Final Evaluation for Tanzanian Men as Equal Partners (TMEP) Project

A Report Submitted to

RFSU TMEP Secretariat, Dar-es-Salaam, Tanzania

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Abbreviation

ARV	Anti-Retro Viral
DED	District Executive Director
DMO	District Medical Officer
DRCHCo	District Reproductive Child Health Coordinator
DSM	Dar es Salaam
FGDs	Focus Group Discussions
FP	Family Planning
GDP	Gross Domestic Product
HAPA	Health Action Promotion Association
HDT	Health Promotion Tanzania
HIV/AIDs	Human Immune Virus Acquired Immune Deficiency
IDI	In- Depth Interviews
IPs	Implementing Partners
LGA	Local Government Authorities
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MI	Male Involvement
MKUKUTA	Mkakati wa Kukuza na Kutokomeza Umasikini Tanzania
MoEVT	Ministry of Education and Vocational Training
MoHSW	Ministry of Health and Social Welfare
MWADEMO	Mwambao Development Movement
NGO	Non-Governmental Organization
PEs	Peer Educators
PMTCT	Prevention of Mother to Child Transmission

RCHS	Reproductive Child Health Services
RFSU	Riksforbundent for Sexuell Upplysning (Swedish Association for Sexuality Education)
RODI	Resource Oriented Development Initiative
Sida	Swedish International Development Agency
SRH	Sexual and Reproductive Health
SRHR	Sexual Reproductive Health Rights
STI	Sexual Transmission Infection
TMEP	Tanzanian Men as Equal Partners
ToR	Terms of Reference
ToTs	Trainer of Trainees
UMATI	Chama cha Uzazi na Malezi Bora Tanzania
UN	United Nations
VCT	Voluntary Counselling and Testing
VEO	Village Executive Officer
WDCs	Ward Development Committees
WEO	Ward Executive Officer
YMC	Youth Movement for Change
YMEP	Young Men as Equal Partner

Acknowledgements

This evaluation report is not a product of the efforts of the evaluators alone; it is a result of the concerted collaborative efforts between individuals and institutions. The evaluation was commissioned by RFSU and the TMEP Secretariat in Dar-es-Salaam, Tanzania and carried out by Health and Development International Consultants (HDIC) of Dar-es-Salaam. As consultants for this assignment, we have enjoyed support from a variety of partners. First, we acknowledge the TMEP Secretariat for identifying us for this assignment. In particular, we thank Mr. Cuthbert Maendaenda (Project Manager of TMEP), Dr. Tim Lee (TMEP Consultant), Mr. George Mutasingwa (Monitoring and Evaluation Officer of TMEP), and other officers for their extensive advice and constructive criticism from the initial planning stages in the field to after we submitted our first draft report. When writing our proposal and explaining our approach and methodology, Mr. Maendaenda and Tim Lee shared with us many documents and input to effectively plan and carry out of the evaluation. Their support is highly appreciated.

In the six districts of Rukwa and Singida where the fieldwork was completed, we interviewed numerous men, women, boys, and girls. We talked to health care providers, government officers such as village leaders, Ward Executive Officers, Ward Education Coordinators, District Medical Officers, secondary and primary District Education Officers, Regional Medical Officers, District Executive Directors, individuals trained by TMEP working as Trainers of Trainers (TOTs), Peer Educators, Ward Coordinators, and Focal Persons, all providing meaningful ideas and substantial information.

While in the field, our close working partners were the regional implementing partners of TMEP, RODI in Rukwa and HAPA in Singida. These partners introduced us to many other institutions and organizations and provided us with useful information in evaluating the work of TMEP in RODI and HAPA. Additionally, their officials helped us to secure research permits and other logistics, making our work easier. We sincerely acknowledge their support and time spent working with us.

The majority of the data are derived from the responses of the research participants who are either direct or indirect beneficiaries of TMEP. Their responses are essential for better understanding various challenges that community members encounter, particularly in terms of women and men and their sexual reproductive health rights, how they deal with the challenges, and how these problems affect their well-being. Thus, the research subjects have been our teachers and have inspired us to learn more. We value their time and memories.

The data in this report were collected by hardworking research assistants. They sacrificed six weeks in the field away from their families, working day and night in an excellent fashion. Their efforts and investment are greatly valued. Finally, although many people have contributed their ideas and thoughts, the weaknesses depicted in this report are entirely ours.

The Executive Summary:

For decades, sexual and reproductive health rights intervention programs have been excluding men. This exclusion did not come as a surprise as most of the organizations were engrossed in a traditional understanding that men have little to do with issues relating to reproductive health rights in an African context. However, this understanding excluded the fact that men hold most of the political, social, and economic power within their communities and families, and that they also control both the domestic and public spheres of life in societies in general, but specifically in sub-Saharan Africa. It is in this context that the Swedish Association for Sexuality Education (RFSU) introduced the "Tanzanian Men As Equal Partners" (TMEP) project in Tanzania in 2009. TMEP project is implemented in two regions by local organizations, namely RODI and MWADEMO in Rukwa region and HAPA and YMC in Singida. The project operates in Sumbawanga Urban, Sumbawanga Rural, and Nkasi in Rukwa region. In Singida region it is implemented in Singida Urban, Singida Rural and Manyoni districts. The project goal is to ensure that the communities fully exercise their right to SRH as a basic human right through partnering with Tanzanian men for gender oriented SRHR promotion. The project's purpose has been to scale up access to SRHR information, education, and services for all, especially the underserved groups.

Since the first phase of the project is coming to an end (2009-2013), RFSU hired Health and Development International Consultants (HDIC) to conduct a **two-in-one study** comprising of an **"End-line Study"** on the one hand and a **"Final Evaluation"** on the other. The findings of these studies are intended to be mutually reinforcing, first comparing changes over time since the baseline data collection, and second to inform the evaluation of the study and enabling us to identify whether TMEP has achieved its goals and desired results. The studies were conducted between June and September 2013 using a variety of methods of data collection. The end-line study was predominantly quantitative and used a survey questionnaire tool that had questions similar to the baseline survey capturing results and performance questions 1, 2 and 3. Through qualitative methods, the evaluation captured information related to almost all of the questions, especially results and performance questions 3 and 5. It particularly used focus group discussions, in-depth interviews, ethnographic observations, unplanned visits at the health facilities, informal discussion with the community members as well as administering essays for in school youth. The two methods were complimented by a thorough review of various project documents that also helped us answer the five performance questions and the project indicators.

A total of 721 people participated in the survey questionnaire process where 343 (47.6%) were from Rukwa and 378 (52.4%) were from Singida. Within Rukwa region, while 64% (221) were males, 36% (122) were females. Similarly, in Singida 63% (237) were males and 37%% (141) were females. Despite categorization among sex, the study participants were further segregated along age groups where three main categories were developed, namely; Adults (males and females); In-School Youths (males and females); and finally, Out-of School Youths (Males and Females). This categorization reflected the project implementation approach in both regions. The evaluation study was composed of a total of thirty-six FGDs in both regions where each district had six FGDs. Similarly, over 147 in-depth interviews were conducted covering RFSU, secretariat, national level partners, regional, influential district, ward, or street people and, finally the IPs.

After assessing the project's overall performance through the project's log frame, goals, purpose, and intended results, the team is of the opinion that the project has made an impressive achievement. Based on the five results and performance questions that addressed the SRHR issues in both regions, there is no doubt that the project has delivered the value for money. The interviews with the project accountant at the secretariat and IPs in both regions indicate that the project received the funding from the donors. This has made them get what they asked for in terms of the budget of their respective units. The permission was sought and there was no delay in decision making that has had a big impact on the performance and execution of the planned activities. Thus the overall burning rate of the project was convincing. The findings on result and performance question one that focus on men as agents of change indicate that since the baseline data, the project has trained 458 and 336 men in Rukwa and Singida respectively as PEs. These are the volunteers for the everyday implementation of the planned project activities in the two regions. Their commitment to the project became evident during the end when 44% of males in Rukwa and 48% males in Singida learned of SRHR issues from the PEs. The data indicate a considerable increase in the rate of MI in SRHR issues and significant changes in both regions. The 2012 TMEP Project annual report indicates an increase of nearly 249% attendances of SRH sessions between 2011 and 2012. The report shows that while the attendances of men were 491,473 in 2011, the number went up to 1,716,280 by 2012.

The project also made a convincing achievement in result and performance question two that focuses on the SRHR information. For instance, the number of men engaging in promoting SRHR activities has significantly improved in both regions since the baseline data was collected. In Rukwa, the attendances of males were 2,797,974 and females around 2,129,256 on accurate SRHR information and dialogues sessions through a variety of methods. Similarly, by the time the first phase of the project ends, at least 837,071 males and 733, 361 females will have attended SRHR sessions in Singida region. These achievements are further supported by the end-line findings. Compared to the 41% of males and 40% of females in Rukwa and 56% of males and 58% of females in Singida during the baseline, the awareness on SRHR issues has raised to 99% of males and 99% of females in Rukwa and 98% of males and 94% of females in Singida. The students' essays further supplemented these findings. It is very clear from student essays that the youth have grasped well the aims and objectives of TMEP and agree the importance of what TMEP advocates to their communities.

The utilization of the SRHR services also indicates a great achievement in both regions. Mainly, the baseline report (2010) demonstrates that when the study was conducted, about 17% of study participants in Rukwa and 7% in Singida were visiting the health facilities and sought improved access to SRH services, and the end-line data indicates a significant increase since the beginning of the project. For instance, about 73% of males and 77% of females who visited the health facilities in Rukwa and about 58% of males and 62% of females in Singida asked for SRH services. For those who had access and visited the SRHR services, counselling is the primary purpose for attendance, which was the case for 39% of males and 42% of females in Rukwa, and about 33% of males and 42% of females in Singida. Furthermore, about 73% of males and females in Rukwa and 58% of males and 69% of females in Singida discussed SRH services. The project documents indicate that since the beginning of the project, at least 158,935 males and 192,935 females have used VCT services in both regions. In terms of STIs, more than 2,912 males and 5,107 females have demanded this service in Rukwa, while in Singida 9,070 males and 6,887 females have done so. The family planning utilization also indicates that while 20,936 males and 224,969 females in Rukwa have visited the services, in Singida at least 27,683 males and 58,076 females visited have visited the family planning services.

The fourth result and performance question focus on the capacity building of the IPs and other stake holders. Our general assessment reveals that the project has made a significant achievement since its inception. For instance, while 101 males and 28 females are trained as ToTs in Rukwa, Singida has trained 89 males and 124 females. Similarly, since its inception, the project has trained 67 males and 65 females in Rukwa and 36 males and 140 females in Singida as health providers on SRHR issues. The project has also strengthened the capacity of the IPs in both regions by providing managerial trainings as well as supporting the infrastructure of the two IPs. However, the team recognized underlying tensions that exist between and among the IPs, Secretariat, and PEs, which affect the performance of the project. Evidently, the resentment and reservation in terms of relations and communication channels between and among the partners is not in the right order.

The last result and performance question address the advocacy and mainstreaming of the SRHR concepts. The annual report indicates that at least three district authorities from each region have integrated TMEP concepts into their plans. Some institutions such as the police, schools, ward authorities, council representatives, and partners such as AFRICARE have also borrowed and integrated the concepts into their plans and activities. The secretariat has had a number of advocacy events with national level partners such as field visits by the Ministries and collaboration with partners such as Femina, EngenderHealth, and the Tanzania Health Promotion. However, our general assessment is that more emphasis and efforts are needed to engage and procure the national partners.

In summary, the majority of the indicators have been addressed since the project commenced in 2010. The planned activities have been carried out with evidence on the ground, and no major changes were seen from the original project plan. As a result, the project has made a significant achievement over the course of the three years. In fact, the team commends the impressive work of various partners, IPs, the secretariat, and the RFSU. We highly recommend the second phase of the project based on the evidence gathered and demonstrated in this report. As aforementioned, the project's benefits exceed its monetary costs, and the money has undoubtedly been wisely spent compared to the total budget. What TMEP is doing is changing Tanzanian men. Rukwa and Singida are showing positive results and confirming that it is possible to change the Tanzanian men. If it is possible, we also recommend the scaling up of this model to other regions of Tanzania in future.

Chapter One: Introduction and the Background:

1.0 Introduction

In Tanzania, as in many other places around the world, men hold most of the political, social, and economic power within their communities and families. Consequently, the men ultimately control the fate of the reproductive health of their families and communities at large. As a result, the potential for men to influence positive social change and their underutilization in such efforts must be recognized. This is not to ignore or reduce the responsibility women have in supporting the health of their families and communities, but rather to highlight the negative effect gender inequality has on efforts to produce positive social change, which has limited the effectiveness of various SRHR related interventions implemented in the past. Up to this point, most intervention programs have focused on women without considering those who ultimately control their reproductive health decisions.

Many intervention programs implemented in Tanzania have for decades been focused particularly on the third, fifth, and sixth development goals outlined in the UN's Millennium Development Goals and the Tanzania National Strategy for Growth and Reduction of Poverty (MKUKUTA Strategies 5.3.2.2 C, D), which call for the improvement and securing of SRHR. These efforts acknowledge that the wellbeing of a community cannot be achieved without ensuring the protection of the rights of its members. However, most studies and interventions designed from such studies focus primarily on the perspective of women, rather than both men and women. As a result, many interventions are either ineffective or exacerbate the problems.

It is this reality that caused the Swedish Association for Sexuality Education (RFSU) to introduce the "Young Men As Equal Partners" (YMEP) project. This approach has been applied in Tanzania from year 2000 to 2002 (YMEP 1) and later in 2005 to 2009 (YMEP 2), executed by RFSU through Sida support, and implemented by IPPF member associations of Tanzania (UMATI). TMEP was therefore not a pilot but rather a scaling up of YMEP project in Tanzania. Research has made known that, on one hand, men influence the protection and promotion of SRHR in their families and communities; and on the other they control their families' reproductive health practices and access to health services. It is evidently true that entangled in SRHR issues is the women's lack of knowledge about such topics, and the effect of such on their ability to adequately meet their SRH needs. However, studies have revealed that efforts to empower women and increase their knowledge and use of available health services have been consistently undermined by men (TMEP Project Document, 5). Thus, without addressing issues of gender inequality and masculinity, efforts to improve the SRH conditions of females will continue to be ultimately ineffective.

TMEP project is implemented by local organizations in Rukwa (RODI) and Singida (HAPA). MWADEMO, another local organization, was subcontracted to implement the youth wing related activities in the Nkasi District. A similar arrangement occurred in Singida where YMC was subcontracted by HAPA to oversee the everyday youth wing related activities. The management of these organizations will be discussed in chapters seven and eight. In order to ensure the proper management and accountability of the project, a project secretariat was recruited and based in Dar-es-Salaam that oversees the implementation of activities, monitoring and evaluating progress, as well as undertaking national level advocacy. This secretariat served as an important link between the RFSU and the IPs in their respective regions.

The first phase of the project is scheduled to conclude at the end of 2013, at which point RFSU and the TMEP secretariat intend to enter the second phase of the TMEP project (TMEP 2). Prior to the execution of TMEP 2 a consultant was commissioned to carry out two studies: the first to collect data that would be compared with the baseline data; the second to evaluate the entire TMEP project to evaluate whether it has achieved its aims and objectives over the course of its three years of implementation. Our firm "Health and Development International Consultants" was earmarked and hired in this context.

1.2: How the Report is organized:

This report is divided into the following key chapters: This first chapter has introduced the background of the report. The second chapter outlines in brief the approach and methodology that was adopted in carrying out both studies. The third chapter summarizes the baseline and end-line studies by comparing the key findings from the two studies. The fourth and fifth chapters focus on results one and two of the project, which regard men as agents of change and SRHR information. The sixth chapter presents in detail the utilization of the SRHR services in both regions where the issues of supply and demand is discussed in detail. The seventh and eight chapters highlight the capacity building, advocacy, and mainstreaming issues respectively. The ninth chapter concludes and offers recommendations for future planning.

Chapter Two: Study Design, Area and Methodology

2.0: Introduction:

The general objective of the end-line and final evaluation was to understand whether communities now fully exercise their right to SRH as a basic human right. The intention was to capture the scaling up of access to SRHR information, education, and services for all citizens. This assignment was a **two-in-one study** comprising of an **"End-line Study"** on the one hand and a **"Final Evaluation"** on the other. The findings of these studies are intended to be mutually reinforcing. The end-line findings are intended to first compare changes over time since the baseline data collection, and second to inform the evaluation of the study and enable us to identify whether TMEP has achieved its goals and desired results. On the other hand, the final evaluation is intended to outline for the TMEP secretariat and other stakeholders the qualitative changes that have occurred within the local population since TMEP was introduced, as well as supplement the end-line data.

2.1: The Study Area and Study Population:

TMEP operates in two underserved regions, namely Rukwa and Singida. Within these regions, the project operates in six districts (three in each region). These districts include Sumbawanga Urban, Sumbawanga Rural and Nkasi in Rukwa region, and they have a total of 57 Wards that benefitted from TMEP. However, the end-line and evaluation studies took place in only six Wards. The three districts in Singida region are Singida Urban, Singida Rural and Manyoni and have a total of 66 Wards. Due to the ongoing administrative restructuring in Tanzania, a newly formed district, Kalambo, which was part of Sumbawanga Rural, also benefited from the project. However, since it was part of Sumbawanga Rural for most of the project implementation, we were obliged to include it as one of its Wards (Matai) and was also part of the baseline survey Wards.

Although initially the consultant team proposed to cover 10 wards that were covered during the baseline study, after discussion with the IPs on site and consultation with the secretariat, it became important to reshuffle the initial idea. As a result, 12 wards were visited, 6 of which were covered and 6 of which were not during the baseline. In terms of findings, the analysis does not suggest major differences between the baseline and non baseline studies. Thus, this report ignores the analysis along baseline and non baseline wards. As a result, we will be referring to the 12 wards in the report.

2.2: Methodology and the Study Population:

2.2.1: The End-line Study Methodology:

A variety of methods of data collection were employed in order to collect data for the two studies. The end-line study was predominantly quantitative and used a survey questionnaire tool that had questions similar to the baseline survey. While the end-line study captured mainly result and performance questions 1, 2 and 3, the evaluation captured information related to almost all of the questions. A population based sample survey, focus group discussions, in-depth interviews, ethnographic observations, unplanned visits at the health facilities, informal discussion with the community members during leisure times, visits to the open markets, and interacting with the communities on important days all contributed to helping us collect volumes of data and information that have been

instrumental in these two studies. The two methods were complimented by a thorough review of various project documents that also helped us answer the five performance questions and the majority of the project indicators.

2.2.2 The Demographic Information of the study population

A total of 721 people participated in the survey questionnaire process. Of these 721 participants, 343 (47.6%) were from Rukwa and 378 (52.4%) were from Singida. If we compare the regional data on the study participants, it is clear that those who participated from the Rukwa region, 64% (221) were male while 36%% (122) were female. From the participating population in Singida, 63% (237) were male while 37%% (141) were female. These data indicate that in both regions almost twice as many males participated in the end-line study than females. This result is not accidental as the project itself focuses on the engagement of males in SRHR issues.

In order to make sure that we hear the voices of all those who participated in the project, we decided to group the study participants into three main categories, namely; Adults (males and females); In-School Youths (males and females) and finally Out-of School Youths (Males and Females). This categorization reflected the style or approach that TMEP used on the ground in order to reach various sections of the population. Based on this arrangement, we find that adult males and female participants from Rukwa accounted for 32.1% (110), while we had 32.3% (122) of the total participating population in Singida. The out-of school youth population that participated (male and female) from Rukwa accounted for 26.8% (92), while those from Singida accounted for 34.4% (130). Finally, the in-school youth population (male and female) that participated from Rukwa accounted for 41.1% (141) of the total participating population, while those from Singida accounted for 33.3% (126). Considering the youth are a particularly active group in society, their representation in this study is relatively balanced.

2.2.3: The Final Evaluation Methodology:

The collection of data for the final evaluation was predominantly qualitative. The methods used included focus group discussions (FGDs), in-depth interviews (IDIs), students' essays, as well as ethnographic observations of health facilities. Thirty-six FGDs were conducted in both regions. Each project district had 6 FGDs divided among adult males and females, in-school males and females and out-of-school males and females. Similarly, in-depth interviews were conducted, which included a variety of participants ranging from representatives from the Ministry of Health and Social Welfare (MoHSW) to the Ministry of Education and Vocational Training (MoEVT). The purpose of interviewing these officials was to understand their level of engagement and willingness to mainstream SRHR issues in government plans and policies. We also interviewed various officials of NGOs that are potential agents for advocating the SRHR issues. Such organizations included Health Promotion Tanzania (HDT), Engender Health, Femina, and Men Engage Network funded by Champion. We also interviewed various officials from RODI and MWADEMO in Rukwa, and HAPA and YMC in Singida, as these organizations were implementing partners (IPs) of the project. We also talked to District Officials, Community Development Officers, District Education Officers, and District Health Officers. Some of these were engaged with TMEP as they are recruited and trained to become TMEP District ToTs. Within communities, we talked to Ward ToTs, Ward Coordinators, Health Workers, Ward Executive Officers (WEO), Village or Street Executive Officers (VEO), Teachers, Gender Desk Officials at Police Stations, and religious leaders. The team also interviewed a large number of Peer Educators, who are at the heart of this project. In total, 147 IDIs were conducted, 57 from Rukwa and 90 from Singida.

The team also conducted several ethnographic observations during the evaluation. In many FGDs, we found that people often felt the participation rate of men was increasing in activities originally considered to be responsibilities of women. In order to evaluate these claims, we conducted observations both in health facilities and communities to observe the frequency with which men accompanied their wives/partners to clinics or took their children to the health facility when they were sick. Similarly, observations were conducted in the local community to determine the frequency with which men participated in domestic chores such as fetching water, cooking, or going to the market.

In order to determine whether TMEP beneficiaries understood SRHR issues and the importance of male involvement in SRHR and women's rights issues, we decided to administer an essay writing session to a few randomly selected secondary school students (males and females) in each study ward. Participation in this activity was required to write a one to two page essay that answers the following question***: What do you understand about the involvement of men in sexual reproductive health rights and gender rights?*** Students were encouraged to express their opinions on the issues and instructed to identify their sex and age but not their names. Between Rukwa and Singida, a total of 23 boys and 23 girls participated in this exercise.

2.2.4: Methods of Data Analysis and Interpretation:

All quantitative data was coded and entered into an SPSS capture screen. It was then cleaned up and analysed in combination with an excel program. Following this procedure, an alternative method of displaying data through tables with percentages, descriptive statistics, pie charts, histograms, and graphs were used to further evaluate and analyse the data. The qualitative data (IDIs and FGDs) were transcribed verbatim in Swahili, organized into themes relevant to the two studies, and analysed using content analysis. Content analysis was also used in analysing the students' essays.

Chapter Three: Summary of the Baseline and End-Line Studies Data

3.1. TMEP Baseline (2010) and End-Line (2013) comparative data

Comparing the baseline with end-line and evaluation findings, it is clear that the project's overall goal which is to ensure that the community fully exercises the right to sexual and reproductive health is largely being achieved. Although the community do not necessarily ask for the SRHR services as a basic human rights, but they understand and demand for the service. The project purpose that is to scale up access to SRHR information, education and services for all groups especially the underserved is evidently showing a positive result. Overall, the end-line data appears impressive, as there has been good progress in changes of behaviour, attitudes, and awareness of SRH services. Looking at the end-line data, there has also been an interesting improvement in behavioural change as compared to the baseline. As one can notice, the end-line information indicates an increase on sexual based violence cases. Although this situation may sound alarming, information derived from the police gender desks in different districts confirms that reported cases are up because more people are aware of their sexual rights now than before, and thus tending to report cases of gender based sexual violence to the authorities. The data also show an improvement in terms of HIV tests, in that more people are checking for their sero-status. Additionally, there is a positive change in Men's attitude on SRH. The data shows an improvement in SRHR and decision making. It is clear that more men have now become aware of both their SRH rights and those of women.

It is also evident from the data that negative perceptions about homosexuality have increased compared to the baseline findings. That is, more people seem to be having a negative attitude towards this kind of sexual relationship. A number of factors could be associated to this: first, the project did not clearly target this group of people or perceptions about these kinds of relationships. Secondly, of late, Tanzania has been involved in global debates that attempted to legalize same sex relationships. The government of Tanzania has stated its position clearly that it does not recognize same sex relationships. According to the government, such relationships are illegal and considered a crime. It is our opinion that these debates have negatively influenced the population's perceptions about homosexuality and likely activated the traditional beliefs, which consider same sex relationships as immoral and a taboo. Table 1 summarizes the main findings of the end-line in relation to the baseline data.

Table 1: TMEP Baseline (2010) and End-Line (2013) comparative data

QUESTION/TOPIC	BASELINE DATA 2010				ENDLINE DATA 2013			
	RUKWA		SINGIDA		RUKWA		SINGIDA	
	%M	%F	%M	%F	%M	%F	%M	%F
AWARENESS								
Ever heard SRH & Rights	56	58	41	40	99.1	99.2	97.5	93.6
Aware that SRH Rights are relevant to everybody	50	52	69	63	80.5	73	89.9	87.2
Aware that married women have a right to decide whether or not to conceive	34	72	63	37	52.5	60.7	48.9	49.6
Married respondents who said married women have no right to decide their SRH including decision to conceive or	67	23	43	49	19.7	13.2	13.6	21.3

not without necessarily getting consent of their spouses								
Agree to see young people making own decision regarding whether to marry or not and whom to marry without necessarily getting consent from their parent	19	56	49	48	52	45.9	59.1	51.8
Men aware that women have a right to deny sexual intercourse if they do not want it	59		65		91.4	86.9	90.5	84.4
Could confidently walk into a SRH or HIV and AIDS Clinic and demand to have a service that one wants and get it if available	59	41	65	35	99.1	99.2	96.6	95
Feels a man attending SRH Clinic for a service is exercising his right	61	40	67	33	78.7	74.6	79.3	74.5
SRH BEHAVIOR								
Had unprotected sex during the past six months	15	17	18	18	10.9	4.1	6.8	4.3
Men scared of both infections and un planned pregnancies from unprotected sex	40		20		65.9		67.4	
Ever involved in sexual based violence during the past six months	7	10	8	7	10	10.7	6.3	11.3
Ever had discussion with their partners on SRH right during the past six months	7	8	6	6	59.7	46.7	59.9	53.2
Ever tested for HIV	53	41	42	38	80.1	72.1	62.4	65.2
Men who would allow their spouses to undergo HIV test	69	67	54	65	90.5		98.3	
Ever tested for HIV(for men who would allow their spouses to test)	67		64		82		64.1	
Ever had sexual intercourse under alcohol influence	41	25	22	14	4.1	1.6	6.8	2.8
SRH&ATTITUDES&INEQUITABLE GENDER NORMS								
Agree that all persons have right of access to reproductive health care services	85	85	88	84	99.5	97.5	97.5	95
Disagree that men need more sex than women do	64	45	51	35	57.5	45.9	67.1	53.2
Men who disagree that women who carry condoms with them are easy to seduce	47		48		59.7		63.7	
Men who disagree that it is a responsibility of a woman to ensure pregnancy protections	14		20		36.2		33.3	

Men who disagree that it is men who should have final word about decision in homes	27		37		69.2		60.8	
Men who disagree that at times women deserve to be beaten	46		66		72.9		73	
Disagree that women should tolerate violence in order to keep family together	18	24	46	35	45.2	44.3	69.6	56.7
Disagree that they will never accept to have a friend who is a gay	37	25	35	16	22.2	16.4	19.4	22

3.2 Brief Presentation of some SRH Indicators

Generally it has been a challenge to follow the data on the prevalence rate of the STI, HIV, and Contraceptives in both project regions. It has been difficult to calculate the prevalence rates and trends overtime because the data we managed to collect was mixed. While some of the data represents prevalence rates and was in percentages, the other data was in raw numbers, and their percentages were not available. It is evident that the data, as shown in the table below, is not consistent. If one looks at the table, it becomes clear that there are many gaps in terms of data. However, if we look at the figures we see an increasing trend of HIV prevalence. This trend could be due to the increased awareness influenced by the project, which in turn has increased demand for the service. Similarly, the contraceptive prevalence is relatively on the increase, likely for similar reasons.

Table 2: STI, HIV and Contraceptive Prevalence in the project regions (the 2013 data is for 6 months only)

HIV,STI AND CONTRACEPTIVE PREVALENCE							
		2011	%	2012	%	2013	%
STI PREVALENCE/DATA	**SINGIDA**						
	Singida Municipal	866	0.4	1283	0.5	1684	-
	Manyoni	1177	-	2129	-	1407	-
	Singida Rural	2462	-	3508	-	3895	-
	RUKWA						
	Sumbawanga District (Rural)	1615	-	995	-	--	-
	Sumbawanga Municipal (Urban)	888	-	1333	-	1091	-
	Nkasi District	1411	-	2281	-	355	-
HIV PREVALENCE/DATA	**SINGIDA**						
	Singida Municipal	9604	3.7	11593	4.1	13746	-
	Manyoni	5014	4.2	6302	8.2	10227	-
	Singida Rural	10138	1.97	11582	2.9	18876	-
	RUKWA						
	Sumbawanga District (Rural)	-	5.6	-	5.6	-	6.6
	Sumbawanga Municipal (Urban)	-	6.5	-	6.5	-	7.1
	Nkasi District	-	3.1	-	3.1	-	4.8
	SINGIDA						
CONTRACEPTIVE PREVALENCE/DATA	Singida Municipal	3623	8	4403	9	2963	-
	Manyoni	12693	19	14900	22	2781	-
	Singida Rural	16350	14	17249	15	18228	-
	RUKWA						
	Sumbawanga District (Rural)	-	27	-	41	-	25
	Sumbawanga Municipal (Urban)	-	21	-	16	-	-
	Nkasi District	-	29	-	38	-	42

3.3 The utilization of the services

This section summarizes the utilization of the services such as attendance for VCT, STIs, FP, ARVs, PMTCT, Male circumcision, and the number of condoms supplied in the two regions. Generally, the utilization of the services has increased compared to the time before the project commenced. As a result, demand for services has increased,

which is a strong confirmation that what TMEP—and probably other stakeholders—has been doing to raise people's awareness about the importance of these services has positively influenced these communities. It is evident that the demand for such services has indeed gone up. These arguments will feature again in the coming chapters that deal with the evaluation of the project.

Chapter Four: Result One: Men as Agents of Change

4.0 Introduction

The improved involvement and participation of men in promoting SRHR and tackling gender inequalities in Rukwa and Singida was the first targeted result of the project log frame. Despite the performance question on the extent and to what effect men have become involved in the SRHR issues, indicators such as number of men trained as SRHR PEs and attendance by men at SRHR promotion activities were set. This chapter relies on the end-line data, evaluation together with the annual reports and project documents to identify how men have become agents of change for SRHR issues. We specifically looked at their attendance at SRHR trainings, the increased frequency with which they accompany their wives and families to health facilities, and other methods by which they have been promoting SRHR and tackling gender inequality in their communities.

4.1 Men trained as PEs on SRHR issues

The project relied heavily on volunteers for the everyday implementation of activities. Such volunteers included youth (in school and out of school) and adult PEs. Generally it has been difficult to segregate the available data along these two categories. The PEs come from varied economic backgrounds: farmers; students; business persons; and professionals. The two categories of youth peer educators represent the youth population both in school and out of school. The in-school PEs were responsible for TMEP concerns within primary and secondary schools, while the out of school PEs represented individuals who had finished primary or secondary education and were now engaged in some economic activity. Males and females were nearly equally represented in the youth population; however, most, if not all, adult PEs were male. Generally, the information generated through focus group discussions and in-depth interviews indicates that youth PEs are generally more active than adults.

Generally, the project has made an impressive achievement since its inception. For instance, at the time when the baseline was conducted, there were no men trained as PEs in either region (Baseline Summary, 2010). However, during the end-line and evaluation studies at least 458 men were trained as PEs in Rukwa region. In terms of trend, more were trained in the first year of the implementation (2011) where at least 400 men joined TMEP. The following year (2012) only 205 were trained. The end-line data indicates that about 44% of the males who participated in the study learned about SRHR issues from the PEs. The rest learned from a variety of avenues: others=35%; health providers=15.4%; Media such as radio, television and folk media=2.3%; and print educational materials=1.4%. A similar trend is evident among females, where about 44% learned about SRHR from PEs, 39% from other sources, and 9% from the health providers. Likewise, when it comes to the invitation to the SRHR sessions, the data indicates that about 41.1% of males in Rukwa were invited by PEs in promoting SRHR activities; about 24% by teachers; 18% by ward coordinators; 7% by the health providers; and 10% by others who were not specified.

However, the evaluation data also reveals a high drop-out rate of trained peer educators. Causes of such include migration, low motivation, and competition from other organizations such as AFRICARE. As one of the PE describes during an in-depth interview:

> *We devote our time to the project, first the topic is such a difficult one to deal with because you are changing people's perception towards tradition. Secondly, it is tiresome work and thus needs a high degree of volunteerism. As a result, if you don't get enough support from the project then*

you are more likely to despair and quit. We need some incentives to continue working with TMEP (IDI: M-45).

The youth who were PEs in school and have graduated have also raised a concern on the sustainability of the project, especially in the work they have been directly engaged in. One youth from Matanga raised a concern that:

…when I was in school I was very active, and I liked what I was doing. TMEP was my priority hobby, but now I am facing a challenge of continuing with what I have been doing…. I am a tailor and meet many people who come for tailoring work, and I can seriously use my time to raise awareness, but I don't have enough support from the project staff. They need to find a way to retain in school PEs who have graduated as I have….. it will cost them less (IDI/PE/Matanga).

Thus, while the project has trained 458 PEs and PEs have played an important role in educating study participants about SRHR issues, the issue of retaining PEs requires serious consideration in the second phase. The project can focus on youth PEs who have graduated, track them, and enable them to become ambassadors in their fields and communities. This tactic will ensure not only the sustainability of the program, but reduce costs as well.

The project is also making similar progress in Singida where 326 men have been targeted as PEs. The number consists of 176 trained PEs in 2011 and 150 in 2012. There was no training planned in 2013 but the project focused in retaining the trained PEs. The TMEP 2011 annual report from the region further reveals that at least more than 150 men were trained from different wards as ambassadors for male's involvement. Although the report does not specify as to whether these are part of the 326 PEs, the idea of having extra PEs as ambassadors is promising for the future progress of the project. The regional coordinator explains thus:

Our target is not to have a project that is run from the regional or district level but a project that is owned, managed, run, and implemented by men themselves. As a result, our focus is to train more men as PEs so that even if we stop working in their respective communities they will continue pushing for the TMEP issues within their communities (TMEP Singida Regional Coordinator).

In Singida, as in Rukwa, the end-line data illustrates that about 48% of male participants and 45% of female participants learned about SRHR issues from PEs. The remaining population, 33% males and 31% females, mentioned other sources, and very few (about 1%) had heard SRHR issues from Community Volunteers, Printed Education Material, or Radio/Television. These findings suggest that these sources are not a primary source for education within communities. Interestingly, while PEs seems to be the primary source of information, when it comes to invitation to the SRHR sessions, the ward coordinators are highly active. The end-line data indicate that about 53% of participants had been invited by ward coordinators; 27% by PEs; 15% by teachers; 4% by others; and 1% by health providers.

The evaluation data indicate a high degree of resentment in Singida. Almost all of the PEs that we interviewed expressed a concern with the difficult working environment. PEs are the stem of the project at the community level, and thus their dissatisfaction with the working environment puts the sustainability of the program at risk. This reality should be carefully considered in the second phase. The best methods of retaining PEs must be identified and implemented in order for the project to move to the second phase, especially since substantial time and resources are invested in the training of PEs and their implementation of the program. Another issue regarding PEs that must

be addressed is the weak relationship between the PEs and their ward coordinators identified through PE IDIs. PEs often feel isolated or insufficiently integrated into the project and are concerned ward coordinators monopolized the project. One PE from Ilongero expresses:

> *…we acknowledge the value of the work done by our ward coordinator, but we sometimes feel left out because a lot is done by one's self. He needs to engage us more so that we are on the same level, rather than feeling subordinate to him. We are as important as he is when it comes to the project (IDI/PE/Ilongero).*

Our observations also revealed that in wards where the ward coordinator works directly with the community, PEs are often under-utilized. This is the case in the Idodyandole ward, where the inadequate large efforts to reach participants were evident, suggesting poor collaboration between ward coordinator and PEs. The PEs interviewed indicated that:

> *We hardly meet….. It is business as usual, and there is clearly no communication between the coordinator and PEs. It is only when it is necessary that we communicate. We don't feel at ease at all. This is volunteer work …… so we need to balance everything that each party has to do to make the work of the other easy and interesting, otherwise no one takes it seriously (IDI/PE/Idodyandole).*

As Idodyandole is the lowest performing ward within the terms of our assessment, the project needs to look at such wards in order to sort out hidden problems that evidently hinder the project. Generally, the project needs to diversify the background of the PEs. For instance, while Rukwa has trained enough teachers, police, and other community officials, Singida appears to lag behind. In fact, generally the project can utilize the religious leaders who are very influential in their respective communities as PEs. This approach will have better and quicker results, as demonstrated in Ilongero where the coordinator is a religious leader who uses versions of the community members' holy book to introduce TMEP related issues.

4.2 Extent of MI in SRHR issues and change in attitudes

The number of men engaging in promoting SRHR activities has significantly improved in both regions since the baseline data was collected. For instance, the baseline summary document indicates that there was no data (zero) by the time the study was conducted. However, at the time of the end-line and evaluation study, at least 1,289,095 attendances were made by men to SRHR trainings and different discussion sessions and meetings in Rukwa. The report also shows that at least 2,792,846 attendances by men will be served through various SRHR activities by the end of 2013 in the region (Reach Table update 2013. This means at least 46% of the targeted number has already been attained. The data indicate a rise on attendances by men in the region from about 35,970 men in 2011 to 1,253,125 in 2012. The number in 2012 is 34 times that of 2011. The target number for 2013 is 1,503,751 attendances, confirming the extent to which the participation rate goals are being met, of which the PEs have been significant contributors. The in-depth interviews with PEs (15 plus) from the Rukwa region prove not only a high degree of volunteerism, but also a commitment to the achievement of the TMEP goals. One informant in Muze ward commented:

> *Sister, we are toiling because we see the benefit of this project. We are fighting against a male dominant society. So it will take time, energy, and also commitment. We want to see an equal*

society where both men and women help each other. But we understand we will only achieve this by bringing more men to ensure better success of the project (IDI/PE/Muze).

Another PE (Matai Ward) highlighted some of the activities they found most effective for reaching the male population. He mentioned 'sports'; 'open markets'; 'drinking places'; and 'resting and drinking places' (IDI/PE/Matai). Interestingly, the annual reports also mentioned activities such as tailor-made weekly training sessions, gender focused discussions, entertainment, sports, and the community sensitizations that sought to reach both men and the community at large. In addition, in-depth interviews and FGDs with PEs, community leaders, health workers, youth (in and out of school), and the community members at large prove that these changes have been facilitated to a larger extent by the TMEP.

The end-line data show a change in men's attitudes and, in particular, the gender norms that are clearly strong in the region with significant and positive increases in the percentage of men who reject traditional gender roles and justifications for gender based violence. When the baseline data were conducted, 27% of men disagreed that men should have the final word regarding domestic decisions. The end-line data indicate that now 69% disagree with this belief, a significant improvement. Unfortunately, the baseline report does not present the percentage of those who agreed with this idea, but the end-line does show about 30% agreed with the idea of male dominance in the household. A similar improvement is also evident in regards to the feelings and beliefs surrounding gender based violence. The baseline data show that 46% of males in the region disagree that women sometimes deserve to be beaten. The end-line data indicate an increase to 73%. The baseline also shows that 18% of males and 24% of females disagreed with the idea that women should tolerate violence in order to keep the family together. The end-line indicates an increase to 45% for males and 44% for females. However, this performance is still quite low, suggesting that more efforts aimed at changing attitudes are needed.

Similarly, about 8% of males and 15% of females are confronted about their gender rights. Regarding issues of perception about household responsibilities, the end-line data indicate that 60% of males disagreed with the idea that women are solely responsible for domestic chores, and about 40% of males continue to hold this belief. When specific examples of domestic chores such as changing diapers or bathing and feeding children were given, 80% of males believed these were chores that both genders were responsible for. Given the patriarchal nature of these communities, this improvement is significant. The evaluation data from FGDs with women further indicate an improvement in the behaviours and practices of men as they noted the greater frequency with which their spouses supported them in the home. Activities such as 'fetching water', 'cooking', 'doing the laundry', 'accompanying the spouse to the clinic', and 'engaging spouses in decision making process' are re-emerging themes in FGDs with both males and females. A male participant in Rukwa illustrated how he helps his wife with the domestic chores:

After a discussion with a PE on sharing the responsibilities and why it is important for both me and my wife, I decided to change. It has been two years since I started helping my wife with cooking. When my friends come I do the same with no fear or shame (FGD/M-57yrs).

The IDIs with the male dominated institutions, especially the gender desk, affirm these improvements as we see a decrease in the rate of reported cases of gender and sexual based violence. They highly commended TMEP's efforts in the community. For example, the data from the Nkasi district shows that while in 2010 at least 102 women reported being harassed by their men, in 2013 there have been only 27 cases. Similarly, the number of reported rape cases has also declined.

The baseline report indicates that 7% of males and 10% of females had been victims of sexual based violence. Interestingly, there is no significant change in the frequency of sexual based violence as the end-line data indicates that 10% of males and about 11% of females had been victims, suggesting that further efforts to change attitudes about sexual based violence in the region are required. The data also indicates that about 16% of males and 17% of females are forced to have unwanted sex by someone of a different sex, compared to the 1% of males and 2% of females that were forced by someone of the same sex.

The rate of MI is also high in the Singida region where the project targeted 1,169,548 attendances by men for SRHR activities and services over the three years. The project has already served 755,734 attendances (65% of the target) for 2011 and 2012, which is a significant improvement from the zero data that was collected during the baseline study. In 2011, at least 83,030 men attended the sessions; by 2012, 67,704 men attended the sessions; in 2013 the project estimate at least 413,814 attendances. A clear change in the attitudes about gender norms and values in the Singida region is evident by comparing the baseline and end-line data. In the baseline report, only 37% of males disagreed with the idea that men alone should have control over the domestic decision making process. The end-line data shows an increase in the rejection of this belief to about 61% of males and 57% of females. Regarding gender based violence, the baseline report suggests that 66% of males in the region disagreed that women sometimes deserve to be beaten. The end-line report depicts that 73% of men rejected this belief. Although the baseline did not include the response of females because the focus was on men, it is interesting to see that 74% of females who participated in the end-line study also disagreed with the notion that women sometimes deserve to be beaten, signifying that about 27% of males and 26% of females agreed with this idea.

Thus, it is crucial that the project addresses these significantly high rates of community members who continue to believe in such patriarchal traditions. Further, while the baseline indicates that 46% of males and 35% of females disagreed with the idea that women should tolerate gender based violence, the end-line demonstrates a significant increase in the rejection of such beliefs to about 70% of males and 57% of females. Similarly, about 93% of males and females rejected the idea that it is acceptable for a man to hit the wife if she does not want to have sex with him. Another change is also evident in that about 76% of males and 67% of females reject the notion that there is no discussion about sex and that it is a man's right. Further, about 52% of males and females said that they would defend themselves by force if someone were to sexually assault them.

In regards to sharing of the domestic responsibilities, about 43% of males and 31% of females reject the idea that women alone are responsible for domestic chores and activities such as changing diapers or feeding and bathing children. The end-line study confirms that the percentage of those who reject such beliefs has increased to about 75% of males and 55% of females. Increasingly both males and females view such activities as shared responsibilities. However, progress still needs to be made in regards to gender rights, as 3% of males and 8% of females continue to subject to SRHR issues in the region. Further, about 3% of males and 6% of females were engaged in gender based violence six months prior to the end-line study.

We see a significant improvement in the rate of sexual violence from the base-line to the end-line study. The baseline report indicates that 8% of males and 7% of females were engaged in sexual based violence in the six months prior to the study, while the end-line report shows that about 2% of males and 6% of females had engaged in such behaviours within the six months prior to the study (see figure below). Interestingly, while about 3% of

males and 7% of females are forced to engage in unwanted sexual acts by a person of a different sex, 0% of males and 3% of females had been forced by a person of the same sex.

Therefore, there are irrefutable improvements in the regions, many of which are the result of activities conducted by the project. The progress demonstrated by the end-line study above is further confirmed through FGDs with the male population in Nkomolo, where participants agreed that TMEP programs had successfully challenged the long-held notions that men cannot engage in domestic chores such as mopping, child care, or cooking. Participants identified that men currently perform these activities in view of the community, thus challenging the traditional habits and encouraging social change.

In summary, the data indicates a considerable increase in the rate of MI in SRHR issues and significant changes in both regions. The 2012 TMEP Project annual report explains that at least 491,473 attendances by males were served in 2011. The number of attendances increased to 1,716,280 in 2012 (an increase of nearly 249%). This number is actually reflected by the change among men on SRHR related issues. The achievement of MIs in these two regions, however, cannot be accounted to the TMEP program alone. Other intervention programs implemented by health facilities, local authorities, media, and various educational methods provided at public events have also contributed to these changes. One method we have found to be largely influential on men are the invitations and letters of acknowledgement given to men when they attend clinics. Such methods are not unique to TMEP, but are often used by such Institutions as the Ministry of Health and Social Welfare. As a nurse from Nkasi narrated:

> *Some of the incentives we offer to men have been in place even before TMEP commenced in the district. We have used the skills we gathered from the TMEP training to improve the service (IDI/Nurse/Nkasi).*

The end-line data suggests that in both regions there is a statistically significant difference of 10% between males and females who get regularly tested for HIV. In Rukwa, about 80% of males and 72% of females have been tested for HIV due to the higher awareness and readiness of men to utilize their knowledge about SRHR in the Rukwa community. Similarly, in Singida about 63% of males and 66% of females have been tested for HIV. TMEP was highly effective in schools where male and female students began to come together. On one hand they helped each other with school activities, and on the other, male students became a force of change in their families as they began to help with such domestic chores as fetching water and washing clothes. However, women continue to express experiences of discrimination and inequality in their marriages and little control over their SRH decisions.

Chapter Five: Result Two: SRHR Information

5.0 Introduction

This chapter addresses the performance question that focuses on the ways in which SRHR information and dialogue have improved due to the implementation of the project in the community. Through end-line study results, evaluations, and a review of documents we are able to assess the improvement of access as well as the community's awareness of SRHR issues in both the Rukwa and Singida regions. Before TMEP, there were no open discussions about sexuality, nor were men expected to participate in reproductive issues let alone go to reproductive and child health clinics. During TMEP, men and young people received access to correct information about SRHR through gender focused discussions, entertainment and sports, community sensitization meetings, community dialogue sessions, women's involvement in meetings, youth bonanza, established youth clubs, and trainings. The status of the community since the inception of the project is presented in the sections below.

5.1 Attendances by community members for group SRHR information and dialogues

In all the IDIs and FGDs, there is a consensus that the project has organized events, activities, and trainings that targeted the various groups. For instance, the Matai IDIs indicated entertainment and sports as the most effective events in capturing the interest of the community. Community theatres, especially the traditional dances and puppet shows, are highly effective in capturing the community's interest. For instance, during the IDIs with trained teachers, one teacher identified the effectiveness of puppetry in bringing the community together and in openly addressing sexuality issues perceived to be 'sensitive'.

Generally, the project displays impressive progress as the number of men and women receiving accurate information on SRHR issues reached 35,970 males and 30,030 females in 2011. In 2012, about 35 times as many males and 32 times as many females had access to accurate information regarding SRHR issues. In 2013, these numbers are again expected to increase by about 20% for both males and females. Thus, the project is approaching its target of serving 3,587,370 attendances by males and 2,766,355 by females in attending SRHR information and dialogue sessions through group contacts in both, Rukwa and Singida region through a variety of methods (TMEP annual report 2012 – reach table).

Although we were not able to capture the number of group sessions and events organized, it is unquestionable that the awareness of the SRHR issues in the community has increased from 56% of males and 58% of females to about 99% of males and 99% of females since the project was launched. Similarly, during the baseline 50% of males and 52% of females were not aware that SRHR issues are relevant to everybody. Through the end-line study, we find that now approximately 81% of males and 73% of females understood the relevance of SRHR issues to everyone in their communities. In terms of gender rights, the baseline data indicates that 34% of males and 72% of females were aware that married women have a right to decide whether or not to conceive. The end-line data confirms a significant increase of about 53% among males, but a decrease among females to about 61%. We believe this trend is due to an over emphasis on male involvement by the project, which has led to the neglecting of efforts to engage women. Similarly, while the baseline data indicates that 67% of males and 23% of females expressed that married women have no right to make decisions about their SRH without obtaining the consent of their spouses, the end-line indicates a significant decrease in this belief with about 20% of males and 13% of females in the region. Regarding the right of women to deny or refuse sexual intercourse to their husbands, the baseline found that 59% of men supported such rights—women were not taken into account on this question

during the baseline. The end-line established that about 91% of males and 87% of females supported the idea of this right. Interestingly, about 99% males and 100% females believe that people have the right to full, objective and balanced information about SRHR. The evaluation data, especially the IDIs with ward coordinators, PEs, and Trained Teachers, indicate that there are at least weekly sessions where SRHR issues are discussed. Similarly, FGDs, particularly those targeting males, suggests that the community is highly active in discussing and addressing gender related issues. For instance, the Matai Ward Executive Officer and the Councillor during their public meetings often invite TMEP coordinators to conduct a short session on a selected topic. According to the councillor, they are given 20 minutes in each of their meetings. The councillor demonstrated how he takes his child to the clinic:

> *I prefer to lead by example than by mere sayings…..the impact is more effective when people see by their eyes that 'ah! The councillor is also doing the same' (IDI/Councillor/Matai)*.

In almost all the IDIs and FGDs, the participants concluded that a majority of the community members had heard about TMEP in their communities. The observation notes confirm a high level of awareness. The informal talks conducted at the two open markets (*minada*) we visited demonstrate a high level of awareness on TMEP in the Matai and Matanga wards. However, it is essential to avoid assuming that this level of awareness is present for all three districts. In actuality, it appears that Sumbawanga Rural and Nkasi are performing better than Sumbawanga Urban.

In terms of information delivery mechanisms, we see a much higher degree of awareness and community involvement in communities where a variety of tools are utilized. These tools include leaflets, posters, community meetings, Ward Development Committees (WDC) for the leaders, community events including national holidays such as SabaSaba, targeting NaneNane for theatre arts (Puppets-vikaragosi), TMEP male and female football leagues, and other important public meetings. Other methods for transmitting SRHR information include radio broadcasts, teaching special lessons at School by Student PEs, house to house education by PEs, and informal group talks by PEs (e.g. in coffee clubs, bars, local brew centres etc.). The clinic days are another opportunity used to transmit SRHR information where health education sessions conducted by health care workers cover SRHRH issues. Additionally, community dialogues about gender issues further effectively transmit information. During IDIs with teachers, we find that the established football clubs known as TMEP leagues in the region are active. One trained teacher in Matai ascertains:

> *… a very powerful way to offer SRHR information with less effort. All you need is loudspeakers, a convenient day that the majority of the people in the village is free, and then announce the event two to three days in advance. You also must prepare enough resources, which include the football, jazz, and an organized match official. Then, before the match starts, you give the SRHR message, and repeat it during the break and at the end before announcing the winner. You also need to organize for enough condoms because we usually put them around the football pitch and people pick them up freely (IDI/Trained Teacher/Matai).*

The IEC materials are also evidently used in Rukwa. In all the Ward coordinators' offices, posters with different TMEP messages were clearly on display. Similarly, the government offices, health facilities, and schools are all decorated with the printed TMEP hood poster materials. The Regional Police Gender Desk demonstrated how they have used TMEPs' printed materials in the community policing education that they won the National Prize for in 2012. The recognition letter was signed by the Tanzania Inspector General of Police (Saidi Ally Mwema) on the 12th of February, 2013. This achievement demonstrates not only how the project is well received in communities, but also confirms that the project concepts are used by other institutions and members to raise awareness in the region. As a result, almost everyone within the community has the right to access information in one way or the other. As demonstrated by a Ward coordinator:

> *…our role has been to educate the community without setting anybody aside; all people within our reach have had an opportunity to access our information either through person to person or group discussions and in public gatherings"(IDI/Ward Co-ord./Kirando-Nkasi).*

This understanding is also clear among the health workers who were interviewed in all the wards visited. They not only liked the TMEP concepts, but appreciated that the dissemination of such to the population has made their work much easier as well. They use the project materials for teaching, training, and distribute them to the people who attend the clinics. They have improved the clinic sessions to be more male friendly by acknowledging and offering first hand service to males who comes to the clinics. This is explained by a female health worker:

> *TMEP is a project that aims at bringing equality in reproductive health services and gender issues between men and women. We took the idea and integrated into our everyday plans and works to enhance our service. We are seeing more men coming for the service but also more and more awareness being raised (IDI/DRCHCo/Sumb-Rural).*

Such evidence shows significant progress of the project in the region. Indeed, as seen in the sections above, the awareness of the people and individuals from different cadres has increased. The project and the IPs especially, are clearly doing good work on the ground. Violence is decreasing, pregnancies in schools are low, and more women are supported in homes.

Although the Singida region is also making impressive progress, we do not see the same level of community engagement with TMEP activities as in Rukwa; with the exception of Ilongero, Irisya, and Kintinku wards. The youth clubs are not very active. While PEs have been trained, they have only met and discussed TMEP issues three times. Teachers are also not so particularly active in their use and dissemination of TMEP materials. Further, the use of folk media and the Fema and Si Mchezo magazines could be utilized more. With the exception of the Ilongero Ward Coordinators Office, almost no other Ward Coordinators Offices had printed materials to use for training and spreading information. Indeed, the IDIs with the Police Gender Desk revealed a high demand for TMEP information, but somehow the link is not very strong. Similarly, the health providers in the wards are trained only once with few or no refreshers or follow up training sessions. However, we do see significant efforts to reach people in the three districts are from the youth wing.

Despite the above general assessment, in 2011 the project managed to serve about 212,851 attendances by males and 169,082 by females in group SRHR information sessions and dialogues. In 2012, the number increased by 77% for males and 107% for females. For 2013, the goal is to increase the participation rates by 65% for males

and 61% for females, meaning by the time the first phase of the project ends at least 837,071 males and 733,361 females will be reached. The group attendance data indicates that both male and female attendance in 2012 is very high compared to 2011. During 2011, the numbers were low due to the fact that the training had just begun. The number for 2013 is low as the reported data was for the first quarters of the year.

The baseline data indicates that only 41% of males and 40% of females had heard of SRHR issues; the end-line findings indicate an increase of about 98% for males and 94% for females in the region. The baseline found that 69% of males and 63% of females were aware of the relevance of SRHR issues to all members of the community. The end-line shows a significant increase in this recognition to about 90% of males and 87% of females. There is mixed improvement regarding sentiments around a married woman's right to choose whether or not to conceive. Baseline data shows that 63% of males and 37% of females believed women should have control over this decision. The end-line data shows a drop in these numbers for men to about 49%, but an increase for women to about 50%. This decrease is attributed to the level of PEs' engagement with the communities and collaboration with Ward Coordinators. The end-line data also indicate that approximately 46% of males who participated in TMEP activities received their information from Ward Coordinators and not PEs. The end-line study found that about 14% of males and 21% of females felt women had no right to make decisions regarding their SRH, a substantial decrease from the baseline which found that 43% of males and 49% of females felt this way. The baseline found that 65% of men supported the idea that women should have the ability to deny sexual intercourse without repercussion. The end-line indicates a significant increase in the support of this idea to about 91%. Unfortunately, this report cannot account for the change in awareness among women on this question as there is no data from the baseline; however, the end-line data indicates that about 84% of women support this idea. Thus, the figures from both the baseline and the end-line reveal not only an improvement but also reflect the tremendous amount of work that the IPs, Ward Coordinators, ToTs at different levels, and the PEs are doing on the ground. As a result, close to100% of males and 98% of females believe that all people have the right to access full, objective, and balanced SRHR information.

This high level of awareness was made possible through a number of events such as trainings, dialogues and discussion forums, in-school clubs—especially in the Majengo ward, and community theatres. The IPs (HAPA and YMC) collaboratively ensure the community acquires the accurate information on SRHR. While HAPA, through Regional and District Coordinators, ensures that adults are getting the right information, YMC deals with the youth wing. Together, the trained PEs, Ward ToTs, Ward Coordinators, District Focal Persons and project management collaboratively ensure this achievement. The IDIs with the regional Police Gender Desk revealed the reasons for an increase in the number of cases reported on gender and sexual violence:

> *…this is a sign that more women are more aware of their rights especially the SRH rights. A simple slap on the face brings a woman here and we have these cases reported (IDI/Police Gender Desk/Singida).*

The regional data for 2012 depicts the number of gender related cases of violence where 37 cases of rape were reported; 15 for molestation; 35 for running with a school child; 19 for pregnancies in schools; 1 for stealing a child; 45 for violence; 19 for injury; and lastly 36 for beating. Unfortunately, the data for 2011 and 2013 were not available. However, the evaluation data from the IDIs with the Ward Executive Officers confirm that the increase of

reported cases of violence is due to the increased awareness of SRHR issues in the community. For instance, Ipembe Ward Executive Officer indicated that:

> *I am receiving more and more cases of gender related violence. This is due to the TMEP project. While we are not very happy about these incidences, it shows that more women are daring to come forward and talk to the authorities. It is a sign that they know violence is unacceptable and that if all the possible means to resolve fail they have to come to either us or the police (IDI/WEO/Ipembe).*

Other evidence collected from the ward level police gender desk reveals a drop in the number of reported cases of gender related violence. For instance, the data from Kintinku indicate that while in 2011 about 66 females and 21 males experienced gender based violence, 69 females (increased by 5%) and 13 males (increased by 38%) experienced such in 2012. In 2013, only 36 females (48% increase) and 8 males (38% increase) have experienced such violence.

The occurrence of rape, school pregnancies, and forced marriages are significantly low in the ward. However, some community members believe that various sessions must target women more than men when addressing issues of access and one's right to information. The IDI, along with a Ward TOT, also confirm this concern:

> *…the education is very useful, but it needs to integrate all groups of the society…I mean, both women and men should be called together (IDI/Ward TOT/Ipembe/).*

The project in the future must utilize the media more effectively, particularly the radio and television, in order to reach more people, which can be accomplished by preparing special TMEP programs. Indeed, generally the project needs to reach more people through the use of public events.

Overall, while the awareness in both regions is increasing, the difference between the regions is statistically significant at 5%. When we examine the evaluation data, the difference is evident (see figure 16in the appendix). It reveals a higher awareness of the TMEP project in the Rukwa than in the Singida region. It appears that the project has reached various members at the community level since its commencement in 2010. People's awareness about the project and its objectives is very clear through the focus group discussions, in-depth interviews, and observations. Indeed, the members of the FGDs charmingly and interestingly discussed the project's achievement with high confidence.

Conclusively, the project's annual narrative report (2012) indicates that at least 499,839 community members in 2011 and 2,977,031 in 2012 attended SRHR activities, which reflects a 124% increase over two years. Nevertheless, it is crucial that we continue to find ways to improve the functioning of the program. For example, as highlighted in previous chapters, it is essential to ensure the retention of PEs, Ward Coordinators, and district ToTs who are often transferred to other areas.

5.2 Attendances by community members for individual SRHR information and dialogues

This section answers the performance question by focusing on the attendance rate of community members to individual SRHR information sessions and dialogues. The report builds the argument on the baseline summary, which indicates that there was 'zero data' in both regions when the study was conducted in 2010.

The end-line data also indicates that the information provided in these sessions was relevant to the participants. About 94% of males and 90% of females found these sessions to be helpful. The end-line data demonstrates that these sessions inspired about 94% of males and 89% of females to take direct action in their families and communities. This motivation suggests that the project is reaching its goal of not only training, but more importantly inspiring trainees to take action. Indeed, about 61% of males and 60% of females who participated in the study went for SRHR services. Thus, it is clear that the TMEP project in the region is achieving the set goals in terms of promoting the attendance of the community to SRHR information sessions and dialogues. When examining these figures, one can note that from January to June 2013 the project surpassed the number of individual attendances reached in 2012.

The end-line data proves that more men are attending the sessions regarding the involvement, with about 52% of males and 39% of females attending, while sessions regarding SRHR issues were the least attended session, with about 3% of males and 4% of females attending. Finally, end-line data shows that about 13% of males and 23% of females attended sessions concerning family planning. Sexual and reproductive health sessions were attended by about 21% of males and 28% of females.

A small portion of participants (about 6% males and 19% females) did not recall the sessions they had attended, which implies that these sessions are not held regularly. When we asked the individuals who attended sessions whether it was relevant to their everyday lives, approximately 85% of males and 80% of females responded "yes". Similarly, about 52% of males and 51% of females in the region visited the SRHR services after attending the sessions. Considering that 37% of males and 30% of females did not take any direct action after attending sessions, we can conclude that the project is making a great progress; however, these percentages must continue to decrease in order for this program to be successful. Similarly, with other interventions, one would expect a high turnout for SRHR services after the sessions.

The series of Fema and Si Mchezo magazines that are distributed in schools also proved to be one reliable source of information for the beneficiaries in particular the youth. In fact the presence of the Fema and Si Mchezo magazines in Rukwa was very clear and during the discussion several topics were brought up by the youth. Thus, the 9 series of Fema and 14 of Si Mchezo is yielding an impact on the ground and support other communication channels. Through collaboration with FEMINA, about 1,624,500 copies of FEMA and 2,288,000 copies of Si Mchezo magazines were distributed carrying messages from TMEP. Since the project invested on these series in terms of time and money, we see the value for money and it has to be kept on board during the second phase. The only observation and concern is that Singida has to utilize this readily available material that the project has immensely invested into. Perhaps the secretariat can provide more copies for the region or push for the IPs in the region to distribute to more schools.

Conclusively, when we compare the individual attendance rates for the two regions, Rukwa is reaching far more members and has made greater progress in reaching its target numbers than in Singida. This comparison is particularly important to note as its target numbers are almost three times larger for males and two times larger for

females than the target numbers for Singida. Therefore, if Singida is to reach more community members, it must increase its annual target and expand the methods of reaching members. One way of accomplishing this aim is to copy the best strategies and implementation techniques from Rukwa and apply them in Singida. As previously noted, some of the activities, such as using the Fema and Si Mchezo magazines, edutainment, such as football clubs and utilizing the in school PEs who have graduated, are not being fully utilized. The participants who attended TMEP activities expressed that they were invited by the ward coordinators, a task that is most effectively done by the PEs.

5.3: The Student's Awareness and Understanding of SRHR:

As indicated in earlier chapters, in order to effectively capture the voices of young people in terms of their understanding of SRHR, we requested some students in both regions to write an essay on the following topic: "***What do you understand with the idea/concept of involving men in issues of sexual reproductive health rights and gender rights?*** They were required to express their views freely as well as what they had learnt and understood from TMEP about the topic. Also, they were required to write their essays in Swahili language. We then collected the essays and typed and analysed their content. Below is a brief summary of the views of most of the students as they appeared in their essays.

Singida

Overall, the students' awareness is high in the project area; they are aware of TMEP and understand its objectives. They also understand that the project has brought a number of benefits to the community and its members. For instance, their answers suggest that the utilization of the service has generally improved. One student describes the benefits of the project in this way:

> *"The utilization of the SRH services has increased, especially the use of condoms. The number of STIs has gone down due to the raised awareness in the community, and early or teenage marriage has decreased" (M/Idodyndole).*

Others' understandings are more limited to the MI; they perceive that TMEP involves sharing the roles and responsibilities of men and women. Other responses are embracing of the more holistic understanding of what it means to be healthy, which covers safe delivery practices, responsibilities within the households among its members, couples attending the clinics together, and partners expressing love to each other. A number of essays also express the responsibilities that men are unable to perform in the home such as breastfeeding and experiencing pregnancy. One student narrated the following:

> *"SRHR is about being healthy physically, psychologically and in many other ways. It encompasses mutual support, and more importantly, it strives to move away from the male dominant system that has been practiced for decades in different communities" (F/Ilongero).*

Benefits of MI:

Diverse viewpoints were included in the students' essays from the region. Although we aimed to comprehend their understanding on SRHR issues, particularly on the MI, their answers primarily cantered around reduced number of

diseases, especially the STIs, distribution of condoms, unplanned pregnancies, and early or childhood marriages. For instance, one individual wrote the following:

> *"The MI benefits not only men themselves but also the entire community as they become aware of the importance of planning the number of children, caring for their children, learning about diseases, and becoming open to discussing family planning." (F/Ilongero).*

Of particular interest is how students link the MI with the improvement of the wellbeing of the family:

> *"When you engage men in SRHR, you are automatically also touching the wellbeing of the entire family. You are making a husband and wife discuss and plan for the future of the family. More importantly, you are reducing poverty, since if the husband understands his roles and responsibilities," (F/18/Kintinku).*

Rukwa

The students' essays from Rukwa reveal a similar trend on the awareness on SRHR and the importance of MI. Most students who wrote the essays indicate that they have heard of and participated in TMEP and comprehend its role in fighting the male dominance system. They also understand that TMEP aims to involve men in SRHR issues.

For instance, most essays reveal that they are aware of TMEP's objective to include men, and as a result change their attitudes and behaviours towards issues such as gender based violence, and in supporting their wives and families. A female student from Majengo ward expressed her views as follows:

> *"The involvement of men in SRHR issues includes fully participating in accompanying their partners to the clinic, providing important needs related to fertility such as care and support during pregnancy, eradicating the patriarchy system, and recognizing the women`s rights in reproductive health" (ST /FE /16 years Majengo).*

Furthermore, others suggested that TMEP is attempting to provide an education to the community, ensuring that community members know their rights and demand the services they deserve from the health facilities. One female student from Muze presented the following views:

> *"TMEP makes people aware of sexual and gender based violence, while also educating men about the importance of participating in the household activities such as cooking, sweeping the compound and raising the children…it also empowers a person to face the doctor, especially when suffering from the STIs or when in need of condoms" (F/18/Muze).*

All essays indicate that the project emphasizes the participation of men in SRH services, especially accompanying the wives and children to the clinics. Most of the essays also brought up the concern of social accountability.

Moreover, TMEP targets gender based violence in the community, including the concept that it is essential for a man to listen to his wife. Other essays focused around obtaining family planning

information and HIV related services, supporting the right to access accurate and quality information about SRHR, and protecting the right not to be sexually harassed.

A thorough analysis of the essays does not suggest any major differences between the regions as the majority of the essays expressed similar or closely related issues. Furthermore, male and female essays also draw similar conclusions, uniformly signifying a need for more health education in the community. They also desire that the education targets youth in order to help them understand their health status and their roles and responsibilities in the community and with their families. The essays from the two regions also recommend increasing SRHR services in the villages where the coverage is not yet substantial enough. Similarly, it is clear that there are a number of wards which are not fully performing. Therefore, they recommend a close follow up and refresher trainings for the ToTs and Ward Coordinators.

Chapter Six: Result Three: SRHR Services

6.0 Introduction

This chapter focuses on the utilization of SRHR services by the communities within the two study regions. In particular, we focus on the attendance rates for VCT, STI, family planning, access to ARV, and other SRHR services. After three years of implementation, we expect to see a high rate of SRHR service utilization by both men and women from the communities as a result of increased access to SRHR information and dialogue. We have assessed communities' use of SRHR services by triangulating data from standard surveys, qualitative methods, and documentary review. Generally, the demand and the use of services have increased in both regions since the baseline was conducted in 2010.

The baseline report (2010) shows that when the study was conducted, about 17% of study participants in Rukwa and 7% in Singida were visiting the health facilities and sought improved access to SRH services. Similarly, the report shows that 30% of study participants from Rukwa who visited facilities and 16% of those from Singida requested RH services. While these circumstances were the reality two years ago, the end-line data indicates a significant increase since the beginning of the project. For instance, about 73% of males and 77% of females who visited the health facilities asked for SRH services in Rukwa. In Singida, about 58% of males and 62% of females asked for such services. Interestingly, about 69% of males and 75% of females in Rukwa and about 55% of males and 65% of females in Singida went to facilities for SRH services. When asked about where they received such services, approximately 49% of males and females in Rukwa went to the public facilities, while 42% of males and females in Singida utilize the public health facilities.

For those who had access and visited the SRHR services, counselling is the primary purpose for attendance, which was the case for 39% of males and 42% of females in Rukwa, and about 33% of males and 42% of females in Singida. For those who visited the health facilities, about 73% of males and females in Rukwa, and 58% of males and 69% of females in Singida discussed SRH services. Interestingly, about 74% of males and 78% of females in Rukwa, and 66% of males and 70% of females in Singida were satisfied with the discussion. Thus, what we have described so far is the achievement of the project in terms of increasing demand for such services, as well as social accountability. The fact that about 76% of participants in Rukwa and 68% in Singida were satisfied with their discussions with service providers indicates that the project is also making substantial progress in supplying such services to communities. We must be concerned, however, in interpreting such findings. While there are many reasons to believe that this achievement is the result of TMEP activities, we cannot ignore that there are other intervention programs being implemented by other organizations or government departments in the region as well.

In the sections below, we will demonstrate the change in service utilization rates for the three services provided. In addition, we consider other available services such as PMTCT, Clinics, and male circumcision.

6.1 Attendances for VCT

This section focuses on the extent to which communities in the two regions use VCT services. Generally, the project has made significant progress in increasing the awareness of, and thus demand for, such services. Comparing the baseline and end-line data regarding demand and utilization of services provides a clear picture of the change in such over the three years of project implementation. The baseline report identifies that the demand for VCT services was very low, but does not report anything regarding the extent to which such services were used by the community (Baseline report, 2010: 32-33). The same is true for the baseline summary. As a result, we rely on the documents to establish the extent to which community members have utilized the VCT services.

There has been a decline in attendance rates from 2011 to 2012: about 21% for males and about 35% for females. There have been notable increases from 2012 to 2013: about 31% for males and about 128% for females. Indeed, compared to the total population and the efforts by the project in the region, one would expect a greater increase in the utilization of VCT services. The IDIs with the health providers illustrate an improvement over the years before the implementation of the TMEP in the region. One health worker claimed:

> *"…we are seeing more and more people coming for VCT compared to four years before the project. This shows great work has been done since the project began. Although the number is still relatively low, we can be proud that the trend continues to increase every year." (IDI/health worker/Muze).*

The data from Singida also show similar trends in the demand for VCT services. When the baseline was conducted, there was low demand for VCT services. Unfortunately, the report does not tell us the extent to which such services were being used by the community. The project's regional annual report shows that in 2011 at least 35,231 males and 23,239 females attended VCT services. There was an increase in attendance rates to VCT services in 2012 to about 46% of males and 21% of females. Data for the first quarters of 2013 are promising to increase attendance rates for VCT service as 37,802 males and 31,489 female have already attended such services. As a result, since the inception of the project, at least 124,441 males and 82,952 females will be attending VCT services in Singida by 2013. This positive trend is also clear from the IDIs with the DRCHCo:

> *"TMEP is a good education…it has helped to inform the community on their rights in issues related to VCT and health in general; however, as you shall see through our clinic data, still, fewer men show up. We are seeing a positive trend if we compare that data for previous years when the project was not yet introduced" (IDI/DRCHCo-SGD Mungumaji.)*

Conclusively, the attendance for VCT per region indicates that Singida is reaching more people, yet the rate of increase has slowed in the first quarter of 2013. From 2011 to 2012 there was about a 36% increase in attendance rates. For the first quarter of 2013 there is a decrease of 13% in attendance rates However, since the project continues to run, and the figures presented are only for half a year, some achievements in the second quarter are possible. While this is true for Singida, Rukwa region is comparatively showing an impressive increase in the attendance rate for VCT services. Between 2011 and 2012, there was a decline of 38%; in the first quarters of 2013 we see an abrupt increase of 42%. Therefore, if we compare the trend in the two regions, it is clear that there is a trend of improvement in attendance rates in the Rukwa region and a decrease in attendance rates in Singida. Overall, since the beginning of the project, at least 158,935 males and 192,935 females have used VCT services. This data suggest that progress is being made in increasing awareness and demand for VCT in the communities of the two study regions. Again, we cannot account such progress to the TMEP project alone, as TMEP is not the sole organization working on these issues in these areas.

6.2 Attendances for STI

The utilization rate for STI services in these regions has also significantly improved since the inception of the project. Unfortunately, the baseline report does not explain the extent to which such services were utilized by communities when the study was conducted. If we rely on the annual reports, a positive trend is extremely clear in the utilization rates of STI services. From 2011 to 2012, there was an increase of 64% for males and 58%for females. In the first two quarters of 2013 there is already an increase of 63% for men and 65% for women in the number of attendees to STI services.

These figures suggest that from the inception of the project to the evaluation more than 2,912 males and 5,107 females have demanded this service. This trend reflects the efforts to increase awareness in the communities about such services and the importance of them to the health of individuals and the community at large. The end-line study shows that about 72% of males and 71% of females who went to the health facilities for SRHR services discussed STI related issues. Interestingly, while men have a high awareness of STI issues, females use such services more frequently than their male counterparts, signifying that more efforts must be directed at increasing the rate of attendance to STI services for men. FGDs with women clearly express the willingness of women to attend such services. Consensus was found with one participant who said the following:

> *"We are more concerned about our health. When one gets a disease, the only way is to be treated, and this is one of the agendas of TMEP for the past three years. However, it is not everyone who goes to the health facility for the treatment, others would use the traditional medicine such as herbs, and others would buy antibiotics from the shops and use them." (Female FGD/Kirando).*

While this is true, a high degree of reluctance can be identified through the IDIs and FGDs. Thus, while the numbers are increasing, it is likely that many other people self-diagnose and use medicine silently or go to traditional healers. This stance was also supported by DRCHCo from Nkasi.

The utilization of STI services in Singida also shows a significant improvement since the baseline study was conducted. For instance, 9,070 males and 6,887 females demanded the service in 2011. There was a slight decrease in 2012 by 19% for males and 26% for females. However, there are tremendous increases for the first two quarters of 2013: 27% for males and 53% for females. Since the inception of the project, at least 25,749 males and 19,814 females will benefit from this service.

The end-line study also indicates a high demand for STI services. About 66% of male participants and 70% of female participants said they discussed STI issues when they visited health facilities. The high demand for such services by both men and women thus becomes clear. However, this also means that future plans must include deliberate efforts aimed at increasing awareness of and demand for STI services among men. During the evaluation study, the DRCHCo expressed their recognition that TMEP has made their work much easier. However, they are concerned about being overwhelmed by the rapidly increasing demand for services, which is not matched by government efforts to improve services by employing more personnel, increasing supply of medication, and/or improving health facilities in general. One DRCHCo from Singida said:

> *"We are happy with the achievement, we are happy that the number of people demanding STI services is increasing; however, we are concerned that the government is not yet prepared to offer quality service for those people who come for the STI service. We sometimes lack enough resources."* (IDI/DRCHCo/Singida Urban & Rural)

6.3 Attendances for Family Planning

The demand for family planning services has also significantly increased in the two regions due to the TMEP project and the activities of other stakeholders that are operating in these regions. For instance, when the baseline study was conducted, the available data collected by the project implementers did not reveal an exact number of people accessing family planning. However, if we establish 2011 as our base for the argument, then there has been an increase in the number of people using family planning services: about 112% for males and 150% for females between 2011 and 2012. The observed increasing difference rates are statistically significant at 5%.

The reported utilization rates for family planning services in Rukwa region are not impressing for the first two quarters of 2013. The utilization rate for men in 2013 is only 16% of that for 2012; for women it is 23% of that for 2012. Thus, more efforts and perhaps new methods must be aimed at increasing the utilization rate of family planning services. The end-line data indicate that about 12% of males and 21% of females attended sessions that targeted family planning issues. The demand for the service by males is low compared to females. As a result, more awareness and campaigns must be directed toward men in order to ensure an increase in men's use of such services.

The use of family planning services by both men and women is increasing in the region, which is evident by comparing the baseline and end-line data. From 2011 to 2012, an abrupt increase of about 275% for males is visible. However, during this same time period, there was a decline of about 42% for women. This drop may have been caused by the emphasis of this project on men rather than women. However, this trend changes from 2012 to 2013 where female utilization rose by 327%, while that for men declined by about 80%. This might have resulted from the redirection of emphasis toward women. By the end of 2013, at least 27,683 males and 25,451 females will be benefiting from family planning services in the region. The end-line data indicate that of those participants who attended the SRHR sessions, about 16% of males and 20% of females attended Family Planning sessions.

Indeed, the IDIs with the DRCHCo of Singida Urban confirmed this significant improvement in the following way:

> *"TMEP is doing a great job in terms of educating the community about their rights to family planning services. We are seeing more and more people coming for the service voluntarily. We are accustomed to being forced, especially by women with problems when they come for the service. This is a good sign that the project's message is touching more and more people (IDI/DRCHCo-SGD Mun.)*

Nevertheless, the findings from the Singida Region present a changing trend in the utilization rates. The instability of these numbers is likely due to a lack of availability or lack of resources, as was suggested by the clinics we visited. A health provider from Irisya health facility commented:

> *"Sometimes we run out of stock, and so we have nothing to offer. Thanks to partners such as Marie Stopes who have monthly outreach programs that come and serve a large number of people…. otherwise, we would say that TMEP brought a big challenge of meeting the demand for services" (IDI/Health workers/Sing-Rural).*

One can argue that while Rukwa reached 20,936 males and 224,969 females, the interventions that targeted women for decades is clearly reflected in their attendance between men and women. As a result, the utilization rate of men is only 9% of that for females using FP services. Similarly, since the inception of the project, Singida has provided family planning services to 27,683 males and 58,076 females. Consequently, the utilization rate of men is 48% that of women using FP services in the region. If we compare the two regions, it is evident that Singida has reached only 35% of those reached in Rukwa.

6.4 Number of people accessing ARVs

Result three also focuses on the utilization and the supply of ARVs in the two project regions. While it is difficult to establish the extent during the baseline as the indicator was not captured, the baseline summary does not show an extent to which ARVs are utilized. As a result, we rely on the annual reports, which clearly show a positive trend in

individuals demanding ARVs in years 2011 and 2012 where there was an increase of 380% for males and 159% for females recorded in Rukwa region. Based on the evidence we gathered through evaluation study, there is no doubt that the project has accomplished a lot in sensitizing \,raising awareness, and demanding the availability of the service at the health facilities.

Despite the difficulties faced, including limited supplies of ARVs as a result of increased demand, the utilization rate for 2013 is already 50% of 2012. Thus, we are not highly concerned about the progress in this regard. This means that from the inception of the project to the end-line and evaluation study, 9,938 males and 18,373 females have utilized the ARV services in the communities. Indeed, health providers during IDIs mentioned the huge demand for ARV that was created by the TMEP project and its efforts to increase awareness:

> *"While we are happy that more and more people are coming for the service, we are not sure if we will be able to provide the service to everyone. If you look at the two years, you clearly see an increase of the people who come for counselling and testing, but also those who need the treatment. This is where the problem comes. On one hand the demand is huge; on the other hand we are not yet prepared. Just last year they fired the in charge of the facility here because some people complained about not getting the ARVs. But to tell the truth, the medicines were not even here" (IDI/health worker/Matanga).*

Singida is also making progress in increasing the utilization rate of ARVs. The increase in utilization rates are a direct result of TMEP activities aimed at raising awareness about the use and importance of ARVs. In 2011, at least 7,546 males and 13,028 females used ARVs. The utilization rate for men increased in 2012 by about 75%. For women, the increase was only about 2% in this same time. Again, the emphasis of this program on men may have influenced the effectiveness of the program to engage women and increase awareness and utilization among this population. In the first two quarters of 2013, we find that the utilization rate for men is only 24% of that from 2012; for women, the utilization rate is only 44% of that in 2012.

These results represent that since the evaluation was conducted, 25,929 males and 32,096 females have benefited from ARV service. When the utilization rates of men and women are compared, it is clear that female utilization surpasses that of males by 34%; thus, deliberate efforts are still needed to increase men's use of ARV services. This positive trend in utilization rates was confirmed during the FGDs with youth groups, adult males, and females. For instance, the youth FGD from the Majengo ward reached the consensus that generally more people come for testing and ultimately enrol in ARVs services. One female youth out of school commented:

> *"…our effort as champions of TMEP is slowly paying off. We are convincing people to go to the health facilities, get tested, and later for those who are positive to have a free service. When we follow up with the health providers, they give us rewarding comments that they are seeing some people coming for testing" (Youth out of school FGD/Amina/Majengo)*

However, as in other services, the health providers raised concerns about not having enough resources to fully provide services. This challenge was especially true in the case of ARVs:

> *"We definitely acknowledge the efforts by TMEP. We appreciate their deliberate move to bring men on board, and for centuries now we have been trying to influence them; however, we need to balance*

between raising the demand and also delivering the service from the supply side." (IDI/Health provider/Ilongero).

In summary, there is an apparent trend that describes a positive and negative pace. The positive pace indicates that the utilization rate among the people is increasing, and hence the demand also increased by 29% in Singida and 213% in Rukwa. Undoubtedly, Rukwa had a higher rate of increase compared to Singida in the period from 2011 to 2012. In the first two quarters of 2013, the utilization rate was only 34% of that reached in 2012, while in this same period of time, the utilization rate in Rukwa was 50% of that from 2012. These findings suggest that Rukwa is on track with the project goals, while further efforts must be directed to increasing the utilization rate in Singida.

The evaluation data reflect the great work being done in these communities to raise the awareness and demand for ARV services. This increase in demand, however, requires that the IPs make efforts to ensure the supply of ARVs to these communities. Such advocacy to ensure supply is necessary for the TMEP project to truly achieve its initiatives. Interestingly, we see more of the population in Singida being reached since the inception of the report than in Rukwa. Overall, since the inception of this project, 33,867 males and 50,469 females regularly seek ARV services. Again, as TMEP was not the only project aimed at addressing these issues, TMEP is not solely responsible for the changes identified. Yet, we can be certain that there have been significant increases in utilization rates for ARVs since the beginning of this project and affirm that TMEP has had a significant role in influencing this increase since 2011.

6.5 Number of condoms distributed

Rukwa

Condom distribution is also on the rise in Rukwa. In 2011, about 150,000 condoms were distributed in this region. This number increased to 401,881—an increase of about 168%--from 2011 to 2012. In 2013, it is expected that this distribution rate will triple and reach about 1,586,121—an increase of about 296%. In addition, the year 2013 is bringing the total distribution over the three years of implementation to 2,138,002.This outcome is in large part a reflection of the changing perception in communities regarding the use of condoms. The baseline found that 47% of men rejected the idea that a woman who carried condoms was easy to seduce. By the end-line, 60% of the population rejected such an assumption. The baseline did not identify a breakdown of women's perceptions regarding condom use and are therefore was unable to identify the change in perception for this population. The end-line, however, finds that about 56% of women reject the association between condoms and easy women. Behavioural changes can also be associated with an increase in awareness and use of condoms. The baseline found that about 15% of males and 17% of females have had unprotected sex. About 11% of males and 4% of females had unprotected sex six months before the study. Unplanned pregnancies, STIs, and HIV are recognized as consequences of engaging in unprotected sex by about 47% of males and 45% of females. Assuming that those who demand condoms use them, one can argue that at present, the number of people who are engaged in safe sex has increased—a good indicator of behavioural change.

Both IDIs and FGDs revealed some of the positive, qualitative changes in perceptions about condoms that have led to an increase in demand. The Ward Executive Officer for the Matanga Ward mentioned that:

"When you provide condoms at public events, they are gone in no time" (I*DI/Ward Executive Officer/Matanga).*

Singida region has also made good progress in changing perceptions about condom use. The baseline data of 2010 shows that 48% of males rejected the idea that women who carry condoms are easy to seduce. The end-line data indicates an increase in this rejection to about 64%. The data for females' responses during the baseline were not available. However, the end-line data indicate about 58% does not believe that women who carry condoms are easy to seduce.

When compared with the number of condoms distributed, we notice a rising trend. In 2011, at least 115,931 condoms were distributed. There has been a 401% increase in distribution from 2011 to 2012. The regional report from 2013 shows a decline in distribution. In the first two quarters of 2013, the distribution has been by 35% of what was distributed in 2012. Over the course of the program, at least 912,184 condoms have been distributed in the region. Generally, there has been an increase in regional distribution.

We anticipate that by the end of 2013, the supply must surpass that of previous years in order to meet demand. Comparing the base- and end-line data, we see a positive trend in condom use and behavioural change. At the baseline, 18% of both males and females had unprotected sex six months before the study. This has significantly decreased to about 7% of males and 4% of females. About 57% of males and 68% of females who used condoms did so to prevent unplanned pregnancies, STIs, and the contraction of HIV.

The FGDs and IDIs revealed a mixed picture of the communities' perceptions of women who carry condoms. The adult males believe that some people, especially those who are not exposed to TMEP, would see her as a 'prostitute'; 'disrespectful'; 'one not to be entertained'; and 'easy to seduce'. However, the same FGDs reveal that members who had attended TMEP activities would see her as 'courageous'; 'one who dares'; 'looks after herself'; and 'not to be feared because she is clean'. The health provider revealed that:

"…Condoms are in high demand; we don't have enough to serve everyone. Thankfully they are available in stores. Otherwise, all that is being taught by TMEP would have gone unnoticed. With such high demand we have had to use a registration system to ration our supply. We give each individual a card that records how many we have given to them" (IDI/HW/Irisya).

Generally, the project annual narrative report for 2012 shows that at least 553,977 condoms were distributed in 2011, this number increased to 1,285,180 in 2012. This increase of about 132% is indeed good progress. Similar positive trends are also clear from the regional reports; we see an increase from 484,365 in 2011 to 847,484 in 2012 and to 490,070 in 2013. Indeed, there is no doubt that if everything remains constant, the figures for 2013 will surpass that of 2012. The 2013 figures presented here are for six months only.

6.6 Other SRH Services

6.6.1 Clinics

The attendance by men to clinics was mentioned in almost all the FGDs and IDIs as an indicator of men as agents of change, which can also signify that men are beginning to change their attitudes. They now recognize that they are supposed to share equal responsibilities with women in issues related to reproductive health, maternal health, and children's health. We find that 79% support the idea of men utilizing PMTCT, as was indicated, for example, in an in-depth interview with a health worker in Mungumaji:

> *"Per month, for example… approximately we see more than 18 men who either accompany or bring children for clinics" (IDI/nurse/Singida Rural*).

When the health care providers in Rukwa were asked whether men are attending the clinics, their responses clearly indicate that more and more men are seen at the health facilities, especially the clinic units.

The evidence collected from the DRCHCo reveals that a tradition exists to acknowledge and appreciate those men who come during the clinic days. A letter of appreciation with the Official Municipal Stamp and a signature by the Municipal Executive Officer is given to men who turn up for the clinics. This letter motivates more men and is highly valued by those who receive it. The content of the letter reads:

> *"…we congratulate you for realizing and caring for the reproductive health of father, mother and child…"* (Section of the Recognition letter)

6.6.2 PMTCT

The number of males and females who went for PMTCT has also increased in both regions since the inception of the project. For instance, in Rukwa only 874 males and 24,189 females went for the service in 2011. The number of males increased significantly by 413% between 2011 and 2012, which is more than five times the male attendance rates from 2011. While this is the picture for males, the number of females attending PMTCT had increased by only 66% between 2011 and 2012. Similarly, the number for 2013 has already shown a significant increase. We see a 2% increase in male attendance rates in the first two quarters of 2013, and a 63% increase for women. Although the number of females for 2013 is still lower than that of 2012, the trend shows that by the end of 2013, more females will have attended the service, assuming everything remains the same. Thus far, 9,940 males and 90,000 females have demanded PMTCT services. This rising trend is an affirmation that awareness of the importance of PMTCT services to both men and women is growing. There is no doubt that TMEP and other stakeholders have to be commended on this.

The figure also shows that the number of men who accompany their partners to PMTCT service has been significantly increasingly yearly since the inception of the project. While we see a trend of more men coming for the service, it became clear from the evaluation that during the farming season men's attendance to the clinics drops. Similarly, most men accompany their partners to the first and last visits only. This issue was raised by the health workers of the facilities we visited. Assuming that this concern is true, it is important to keep educating men on the importance of being involved in issues of reproductive, maternal care, and child health care during the whole process, rather than practicing partial participation. This trend was confirmed by one DCRHCO of Nkasi who said the following:

"We see more men accompanying their partners for the PMTCT service. Although this service is meant for mothers, we are happy that more and more men are coming up" (DCHRCo/Nkasi).

The above facts show progress, but more importantly they represent that the community recognizes that even those services meant for one sex can equally be benefited from by the other. Thus, although the number of men is lower (by about 27%) of that attained by women, the project must appreciate the slight achievements that have been made over the previous figures and be sure to be objective in the next phase.

When we look at the data for Singida, a similar trend in the utilization rate of PMTCT is recorded. There has been an increase of 83% in 2012 among the males and a 319% increase for females. Data for the first two quarters of 2013 are very impressive. Attendance rates for men are 62% of those from 2012, and 70% for females. This progress reflects the positive influence of TMEP campaigns. This is confirmed by one DRHCo participant as follows:

"We are making good progress in terms of people coming for the PMTCT services. We are recording a high number annually, and we are seeing a positive trend in attendance rates. Although we are not sure if it is TMEP per se or world vision, Maria Stopes, the Ministry, and other partners, we know for sure TMEP has been a significant contributor if you consider the massive campaign they are implementing on the ground" (IDI/DCHRCo Singida).

In conclusion, we can claim that by comparing the figures for two regions, Rukwa has higher PMTCT attendance rates than Singida. Singida's attendance rate was only about 71% that of Rukwa. Interestingly, the number of men attending PMTCT in Rukwa is one third that of Singida. Since the number of men attending PMTCT is lower in Rukwa than in Singida, we recommend more efforts should continue to target men in this aspect so that they become authentic equal partners. Despite lapses in some records, the project has influenced increased PMTCT attendance rates to 36,139 men and 134,287 women.

In summary, as the various indicators presented above reflect, the utilization of SRH services by men is increasing. More men were reported to be showing up for the services. In terms of the indicators, if we compare the baseline report, baseline summary, annual reports, end-line, and evaluation data, we see very positive achievements in terms of the targets and indicators that were set at the beginning of the project. Generally, the demands for the services are high; as a result, in almost every case the supply side struggles to meet demand in both regions due to a lack of resources. It is important to note that at this point we cannot account all these positive achievements to TMEP alone. As mentioned throughout the section, parallel interventions have been in implementation in both regions. The government, through the Ministry of Health and Social Welfare, together with other partners such as AFRICARE, JHPiego, Plan International, Marie Stopes, and World Vision are clearly active the ground. However, as the chapter demonstrated, especially through end-line and evaluation, TMEP has clearly spurred raising awareness on SRHR issues and thus increasing demand. In short, the community looks forward to the second phase of the project, as they are pleased with the results thus far.

Chapter Seven: Result Four: Capacity Building

7.0 Introduction

This chapter focuses on the capacity building of the implementing partners and other stakeholders. The focus is to see whether the implementing partners and stakeholders have a strong capacity for promoting gender oriented SHRH issues in order to meet the demand and needs of both men and women in the communities where the project is implemented. The indicators for the result include not only the number of ToTs trained, but also ToTs who are active; the number of teachers trained in SRHR; the number of SRH service providers trained in SRHR; and finally the number of IPs staff and Board members trained in SRHR. In order to achieve the set targets, activities such as refresher training of District and Ward ToTs; training on documentation and dissemination of success stories; training on project planning and proposal writing; supportive supervision from the secretariat and others, such as: the training of RODI board, strategic planning workshops, M&E training and training on masculinity, leadership and gender equality was done. If we refer to the baseline summary report, we see great achievements in terms of all these indicators. However, there are some drawbacks that emerged during the two and a half years of the implementation of the project. The details will be demonstrated in the next sections. The data for this chapter was collected through documentary reviews and interviews with stakeholders, TMEP secretariats, and IPs. Similarly, during the FGDs, we were able to introduce the issues related to the capacity of the IPs in their respective areas.

7.1 Number of TOTs trained and active

The ToTs come from a variety of different backgrounds such as teachers, community health workers, community development officers, and educational officers. Indeed, the evaluation revealed a comprehensive and complete mixture of ToTs from all the possible angles that TMEP can benefit. The project recruited ToTs at both ward and district levels.

The annual reports for Rukwa indicate that at least 95 males and 24 females were trained as ToTs by 2011. The target was thus missed by four ToTs. In 2012, six males and four females were trained. The project did not plan for trainings in 2013. This means since the inception of the project, at least 101 males and 28 females have been trained as ToTs in the region. In every district, there are at least two district ToTs responsible for training the ward coordinators and PEs. The general impression is that the ToTs are effectively carrying out the planned activities, and their efforts are clearly paying off. Since their first training, they have been engaged in a number of activities as demonstrated by one of the Ward ToTs:

> *"We are being trained on TMEP issues; as a health worker I have been training the PEs and offering training in health facilities and schools. I have also been invited at trainings organized at other places" (IDI/ToT/Sumbawanga-Rural).*

The annual reports also show that a total of 167 males and 65 females were trained in Singida by 2011 and 2012, implying that Singida trained more TOTs than Rukwa during this period. We have observed that the majority of the District ToTs belong or work in education, health, or community development sectors, which is a good strategy as TMEP issues clearly fit into these categories. One of the interesting practices in Singida that might be useful to Rukwa is the recruitment of the focal persons. In some districts, these turn out to be trained on TMEP issues but

are also district ToTs. For instance, the Manyoni focal person explained how conversant he is with TMEP project and concepts:

> *"Ever since I attended the training, I have been impressed with TMEP, and it has become one of my priority activities. I always feel indebted if I do not participate in the TMEP activity of the week. Even a simple visit and talk about MI gives me a unique satisfaction" (IDI/District ToT/Manyoni)*

Their ability to build capacity and use fewer resources, while being government employees themselves and thus close to the higher authorities within the local government, are why the focal persons are important resources to use in future plans. The only challenge we see is how best the project can utilize their expertise, while at the same time how they can execute their government related responsibilities. Secondly, there must be clearly defined roles and responsibilities so that they do not end up doing the activities that are meant for district project officers. This was the case in the Manyoni district where the focal person who was also the Community Development Officer seemed more knowledgeable about the project and its logistics than the District Project Coordinator.

It is interesting to note that the project strategically identified and recruited the ToTs. One of the main criteria and expected benefit is to promote TMEP integration in their respective sectors. While this is true, we feel that their retention could pose a challenge for the project. For instance, the District Community Development Officers, District Educational Officers, District Health Officers, and the ToTs who operate at the ward level are often government employees, and are thus subject to transfers to other places for administrative purposes. One way of overcoming this challenge is to inform and train them to be project ambassadors after they move out of the project area. In this way, the project will benefit and expand its coverage.

Therefore, the achievements identified so far in the report are primarily the result of the TOTs' efforts. Interviews with these actors revealed the need for more refresher and re-training courses, as well as regular meetings in order to appraise themselves with new concepts that emerge during the implementation of the project and ensure that everyone is on the same page. There is also a need to retain the TOTs that are being trained. Most are using their spare time in order to work for TMEP, and we must be cognizant and respectful of this fact.

7.2 Number of teachers trained in SRHR

The baseline report points out that there were no trained teachers on SRHR issues. Since the project commenced, significant progress is reflected in the annual report. In Rukwa, the project targeted to train 300 teachers. By the end of 2011, 178 males and 70 females were trained. This is about 83% of the target for the project at large. The target for year 2012 was 100 teachers, but 113 teachers were trained, of which 71 were males and 42 were females. This is impressive since it reflects an over 100% achievement. As a result, thus far 249 male and 112 female teachers are trained on SRHR issues in the region.

Other teachers organize visits and discussions within TMEP clubs. Thus, they are actively continuing to push for the TMEP issues and related programs. This was mentioned by teachers from the Muze Ward. Others organize their own training within schools for other teachers who do not have an opportunity to attend trainings organized by

TMEP. For instance, the Matai ToT who happens to also be a trained teacher trained the head teacher and others who teach science subjects on TMEP concepts.

Interestingly, while there are many success stories from the evaluation study, a mixed opinion on the training of teachers, especially the refresher courses, was expressed, although the team did not visit all the schools. The data indicate that there are some trained teachers who are active in SRHR issues but others who are not. This is particularly true in the Nkasi district where the IDI with the primary and secondary teachers revealed this picture:

> *"…we need to be involved in refresher courses for example, since we were trained in 2011, we never attended any other training session …. I feel that I am not motivated any more, no new skills are taught in classes…they could at least take us to refresher courses…." IDI/Teacher/Nkasi).*

The annual reports for Singida show that a total of 297 males and 250 females were trained on SRHR. This total comes from 97 trained males and 150 trained females in 2011, and 200 males and 100 females in 2012. This is a success story in terms of capacity building in schools, where the majority of youth receive their basic education.

With the exception of the Ipembe and Ilongero Wards, the remaining Wards that were visited reveal a mixed picture of the progress. Some of the teachers were engaged in TMEP activities once, and to some this is only when they were invited for the training. This lack of activity was also demonstrated by the in School Youth Clubs, which only met once or twice over the course of the project. Youth Clubs, which are clearly one of the most effective avenues for introducing TMEP into communities, are not utilized efficiently due to a lack of refresher courses and follow up activities in schools. When the team visited Mungumaji Ward, some teachers commented:

> *"First we were shocked for the invitation; this is the third time we are engaged in TMEP discussion. The first was the initial training and the second was a few days before your visit. It is also the first time we are hearing that HAPA people are also engaged with TMEP" (IDI/Teacher/Singida Urban).*

Therefore, generally we can conclude that although some effort is in place to build capacity in the two regions, progress has thus far been limited in Singida. What we saw in schools in Rukwa including teachers' confidence, success stories, enthusiastic students, and a strong presence of TMEP issues in curriculum, is clearly missing in Singida.

7.3 Number of SRHR service providers trained in SRHR

The annual reports show good progress of the project since it commenced. In Rukwa, a total of 89 males and 124 females were trained on SRHR. The evaluation data indicate that almost all the targeted people for training are aware of TMEP. Indeed, the project captured the important key players at the district level such as DMO, Health Workers, DCRHCos, Community Development Officers and Focal Persons. The IDIs with the District Education Officers, DEDs and DMOs raised a huge demand for the training of more service providers. For instance, the Nkasi District Educational Officer commented:

> *"When you plan for future activities please make sure that even those at the high levels are informed and trained. This will help the project, especially when it comes to mainstreaming*

because if you target the lower cadres who will not attend these meetings, your efforts will definitely take much longer to accomplish the project goals" (IDI/education officer/Nkasi)

Similarly, in Singida about 36 males and 140 females SRH service providers were trained by the project. While this difference between the sexes is significant, it reflects the gender ratios in the health sector for the providers. This is particularly true for the lower cadres where the number of nurses at the clinics surpass that of males. The evaluation data indicates not only a positive outcome but also the commitment of the service providers to the community members who demand the service. In the health facilities that we visited it was clear how motivated they were, especially in conducting the pre-service discussion sessions on clinic days. The presence of the TMEP printed materials is evident in the facilities, but, more importantly, they are being used during these sessions. The most important characteristic was the confidence of the service providers. During the IDIs, their knowledge about TMEP was very good, and we found that they were using the skills they had acquired in training when providing service.

7.4 Number of implementing partner staff and Board members trained in SRHR, by sex

Although the baseline did not have any record of the number of implementing partner staff and board members trained on SRHR during the baseline study, a number of events have occurred since the inception of the project. Annual reports reveal that a total of 21 males and 9 females from HAPA staff have been trained in Singida, while the IP's from Rukwa have received training on SRHR. The documents did not contain detailed information about the content of these trainings. However, the evaluation study, especially with the IDIs and FGDs, revealed not only the effectiveness of the training but also active participation with SRHR issues. If we compare the status of the IPs before and after the project commenced, the evaluation data reveals significant progress. For instance, the IDI with the Secretariat reveals a big achievement in terms of improving the capacity of both RODI and HAPA, establishing and expanding the infrastructure of the two organizations, conducting trainings, and refresher trainings on SRHR chosen topics for discussion. During the interview with the project manager, he illustrated that:

"If we compare the situation now to where we came from, we see a tangible achievement. We have a story to tell in front of the people who work in similar or related issues....our self-assessment tells us that we have grown, our IPs have grown, and their capacity just needs a little polishing" (IDI/Secretariat/DSM).

This understanding was also shared by RFSU consultant. In retrospect, the project has achieved a number of milestones in terms of strengthening the issues related to the management.

The project has also supported the training of seven staff, where five are from HAPA and two are from RODI who attended the M&E workshop organized by University of Dar-es-Salaam. Again, one Project Officer attended training on Masculinity, Leadership and Gender Equality in South Africa. The Secretariat has, over time, engaged in strengthening the Board Members of the implementing partners, especially HAPA and RODI. Through consultancies, the Secretariat has put in place the Board of HAPA and trained on its importance to enhancing the performance of the project. However, the evaluation data reveal an ineffective performance, particularly when pertaining to holding the management committee of the organizations responsible. The evaluation data demonstrate weak boards between the two IPs organization. The IDI with the secretariat indicates that:

"Despite several attempts to convince the IPs of the importance of having an active Board in place that can meet often and make some decisions, the Boards of HAPA and RODI are still quite weak. Similarly, the youth wing is largely lagging behind in that there are no Boards set, and at times these organizations are run by either one or two individuals" (IDI/secretariat/DSM).

While RODI has built much stronger relationships between and among several key players in the chain of implementation, Singida continues to face challenges in this area. In-depth interviews with the Ward Coordinators and PEs reveal a large disconnect between the Regional and District Coordinators with the lower structures.

7.5 Management issues

The management issues are evaluated with a focus on the relationships between secretariat and IPs, IPs and IPs, and one region to the other. Generally, the data indicate that substantial progress has been made around management related issues. The team has a general impression that before the commencement of the project, the IPs had no well-established management structure in the respective communities. Neither RODI nor HAPA had a strong management system overseeing the projects, and as a result, the secretariat had to invest in strengthening the human resource. This issue was raised by the secretariat and also the management of the IPS in both Rukwa and Singida. The IPs openly discussed and acknowledged the input, in particular the trainings, resources and mentorship that were provided by the secretariat. For instance, the program manager of RODI believed that through TMEP they are empowered and can find more potential opportunities to utilize in order to make their organization stronger and engage with the community, government, and other partners. She strongly claimed that:

"TMEP opened our eyes. We see a lot of opportunities out there, we are known, we are approached, we are asked for partnership, and we are growing and expanding our services to other places." (Program manager/RODI)

Similar claims were also made by HAPA's Executive Director. He particularly referred to various trainings and mentorship offered by the secretaries since the inception of the project. Being impressed with the project's concepts, he claimed that they integrate these concepts in the other four projects that they are running in the region. They approach the community through a male's perspective, and this was made possible by TMEP.

Indeed, these are all positive results, as RFSU consultant commented that:

"Great success has been made, but it has been quite a struggle" (IDI/RFSU).

The team was made aware of this past struggle and was also informed about the existing traces of tension around management at the different levels. These struggles have slowed down the development and progress of the project, especially with regards to the collaboration between and among IPs in both regions.

For instance, in terms of the performance and engagement of the youth wing, while YMC is doing a good job in Singida, MWADEMO is clearly lagging behind. One would have expected MWADEMO, which operates in only one district in Rukwa, to be far ahead of YMC, which has to cover three districts. On the other hand, when it comes to the relationship between YMC and HAPA, or MWADEMO and RODI, serious tensions exist. There is a high degree of resentment between YMC towards HAPA and HAPA towards YMC. Similarly, there is a clear tension between MWADEMO and RODI, as well as between MWADEMO and District and Regional Project Coordinators. These

tensions, as mentioned during the IDIs with the Secretariat, have existed throughout the project. Some initiatives are already in place to resolve them but have shown little success thus far. Interviews with IPs revealed how reluctant they are in sharing information and responsibility for activities. One of the cases in point is that often the groups that perform during events are primarily youth groups. YMC believes that they have an upper-hand in controlling and claiming the ownership of activities, while HAPA also believes that, since they have subcontracted YMC, they should have control over activities.

In view of this, while MWADEMO is not performing well in Rukwa and continues to require more support from the District Project Coordinator, in Singida it is a different picture. YMC, although requiring a lot of support in terms of capacity, has demonstrated an eagerness to address TMEP issues. Further, they are more well-known than HAPA within the youth wing. They have integrated some of the TMEP concepts and have registered groups in almost every ward. They have asked for at least 50 hectors of land from the village authorities. Similarly, YMC has asked for more than 500 hectors of land for the organization. Although all this is positive news, the sustainability of these ideas is questionable if deliberate efforts are not made to make sure that the organization has a Board and Full Management Team. YMC has already attracted four other projects due to the commitment of the few leaders. We recommend their participation to be reconsidered in future plans, especially that they be given more tasks and autonomy. However, this needs to happen after an effective functional Management Team is on board.

Similarly, in terms of the relationship between RODI/HAPA with the Secretariat, the evaluation team discovered another underground tension that limits the performance of the project. This tension is more clearly an issue in Singida than in Rukwa. One aspect that requires attention in the future is the need for consensus on the modalities of communication between the Secretariat and the IPs on the ground. RODI and HAPA feel by-passed when the Secretariat communicates with the youth wing in the two regions. Similarly, the IPs feel by-passed when the Secretariat communicates directly with TMEP project staff in the regions. In turn, the management of RODI and HAPA feel excluded when such communications take place.

The management of the project and the implementation by IPs and the secretariat in the second phase could be strengthened by having representative at IP offices. While the secretariat is a much needed structure that overlooks the overall performance of the project, there has to be an immediate structure that helps it. As it stands, the secretariat does more than what it should be doing. In fact, the observed and reported tensions especially in terms of communication could be avoided if there was someone responsible for TMEP project at the regional level. In the current structure, the regional coordinator is also serving as a district coordinator. For Singida the coordinator is also serving as health manager under HAPA structure. This implies more responsibilities under one person and tensions on her. While the Rukwa regional coordinator is responsible for TMEP project only.. One way to avoid this is to have a regional coordinator who oversee the performance of the district coordinators as well as report to the secretariat. This will improve the performance at the regional level but also bring a positive relationship between the regions and the secretariat as all the information has to be channelled through him or her.

The new structure will make each level perform better and the accountability more visible and executable. For instance, the flow of responsibilities will be clearer from RFSU-Secretariat-TMEP regional coordinators-District coordinators-ward coordinators and the rest at the very lower level. A chain of command will also be clear and this structure will make it possible to see the strength and weakness in terms of performances. Generally, the idea is to

avoid double responsibilities that hinder the performance of the project and that bring confusion when it comes to accountability, effectiveness and close monitoring.

Indeed, some polishing is needed in methods of collecting, compiling, sharing, and using the data. As a result, the M&E unit has to be strengthened. For instance, one of the challenges for the evaluation was to have a reliable database that was consistent throughout this study. If we compare the utilization of SRHR data from the DMOs with what is compiled and shared with the consultant team, the difference of figures raises considerable doubt. It is surprising that the total sum of data for the district is higher than that for the region (Refer to the utilization of the SRHR services with the REACH table). These are the areas that the M&E officer has to focus on in the future. Indeed, having accurate and reliable data is in itself a big step during intervention. Thus, we recommend further scrutiny of the data that is submitted to the Secretariat from the two regions. It is essential to have close monitoring of data that comes through project staff. A parallel mechanism must be put in place in order to check the accuracy and reliability of the data from government units providing SRHR services, such as district and regional health facilities. In fact, it will require minimal time, effort, and resources to collect data immediately at the health facilities, which are located in every ward where there is a project coordinator. Since the health providers of these facilities are trained, it will likely be more effective to work with them, pull the data from their records, and share directly with district, regional, and the Secretariat. However, prior permission must be sought as this is government data, which will later be shared with many other partners. We also understand that the project, and in particular the secretariat, has made significant effort to put in place the mechanism for collecting data from the health facilities which did not bare positive results. With more training in the second phase, we hope the health providers at these facilities will recognize the importance of having clean and reliable data in their daily implementation.

Generally, at the national level it is indicated that there has been a number of capacity building activities that have been implemented on the ground. On the one hand, these efforts range from Secretariat trainings of the IPs and the opportunities that have been created by the Secretariat and provided to the members of the IPs. These trainings include dissemination and documentation. Others include the training of RODI and HAPA Board members and provision of office equipment to RODI and HAPA as well as to MWADEMO and YMC. This is in addition to procurement of office building for RODI. Furthermore, TMEP supports office running in Manyoni (Singida) and Nkasi (Rukwa), strategic planning workshops, M&E trainings, as well as training on project planning and proposal writing—through which six proposals have been developed. TMEP also supported the establishment of an accounting system to HAPA and RODI through procurement of software and training of their accountants.

Some of the success stories include the ability of HAPA to include concepts of Male Involvement in their other projects though the male centred approach. This reflects the influence of the TMEP project on other HAPA projects. YMC also integrates and uses TMEP concepts, especially with the youth groups in order to provide a base for establishing income generating activities. Indeed, this is a positive sign as it improves the sustainability of the project.

Based on the above evaluation, we strongly believe that the project has delivered value for the money spent. Indeed, the IDI with the project's accountant at the secretariat and HAPA indicated how the project's money and other resources are well spent. Thus, the value for more than 40million SEK that is invested in TMEP is clearly seen on the ground. The activities budgeted for are implemented, as a project accountant claimed that:

> "…comparing what we have invested and what we have achieved, we say that we have achieved more than what we expected." (IDI/Project accountant/DSM)

Indeed, with monthly reports and a general review of the project's planned activities and budgeted related issues in November of each year, it is clear that not only the money will be spent but that the planned activities are finally supported and money allocated will be spent accordingly. Since what is budgeted is what the money is spent for, the desired objectives finally are achieved as demonstrated in 2011 and 2012.

The auditing reports further reveal how the donors' money is spent. While in the first year there were some minor queries, the second and third year shows a meaningful progress. This progress is made after experience is gained and a clear accounting system is in placed in both Rukwa and Singida.

Based on the reports, interviews and the observation with the accountants in general, we see a thoroughly coordinated flow of resources. As explained to us, there were no delays of funding from the donors, similarly the accountants in both RODI and HAPA did not mentioned anything related to delaying in disbursement of funding from the project accountant. This being the case, the performance of accountant as well as the confidence is somehow unbalanced between Rukwa and Singida. Perhaps as project moves to the next phase, the Singida accountant could be given more exposure and training to cope with the pressure experienced within HAPA as a relatively bigger organization. Similarly, the secretariat could also negotiate with the HAPA management the modalities for giving the TMEP accountant more freedom. So far she has to go through a very bureaucratic management structure if she wants to draw project money for planned activities. All in all, the money requested and availed was used for the planned activities the proof being the many success stories on the ground. No ward coordinator complained of delays of their incentives which is already a good sign.

Chapter Eight: Result Five: Advocacy and Mainstreaming

8.0 Introduction

This chapter addresses Result 5 of the project, which concerns advocacy and mainstreaming. It also answers the performance question for male involvement and the integration of gender oriented SRHR into plans and activities of national government and civil society organizations. The team collected data from project documents and the baseline, annual, and evaluation reports. If we compare the baseline study to the end-line study, we can conclude that the project has made impressive progress since its inception. The project's progress so far demonstrated in this report is the result of the efforts of the IPs in the respective districts and communities. Generally, the advocacy activities targeted both district and national levels. While the IPs at the district level are expected to take a leading role in advocating TMEP related issues in their respective areas, the Secretariat's responsibility is to deal with the potential Government Ministries that would integrate TMEP concepts into government policies, guideline and laws..

8.1 Number of district authorities integrating male involvement and gender oriented SRHR concepts and activities into their plans

The baseline report had no data for district authorities that have been directly trying to integrate MI and gender oriented SRHR concepts in either Singida or Rukwa. The annual reports, however, indicate that there has been progress since the inception of the TMEP in the project regions. The Reach Table data for Rukwa indicate that a total of three district authorities have been involved in integrating MI and gender oriented SRHR concepts and activities in their plans. The evaluation data indicate a number of initiatives that have been implemented so far to integrate MI and gender oriented issues into district and Ward plans. These were discussed in interviews with the Ward Executive Officers. Similarly, Councillors also demonstrated in their interviews how they invited TMEP Coordinators and PEs into their meetings to demonstrate TMEP issues. In Sumbawanga one of the Councillors commented:

> *"…during ward development committee meetings, we invite TMEP representatives to introduce issues related to their plans. This makes it easier for some of us to then push into the agenda. This approach works better than relying on sensitizing the community" (IDI/Councillor/Sumbawanga).*

At the district level, some of the activities targeted CHMTs. During their meetings, the focal persons would attend and introduce TMEP concepts. Although it is difficult to substantiate the effect of this practice, the IDIs with health workers indicate some progress in the integrating of TMEP issues into their activities. Nkasi DMO also indicated how he was trying to integrate TMEP concepts in his plans. We find it significant to point out that during his regular meetings with health workers he uses some of the TMEP concepts as tools for improving their performance.

Despite the progress noted above, in Rukwa, for example, advocacy was conducted by the TMEP secretariat whereby 14 NGOs, including AFRICARE, Council Representatives, and Rukwa Press Club, were invited. The workshop enabled the formation of the Rukwa Network, which was planned to address the issue of MI in the region**.** Similar achievements are also noted in Singida where about three district authorities have integrated MI and gender oriented SRHR concepts. For instance, the interview with the District Education Officer indicates:

"We are integrating TMEP issues into our plans. Although a lot of things are not formal, we informally discuss and invite TMEP concepts in the areas that are related. We are seeing how TMEP has advocated for the prevention of unplanned pregnancies and we are seeing a positive result in that the number of pregnancies in schools is going down. In fact, we haven't seen many cases so far" (IDI/District Education Officer/Singida).

The discussion with the District Education Officer of secondary education for Singida Rural also confirmed such progress. He went further to illustrate his point as follows:

"It is not only about school pregnancies. If we compare the performance and confidence of the pupils who are in TMEP clubs to those who are not, you clearly see how TMEP has contributed" (IDI/Education Officer/Singida).

The lack of willingness and acceptance of TMEP was clear in some of the wards where the team found it difficult to find enough in-school youths to be interviewed. This was in part due to the fact that these interviews took place during school holidays. However, when we asked the teachers to help in the recruitment of students to take part in the research, it did not take long to find them. Indeed, in the opinion of the teachers, classes could be cancelled for TMEP activities because they knew that at the end of the day the students would have learned meaningful lessons.

The integration of TMEP concepts and MI into district plans was further confirmed by the Manyoni District Focal Person:

"As the community development officer, I am pushing for the integration of the TMEP issues into the district plan. It is not an easy task, but we are slowly talking the same language with colleagues who make decisions. When we discuss reproductive health issues and budgets, I always bring in the same TMEP concepts." (IDI/Focal person/Manyoni).

Also, the Community Development Officer of Nkasi District informed us during our interview with him that the Nkasi District Council had already budgeted funds for implementing many things that are being advocated by TMEP in the 2013/14 budget year. This is indeed an affirmation that at least in this district, the District Council is serious in mainstreaming what TMEP advocates.

Furthermore, officials at the police gender desk for Rukwa are not only aware of, but often use TMEP concepts during competitions, which led to a victory for them (ref. chapter three). The police gender desk uses TMEP concepts, especially the printed materials, in educating partners who are in conflict. According to the IDIs, it helps to make their work much easier. Similarly, the IDI with YMC revealed that they are pushing for more funding for youths, with the intention that at least all the district authorities should raise the annual budget for youth related activities from 5% to 10%. For instance, he illustrates:

"We push for more budget allocation for youth; we want them to rise from 5% to at least 10%. Importantly, we want to see that this money is allocated and used for the activities it is planned

for. We have been doing this and we are seeing some positive results. It takes time and collective efforts (IDI/YMC/Singida).

Therefore, if we consider the status of the SRHR projects in the two regions from the baseline to the end-line, we see good progress in terms of advocacy. However, the project needs to push for more mainstreaming of SRHR issues in order to have better results. This is particularly true for Singida. The same effort used in advocacy can be used in mainstreaming. The awareness of the project is generally high; the evidence of the recognized relevance of TMEP is also unquestionable. What is needed is to have more resources for mainstreaming, which will later ensure the sustainability of the project.

8.2 Number of TMEP advocacy events targeting policies, plans or guidelines

As mentioned earlier, the project has made significant progress in terms of targeting policies, plans, and guidelines compared to the baseline where there was no information on SRHR issues. While the advocacy officer has been dealing with the national partners, the IPs have overtime engaged with advocacy at the district and lower levels. As a result, at least some government ministries, such as those of Education and Health, are not completely unaware of TMEP. However, it seems that the project did not do enough to engage the important partners in Government, especially the Ministry of Community Development, Gender and Children. Some efforts have been made to bring on board the Ministries of Health and Social Welfare and recently the Ministry of Education and Vocational Training. While it is true that SRHR issues touch the two ministries, it is also important to consider other Ministries. However, IDIs with the advocacy officer reveals:

"…first there is limited budget for the national level events; and second, meeting the timeline is the biggest challenge when dealing with the policies. Some of the policies are only reviewed after a set period. Thus, no matter how one pushes for a review, at the end of the day it will have to wait until the government procedures are followed, and the need for such a review becomes evident" (IDI/secretariat/DSM).

The deficit in the national advocacy is something that is not unique to a project or organization. It seems other organizations also experience similar encounters. While TMEP advocacy officer shared his concern, the representatives from Health Promotion Tanzania organization and Engender Health all raised similar issues. Indeed, RCHS director who is from the government revealed as to why it is costly to deal with the bureaucrats. She explained:

"We need more meetings to unpack the policies, plans and guidelines that can accommodate TMEP concepts. It is okay approaching the lower levels, but at the end of the day the decisions are made at the national level. One of the targets could be to identify some key players at the national level to make the project known and sustainable. Thus, there has to be a mechanism to engage the national key players from the beginning. We know that the government is not so keen to change the policies but the partners have to plan their agenda beforehand, rather than waiting to see the result in one or two years" (IDI/RCHS/DSM).

Her views clearly show as to why the advocacy is so costly in terms of time and resources. While at the national level there are only a few events, in Rukwa, for example, over the three years of project implementation, there

have been a number of TMEP events that have been advocating for and targeting policy, plans and guidelines. There have been about 10 events in total. These include: organizing Police Jamii Football Bonanza, participation at the national events occurring at the regional level such as Local Government Authorities, and also participation on the women's day whereby TMEP was to design a program of commemorating the Women's Day. These have been the platform from which TMEP issues are advocated and mainstreamed. We strongly commend these efforts/initiatives, and we believe Singida can also reproduce what is happening in Rukwa.

8.3 Number of national government policies, plans or guidelines changed to include male involvement and gender oriented SRHR concepts and activities

Data from the evaluation indicate a need for more effort at the national level in advocating and mainstreaming male involvement and gender oriented SRHR concepts. The partners' views are to focus on developing tools and plans rather than the general policy document. With this strategy, it will be easier to see the results of involving men in a short period of time with fewer fiscal resources. A discussion with one of the TMEP partners from the Ministry of Health and Social Welfare revealed the following:

> *"...you know reviewing the health policy takes time and money. However, developing specific tools of actions for the national guideline will push things along quicker with better results…" (IDI/RCHS/DSM)*

This concern was also raised when the team had a discussion with the policy implementers from the Ministry of Education and Vocational Training:

> *…it's hard to change the curriculum, but it is easy to review the syllabus from time to time whenever the need arises…after our field visit, we have seen what is happening on the ground, we have seen the relevance of the TMEP in schools, we promise revisiting the guidelines and plans so that it can accommodate TMEP issues (Inspector of education in Tanzania).*

The IDIs with the Secretariat show that the advocacy activities require more resources than the current allocation. The planned activities at the national level do not only require more funding but also time, commitment and tolerance. This was expressed by one of the TMEP advocacy partner that TMEP could further learn from their 'direct approach' where they bring together key players who are asked to form clubs, which are then supported. She explained her views as follows:

> *"Usually what we do is use a direct approach where we go to the parliamentarians or councillors and ask them to form reproductive health clubs. For us it becomes easier to support them through these clubs and they also become our ambassadors when they go back to their constituencies. Importantly, it is easier for them to push for reproductive health when they attend the decision making meetings" (IDI/Partner/DSM).*

Since the issue of resources came not only from TMEP advocacy officers alone, there has to be deliberate efforts directed to the allocation of more resources in the future. Indeed, the partners we interviewed, such as Femina, Health Promotion Tanzania, Champion, RCHS, Ministry of Health and Social Welfare, and the Ministry of Education and Vocational Training agreed with the need to have enough resources for advocating TMEP ideas and issues. They all agree that good advocacy strategies require sufficient resources.

During the interview with the Secretariat, the fact was highlighted that the focus has been on dialogues with decision makers at the national level, especially with the decision makers from the Ministries of Education and Vocational Training and the Ministry of Health and Social Welfare who had an opportunity to visit the regions. One key Ministry that should certainly be the leading pioneer of TMEP issues is the Ministry of Community Development, Gender and Children Affairs. It is still unknown to us why this Ministry has not been reached. It is important to make sure that this Ministry is reached and becomes one of the leading key players in not only advocating TMEP issues, but also in enacting policies, plans and laws that can ensure TMEP aims and objectives become a reality.

According to the Secretariat, TMEP also meets with other partners, especially through Men Engage Network, which has more than twenty members. The Men Engage Network provides an avenue for policy dialogues, especially for the National SRHR Policy Guideline and the training manual for adolescent reproductive health. While this is true, the IDIs with partners who are engaged in this network indicate that:

> *"TMEP came on board late, they are supposed to be the pioneers of the network. However, they are just like other members. In the future they need to host and even push for more agendas as males issues nicely suite in their activities. We would like to see this network become more active, and we think TMEP can be in a better position than the rest of us who are more accommodative to almost everything" (IDI/Partner/DSM).*

Thus, the above discussion suggests the need for more efforts directed at future advocacy and mainstreaming of plans. The IDIs along with the partners, especially government officials, reveal a willingness to have a policy and to have the MI guidelines integrated into different plans. Furthermore, TMEP needs to synchronize and harmonize its activities to cater for government efforts to reduce maternal mortality. There are numerous partners in this area, and it is important for TMEP to work with other NGOs as well as UN organizations such as UNFPA, UNESCO and UNICEF, which are also advocating a similar cause. This approach will easily influence and convince the government to be a key player in reproductive health issues. There also must be deliberate efforts aimed at improving the collaboration of other partners to ensure the mainstreaming and advocacy of SRHR issues.

In summary, while the advocacy strategy is demonstrating a number of positive results at the district and ward levels, more work needs to be done at the national level. Almost all partners we have interviewed have expressed how partial they are to TMEP. Indeed, most of them are willing to work and even eager to know more about TMEP. We certainly recommend that TMEP should take advantage of this opportunity and the willingness of these partners in order to advance TMEP's agenda. Femina appears to be more informed about TMEP than other organizations. Reaching more than 2,436 schools in 2011 and 2,498 schools in 2012, Femina is accomplishing a lot among youth. In fact, sexual and reproductive health is one of the three agendas they deal with. Thus, as already demonstrated, TMEP's engagement in their series proves to be yielding positive results in the two regions. It is clear from the findings that most of the partners have learned of TMEP through MenEngage Network, which is another important avenue for advocating the project. In terms of the two regions, there is no doubt that Rukwa is doing significantly better than Singida. The data indicate that generally the government in Rukwa is more familiar with the project than that of Singida. Indeed, YMC is doing more advocating for project related issues than HAPA

and has therefore reached a larger population through its various activities. While we were in Singida, it was clear to us that YMC was more prevalent in the communities than HAPA.

Chapter Nine: Conclusion and Recommendation

9.0 Introduction

This chapter summarizes the key findings, offers recommendations, and highlights what one could consider the best practices. In brief, our aim is to present our final assessment and demonstrate whether the following have happened or not during the last three years of TMEP implementation. A key issue in this chapter is to evaluate whether there has been an improvement in the participation of men in promoting SRHR and gender oriented issues:

9.1 Conclusion

- Generally, there has been tremendous progress in terms of men becoming agents of change. The evidence of men engaging and supporting their partners is undoubtedly high in both regions. The number of men trained as SRHR PEs in both regions, as well as their attendances in promoting SRHR activities, is very apparent. Thus, the trend clearly shows progress and enormous achievement since the commencement of the project in the Rukwa and Singida regions.
- The project has raised awareness and also changed the behaviour of men. Importantly, chapter four has demonstrated the active engagement of men in promoting SRHR issues. This engagement is demonstrated by their attendance to group and individual SRHR information sessions and dialogues. The data indicate that the community is changing and is beginning to question the traditional beliefs and practices of male dominance not only in the domestic sphere of life but in the public one as well. An interesting new challenge that the project has to address is how to balance the behaviours of male dominance and the reluctance of women to agree and adapt to changes that are introduced by TMEP.
- When comparing the findings of the end-line study between the two regions, there is a slight difference in terms of performance. As said earlier, there are many parallel interventions being implemented in Singida. The region has more partners who have been working for decades on health issues. Similarly, its geographical location is more favourable than Rukwa's. For instance, the Manyoni district is less than 150 kilometres from Dodoma, the capital city of Tanzania. Almost all the traffic that goes to Mwanza, Tabora, Kigoma, Kagera, and other regions pass via Singida. The region is also less than 200 kilometres from the Arusha and Manyara regions. As a result, it has been benefiting from interventions that take place in other regions. Thus, it is evident that more interventions that complement what TMEP does are being carried out in Singida than in Rukwa.

  The Rukwa region is indeed isolated, and to date is not easily reachable. Besides TMEP there are very few players on the ground implementing interventions similar to TMEPs. Recently, AFRICARE, Plan International, and JHPIEGO entered Rukwa and have begun working. Some organizations such as AFRICARE are employing many PEs that have been trained by TMEP. Certainly, the comparative advantage that Singida has should make work much easier for HAPA than for RODI in Rukwa. In this case, one would expect TMEP to perform much more wonderfully in Singida than in Rukwa. Unfortunately, that is not the case.
- Generally, with high utilization of the SRHR services, the evidence, as highlighted in the previous chapters, suggests that all these efforts will contribute to reducing maternal deaths. For instance, both regions have reported reduced cases of unplanned pregnancies, increased demand for FP services, and increased male participation on issues that are traditionally viewed as the domain of women. The findings show that most

women who were pregnant were receiving significant support from their partners. All of these components have influenced positive changes and results in the maternal health arena in the region.

- The sustainability of the project is another aspect that has been discussed in this report. Indeed, as the findings suggest, government officials in Rukwa at almost all levels are aware of TMEP. However, deliberate efforts must be made in Singida to increase the local government's awareness of the project. The IPs need to advocate for the project if in the future the ownership of the project is to be handed to the community and the local authorities.
- The findings further revealed that there is social accountability in both project regions. When the service is substandard and/or not available, the communities could easily make demands that their needs be met. For instance, some of the service providers have been held accountable for poor service or lack of resources. While true, as demonstrated in chapters four and five, the supply side requires equal attention in the future in order to have a balanced provision of the service. All the health providers we talked to raised serious concerns about meeting the huge demand increase influenced by the project. TMEP and other interventions that are taking place in Rukwa and Singida have raised awareness, which in turn is raising demand for services. If this rising demand is not matched with a reasonable supply of services, there is a higher chance of people becoming demoralized.
- The policy and practice as the last result in the log frame requires some serious consideration. Almost all the interviews we conducted with the partners indicated a need to see more TMEP volunteers taking active roles in the available opportunities. With an exception of Fema who are seemingly informed about TMEP, more networking is needed especially at the national level through advocacy. The government officials who were interviewed were impressed with the project, especially after the site visits. However, they raised the concern that this came too late and that all these efforts would have made sense if they were practiced from the beginning. Thus, the advocacy unit must use a different strategy to capture more attention of the policy makers. One of the options is to have TMEP clubs at various levels as is practiced by other organizations.
- In summary, the findings from the two studies (end-line and evaluation) have shown and demonstrated not only the achievement of the project but that the activities that were indicated and planned for in the project document have been implemented. The team did not see any monumental variations in terms of what was planned and what is implemented. This consistency in terms of implementation has largely contributed to the noted higher performance of the project in both regions. Thus, we can say that what TMEP project has done during the last three years is worth donor's money. The achievements confirm the value for money as the project utilized resources requested and availed. The funds were disbursed timely and in case of any delays an immediate communication was made between and among the partners. Generally there was no activity that has failed due to funding related issues. By changing people's lives, the money investment by SIDA is reaping very positive results. We must commend the donors for supporting this important endeavour.

9.2 The general recommendations:

9.2.1 TMEP needs more time to reach more of the population. The utilization of the SRHR services will hardly be equal with that of women because a lot of what is happening in these communities is historical. For decades, interventions have focused on women; thus, changing these understandings in less than five years is a daunting task.

9.2.2 The project needs a new approach for retaining, recruiting, and motivating PEs. The experience of Rukwa has so far shown how much potential PEs have in contributing to project goals and how other

organizations are utilizing them. Agreements must be made with other organizations that use TMEP PEs. Thus, joint incentives or agreements that monitor and regulate outside organizations' use of TMEP PEs must be implemented.

9.2.3 Having seen the importance of having project offices in the wards, we recommend that the Ilongero ward which has an office demonstrate how they mobilize the resources and influence the local authorities for project space within limited resources.

9.2.4 Perhaps in the future, the recruitment of the Ward Coordinators should be given priority and not left to the local authorities alone. One can clearly see that it is the personal initiative of the coordinator that influences the performance of the project with each ward.

9.2.5 We recommend that YMC and MWADEMO be strengthened to be able to stand alone and run the youth wing than relying on RODI and HAPA which have their own managerial challenges. Thus, in the second phase the sub-contracted organizations should be supported more.

9.2.6 Regular training for TOTs is needed and will enhance their abilities to educate and reach more population.

9.2.7 There is also a need to share and plan for more activities that can reach more people like distributing more fliers, organizing and supporting sports events as well as attending the public meetings and pushing for an agenda in these meetings as demonstrated in some wards.

9.2.8 There is a need for serious contemplation regarding how the secretariat operates and relates to the IPs in the second phase of the project. The tensions, flow of information, and communication practices need to be thoroughly handled. The Secretariat has to make it clear to the IPs that it has a mandate to decide and communicate to any of the TMEP employees, whether be it with HAPA or RODI.

9.2.9 One issue of great concern is how to make HAPA an effective player in order to make sure that TMEP performs as well in Singida as it did in Rukwa. It is possible that there is an urgent need to re-organize the TMEP section and how it operates within HAPA. There appears to be a major weakness with those who are responsible for TMEP within HAPA.

9.2.10 Since there is some doubt on the data from the IPs, the M&E department should make a deliberate effort to follow up on the data collection and compilation. This will improve the performance as well as help the planning in the future for the project.

9.2.11 TMEP achievements in these two regions clearly confirm that it is possible to change men's mentality towards gender inequality. We are beginning to see positive results in both Rukwa and Singida. RFSU should mobilize resources to enable a possible second phase for TMEP..

9.2.12 The other area that needs further inputs is the national level advocacy. As mentioned earlier that while the IPs are doing impressive work in the districts and wards, the national level advocacy need further support especially in accomplishing the planned activities. The experience of NGOs we visited shows how hard bringing the national level players on board is, perhaps the advocacy unit can have more sessions and discussion with these NGOs to learn from them. Similarly, it can have more sessions and meeting with the influential players such as policy and decision makers and bring them to the field to see by themselves the good work that is done in the two regions. In fact, our discussion with the representatives from the Ministries of education and health touched the point of having these regular visits.

Annexes:

Annex 1: Questionnaire for End-line Study Project on Tanzanian Men as Equal Partners (TMEP)

Questionnaire No……

Section 1: RESPONDENT'S ID

1.1	Identification number of respondent (ID No.)	
1.2	Date of interview	|_ |
1.3	Interviewer's Code number	|_ |
1.4	Region 1=Rukwa; 2=Singida	|_ |
1.5	District (Write name)	|_|
1.6	Ward (Write name)	
1.7	Village/Street (Write name)	
1.8	Hamlet (Write name)	
1.9	Balozi (Ten cell leader-if known)	

Section 2: DEMOGRAPHIC INFORMATION

2.1	Sex 1=Male 2=female	|_|
2.2	Age	|_|
2.3	Marital status 1=married; 2=single; 3=Widow/widower; 4=Separated; 5= Cohabiting	|_|
2.4	Have you had a formal education? 1=Yes; 2=No; 9=NK	|_|
2.5	What is your level of education? 1=primary; 2=secondary; 3=College; 4= University; 5= adult education; 6= Religious education	|_|
2.6	What is the main way in which you earn your livelihood? != Farming : 2=Tending; 3= Livestock; 4= Small Business; 5= Large business 6;=Professional; 7=Driver 8= Skilled Manual Worker 9= Unskilled laborer;10= Fishing; 11=Bar Work; 12= Other (Specify)	|_|
2.7	Where did you live before moving here?	

	1=other part of the Ward;2=Another part of the district outside the Ward ;3= Rukwa/ Singida town; 4=Another part of Rukwa/ Singida Region; 5=Another part of Tanzania;6=Another country;7= Always lived here	|_|
2.8	What type of place was it? 1=rural- remote;2= rural on Main road;3= Urban	|_|

SECTION 3: PERFORMANCE QUESTION RESULT ONE

"Men as agents of change: the performance question tries to answer the extent to which men have become more involved in SRHR, how, and to what effect **"**

3.1	Have you ever heard about SRH Rights? 1= Yes 2= No	|_|
3.2	From whom/where did you hear? 1= TMEP 2= Other -- specify	|_|
3.3	Did you participate in SRHR session in the past 1 year 1= Yes 2= No If no skip to 4.4	|_|
3.4	Who organized the session 1= Peer educator 2= Teacher 3= Ward coordinator 4= Health provider 5= any other, specify	|_|
3.5	What was the session about 1= family planning 2= male's involvement in SRH 3= gender based violence 4= sexual reproductive health 5= sexual reproductive health rights 6= any other, specify	|_|
3.6	Was the session helpful? 1= Yes 2= No	|_|
3.7	If yes give reasons……	
3.8	If no give reasons ……	
3.9	Did it inspire you visit the session 1= Yes 2= No	|_|

3.10	Did you visit the SRH services after the sessions 1= Yes 2= No If yes mention ……. ……	|_|
3.11	For whom do you think SRH Rights are relevant? 1= Unmarried People 2= Married people; 3=Men: 4= Women; 5= Every Individual; 6= other (specify)	|_|
3.12	Have you seen more men going for SRH services/ issues in the past 6 months 1= Yes 2= No	|_|
3.13	Can you confidently discuss the SRH services with peers? 1= Yes 2= No	|_|
3.14	Did you discuss the SRH services with your partner in the past 6 months? 1= Yes 2= No	|_|
3.15	Did you discuss the SRHR issues with your partner in the past 6 months 1= Yes 2= No	|_|
3.16	Can you allow your partner to attend the SRH services 1= Yes 2= No	|_|
3.17	Can you confidently walk to the SRH services and demand the service? 1= Yes 2= No	|_|
3.18	If a man is engaging in supporting a partner on household domestic chores how would his community look at him? 1= coward; 2= un caring; 3= caring; 4=brave;	
3.19	Do married women have a right to decide about their SRH including decision to conceive or not without necessarily getting consent of their spouses? 1= Yes 2= No	|_|
3.20	Would you think women have a right to deny sexual intercourse if they do not want to have one even if with their husbands? 1= Yes 2= No	|_|
3.21	Whom would you blame for unplanned pregnancy? I. A woman who conceived II. A man who made the woman pregnant III. Both, the woman and the man IV. None V. Others, specify----------	|_|

3.22	Can you confidently walk to a SRH or HIV/AIDS clinic and demand to have a service you want and get it if available? 1= Yes 2= No 3= Not sure	|_|
3.23	How would you feel if you are seen as a man attending a SRH clinic for a service? I. He is exercising his right II. He is lost to a women place III. Perhaps something is wrong with his life style IV. Others – specify	|_|

SECTION 4: PARFORMANCE QUESTION RESULT TWO

"SRHR information: the performance question requires us to understand if the SRHR information and dialogue has improved due to TMEP"

SRHR INFORMATION : AWARENESS AND KNOWLEDGE		
4.1	Have you heard about where SRHR services are offered? 1= Yes 2= No	|_|
4.2	From whom did you learn about SRHR? I. 1= Health Provider 2= Peer educator 3= Community volunteer 4= Print educational materials 5=From radio/television 6=From folk media 7=Others, specify	|_|
4.3	For whom is SRHR services relevant 1= men; 2= women: 3= girls ; 4= boys ; 5: all of the above	|_|
4.4	Out of the following groups whom do you think should access SRH rights information and related services and whom should not? I. HIV positive 1= Yes (should) 2= No (should not) II. Homosexuals 1= Yes 2= No III. Unmarried 1= Yes 2= No IV. Commercial sex workers 1= Yes 2= No V. Students 1= Yes 2= No	|_| |_| |_| |_| |_|
4.5	Who shall make the decision on SRHR services 1=Men 2=women	|_|
4.6	Would you agree to see young people making own decision regarding whether to marry or not and whom to marry without necessarily getting concert from their parents? 1= Yes 2= No	|_|
4.7	Would you think both men and women have a right to deny sexual intercourse if they do not want to have one even if with their husbands? 1= Yes 2= No	|_|

SECTION 5: PRACTICE AND BEHAVIOR RELATED TO SRH& SERVICES		
5.1	Have you ever had sexual intercourse? 1= Yes 2= No **if No, move to question 4.5**	|_|
5.2	Have you ever had un protected sex during the first six months? 1= Yes 2= No	|_|
5.3	What scares you from unprotected sex? 1= unplanned pregnancy; 2= STIs; 3=HIV; 4= all the above equally i.e. pregnancy, STIs and HIV; 5= not worried	|_|
5.4	Men scared of both, infections and un planned pregnancies from unprotected sex 1=Yes 2=No	|_|
5.5	During the past 6 months, have you been forced by someone of same sex to have sex while you did not want to have it? 1= Yes 2= No	|_|
5.6	During the past 6 months, have you been forced by someone of the different sex to have sex while you did not want to have it? 1=Yes 2= No	|_|
5.7	Have you ever been confronted with someone about your gender rights in the past 6 months? 1= yes 2= No	|_|
5.8	Have you ever been involved in gender based violence during the past 6 months 1=yes 2= No	|_|
5.9	Have you ever been involved in sexual violence either as a victim or culprit in the past 6 months? 1= Yes 2= No	|_|
5.10	Have you ever had discussion with your partner on SRH rights during the past 6 months? 1= Yes 2= No	|_|
5.11	Have you ever undergone HIV test? 1= Yes 2= No	|_|
5.12	If NO why? 1= My partner/spouse had checked so I do not need; 2= Service not available; 3= I am scared to know my sero-status 4= Never had opportunity to have sex; 5= Other, specify	|_|
5.13	Would you allow your partner to undergo HIV testing 1= Yes; 2= No	|_|
5.14	If NOT why?	

	1= It scares me; 2=may cause my relationship to break; 3= it is costly to access service; 4=the counselors may want me to go as well and will not be ready for it; 5= others, specify……	|_|
5:15	Have you ever had sexual intercourse under alcohol influence? 1= Yes; 2= No	|_|
5.16	Have you ever had multiple sexual partners during the past 6 months? 1= Yes; 2= No	|_|
5.17	How do you support your spouse to ensure you have safer sex? 1= ensuring contraceptives are used; 2= ensuring we always have and use condoms; 3= I avoid other sexual relations; 4= ensuring all of the above; 5= Abstain from sex; 6= others, specify……	|_|
5.18	Where do men go for condom supply in your community? 1= SRH clinics; 2= shops/kiosks; 3= From community health educators; 4= Peers; 5= others, specify……	|_|
SECTION 6: SRH ATTITUDES AND INEQUITABLE GENDER NORMS		
6.1	Do you agree that all persons have the right to access to reproductive health care services 1= Yes 2= No	|_|
6.2	Men are always ready to have sex 1= Agree 2= Disagree 3= Don't Know	|_|
6.3	Men need other women even if sexual relationship with his wife/girlfriend is fine 1= Agree 2=Disagree 3= Don't Know	|_|
6.4	Men need more sex than women 1= Agree 2= Disagree 3= Don't Know	|_|
6.5	You do not talk about sex, you just do it 1= Agree 2=Disagree 3= Don't Know	|_|
6.6	Women who carry condoms with them are considered to be easy to seduce 1=Agree 2=Disagree 3= Don't Know	|_|
6.7	It is the responsibility of women to ensure pregnancy protection 1= Agree 2= Disagree 3= Don't Know	|_|
6.8	(If I had sexual partner) I would be outraged if my partner asks me to use a condom 1=Agree 2= Disagree 3= Don't Know	|_|
6.9	Woman's most important role is to take care of her home and cook for her family 1= Agree 2=Disagree 3= Don't Know	|_|
6.10	Changing diapers, giving kids bath and feeding the kids are mother's responsibilities	

	1=Agree 2= Disagree 3= Don't Know	|_|
6.11	A Man should have final word about decisions in his home 1= Agree 2= Disagree 3 = Don't Know?	|_|
6.12	If someone sexually insult me, I will have to defend my reputation with force if I have to 1= Agree 2= Disagree 3= Don't Know	|_|
6.13	There are times when a woman deserve to be beaten 1=Agree 2=Disagree 3= Don't Know	|_|
6.14	A woman should tolerate violence in order to keep her family together 1= Agree 2=Disagree 3=Don't Know	|_|
6.15	It is okay for a man to hit his wife if she will not have sex with him 1=Agree 2=Disagree 3= Don't Know	|_|
6.16	It disgusts me when I see a man acting like a woman 1=agree 2=Disagree 3=Don't Know	|_|
6.17	I would never have a gay/lesbian friend 1= agree 2= Disagree 3= Don't Know	|_|

SECTION: 7 REFORMANCE QUESTION RESULT THREE

*"SRH services: the performance question requires us to capture an **INCREASE** and the **IMPACT** of the utilization of the SRHR services in the community "*

7.1	Did you ever asked for SRH services ? 1=Yes; 2=No	|_|
7.2	How many times did you receive education? 1=one time; 2=two to four; 3=more than	|_|
7.3	Was this education helpful? 1=Yes; 2= No	|_|
7.4	If ever asked, where did you go for the SRH services in the last visit 1=a shop; 2=a kiosk; 3=a pharmacy; 4=a Public Health Facility; 5= others, specify……..	|_|
7.5	What was the reason for the visit 1= was sick; my partner was sick; 3= for counselling; 4= was worried that I had STDs; 5= others, specify……..	|_|
7.6	Did you ask for the SRH services 1= Yes; 2= No	|_|
7.7	If NOT, why 1= Was scared; 2= shy; 3=it is costly to access service; 4= others, specify……	|_|
7.8	Did you discuss STDs	

	1=Yes; 2= No	|_|
7.9	If NOT, why 1= Was scared; 2= shy; 3=it is costly to access service; 4= others, specify……	|_|
7.10	Were you satisfied 1=Yes; 2=No	|_|
7.11	If NOT, why 1=Unfriendly service provider; 2= Lack of privacy 3=Others, specify……	|_|
7.12	People have a right to full, objective and balanced information on sexual and reproductive health including HIV/AIDS and other sexually transmitted infections 1= true; 2=False; 99 Don't Know	|_|
7.13	All persons have the right to protection against a forceful or against the person's informed consent to be married 1= True; 2= False; 99= Don't Know	|_|
7.14	All persons have the right the access SRHR services including those who are infertile or whole fertility is jeopardized by STIs 1= True; 2= False; 99= Don't Know	|_|
7.15	All women have the right to access information and education on SRHR services 1= True; 2= False; 99= don't Know	|_|
7.16	All women have the right to access SRHR services including safe mother hood, safe abortion which are accessible, affordable, acceptable and convenient to all users 1= True; 2= False; 99= Don't know	|_|
7.17	All persons have the right to be free to choose and to use a method of protections against unplanned pregnancy which is safe and acceptable to them 1= True; 2= False; 99= Don't Know	|_|
7.18	All the persons have the right from to protection from rape, sexual assault, sexual abuse and sexual harassment 1= True; 2= False; 99= Don't Know	|_|

Annex 2: Guidelines for FGDS/IDIS Youth&adults

Introduction: General questions

1. What is TMEP all about? What is the project trying to achieve?
2. If you were engaged in TMEP activities, what is your proudest achievement?
3. Which of the TMEP activities do young people find most challenging? Why?

Men as agents of change: If men are involved/participated in SRHR services

1. To what extent have men become more involved in SRHR services in this community? Probe the following:
    a. If TMEP project has contributed to a change on men's perceptions on SRHR?
    b. If they see a new trend where men attend, utilize and make decision that can be associated with the project
    c. If they notice differences in men's attitudes in terms of before and after the launching of the TMEP project
    d. If men accompany their spouses for the service, attending the service, discussing and what are the stories, bringing children.

e. If men discuss with their partners about sex reproductive health and rights. For example discussion about Family Planning.

SRHR information (increased access to accurate information)

1. What is your opinion on rights to SRH information and services?
    a. Regardless of SEX, AGE, Education or MARITAL STATUS?
    b. Do you think any of the above group (by age, educational background or marital status) should have restrictions and why?
2. How do men and women get the information about SRHR in the community?
    a. How do you know if they have best practices?
    b. Probe on meetings, informal gatherings, seminars, posters, trainings, campaigns
    c. Probe if this has changed since the implementation of the TMEP project and ask what has changed
3. Has SRHR information and dialogue improved due to TMEP?
    a. In what ways?
4. To what extent has utilization of SRHR services increased, and with what impact?
    a. Do you think this change/increase is due to TMEP project? Why do you think so?
5. Do you think HOMOSEXUALS should be respected, and have right to SRH information and services?
    a. PROBE on fears against them?
    b. What should be done in order to ensure their rights as human beings?
6. Should people leaving with HIV be encouraged to access SRH information and services?
    a. If yes, why? If not why?
7. Do people treat differently when a man is found having condoms as opposed to a woman?
    a. If yes, why do they do so? Is it fair?
    b. If people treat it different, is it fair?
8. How do men feel when they make a girl/a woman pregnant before marriage?
    a. Do majority of such men marry women they ever had a baby with? If not why?
9. What are things that men do not know about women's SRH rights?
10. Which people in this community do not know about SRH rights of the following?
    - Young people
    - HIV +ve people
    - Homosexuals
    - Commercial sex workers

The utilization SRHR services

1. What kind of SRHR services exist/are available in this area? Probe the nature of the services; their type, quality and accessibility.
2. Are communities increasingly exercising their rights to SRH services?
    a. Probe the reasons for their answers (How?) Request for the evidence that support their response (How do you know?)
    b. Concentrate on the outcomes such as unwanted pregnancies, spacing of children, less gender violence, family planning services.
3. Which groups in this community finds it hard to access SRH services why?
    a. What need to be done to ensure all individuals have rights to SRH information and services?
4. How does culture in this community affect SRH rights?
    a. Negatively or positively?
    b. What need to be done?

5. How has TMEP project enhanced access to the SRHR services in the community
    a. How?
    b. Has the project enhanced access to the services?
    c. Do people openly discuss these issues, in groups, schools, among peers, families e.t.c?
        i. How or what do they discuss?
6. To what extent has TMEP improved and expanded access to SRHR services, especially for underserved groups?
    a. Probe how they know?
    b. Which underserved groups were targeted?
    c. What does TMEP project do in order to expand these services?

Finally, can you please share with us in terms of what you think TMEP should do in order to improve and expand its services? Which area should they focus or target most? Which population group should be targeted more?

Thank you for cooperation

Annex 3: Guiding Questions for IPs

Introduction:

1. How did you get involved in TMEP project?
2. Why did you want to get involved in TMEP project?
3. What is TMEP all about? What is the project trying to achieve?
4. What is your proudest achievement in TMEP so far?
5. Which of the TMEP activities are the most challenging for you as RODI (MWADEMO) and HAPA (YMC) to implement?
6. How do you surmount them?
7. Which of the TMEP activities do the community find most challenging? Why?

Men as agents of change: Wanaume kama mawakala wa mabadiliko

1. To what extent have men become more involved in SRHR, how, and to what effect?
    a. Probe on the evidence of practices
    b. As implementing partners how can you show this
    c. What are the practices that demonstrate men's involvement in SRHR services

SRHR Information (Taarifa za SRHR)

1. How has the community attitudes changed as a result of access to SRHR information
    a. How do you know this
2. How has SRHR information and dialogue improved due to TMEP?
    a. In what ways?
    b. Probe on access to gender related knowledge

Utilization of the services (utumiaji wa huduma)

1. Are communities increasingly exercising their rights to SRHR services?
    c. How do you know? What evidence do you have?
2. In what ways has TMEP improved and expanded access to SRHR services?
    d. Probe on the underserved groups and areas?
    e. Which underserved groups and areas have you targeted?
    f. How can you demonstrate this-trainings offered etc
3. To what extent has utilization of SRHR services increased, and with what impact?

Capacity building

1. Has your organization become stronger at promoting gender-oriented SRHR?
    a. How do you know this/demonstrate this
2. Who are the other organizations you collaborate with in providing SRHR service
    a. Probe if they also provide other services apart from SRHR
3. What are the services that you have conducted in the past 6 months alone or with the partners
4. If they have or acquired through experience gender related knowledge
    a. From who and how
5. How can implementation of TMEP be improved by RODI/HAPA?
    a. Probe the best way that you can improve your M&E for TMEP?
    b. How can you (RODI/HAPA) improve your project management of TMEP?
6. How do you build capacity of communities on SRHR issues. Do you perform any form of training? What are your target groups?
7. Suppose TMEP phases out today, what are you able to continue doing on your own without TMEP support?
    a. Probe on what they are capable- mobilization of local resources
    b. Probe also on what they are not capable-allow them to explain the reasons for not being capable.
8. As you implement the everyday activities of TMEP, do you somehow envisage and prepare for this phase out?
    a. What are the possible opportunities in case TMEP phases out

Project Management:

1. Have you had any challenges around financial management (budgeting, receiving disbursements, spending, or accounting/reporting)? Why? Were the challenges solved? How?

2. Have you had any challenges around project management of TMEP (organizational management, planning, staff issues, volunteer management, finance etc.)? Why? Were the challenges solved? How?
3. How can you (RODI/HAPA) improve your financial management of TMEP?
4. How can implementation of TMEP be improved by the TMEP Secretariat?

Mainstreaming and advocacy

1. To what extent has male involvement and gender oriented SRHR been mainstreamed by government and CSO stakeholders?
    a. Probe if they can demonstrate this.
2. What kind of SRHR activities are mainstreamed into the district budgets
    a. Budget
    b. Any other issues/activities that have been integrated into the district plans

Social accountability

1. How do you know that the community know their rights
2. If the community are empowered to demand for the service, do you think they can stand and demand for the service
3. How do we ensure the sustainability of the TMEP best achievements
    a. Probe on the sharing of the lessons learnt with other partners at the local levels
    b. The ward executive committee meetings-used to discuss these issues
4. Can community members stand and demand for the services from the service providers?
    a. If not what need to be done
5. As implementing partners what do you thing are the best ways to ensure social accountability

a. Probe on their commitment towards action plans
b. Probe how they will work with the ward executive committee
c. How can they strengthen partnership among HAPA/RODI, ward executive committee and the volunteers- this will ensure the sense of ownership

6. Anything else you would like to mention? Any other ideas for improving TMEP?

FINALLY:

1. Looking ahead, do you think TMEP has so far succeeded in delivering the desired results?
    a. Why/why not?
2. What do you think are the main challenges that might limit success?
3. What are your recommendations?

********** ASANTE KWA USHIRIKI WAKO **********

Annex 4: Guidelines Questions for National Partners

1) How have you heard of / been involved in the TMEP project?
2) Do you think that male involvement in SRHR is important? Why?
3) What do you like best about the TMEP project?
4) What do you like least about the TMEP project?
5) The purpose of TMEP is to scale up access to sexual and reproductive health and rights information, education and services for all, especially underserved groups. Do you think it is achieving this? In what ways?
6) How can implementation of TMEP be improved by the TMEP Secretariat or the implementing partners at regional and district levels?
7) Looking ahead, do you think TMEP has succeeded in delivering the desired results? Give reasons for your answer. If no, what do you think are the main challenges that have hampered its success? What should be done in future in order to surmount these challenges?
   For example: How has TMEP faired (performed) in terms of:
    - Improving the involvement and participation of men in promoting SRHR and tackling gender inequality (Result 1)
    - Increasing the understand of SRHR and demand for SRHR (Result 2)
    - Has TMEP influenced the increase of utilization and supply of SRHR? For example, has the government increased SRH services? Has the utilization of SRH increased? (Result 3)
    - Has TMEP built local capacity of implementing partners and stakeholders in promoting gender - oriented SRHR policies in a sustainable way? (Result 4)
    - How is the government at all levels and civil society organizations integrating gender – oriented SRHR and male involvement into their policies, plans and activities? (Result 5). Give concrete examples.
    - Should TMEP enter a second phase, what do you recommended in terms of achieving the above 5 results? What else should TMEP do? What should be TMEP Project's focus and target? Why do you think so?
8) Do you think government officials are aware and understand the right based approach and their responsibilities as duty bearers?
    - Probe if they know that it is the communities rights to get the service
9) The partners increase the demand of SRH services, how is the government prepared to cope with this demand?

10) How is the government and education sector willing to integrate sexuality education in schools?
11) What more strategies should the government adopt in order to improve human resource in the health sector? How different are these strategies from the existing government plans?
12) How far has the government revised and integrated MI and Gender issues in the policies?
    - Since the government officials were supported for a study visit, how has that visit influenced their decision on MI and gender issues?
    - Do you think the visit was of significance to the MI and Gender issues?
    - What did they bring to the revised policies that are a result of the visit?
13) How much of the sexuality, gender and MI related issues are integrated into the National adolescent sexual reproductive (ASRH) health training manuals?
14) What plans do you have to improve the human resource in the health facilities?
    - Probe on the specific plans
15) What initiatives do the government has to mobilize resources to ensure the sustainability of the activities that were implemented by TMEP?
    - Probe on the initiatives and the activities that are already integrated
16) Anything else you would like to mention? Any other ideas for improving TMEP?
17) How effective are the working groups such family planning, reproductive health, and men engaged in lobbying and advocating for the policy change on issues they represent?
    - Probe if these groups have managed to integrate some of the family planning, reproductive health and men's issues into the government policies.
18) To what extent has male involvement and gender oriented SRHR been mainstreamed by government and CSO stakeholders in Tanzania?
    - How? Why?
19) Is there anything that you would like TMEP to do differently?
20) To what extent do national government policies, plans or guidelines include male involvement and gender oriented SRHR concepts and activities? Could more be done? What does government require to be able to move forward on this?

Annex 5: Self Administered Guideline Questions for RFSU Consultant

As a consultant for TMEP since its inception we consider you as someone who knows TMEP very well and that you are the TMEP main advisor.

(1) What are your proudest achievements and experiences so far since you started working with RFSU and TMEP.
(2) In your opinion what do you think are the main challenges that TMEP has been facing during the last two or more years of its operation? How have these challenges (if any) affected the performance of TMEP in terms of achieving its goals (aims and objectives)?
(3) Looking at the targets that TMEP planned to achieve during the first phase. What targets were achieved and which ones were not and why? What should they have done in order to achieve them?
(4) Should TMEP enter a second phase what other different strategies should TMEP employ in order to improve its performance in order to achieve TMEP's intended goals.
(5) As a consultant how do you assess the relationship, communication, performance and project management between RFSU and TMEP Secretariat and also between the two and yourself? Is there any need for improvement?

(6) TMEP is currently donor dependent. Assuming that donor money stops what do you recommend to the Secretariat as a smooth exit strategy? Of course it is our understanding that the government is supposed to mainstream in its plans and policies what TMEP advocates. What if this does not happen? What is the best way of making sure that the TMEP good ideas are maintained and scaled up?

(7) At present TMEP works with RODI in Rukwa and HAPA in Singida as Implementing Partners (IPs). It is our understanding that these organization never participated when the original ideas of creating the TMEP Project were being formulated. Having experienced this working model for a long time, what are its pros and cons in general, but particularly in terms of making sure that what TMEP does remains sustainable?

Annex 6: Guideline Question for TMEP Secretariat:

Communication

1. Since baseline report, how have you improved communication between:
    a. the IPs and the secretariat
    b. Secretariat and the National government
    c. Secretariat and RFSU
    d. Provide evidence for this and show how improved communication has improved the performance of TMEP?
    e. Probe on the challenges encountered
    f. How did you overcome these challenges, especially between Secretariat and the IPs

M&E Data

1. What has the secretariat done in order to make sure that the M&E data is used properly?
    a. Our field experience shows that there is timely flow of data from the PE and Ward coordinators, where do you think the delay comes?
2. To what extent is the management now using the M&E data in making its decisions?
    a. Give concrete evidence for your response.
    b. If not please explain why?

Management Issues

1. How is the relationship between the secretariat and IP
2. Disbursement
3. Are you happy with the organogram and the structure of various IPs
4. What needs to be improved-please recall the tensions, challenges and how best these can be avoided as you move to the second phase?

Advocacy

1. What kind of strategies has TMEP adopted in order to improve links with the government?
    a. What challenges is TMEP facing and how is it surmounting them?
    b. The evaluation team has notice some achievements by various IPs, districts and wards, how can these efforts be improved.
2. What kinds of advocacy strategies are being used?
    a. Which ones seem to be working?
    b. Which ones do not and why?
3. What kind of the national activities have been brought to the core of the secretariat's work?
4. Should TMEP end now; are you comfortable that the local capacity is capable of continuing these objectives and goals in a sustainable way? Give reasons for your response.
5. Do you think strong local social responsibility and accountability is now in place?
    a. Why do say this so?
    b. If not explain why?

6. What is your exit strategy that guarantees smooth transition of the project to local institutions?
7. What kind of resource mobilization strategies are being carried out at local level in order to reduce dependency on foreign funding?
8. Should the project continue into another phase, what do you plan to be the main focus of the new phase and why?
9. Based on your experiences of the TMEP first phase, do you think communities are increasingly exercising their rights to SRH?
    a) To what extent has TMEP improved and expanded access to SRHR services, especially for underserved groups?
    b) What indicators do you have that shows men have changed, please recall the field visits, follow-ups, data and other experience shared by IP
    c) To what extent have men become more involved in SRHR, how, and to what effect?
    d) In what ways has SRHR information and dialogue improved due to TMEP?
    e) To what extent has utilization of SRHR services increased, and with what impact?
    f) Have implementing partners become stronger at promoting gender-oriented SRHR?
    g) To what extent has male involvement and gender oriented SRHR been mainstreamed by key actors and stakeholders?
    h) What have been the main targets, themes and accomplishments for TMEP advocacy?
10. How has your collaboration with other stakeholders especially NGOs, improved?
    a. Who do you collaborate with at the national and regional level?
    b. How has this collaboration changed since the mid-term review?
11. Looking back since the project was launched, can you tell us what has happened, what went well and not so well, what has been learned and what can be improved in terms of:
    a. Management performance (issues including: planning, implementing, monitoring
    b. Assessment of RODI/HAPA
    c. M&E (issues including: designing, implementing, quality assurance, reporting)
    d. Financial management (issues including: costing, budgeting, monitoring, adjusting, reporting)
12. By referring to the project log frame, what do you consider as still relevant? What do you think requires clarity, omission and addition should the project enter the second phase?

Thank you for your cooperation: