study Population

Study population was staffs in the health department, such as municipal reproductive and child health coordinator (MRCHCo), municipal youth coordinator and health staff who provide AYSRH services. Also, Jhpiego AYSRH programme coordinator, adolescent and youth in programme were part of study.

3.7.4 Study Units and Sampling Units

Study unit were Kinondoni Municipality with individual's health managers at different positions, health facilities, school and out of school. In this study, the sample units were young people in school and outside the formal education system, peer educators, health staffs provide services in and out of health facility. All the respondents helped generating insight implementation process, factors facilitating implementation, factors impinging the programme implementation and establish best practices for attaining intended outcomes.

3.7.5 Sample

This study selected MRCHCo and youth coordinator for interview to determine in-depth how they were implementing programme activities in 2018/19. HMIS coordinator was selected to examine how data were managed from facility level to council level during implementation. 10 health facilities were selected to observe youth friendly services, and health care provider from each facility was selected for interview to determine their knowledge and how did they provide services to young people. Also determining factors facilitated and impinged the program implementation. Sample of 3 female and 1 male AY were selected to examine how they were provided services in and out of facilities. One peer educator leader was selected and interviewed to get in-depth information on how they play role on the provision of young people services. A total of 19 respondents were interviewed in this study, all interviews, observations and documentary review were conducted to establish best practices influencing attainment.

3.7.6 Sampling Technique and Procedure

Purposive sampling procedure was employed to respondents who involved in programme designing, planning and implementation. Purposive sampling was used to select respondents by virtue of their position and involvements in Adolescent and Youth Sexual Reproductive Health program design to implementation and data management of young people programme; Reproductive and child health coordinator, youth coordinator, Health Management Information System Coordinator and Programme Manager. Convenient sampling used to select trained health care providers who were on duty in health facilities by the time data were collected. Also convenient sampling applied to select any adolescent and youth who came to attend services in young people service provision area. Those approached by the researcher, were included in the study. Purposive sampling used to select 10 health facilities which provide Adolescent Youth Sexual Reproductive Health services to observe youth friendly health services.

3.7.7 Inclusion and Exclusion Criteria

Health managers, who were involved in the programme designing, planning implementation and their position serve adolescent and youth sexual reproductive services and data management were included in the study. Trained staffs found on duty in health facilities providing young people services (AYSRH) on the day data were collected, were included in the study. Adolescent and youth attended sexual reproductive services during data collection were included in the study.

Health managers who did not participate in programme designing, planning, implementing and data management of Adolescent and Youth Sexual Reproductive Health programme were excluded in the study. Trained health care providers who were not on duty during data collection were excluded in the study. Health facilities which do not provide Adolescent Youth Sexual Reproductive Health services were excluded. Adolescent and youth who were not willing to participate in the study were excluded.

3.8 Data Collection

This study used in documentary review, observation and in-depth interview. The methods were used to capture all the important information to answer evaluation questions.

Documentary review was conducted by reviewing training contents as per training guideline for adolescent and youth sexual reproductive health services. Implementation reports were justifying the increase number of young people utilising services during implementation process. Data extracted from District Health Information System (DHIS2) were reviewed to justify number of young people using adolescent youth sexual reproductive health services and determining data management of the programme.

Observation data collection technique was conducted by identifying how the Adolescent and Youth Sexual Reproductive Health services are provided in health facilities. Friendly youth services were observed by checking characteristics of health facilities environments, of health care providers, programme, policies and procedures.

In-depth interview conducted to get in-depth information on how the programme has been implemented, and identifying the factors facilitating and impinging the programme implementation also establish best practices for attaining programme outcomes. The interviews were translated in Swahili and during data collection the researcher used probes to get relevant information according to objectives. The researcher interviewed municipal reproductive and child health coordinator (MRCHCo), municipal youth coordinator, Health Management Information System (HMIS) coordinator, Jhpiego programme manager and trained health staff who provide adolescent and youth sexual reproductive health services, peer educator and young people attended sexual reproductive health services.

Interviews were conducted for 25 to 40 minutes. Health managers were interviewed at their health department offices and Jhpiego office. Health care providers, peer educator, adolescent and youth were interviewed at health facilities in service provision area which maintained privacy. Total of 19 in-depth interviews were recorded by voice recorder.

3.8.1 Data Collection Tools

Semi-structured interview guide was developed and pretested to one AYSRH oriented health manager, one health care provider trained for AYSRH services but not providing services in selected health facilities and two adolescents and youth using services.

Unstructured Observation Checklist guided the researcher to examine friendly youth services in health facilities. This included observation on characteristics of health facilities, health providers and programme. Observation conducted to examining policies and procedures on provision of services. This checklist was adopted from WHO 2012 and improved according to requirements of Adolescent and Youth Sexual Reproductive Health programme.

3.8.2 Data Collectors

Data collectors were a researcher and one assistant who trained for 2 days on objectives of the study, understanding what was important to be obtained during data collection from each objective.

3.8.3 Data Collection Field Work

Data collected by voice recorder and note taking to make sure important information are captured according to objectives.

3.9 Data Management and Analysis

Data management

Data management conducted by listening carefully the interviews from voice recording, and transformed to written form by word to word (verbatim). Transcriptions were conducted by translating verbatim into English language, this was done 1 hour after interviewing respondents to determine if the intended questions have been answered. Saturation was determined when different respondents provided similar information about evaluation questions. Evaluation question which were not provided enough information, the researcher made appointment with the respondents for next interviews by face to face and through mobile phones.

Observation data were managed by writing comments on each indicator, additional information about specified indicators were taken to be referred later.

Data analysis

Interviews were transcribed in English from audio to written form (verbatim). The transcriptions were imported in ATLAS.ti 7 software as primary documents. Codes were created by selecting text, quotations and paragraphs into categories and labeled to generate themes according to predetermined objectives (Inductive). Important information from the interviews which emerged during data collection (Deductive), were coded and saved into memos. The similar codes were grouped together and form families. Output report was generated with all codes and memos, and then study results were written from output report.

Observation data were summarized by considering specific characteristics of health facilities, health care providers, programme, policies and procedures. All the characteristics and activities were linked to indicators specified by WHO (2012) to determine how services were provided in health facilities. Indicators such as convenient opening hours for Adolescents-Youth, spaces set aside for Adolescents-Youth, services offered for free, privacy, confidentiality, respect, trained staff, and referral mechanism. By doing this the study managed to analyze youth friendly services provided in health facilities and determining attitude of health care providers to young people.

Documentary review was analyzed by content analysis. Contents analysis of Training Package of Adolescent Sexual Reproductive Health (MoH, 2004), A National curriculum for Service Providers on Adolescent Reproductive Health (MoH, 2006) and supportive supervision guideline were reviewed by establishing contents of the Adolescent and Youth Sexual Reproductive Health programme performed by health care providers. This aimed to determine instructions provided were implemented by staff and how services are provided by ensuring standards initiated by guidelines. Differences established could contribute to impinging factors of attaining programme outcomes. District Health Information System (DHIS2) data were reviewed to determine the increase number of Adolescent and Youth Sexual Reproductive Health users resulted by program implementation.

3.10 Ethical Issues

Ethical issues were considered when Mzumbe ethical clearance committee approved proposal and provide a letter with Ref. No. MU/DPGS/INT/38/Vol.IV and submitted at Dar es Salaam Regional Administrative Office. Regional office provided a letter to Kinondoni Municipality Administrative Office.

Kinondoni Municipal Administrative Office provided a letter with Ref. No. AB.320/378/01B to Kinondoni Municipal Director. Municipal director forwarded the letter to municipal medical officer (MMOH). MMOH office wrote a letter with Ref. KMC/R.18/1 for allowing data collection within specific areas.

Prior to participation in research, respondents were asked for their informed consent on evaluation. All respondents were assured confidentiality on provided information, that will only used for research evaluation on purpose and not otherwise. Privacy was assured and maintained when data were collected for respondents to be free and avoiding interferences. Respondents were asked permission to record the interviews through audio recorder.

3.11 Limitations of the Evaluation

Adolescent and youth sexual reproductive health issues are sensitive for respondents to be free explaining to person whom they do not know and trust. This created difficulties to obtain information on the use of the services among young people. The researcher managed to get information by creating rapport and probing to avoid limitations.

Respondent, who was purposively selected, did not provide important information which was supposed to be known at that management position because was not working in Kinondoni Municipal before AYSRH programme implementation. The researcher managed to obtain information from other selected respondents who were experienced with the required information.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter represents the findings and analysis of process evaluation of AYSRH programme on utilisation of sexual reproductive health services among adolescents-youth in Kinondoni Municipality. Number of 19 respondents were interviewed, 3 council health management team members, 1 Jhpiego manager and 10 health care providers at facility level including Magomeni and Tandale health centres, Hananasif, Kigogo, Mwenge, Salasala, Kawe, Bunju, Tegeta and Kunduchi dispensaries. 4 adolescent and youth using SRH services and 1 peer educator were interviewed. Observation conducted in all 10 health facilities to observe friendly health services. Documentary review based on service provision guideline and implementation reports of the AYSRH activities.

4.2 Demographic Characteristics of Study Respondents

This study included both male and female respondents of different ages. Health managers were 2 females and 2 males. Health care providers range at 29-59 years. Adolescent and youth in and out of school were involved in the study. Tables below show demographic characteristics of respondents.

Table 4.1: Adolescent and Youth Respondents

Participants	Gender	Age	In/out of school
Respondent 1	Male	24	Out of school
Respondent 2	Female	23	Out of school
Respondent 3	Female	16	In school
Respondent 4	Female	18	In school
Peer Educator	Male	24	Out of school

Source: Researcher 2019

Table 4.2: Health Care Providers in Health Facilities

No	Health Facility	Age of Respondent	Cadre
1	Magomeni	59	Assistant Nursing Officer
2	Tandale	51	Clinical Officer
3	Hananasif	27	Assistant Nursing Officer
4	Salasala	27	Laboratory Assistant
5	Mwenge	27	Nurse
6	Bunju	38	Assistant Nursing Officer
7	Kunduchi	39	Assistant Nursing Officer
8	Kawe	29	Nurse
9	Tegeta	52	Nurse
10	Kigogo	29	Nursing Officer

Source: Reseacher 2019

4.3 Implementation Process of AYSRH Programme

The Adolescent Youth Sexual Reproductive Health programme was implemented in according to established toolkits on demand generation, advocacy, Services and supplies. These aimed at intended beneficiaries to accessing information and receive services in and out of facilities. Also awareness to people with influence in urban community to support utilization of sexual reproductive health services among young people.

4.3.1 Demand Generation

Demand creation was conducted through adolescent and youth dialogues in health facilities, these dialogues include young people. Health care providers and community based health workers participants. Community health workers invites and informs adolescent and youth on the date, time and place to conduct the dialogues but most of them are done in health facilities. In some facilities where there are peer educators such as Magomeni and Tandale health centers, they played role on inviting their fellows and providing education about services. In dialogues different issues are discussed depends on topics selected, then adolescent and youth are able to ask questions and providers answer them in dialogues. Those issues needed action at facility level or council health management team level, feedback were provided by action and in next dialogues. After discussions services are provided to those who were willing.

Community Dialogues

In dialogues adolescent and youth were free to explain and ask questions without shame. Answers to their questions provided in the same dialogues, whenever there was misconception or little understanding, health care providers explained in deep about the specified topics. Most of the dialogues are conducted in health facilities so as to provide services to adolescents and youth soon after discussions to those who need the services. One respondent who participated in dialogues explained how dialogues were conducted.

“I participate in youth dialogues, it includes both male and females, and you have freedom to express anything and what you need to know without shame. We discuss a topic to educate youth. If we lack some knowledge they teach us in deep. Participants are health care providers, members of youth organisations. If we discuss about proper usage of condoms, and after there we are provided condoms”
(Respondent 1)

Health manager elaborated that, in collaboration with community health workers, ward and village executive officers (WEO and MEO) were inviting adolescent and youth in their streets to join dialogues for discussion on health issues. All WEO and MEO were oriented on how to conduct such activities in creating awareness for young people to access and utilise sexual reproductive health services.

“it was one day we met MEO and WEO, were 126. We conducted at a hall in Manzese, also we explained, they are important to know because WEO and MEO are government authorities in streets. But a challenge for this SRH right to youth is that, many people think it is ‘uhuni’ or prostitution. But when administrators know, it is easy for them to address the community. And when community understands it will be easy for them to allow youth obtaining education and attending the services. They will help to announce and explain what will be going on, which is easy for people to understand their leader. But even in their street or ward meetings, if they understand the importance they sensitise community, also there are champions who are active, they address in the meetings, and meet with youth, or in streets example bodaboda group; sooo, they help to address issues like that” (Municipal Youth Co.)

Health care providers, provide education through different means in streets, health facilities and schools. In some health facilities where there were peer educators such as Tandale, Magomeni, Tegeta and Hananasif, they provide education to their fellow

young people in and out of health facilities. One health care provider explained that, they visited schools to provide health education to students. In primary schools they educated standard six and seven because most of them are adolescents. In secondary schools education mostly were provided to form 1, 2, 3 and 4.

“We conduct two or three community dialogues per month, we have gone in almost all schools, except one Muslim school there are some challenges. We discuss with them and ask their challenges especially form two, three and four. We target students at growth stage. In primary schools we provide education to standard six and seven, with expectation to reach 10,12, 13 years old, this group do not understand anything but are approaching to enter in youth stage” (Hanasif Disp. HCP)

Another respondent elaborated how she got information in school and started to use services.

“I got information about the services from school, learned about unprotected sex, risk issues. I started to use when I saw my friend was seek and got medications” (Respondent 4)

Peer educators provided health education in and out of facilities even if health care providers were not around, and clients who needed services were referred to health care providers. Some peer educators were going house to house and door to door in providing health education. Example Tandale peer educators used mats (mikeka) to seat with young people and their parents to discuss sexual reproductive issues.

“Eeh I have peer educators who go to streets and schools to provide adolescent and youth health education. We have 6 streets, I arrange time table and divide peer in every months in those streets to provide education about something. Example they can provide education on condom demonstration. It depends on age, or problems of getting pregnant at young age, or family planning issues. Difficult issues they bring in health facilities and be attended by health care provider. Also, they provide information about when different services will be provided in outreach example cervical cancer tests, or Vitamin A so as to capture all activities” (Tandale HCP)

One peer educator provided experience on how they provided education

“we are about 20 youth peer educators in this health facility, we divide ourselves in 6 streets of Tandale, every street about 3-4 peer educators. Sometimes every peer with one street going house to house, or all of us in 1 street going door to door example in Kwatumbo or Pakacha street. We ask parents we need to talk to their youth children and provide education. Youth with difficult challenges or in need of services, are referred to health facility to see health professionals. This has impact because we educate young people with their parents in different ways” (Peer educator)

4.3.2 Advocacy

In this toolkit, the municipal conducted sensitisation to 114 ward and street executive officers, only 2 among 116 did not attend because of sickness. Orientation to these people conducted because they are representatives of the government at wards and streets levels who are closer to people in their respective areas. They helped peer educators and health care providers by authorising their presence in respective areas and inform people. Peer educator explained how they were helped by WEO and VEO in streets.

“When we meet challenges in streets we ask street government authorities, some parents are crucial but through WEO and VEO we get support in providing education. We cannot go in streets without informing them. Sometimes they help by explaining the importance of the services to parents” (Peer educator)

Sensitisation also was conducted to 40 Municipal Councilors as planned for one day, and Council Management Team (CMT) members were oriented for 3 days. Health manager explained how it was conducted.

“That was conducted in the first period of implementation, because this is sensitisation it is one day thing. They will help during implementations because there are other activities involve schools, so when the head of department of education knows it is good even on facilitation, because will know the importance” (Municipal Youth Co.)

4.3.3 Services and Supplies

In service provision, the municipal conducted training to health care providers in 14 days which facilitated by national trainers who used Training Package of Adolescent

Sexual Reproductive Health (MoH, 2004) guideline. Training needs were identified by Municipal Reproductive Health Services Coordinator with involvement of Health Facility In-Charges to identify staff that would provide the services. Also, programme partners helped by conducting landscaping assessment which identifies the capacity and gaps of the municipal to implement the programme. Health manager elaborated how the training was conducted to health care providers.

“We have conducted training to all 30 health care providers. First the training was for 14 days. We had 2 national trainers and was done for 14 consecutive days. Though these youth friendly reproductive services were provided, but people were not providing with knowledge or skills which help to provide services to youth as it is required according to standards. Sooo when this project came it was seen that in order to increase efficiency in services, it is good for Health care providers to be capable, and that was the reason of conducting training” (Municipal Youth Co.)

Another health manager added that, training was conducted in class and demonstration in health facilities. After training staff were supposed to orient and provide feedback other health care providers in the facilities. 2 health care providers were trained from each public health facilities. A total of 10 health facilities were targeted to improve services.

“training needs was identified in those supported 10 public health facilities and those facilities were selected because they have high number of adolescent, risk areas, population density and need, high volume site, early and teenage pregnancies. After that we cooperated with facility in-charges and set variables such as age not above 55, very active and committed. We had 3 national facilitators from ministry of health and community development who trained on friendly youth services. Training based on guideline of youth friendly services for 10 days from morning to evening. Then last 2 days were conducted in site for practice orientation, there were different methodologies lecture, power point presentation, book work, role playing, flip chart and we printed participant manual to all 30 HCPs for reference when providing services” (MRCH Co)

Also activities progressive reports showed that, all staffs in 10 health facilities were oriented on AYSRH services provisions by conducting whole-site orientation to 200 health care providers. In-reaches services were conducted in 5 days in every month in each public health facility, also 3 days integrated outreach services to 6 distant

communities were conducted in each quarter. Mentorship to 30 health care providers from 10 public health facilities on AYSRH including proper documentation in HMIS book were conducted quarterly. Together with supportive supervision of 5 days on AYSRH in all 10 health facilities, using a checklist developed by health managers at council level. Project implementation team (PIT) meetings for CHMT and other implementing partners were conducted in every month to discuss issues pertaining to family planning and AYSRH services.

Supplies and commodities

Supplies and commodities were provided by Kinodnoni Municipal Council together with health facilities. The stakeholder (Jhpiego) was not responsible for providing commodities and supplies, they conducted training on commodities security, together with availability tracking, only in case there is out of stock. This was being included in budget of CCHP 2018/19. A manager from Jhpiego Organisation explained.

“We are supporting the issue of commodities security which goes together with commodities availability tracking, first of all the government has to ensure that the commodities are available but if there is any shortage on availability of the commodities we support. So when they are designing their project they take action for it and budget to ensure that specific commodities that are available. For instance, the key of our nation is on LARC, making sure IUCD are there, but also not only making sure availability of IUCD, but building capacity training the providers to be able, all the facilities to be able to provide the IUCD which is some of it is a bit complicated, BTL which is a bit complicated”(Jhpiego Manager)

In-reaches and outreach services

On the provision of services, in-reaches (in health facilities) were conducted differently by considering age group which is 10-14 years, 15-19 and 20-24 because they differ in needs and growth.

“On adolescents there are issues which we also address, there are issues of teenage pregnancy, we want to see these children of 10-14 years 15-19 how they are exposed and to what extent”(Jhpiego Manager).

Services were provided differently as per age group basing on risk and needs differences. Also, health education is provided per age group, 10-14 years are directed

on cleanliness, how to protect themselves but if they have started sexual issues they will be taught on sexual transmitted diseases protections and what service will protect them from teenage pregnancies. Other group of 15-19 is being taught about STI protections, family planning utilisation, HIV/AIDS protections and the likes.

“There are 3 groups of youth 10-14, 15-19 and 20-24, there are educating flip charts, so when 10-14 year come we test his/her understanding, they can tell us big issues which wanted to hide from the first place. But 10-14 years are given information on how to protect themselves, how to clean their bodies, to follow life skills values, when taught 10 life skills. Within those there are teachings on how to protect themselves, example self-awareness, communication, relationships, involvement, ushirikeli, authenticity, dealing with problems, T3. after teaching them, questions arise from there, such as diseases, family planning, condom. In sexual reproductive health we teach both male and female body parts and their functions, and what how they can be infected, also the effects. By using life skills will acquire properly. (Magomeni H/C HCP)”.

Outreaches were conducted quarterly by identifying areas with high needs. It was integrated outreach where community health workers and peers inform people around the area when, where and what services will be provided. Health manager explained that, same services which are provided in health facilities were also provided in outreaches, but if there was need for more investigations, clients were given referrals to health facilities.

“Those are services which provided outside facility, instead of clients to come in health facilities. We go in streets where they are, by identifying the place where there is need and construct tents to provide services. First we communicate with street government authorities this is very important for them to know what is going to be conducted, what is the aim, for how many days then they will help us to conduct sensitisation then you set your tents and equipment, people come to get services” (Municipal Youth Co)

Another manager elaborated what services are provided in health facilities and how. That, Services provided in health facilities were counseling and testing, sexual reproductive services, HIV and AIDS, sexual transmitted infection, family planning, antenatal. All the services and treatments mentioned were free but when they come for other services such as Malaria they are obliged to pay.

“Services in health facilities are proper counseling to AY on sexual reproductive health services, because they pass through changes of their bodies and they do not understand their situation, counseling and testing for those who need, STIs testing and treatment, those who are pregnant we provide antenatal services, those who have abortion problems we provide those services, family planning services, HIV testing on pregnant youth and treatment” (MRCH Co)

4.3.4 Friendly Youth Services in Health Facilities

Health facilities were observed by checking 4 characteristics of friendly youth services. They were based on health facility, health care providers, programme, policies and procedures. Interviews to health care providers were conducted to examine how adolescent youth friendly services were provided. Health facilities observed were Bunju, Hananasif, Kawe, Kigogo, Kunduchi, Mwenge, Salasala, Tegeta dispensaries and Magomeni, Tandale Health centers.

All 10 health facilities are located near places where adolescents and youths can meet together. Some are located nearby secondary schools, market, business areas and tuition points. Adolescent and Youth Sexual Reproductive Health Services are provided at convenient hours on weekdays and weekends.

Table 4.3: Special Hours for Adolescent and Youth Services

Health Facility	Special Days	AY Services Hours
Bunju Dispensary	Tuesday and Friday	1:00 pm – 5:00 pm
Hananasif Dispensary	Monday to Friday Saturdays	2:00 PM From Morning
Kawe Dispensary	Monday to Friday Saturday	2:00 pm – 4:00pm Morning – Afternoon
Kunduchi Dispensary	Wednesday Saturday	2:00 PM 10:00 AM
Mwenge Dispensary	Monday to Sunday Saturday	Any time 9:00 am – 7:00 pm
Kigogo Dispensary	Monday to Sunday	Any time
Salasala Dispensary	Wednesday Saturday	3:30 PM Morning – Afternoon
Tegeta Dispensary	Wednesday Saturday	2:00 PM Morning - 1:00 pm
Magomeni H/C	Monday to Friday Saturdays	8:30 am - 5:00 pm 9:00 am - 1:00 pm
Tandale H/C	Monday to Friday Saturday	2:00 pm - 5:30 pm 10:00 am - 2:00 pm

Source; Researcher 2019

Respondents revealed that, health care providers informed clients who came for other treatment before special hours for adolescent and youth, availability of friendly youth services. Also young people needed services before special hours were considered.

“When they come for treatment we tell them there is friendly services that we provide, from 10-24 years and we tell them days for those services. If they come in other days we help according to their needs. SRH services we provide for free but others are paid” (Kunduchi Disp. HCP)

“We provide services almost every day at every time when the facility is open, but we have tendency of conducting dialogues at the end of the month. We do not have specific time to provide services, any time when youth come we attend because if you leave them till specific hours, you won’t get them” (Kigogo Disp. HCP)

In 8 dispensaries there was no specific area for adolescent and youth service provision but services are free of charge. Services were provided in Reproductive and Child Health (RCH), Care and Treatment Centre (CTC) and Family Planning sections. Only in health centers (Magomeni and Tandale) had special buildings to provide adolescent and youth sexual reproductive health services. Youth friendly services buildings are located separate from outpatient buildings and the rooms can maintain privacy when clients are attended. Health care providers explained through interviews where they provided services in facilities.

“we do not have special area for providing services, usually we use RCH room after working hours, in working hours I work in other sections example you saw me in vaccination, but if they come example for family planning services or he/she want to see a doctor, you don’t need to harass them, we call and give them priority to see a doctor” (Bunju Disp. HCP)

“We do not have specific area to provide services, but when youth come we give them priority and if they have emergence issues example rape or abortion, we attend at the right time but if it’s not emergence also we attend and tell them to attend the friendly services hours especially when it is counselling issues” (Salasala Disp. HCP)

“we share services in rooms example this is family planning office together with youth, this room provide family planning services, youth friendly services and cancer screening” (Kigogo Disp. HCP)

Another respondent explained that

“There is no special area to provide services because of rooms’ shortage we use family planning rooms, that’s why we set special hours, in afternoon I am available only for youth clients...” (Kawe Disp. HCP)

Feedback method for complaints were provided through dialogues conducted in those specific areas.

Health Care Providers, Policies and Procedures Characteristics

Health care providers in all health facilities have been trained to provide adolescents and youth friendly services, and all staff in health facilities were oriented on AYSRH friendly services including supporting staff. Staffs demonstrate respect, ensure privacy, confidentiality and use enough time to interact with clients. Also providers

were assessed by Council Health Management Team (CHMT) and Ministry of Health (MoHCDGEC). Peer educators were available at Magomeni, Tandale health centres and Hananasif, Tegeta dispensary, but other health facilities did not have.

Only in those health facilities with peer educators, adolescent and youth performed their own activities such as drama, football matches and other method of providing education to young people. They also involved in monitoring the quality of services. Health care providers declared about having and not having peer educators. Some facilities were in process of selecting peer educators.

“we have 2 sensitisers but not peer educators, also we want to create football team, because we have just started, we are in the process of creating football club and we have a target of reaching at least 20 clients per those specific days” (Bunju Disp. HCP)

Another respondent explained that;

“Youth have their own activities example now they want to dramatize on early pregnancies and their damages, and football. And I was planning to teach them how to make Batiki, vyungu of towels, decorations of bottles so that those who are in streets do not have work to do so, therefore I was thinking of sponsors to help us because materials needs fund. Facility budget plan is for outreaches example if I go at Feza secondary to provide health education, or in streets I go with peer educators”. (Tegeta Disp. HCP)

Respondents clarified how peer educators helped them to link with young people with challenges and provide health education and services.

“we collaborate with youth in some activities, example we have permanent youth with many challenges, So they trace us about the challenges and want to meet with us and discuss” (Hananasif Disp. HCP)

“Peer educators also involved in outreaches, in every month I arrange time table for them to pass in 6 streets. They sensitise on exercise to be conducted such as family planning, cervical cancer screening, testing, underfives Vitamin A” (Tandale H/C HCP)

Adolescent and youth found in health facilities attending services without the consent of their parents. Wide range of services were available to both male and female young people including Family Planning (FP), Sexual Transmitted Infections (STI) treatment

and prevention, HIV/AIDS, counseling and testing, antenatal, delivery care, postnatal care, Comprehensive Post-Abortion Care (cPAC) and other services concerning group of age (10-14, 15-19 and 20-24). Some expired commodities found in Hananasif dispensary, in other health facilities were not found.

“We provide services of family planning, STI diseases, condom demonstration, post abortion care, VCT and other treatments including different counseling. Also, we have different drum groups, drama, so youth activities are conducted in streets, we have peer educators, they come from 2:00 pm hours, others are at schools and collages”
(Tandale H/C HCP)

A National Curriculum for Service Providers on Adolescent Reproductive Health (MoHSW, 2006) guideline was available in every health facility. It was observed that condoms were available but were only provided during service provision hours to those needed due to its scarce at Medical Store Department (MSD), example in Hananasif dispensary they were not available for past 6 months.

Education materials (audio and visual) and posters were available in Magomeni, Tandale health centers and Tegeta Dispensary. Other health facilities did not have education materials (audio and visual) and posters to provide knowledge to adolescent and youth; *“We educate by using music, entertainments, TV, jerseys for youth football matches”* (Magomeni H/C HCP)

Figure 4.1 Education Posters - Tandale health centre



Picture by researcher, 2019

Referral mechanism is available for medical emergencies, mental health and psychosocial support. Adolescent specific indicators were monitored example number of adolescent clients (by age and sex). All health facilities welcomed and accommodated young people for services. Facilities provided contraceptives which are most popular among youth clients.

Contraceptives which are most popular among youth clients are condom implanone/Jadelle, Combined Oral Contraceptive pills (COC), injectables and IUCD). Health care providers from each facility explained preferable methods among youth; *“Most of them like syringe methods” (Bunju Disp. HCP)*

Respondent from other facility explained

“Many youth use long acting reversible methods, it depends others have started and experienced in sex, so we advise to use family planning without forgetting condom use for disease preventions. But they use implanon, condom for pregnancy prevention” (Kawe Disp. HCP)

At facility which receive most clients were students from tuition points elaborated that

“In family planning we provide condom, implanon and circle bins (calendar), we provide those methods because youth do not want IUCD” (Mwenge Disp. HCP)

Respondent from Salasala dispensary prevailed that the most contraceptive methods preferred by clients were pills and IUCD

“On family planning we prefer them to use Oral Contraceptive Pills or implanone because are methods they can properly use, but if we get example a 19 years old student who had pregnant and abortion we can provide IUCD because uterus can receive that, also we like to teach them about emergence contraceptives to help them example those who go to drunk” (Salasala Disp. HCP)

Respondent from kigogo added that

“We most provide COC, implanon, male and female condoms. Those are family planning services, we provide SRH services free of charge” (Kigogo Disp. HCP)

Hananasif respondent explained

“In family planning implanon, IUCD, injectables we to provide best methods to youth, for now is implanon. Example if you don’t have a kid we won’t provide a method with hormones, we know their effects”

At Magomeni, young people used condoms, pills, implanon and Jadelle

“First family planning method to youth is condom but for ladies implanon/Jadelle, also recommended to provide implanon, oral contraceptive pills, they don’t have many side effects unless she has many lovers, we give them advantages and disadvantages” (Magomeni H/C HCP)

At Tandale area most clients used Combined Oral Contraceptive pills (COC) and DEPO

“We mostly provide COC, now others use implanon, condom, most of them like DEPO but I explain to them why they should use and not using a certain method” (Tandale H/C HCP)

4.3.5 Documents on Guiding Service Provision

Adolescent Services Provision Guideline

Health facilities had guidelines for guiding health care providers in providing services to adolescent and youth; A National Curriculum for Adolescent Reproductive Health, of MoHSW (2006) aimed at making reproductive health services adolescent friendly. This curriculum combines 10 units explaining different issues about adolescent and guidance on how to provide services to them. It includes; Unit A is an introduction, unit B provides meaning of adolescence and its implications for public health, unit C explaining how to communicate with and counsel an adolescent, unit D is about adolescent sexual and reproductive health, unit E is adolescent friendly reproductive health services, unit F provides pregnancy prevention and management of unsafe abortion in adolescents, unit G explains care of adolescent pregnancy and child birth, unit H is about sexually transmitted infection, unit I explains HIV/AIDS in young people and unit J is conclusion.

Supportive Supervision Checklist

The municipal prepared a supportive supervision checklist for adolescent and youth services provisions titled, Checklist for Reproductive, Maternal, Newborn, Child & Adolescent Health Score Cards Indicators (RMNCAH). The checklist included adolescent and youth indicators such as; % of women received family planning contraception/proportion of long term Family planning methods, % of male spouses involved in RMNCAH services/% of adolescent pregnancy, Antenatal Care 1st visit before 12 weeks rate, % of institution delivery/% of deliveries with skilled personnel, % Antenatal Care IPT2 Coverage/Proportion of pregnant women receiving FEFOL and IRON supplementation, % of mothers given Uterotonic intervention, Post natal Care (PNC) mothers within 48 hours PNC/2days baby and % of girls received Human Papillomavirus (HPV) vaccine.

In each indicator needed to show means of verification to determine data recorded in Health Management Information System (HMIS) register books and data management.

4.3.6 Data Management of AYSRH Services Programme

The programme used two data management systems, they were supposed to be reported to government system, District Health Information System (DHIS2) and Jhpiego system called Open Data Kit (ODK). All staff were oriented on how to document on health management information system (HMIS) manually and in DHIS2, also DHIS2 was connected in ODK for reporting. If data are not reported in time in ODK, payment of activities conducted activities were not made.

“We have a system which we use called ODK. Open Data Kit which is real time data reporting system we use it to track those results of those interventions, everything goes to ODK reporting system, every activity which is conducted. So what they do, after conducting the activity they just send through ODK” (Jhpiego Manager)

Another participant from health management added that

“We usually conduct data review meeting, we have data quality assessment. Data review meeting we look on the gaps of data in a month then we do analysis, then we call and sit together with them to provide their challenges, after that we make action plan, then in each quarter we conduct data quality assessment we look on the quality of data those entered in registers, tally sheet, those submitted to us from the system, also we compare if data match, then after that we make action plan. But apart from that, we created a system in each facility in every end of month, in 5th date, before submitting reports, they conduct themselves data review meeting to cross check if data are good, then they submit to us or entering in DHIS2 themselves. Also in every week we do data checks to assure if they are using proper tools” (HMIS Co.)

4.3.7 Young People Used Sexual Reproductive Health Services in 2018/19

Family Planning Services

The study found that adolescent and youth used family planning in Kinondoni Municipality by different percentages according to methods received. On short term methods; Injectables were 41%, oral contraceptive pills by 40%, male condoms 46%, female 49%. On long term family planning methods; Implanon was 41%, IUCD by 29%. On other family planning methods were; Traditional methods 49%, other methods 48% and emergence methods 37%. The table below shows number of FP clients by age categories and percentages of young people received the methods.

On post abortion adolescent and youth were; Jadelle was 33%, implanon by 45%, other methods 40%. Family planning 42 days after delivery; Jadelle 34%, implanon 36% and other methods 45%.

Sexual Transmitted Infections Services

New clients (adolescents and youth) attended for sexual transmitted diseases were 26% of all new clients attended in 2018/19. Clients who received counseling services and advised to use condoms were 24% and those linked to HIV counseling and testing were 24% of all clients.

HIV Counseling and Testing

New clients (adolescent and youth) received HIV counseling and testing services were 30% of all new clients attended that service, among them adolescent and youth clients receive results after counseling and testing were 30% of all clients.

4.4 Factors Facilitated Attainment of AYSRH Programme Intended Outcomes

Factors facilitated attainment number of clients use family planning and other sexual and reproductive health services were Tupange Pamoja spirit, government commitment and capacity building to health care providers.

Tupange Pamoja (Ownership)

This programme of family planning was conducted by giving room to municipal council to planning for their own activities with technical support provided by Jhpiego. Therefore, there was involvement of health managers from planning, implementing and evaluation. Respondents explained that;

“Normally most of donors they say this is our project, for us we say this is a matching of funds, TUPANGE PAMOJA so we sit down together as a team, which facilitated success actually of this project, the other thing TCI creates ownership on sustainability, without TCI it couldn't be here, so it has ownership”(Jhpiego Manager)

Government Commitment

Health manager elaborated that, the municipals were ready to budget and increase fund for family planning and sexual reproductive services. Before the programme implementation the budget of family planning was estimated to be 25million shillings, during first year of implementation 2018/19 it increased to 75 million shillings and in the next year the budget was above 100 million shillings.

“Local government commitment we have seen a lot of commitment, for instance when we started the regional CHMT budget was for FP was 25 million that was kept in CCHP, after one year after seeing the results, the amount that was budgeted was 75 million, and this year the commitment is above 100 million, so increasing local government capacity” (Jhpiego Manager)

Capacity Building (training)

Respondent revealed that sensitisation conducted on adolescent and youth champions such as WEO and VEO, Municipal Councilors and training to health care providers were helped the implementation of the programme successful.

“The other thing we have trained community leaders we call A-Y champions, which we have the councilors, religious leaders, municipal mayors and the likes, those are person of the project and sort of advocacy, the other thing is a capacity building, we capacity building them for them to implement this project”
(Jhpiego Manager)

4.5 Examine Factors Impinged the attainment of AYSRH Programme intended outcomes

Bureaucracy

Health manager revealed that, there was long process of disbursing fund. After implementing activities, report writing, submission and fund will be disbursed to council level. Then government procedures of requesting fund started.

“They want you to conduct activity, submit report, they verify if it is okay, then disbursing fund. In facilities are given control number example Magomeni, so the specific facility supposed to provide control number to receive fund, then following fund request procedures, has to be signed by DMO, and all the procedures, voucher, check. So it leads late disbursement but it is okay on controlling fund but things are not done timely” (MRCH Co.)

Late Submission of Reports

Late submission of report was one of the problems because fund is disbursed according to implemented activities, sometimes the submitted reports are not proper recorded, therefore they have to correct them and resubmit. Respondent explained that;

“Also, submission of reports, because after conducting activity within 3 days you have to submit report but it is a challenge though there is high workload and few healthcare providers, so early submission of report is a challenge or missing of some items example activity is conducted but no pictures for justifications or data were inappropriate taken” (MRCH Co)

Unavailability of condoms

Condoms were not found in outlets they were provided during services delivery hours and are stored in the closed cabinets, this might be barriers for AY to access them because not all clients are confident enough asking for condoms.; *“Even these condoms, they can provide only 40 condoms while we are 80, so they have to increase condoms”* (Respondent 1)

Shortage of Staff

Clients were complaining about shortage of staff and long waiting time. One staff may provide services in more than one section at the same time. Respondents revealed that health facilities provide good services but numbers of staff were not enough.

“They sensitise and many youth attend to get services but the problem is waiting time, clients are many but waiting time is too long. I recommend increasing of enough health care providers. And even these condoms, they can provide only 40 condoms while we are 80, so they have to increase condoms” (Respondent 1)

Another respondent said that

“We get services but we wait for so long because of many clients and few nurses. It takes a day and limits us doing other things. They should employ enough doctors to avoid long waiting time” (Respondent 2)

Respondent added that

“Service providers should be added because there are many clients, others don’t want to be seen in service provision area. This might lead to challenge of people to use services” (Respondent 3)

4.6 Establish best practices influencing attainment of AYSRH programme

This programme had best practices in the implementation process to attain the intended outcomes on utilisation of sexual reproductive health services among adolescent and youth.

Programme Design at Council Level

This programme provided room for municipal level to develop its own programme design to match meet needs of the context. They planned for activities which would address problems, implementing fully, conducting supervision and evaluation of the progress. Health manager revealed that

“We developed proposal, they told us to develop programme design showing areas which need to be addressed with supporting document which shows extent of early pregnancies, how many youth do we have. So, we participated from the beginning, and we won the proposal. Then we planned for activities for implementation, on implementation off activities we participate from the beginning to the end. We evaluate the programme with them in mid evaluation, quarterly we participate to see how the performance going. Also in annual evaluation we compared from previous years. In short we participate fully (MRCH Cord.)

Community dialogues

Respondent revealed that, discussion of different topics helped young people to have self-determination and make decisions and utilising family planning. Tandale health centre went further by conducting dialogues in different ways. They had Jamvi la wanawake for discussion between female parents and female young people issues in every street to raise awareness to parents on importance of talking to youth in solving their challenges and allow utilisation of SRH services. Also stories of kijiweni programme included male parents and male youth in streets discussing how important it was for parents to speak with their children.

“We have jamvi la wasichana, where female young people meet and talk about their health issues, we prepare programme and topics, soft drinks. We enter in streets to meet with 30-50 participants. In this platform we include 2-3 parents and young people to discuss, we found that many parents do not talk to their youth children especially in adolescent age. We educate the importance of talking to their children about different issues example menstrual issues. We have story kijiweni for male young people, we talk to them about challenges they meet, because male parents do not talk to their male children. Also, we have shika fagio programme, it includes leaders, youth, and people in respective areas. We provide education about cleanliness, because when we have clean environments we will be healthier. Those three programmes are in every streets” (Peer educator)

Figure 4.2 Mats used for jamvi la wasichana dialogues



Picture by researcher, 2019

Data management

Data were managed from the field, facility, council levels and programme stakeholder's level. Staff oriented to document services in HMIS books and Open Data Kit system (ODK). Payment is being done when data for services are sent appropriately. This helped to monitor quality of data and control of funds. Respondents elaborated in about how data management was being conducted.

“we created a system in each facility in every end of month, in 5th date, before submitting reports, they conduct themselves data review meeting to cross check if data are good, then they submit to us or entering in DHIS2 themselves”(HMIS Cord.)

Another respondent added that;

“we have the HMIS system, so we have linked, for us we have a TCI management information system dashboard, which has good data visibility, shows each and everything which happening, but also we have the ODK reporting system and outpatient which is also linked with the TCI data management information system and however MI system is also linked to HMIS system”(Jhpiego programme manager)

Youth Friendly Services Sign Boards

In all 10 health facilities there were sign boards showing availability of youth friendly services services. In Tandale health centre, there were enough sign boards to direct clients from main gate to services area. In some health facilities, services are shown on main sign board and separate board specific for youth friendly services. They also indicate hours for young people services.

Figure 4.3 Tandale Health Center Sign Board



Picture by researcher, 2019

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This chapter presents discussion of findings pertaining to study objectives. Qualitative case study design was employed to generate information on determining outcomes of AYSRH programs and how implementation conducted to increase family planning acceptors, having number of AY served from integration service areas, increasing awareness on AYSRH services and changing in behavior among target population.

5.2 Objective 1: *To examine implementation process of AYSRH programme in Kinondoni Municipality*

Implementation of Adolescent and Youth Reproductive Health programme allowed participation of health managers at council level from program designing, planning and implementation. Municipal council planed for activities according to the need clients in Kinondoni municipal. The council identified areas with high need of the services and population density which resulted to increase in number of AYSRH users.

5.2.1 Services and Commodities

Wide range of services provided such as sexual transmitted infections testing and treatment, HIV/AIDS, post abortion and delivery care, counseling and testing, cervical cancer screening and family planning services were provided in health facilities, and out of facilities to meet client's needs.

In family planning different methods were provided including short and long term methods for young people to make informed choice. Methods available in the facilities were implanon, Intra Uterine Contraceptive Device (IUCD), oral contraceptive pills, injectables, jadelle and other methods, this contributed to clients having options which are concrete according to their situations.

This is supported by study conducted by Malhotra (2014) explaining strategies for improving family planning. The study suggested that utilization of contraceptives is influenced by expansion of contraceptives, expanding access to financial and physical acceptance of contraceptives, also increasing knowledge and awareness of providers and acceptors (Malhotra, 2014). However, commodities and supplies were provided by Municipal Council and health facilities. Budget for family planning and other supplies were planned in the Comprehensive Council Health Plan (CCHP) and Facility Health Plans of 2018/19. This might create sustainability of the services because municipal council level has been built capacity for providing supplies and commodities. But during this study it was found that, condoms were not available in outlets and this was due to out of stock at MSD for some months, which led health care providers to hide them until provision of services only. This might be the impinging factor of program implementation. Also sustainability of services would happen because there were Adolescent Youth Sexual and Reproductive Health trainers at management level, Tegeta dispensary and Magomeni health centre.

Provision of services by considering age groups 10-14, 15-19 and 20-24 was the best way of providing services according to clients' needs and risks. This is supported by OU (2011), that in designing and implementing young people interventions, it is important to consider their needs because they vary by age, sex, educational status, marital status, migration status and residence. Adolescence (10-14 years old) might be at primary schools and not yet married and adolescence (15-19 years old) are more likely to start sexual relationships (OU, 2011). From this fact, it was important to determine the type of information and services that would be appropriate for them.

5.2.2 Service Provision Guideline

In all health facilities there was a guideline A National Curriculum for Service Providers on Adolescent Reproductive Health (MoHSW, 2006) for health providers to offer proper services to adolescent and youth according to standards. The guideline provides information of dealing with different issues including case studies as vivid examples. But there was a need for more copies of guidelines because during observation some staff started finding the document from other health care providers and peer educators who used it.

However, there is importance of reviewing this guideline by MoHCDEC because it identifies only adolescent issues at large from its title and not youth. There is a need for reviewing and come up with the guideline which reflects adolescents and youth, as Ministry of Health of Kenya guideline titled; National Guidelines for Provision of Adolescent Youth-Friendly Services (YFS) in Kenya of 2005, addressing issues of both adolescent and youth (10-24 years) but for Tanzania only adolescents (10-19 years).

5.2.3 Friendly Youth Services in Health Facilities

There were only 2 health centers with special buildings for providing young people services, but all 8 dispensaries did not have separate building for youth friendly services. That was not an excuse for dispensaries to provide services, they used other sections at convenient hours for young people to attend. Most of them used Reproductive and Child Health (RCH) rooms', especially family planning rooms which are well equipped with Comprehensive Post-Abortion Care (cPAC) services. The rooms maintained privacy and each health facility provided different SRH services such as family planning, HIV counseling and testing, STI testing and treatment.

Among those health facilities only Magomeni and Tandale health centres had permanent buildings for providing AYSRH services, the section was located separate from other services as friendly environment for young people to visit and access services. These buildings are well equipped by counseling and testing rooms, education materials both posters and audio visuals, which provide direct information in different ways about the services. In other 8 dispensaries AYSRH services were provided after Family Planning clients had been attended, whereby most of them starts at 2:00 pm to evening in weekdays. Except Magomeni health centre starts the services at 8:30 am because the area is surrounded by offices and organized families where young people are not found all the time. Many clients are studying in day and boarding schools, colleges and universities, so they decided to provide at those times to make sure they do not miss clients because of limitation of opening hours.

All rooms in health facilities for providing services were maintaining privacy and confidentiality. On weekend all facilities provide services in Saturdays from mornings to afternoons which are convenient hours for youth to attend services because some clients are at school.

The above discussion was in line on the review conducted in Niger. It was observed that, the government set up many youth and counseling centers for providing services, but demand side interventions were scarce to create awareness and knowledge for young people to use services (World-Bank, 2016). This justified that both demand and supply of services are important areas to be given priorities in providing young people services. But services can be provided in health facilities by using same buildings at different hours which are convenient to young people.

5.2.4 AYSRH Services Data Management

The program managed to orient 200 staff on proper documentation of AYSRH services in HMIS register books, and AYSRH trained staffs were oriented on open data kit (ODK) system. Also there was good system of tracking data and conducting data quality assessment from health facilities to council level. The municipal managed to provide capacity building to health facilities on checking their data before submission at council level, this was the best practice for health facilities to own their quality data for decision making. This was also suggested by study conducted by Anasel et al (2019) that government should prioritize capacity building programs for health professionals to strengthen their data skills by conducting frequent on-job and off-job trainings by collaborating with other stakeholders such as the private sector, development partners, and nongovernmental organizations. The study suggested that this would change the attitude of health care providers on data collection, analysis, and use in decision making and build a strong culture of data use for evidence-based planning (Anasel, 2019)

The system of disbursing fund after conducting activities with evidence of data and pictures included in the reports, helped staff to be committed on providing services and not forging.

5.3 Objective 2: To examine factors facilitating attainment of AYSRH programme intended outcomes on utilisation of sexual reproductive health services among adolescent-youth in Kinondoni Municipality

Capacity building to health care providers, orientation of whole site staff, commitment on government to budget on family planning activities and training staff on provision of services were the main factors for improvement of the AYSRH program. Clients were provided services they need in proper according to age groups to meet their needs. Also for municipal to increase budget on supplies and commodities was the foundation of sustainability of the program even after phase out of program funders. These resulted for number of young people to use sexual and reproductive services especially family planning.

The study conducted in Ethiopia found that, 64% of young people who utilized youth friendly services, because they had information from different source. Also conducive environment for training health care providers especially in government institutions facilitated the use of sexual reproductive services among young people (Motuma, 2016).

5.4 Objective 3: To examine the factors impinging attainment of AYSRH programme intended outcomes on utilisation of sexual reproductive health services among adolescent-youth in Kinondoni Municipality

The main factors impinged attainments of intended outcomes were late disbursement of fund and bureaucracy after completion of conducting activities. This was caused by late submission of reports and process of approving fund in different departments. Another factor was late and improper submission of reports at council and Jhpiego levels, which led to late disbursement of fund. Unavailability of condoms in the outlets and out of stock at Medical Store Department (MSD) level for some months, created barrier for young people to be provided condoms when they needed, which might be risk for them in acquiring diseases and unwanted pregnancies.

According to study conducted by Binu et al (2018) in Ethiopia, revealed that, different factors were associated to affect program implementation including inconvenient times, lack of privacy, religion, culture, and parent prohibiting their children to use use

sexual reproductive health services (Binu, 2018). While in Kinondoni Municipal the factors are at facility and council levels except availability of condoms.

5.5 Objective 4: Establish best practices influencing attainment of AYSRH programme outcomes towards utilisation of sexual reproductive health services among adolescents-youth in Kinondoni Municipality

The best practice in AYSRH program were designing program at council level, while previous programs were designed by non government organization and require councils to implement. This considered important issues to be addressed at Kinondoni area. Another best practice was community dialogues which helped young people to get knowledge and ask questions for clarifications, and after dialogues they were provided services instead of waiting for them attending in other days. Data management process was good from field reporting through open data kit, and report in HMIS tools and data quality assessment, also payment was made with evidence of data. Youth friendly services sign boards helped to identify availability of services in all 10 health facilities providing young people services.

This is in line with the study conducted by Women's Refugee Commission (2012) in Gulu District Uganda, identified best practices of the youth center programs. The study show those convenient hours from 8:30 am -17:00 pm in week days and Saturdays was best practice for program implementation. Other best practices were participation of adolescents in the program designing by taking part in drama, volleyball and football competitions. Data records of all services in designated form and use for decision making in program was another best practice (WRC, 2012).

Therefore AYSRH programme implementation created awareness to young people on utilizing sexual Reproductive health services through implementation of activities based on demand generation, advocacy, services and supplies. Also the Council level to design programme was one of the best practice to allow planning of required activities which improved services which were not provided in standards.

CHAPTER SIX

CONCLUSION, RECOMMENDATIONS AND POLICY IMPLICATION

6.1 Conclusion

Major conclusion is that, Adolescents and Youth Sexual Reproductive Health program helped to increase the use of family planning among young people at percents according to methods ranges 29% to 49% during implementation, but before it was below 29%. These contributed by demand created from community level to council level for supporting youth accessing and utilize the services for their health. Demand was created by community health workers, peer educators and health care providers through dialogues and health education in schools, schools and in health facilities.

Ward and village executive officers created advocacy in their respective areas and providing support to health care providers and health educators in providing education and outreach service provision. Capacity building through training and orientation of health care providers built skills and competence for them to provide proper health services to young people at appropriate hours in all 10 health facilities.

The program had good system of data management and use for decision making especially on releasing fund and for planning. Program design at council level allowed the implementers to plan for activities which match the reality to address young people problems at Kinondoni municipality area which contributed to the increase of contraceptive prevalence rate.

6.2 Recommendations

On shortage of staff, the council should have a plan for training other health care providers on job, in case a trained one is transferred to other facility. Also to plan for next financial year on training enough staff to provide young people services. This is suitable because many health facilities provide services after working hours, and on the weekends (Saturdays) which can allow providers to double shift, but payment for extra duty allowance is important since employment of new health staff is not released in MoHCDGEC.

Health facilities should budget in their plans to procure posters, audio and visual materials for education to young people, also to make separate sign boards to informing clients about youth friendly services.

Kinondoni municipal council has to acknowledge peer educators efforts because they play a big role in providing health education for youth to attend sexual reproductive health services. The evidence from Tandale, Magomeni and Tegeta health facilities about peer educators' role, should taken into account.

The council and Non Government Organisations (NGOs) should make sure condoms are available in health facilities condom outlets all the time. Due to out of stock for some months, condoms were not found in condom outlets, this might affect attainment of program outcomes.

6.3 Policy Implications

Tanzania has been playing role of addressing adolescent issues by providing guideline of providing SRH services of 2006, A National Curriculum for Service Providers on Adolescent Reproductive Health of MoH, and National Adolescent health and Development Strategy 2018-2022 of MoHCDGEC (2018) which has vision of Tanzania to create an environment that promotes and supports the growth and development of healthy, educated and empowered adolescents who are empowered to transition into adulthood and contribute to the country's development vision. This will be accomplished through strong multi-stakeholder action.

There is a need for Tanzania government to address both adolescent and youth issues in guidelines and strategies because of their health needs and challenge differences. This study found all health facilities using one guideline (MoH, 2006) on providing services to all young people and strategy (MoHCDGEC, 2018) used to implement AYSRH programs for both adolescents and youth (10-24 years). The good example is in Kenya Guidelines for Provision of Adolescent Youth Friendly Services (2005), provides strategies and actions by identifying challenges for all age groups of young people (10-14, 15-19 and 20-24 years).

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APPENDICES

APPENDIX 1: In-depth interview (jhpiego manager)

How are you!

Thank you for agreeing to talk with me today, my name is Winfrida Leonard Muhoja, A Msc Health Monitoring and Evaluation student in Mzumbe University. My study requires me to undertake an evaluation of a health programme which will allow me to write a report as requirement for the partial fulfillment of the award of the master degree. I am conducting process evaluation of AYSRH programme on utilisation of sexual reproductive health services among adolescents-youth in urban community. Any information obtained in this session will only be used for the purposes of the study and not otherwise. I would like to assure you that no information given will be disclosed to unintended audiences but only to the faculty of Mzumbe University, regional authority and Municipal authorities. The information will be treated in high anonymity and will be stored carefully. You are free to agree or disagree to participate to this study or decline at any time.

Our discussion will take hardly 25 to 40 minutes. Can we start the interview?

1. Why adolescent and youth in this programme?
 - a. Why adolescent separate to youth
 - b. Does the programme target both male and female?
2. Did adolescents and youth from the intended audience participate in designing the programme by communicating their needs and preferences? Probe how?
3. Does the programme have school based component? If yes probe
 - a. If school administrators, teachers and school staff have been involved in programme planning and implementation, probe how?
4. Did parents, relatives, caretakers and/or guardians been involved in programme planning? If yes, probe how
5. Did policymakers/local government leaders been involved in programme planning? How?

6. Did community elders and/or leaders been involved in programme planning?
How?
7. Did service providers been involved in programme planning? How?
8. Do the adolescents and youth help implement the programme?
 - a. Probe; where and how do adolescent-youth participate in programme implementation?
9. Do staff and volunteers know, understand and accept the goals and objectives of the programme?
 - a. Probe; what did you do to make sure they understand goals and objectives?
10. What is your role in AYSRH programme from planning to implementation?
11. Did you develop a logic model linking inputs, activities, outputs and outcomes?
 - a. Probe; Ask for a document which show logic model/log frame
 - b. What are the activities of this programme at Kinondoni Municipality?
 - c. How do you implement them
 - d. What are the outputs of those activities up to date? Ask a document for a justification
12. How do you identify training needs of AYSRH?
 - a. Probe; who were trainers of trainees of this programme and how did you select them?
 - b. Who were trainees of this programme?
 - c. Probe; why those were trained and their role in AYSRH programme
13. What were the training contents on each group of trainees?
 - a. Probe; did you use training guidelines?
 - b. Probe; what guideline did you use for training
 - c. Observe; according to whom were trained, by reading the guideline contents and what was considered in the training during implementation
 - d. Are there on-job trainings in this programme? If yes, how does it conducted
14. How do you implement AYSRH toolkits in Kinondoni Municipality?

- a. Probe: how demand generation toolkit is being implemented
 - b. Probe; how advocacy toolkit is being implemented
 - c. Probe; how services and supply toolkit is being implemented?
- 15. What about availability of commodities and resources? Who is responsible to provide resources and commodities?
- 16. What are the outputs of AYSRH toolkits at Kinondoni Municipality?
- 17. How do you assure data management of AYSRH?
 - a. Probe; on HMIS documentation
 - b. How do you use data for decision making
- 18. Why HODs, WEO&VEO, councillors were sensitised in this programme?
Probe; how are they involved and their roles in AYSRH programme?
- 19. What implementing partners do you have and what are their roles on AYSRH programme?
- 20. How do you conduct supportive supervision of AYSRH services? Probe; How often is SS conducted? Observe time table for SS
- 21. How do you monitor AYSRH activities and evaluate the programme implementation?
- 22. What achievements do you have in the implementation of the programme?
Probe: what factors facilitate the achievement?
- 23. What challenges do you have in programme implementation? Probe; in each approach and its contents
- 24. What are your recommendations on improving programme implementation

APPENDIX 2: In-depth Interview (CHMT – MRCH Co, Youth Co, and HMIS Co)

How are you!

Thank you for agreeing to talk with me today, my name is Winfrida Leonard Muhoja, A Msc. Health Monitoring and Evaluation student in Mzumbe University. My study requires me to undertake an evaluation of a health programme which will allow me to write a report as requirement for the partial fulfillment of the award of the master degree. I am conducting process evaluation of AYSRH programme on utilisation of sexual reproductive health services among adolescents-youth in urban community. Any information obtained in this session will only be used for the purposes of the study and not otherwise. I would like to assure you that no information given will be disclosed to unintended audiences but only to the faculty of Mzumbe University, regional authority and Municipal authorities. The information will be treated in high anonymity and will be stored carefully. You are free to agree or disagree to participate to this study or decline at any time.

Our discussion will take hardly 25 to 40 minutes. Can we start the interview?

1. Before this programme started its implementation at Kinondoni Municipality, what other programmes related to adolescent-youth were implemented and at what time. Is there any document show their presence at Kinondoni?
2. Have you been involved in programme planning? How?
3. Do you know AYSRH Toolkits?
4. What are the outputs of the following activities and how were they conducted?

Ask a document for justification

- Training on AYSRH to 30 HCPs from 10 Public Health Facility on AYSRH
 - a. how did they identify training needs
 - b. how training was being conducted, probe; ask training guideline for documentary review
- Whole site orientation to 200 HCPs from 10 Public health facilities on AYSRH

- 3 days orientation to 30 CHMT members on AYSRH
 - Mentorship to 30 HCP from 10 Public and health facilities quarterly on ARSH including proper documentation in HMIS book
 - 3 days ASRH integrated outreach services to 6 distant communities quarterly
 - 5 days in-reaches for AYSRH in one public health facilities monthly
 - Conduct 5 days AYSRH supportive supervision to 10 public health facilities providing AYSRH
 - Conduct monthly PIT meetings for CHMT and other implementing partners
 - To conduct one day sensitisation meeting to 30 municipal head of departments (CMT)members bi-annually by June 2019
 - Conduct one-day sensitisation meeting to 116 WEOs and VEOs members on AYSRH by June 2019.
 - To conduct one day sensitisation meeting to 40 Municipal Councilors on AYSRH by June 2019
5. What SRH services are provided to AY at this facility? Probe; documentation of services provided on HMIS data, Probe; which contraceptives are recommended to youth? Why?
 6. How about cost sharing of the services? Probe; who is responsible on making price list?
 7. Who is responsible to provide resources and commodities? Probe; How do you assure availability of commodities and supplies
 8. How do you reach AY on of different categories on providing information i.e in school, out of school?
 9. Do A-Y have their own activities? How do you help them to have self reliance?
 10. Do you have school health coordinator? How does she/he play role in AYSRH programme?
 11. How many adolescent have been reached and use SRHS in and out of facilities?
 12. How many youth have been reached and use SRHS in and out of facilities?

13. Why HODs, WEO&VEO, councillors were sensitised in this programme?
Probe; how are they involved and their roles in AYSRH programme?
14. What implementing partners do you have and what are their roles on AYSRH programme?
15. How do you conduct supportive supervision of AYSRH services? Probe; How often is SS conducted? Observe time table for SS. Ask a supportive supervision tool
16. How do you assure data management of AYSRH? Probe; documentation on HMIS
17. How do you monitor AYSRH activities and evaluate the programme implementation?
18. How do you use data generated by M&E conducted? How?
19. What achievements do you have in the implementation of the programme?
Probe: what factors facilitate the achievement?
20. What challenges do you have in programme implementation? Probe; in each approach and its contents
21. What are your recommendations on improving AYSRH programme?

APPENDIX 3: In-depth Interview (health care providers)

How are you!

Thank you for agreeing to talk with me today, my name is Winfrida Leonard Muhoja, A Msc Health Monitoring and Evaluation student in Mzumbe University. My study requires me to undertake an evaluation of a health programme which will allow me to write a report as requirement for the partial fulfillment of the award of the master degree. I am conducting process evaluation of AYSRH programme on utilisation of sexual reproductive health services among adolescents-youth in urban community. Any information obtained in this session will only be used for the purposes of the study and not otherwise. I would like to assure you that no information given will be disclosed to unintended audiences but only to the faculty of Mzumbe University, regional authority and Municipal authorities. The information will be treated in high anonymity and will be stored carefully. You are free to agree or disagree to participate to this study or decline at any time.

Our discussion will take hardly 25 to 40 minutes. Can we start the interview?

1. Gender.....
2. What is your age.....?
3. What is your designation.....?
4. How long you have worked on AY programmes/project?
5. How long have you worked at this health facility? How many staff trained/provide AYSRH services?
6. How many days per week AY reproductive health services are offered at this health facility? Observe; a sign announcing that reproductive health services are available, posters?
7. Is there special area for AYSRHS? Probe; if there are special hours or days for youth clients? What time?
8. How do you provide services to youth who come normal time of services? Probe; how their data is being incorporated to programme?
9. Have you attended the training on provision AYSRHS? When and where? Who were trainers? What did you learn?

10. Can you tell me about your activities on AYSRH programme at this facility?
11. What SRH services are provided to AY at this facility? Probe; documentation of services provided on HMIS data, Probe; which contraceptives are provided at H/F
12. How do you provide services to adolescent and youth? Probe; are there any procedures that you consider during provision of services different to adults? Explain
13. Are they paying for the services? Do you have price list?
14. Are HCPs of AY available all the time at AYSRH section or they serve other services at the same time?
15. Do A-Y have their own activities?
16. What are other activities do you conduct about AYSRHS? (Example Outreach.) How?
17. What guidelines that you know help you providing AYSRH services at this facility? Probe; ask a guideline document and crosscheck
18. Do you have target of how many adolescent and youth to reach? How many have you reach? What is the trend since you started the programme

APPENDIX 4: In-depth Interview (peer educator)

How are you!

Thank you for agreeing to talk with me today, my name is Winfrida Leonard Muhoja, A Msc Health Monitoring and Evaluation student in Mzumbe University. My study requires me to undertake an evaluation of a health programme which will allow me to write a report as requirement for the partial fulfillment of the award of the master degree. I am conducting process evaluation of AYSRH programme on utilisation of sexual reproductive health services among adolescents-youth in urban community. Any information obtained in this session will only be used for the purposes of the study and not otherwise. I would like to assure you that no information given will be disclosed to unintended audiences but only to the faculty of Mzumbe University, regional authority and Municipal authorities. The information will be treated in high anonymity and will be stored carefully. You are free to agree or disagree to participate to this study or decline at any time.

Our discussion will take hardly 25 to 40 minutes. Can we start the interview?

1. How old are you?
2. How have you found out about A-Y services?
3. When did you start to use SRH services?
4. Are you trained? Probe; Where, by who, when and how
5. How do you see the services provided for young people?
6. Do they provide you with all the services you want/require? How?
7. What activities do you conduct and how?
8. What challenges do you encounter on AYSRH services?
9. What are your suggestions on improving AYSRH services?

APPENDIX 5: In-depth Interview (Young People)

How are you!

Thank you for agreeing to talk with me today, my name is Winfrida Leonard Muhoja, A Msc Health Monitoring and Evaluation student in Mzumbe University. My study requires me to undertake an evaluation of a health programme which will allow me to write a report as requirement for the partial fulfillment of the award of the master degree. I am conducting process evaluation of AYSRH programme on utilisation of sexual reproductive health services among adolescents-youth in urban community. Any information obtained in this session will only be used for the purposes of the study and not otherwise. I would like to assure you that no information given will be disclosed to unintended audiences but only to the faculty of Mzumbe University, regional authority and Municipal authorities. The information will be treated in high anonymity and will be stored carefully. You are free to agree or disagree to participate to this study or decline at any time.

Our discussion will take hardly 25 to 40 minutes. Can we start the interview?

1. Sexhow many years do you have?.....are you a student?.....
2. Where did you get information about youth friendly services? When?
3. What have you learnt about youth friendly services?
4. When did you start to use youth friendly services? Why you started to use services?
5. How do you see about provision of these services?
6. Have you participate in community dialogues? How do they conduct? Who were participants? What issues were you discussing?
7. How do you get feedback about your opinions?
8. How do health care providers provide services to you?
9. Are you using family planning services? Which method do you use? Why that method?
10. Do health care providers provide services that you need? How?
11. Which services do they provide to youth? How?

12. What issues do you think should be improved in providing youth friendly services?
13. What issue might affect you to use youth friendly services?
14. What are good things in the provision of services?
15. What are your opinions on provision of youth friendly services?

APPENDIX 6: Observation Checklist

Checklist for Adolescent & Youth-Friendly Services

HEALTH FACILITY CHARACTERISTICS			
Characteristics	Yes	No	Comments and Suggestions
Is the facility located near a place where Adolescents-Youth both female and male can gather together? (Youth centre, school, market, etc.)			
Is the facility open during hours that are convenient for Adolescents-Youth, both female and male (particularly in the evenings or at the weekend)?			
Are there specific clinic times or spaces set aside for AY?			
Are SRH services offered for free, or at rates affordable to adolescents?			
Are waiting times short?			
If both adults and Adolescents-Youth are treated in the facility, is there a separate, discreet, entrance for adolescents to ensure their privacy?			
Do counseling and treatment rooms allow for privacy (both visual and auditory)?			
Is there a transparent, confidential mechanism for adolescents to submit complaints or feedback about SRH services at the facility?			
HEALTH PROVIDERS CHARACTERISTICS			
Have providers been trained to provide AYSRH-friendly services?			
Have all staff been oriented to providing confidential AYSRH-friendly services? (Receptionist, security guards, cleaners, etc.)			
Do the staffs demonstrate respect when interacting with adolescents?			
Do the providers ensure the clients' privacy and confidentiality?			
Do the providers set aside sufficient time for client-provider interaction?			
Are peer educators or peer counselors available?			
Are health providers assessed using quality standard checklists?			

PROGRAMME CHARACTERISTICS			
Do Adolescents-Youth (female and male) play a role in the operation of the health facility?			
Are adolescents involved in monitoring the quality of SRH service provision?			
Can adolescents be seen in the facility without the consent of their parents or spouses?			
Is a wide range of RH services available? (FP, STI treatment and prevention, HIV counselling and testing, ante- and post-natal care, delivery care etc.)			
Is the SRH services provided with other services			
Verify of non-expired units of each method available either in the facility or the storeroom.			
Are there written guidelines for providing Adolescent-Youth services?			
Are condoms available to both young men and young women?			
Are there RH educational materials, posters or job aids on site, which are designed to reach adolescents?			
Are referral mechanisms in place? (For medical emergencies, for mental health and psychosocial support, etc.)			
Are adolescent-specific indicators monitored on a regular basis? (e.g. number of adolescent clients, disaggregated by age and sex)			
POLICIES AND PROCEDURES			
Youth drop-ins are welcome and accommodated			
Group health discussions are available			
Necessary referrals are available			
Services are offered to both male and female youth clients			
Young male clients are equally welcomed and served as young female clients are			
Facility provides informational and/or audiovisual materials on RH services and concerns of youth clients			
Facility provides contraceptive methods that are most popular among youth clients			
Facility offers wide range of services			
Services are linked to other youth service and programme networks			
Service fees are affordable for adolescent clients			

APPENDIX 7: Respondent Consent Form (English)

Issue	Respondent's Initials
I have read the information presented in the information letter about study	
I was given opportunity to ask questions and provided satisfactory answers about the study	
I am aware that information from this interview might be included in publications	
I give permission of audio records for this interview	
I understand that, relevant sections of the data collected during the study may be looked at by individuals from Mzumbe University. I give permission for these individuals to have access to my responses	

With full knowledge of all foregoing, I agree to participate in this study. I agree to being contacted again by the researchers if my responses give rise to interesting findings or cross references

YES..... NO.....

If yes my preferred method of being contacted is

Telephone.....

Email.....

Other.....

Participant Initial.....

Signature.....

Date

Consent by.....

Signature.....

Date.....

APPENDIX 8: Fomu ya Idhini ya Utafiti kwa Mhojiwa (Kiswahili)

Suala	Herufi za Awali za Majina ya Mhojiwa
Nimeelewa taarifa zilizotolewa katika barua ya utambulisho	
Nimepewa nafasi ya kuuliza maswali na kujibiwa ipasavyo	
Nimeelewa taarifa nitakazotoa zinaweza kuwa katika chapisho	
Naruhusu kurekodiwa sauti katika mahojiano haya	
Nimeelewa taarifa ninazozitoa zinaweza kusomwa na watu wa Mzumbe University. Ninaruhusu taarifa zangu kusomwa	

Kutokana na kuelewa kwangu nakubali kushiriki katika utafiti huu. Ninakubali kuhusishwa tena na mtafiti ikiwa kuna uhitaji wa mahojiano zaidi

NDIO..... HAPANA.....

Kama ndio, njia ya mawasiliano ninayochagua ni

Simu.....

Barua pepe.....

nyingine.....

Herufi za awali za majina ya mhojiwa.....

Sahihi

Tarehe

Imaeidhinishwa na.....

Sahihi.....

Tarehe.....