

Addressing the Reproductive Health Needs  
and Rights of Young People since ICPD -  
**The Contribution of UNFPA and IPPF**



# Tanzania

Country Evaluation Report



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für  
Zusammenarbeit  
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**Addressing the Reproductive Health Needs  
and Rights of Young People since ICPD:  
The contribution of UNFPA and IPPF**

**Tanzania Country Evaluation Report**

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## ACRONYMS

1CP	First Country Programme
1SP	First Strategic Plan
2CP	Second Country Programme
2SP	Second Strategic Plan
3CP	Third Country Programme
3SP	Third Strategic Plan
4CP	Fourth Country Programme
5CP	Fifth Country Programme
AFHS	Adolescent Friendly Health Services
AHD	Adolescent Health and Development
AMREF	African Medical Research Foundation
Angaza	VCT services provided by AMREF (locally-used term)
ARH	Adolescent Reproductive Health
ARRA	Adolescent Reproductive Rights Advocacy
ASRH	Adolescent Sexual and Reproductive Health
AYA	Africa Youth Alliance
BCC	Behaviour Change Communication
CAFS	Centre for African Family Studies
CBD	Community Based Distribution
CBO	Community Based Organisation
CEDAW	Convention for the Elimination of All Forms of Discrimination Against Women
CGM	Consultative Group Meeting
CO	Country Office
CP	Country Programme
CPA	Country Population Assessment
CRC	Convention for the Rights of the Child
CST	Country Support Team
DAC	Development Assistance Committee (of OECD)
DHS	Demographic and Health Survey
FGC	Female Genital Cutting
FGDs	Focus Group Discussions
FGM	Female Genital Mutilation
FLE	Family Life Education
FPA	Family Planning Association
GA	Gender and Advocacy (UNFPA sub-programme)
HSBF	Health Sector Basket Fund
HTP	Harmful Traditional Practice
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IPPFAR	International Planned Parenthood Federation Africa Region
ILO	International Labour Organisation
IPH	Institute of Public Health (Muhimbili)
JPO	Junior Professional Officer
KAP	Knowledge, Attitudes and Practices
MCDGAC	Ministry of Community Development, Gender and Children
MCH	Maternal and Child Health
MEC	Ministry of Education and Culture
MEES	Moral Ethics and Environmental Education
MIS	Management Information System
MLYDS	Ministry of Labour, Youth Development and Sports
MOH	Ministry of Health
MUCHS	Muhimbili University College of Health Sciences
NACP	National AIDS Control Programme

NPERCHI	National Package of Essential Reproductive and Child Health Interventions
NPO	National Programme Officer
NPPP	National Professional Project Personnel
PAU	Policy Advocacy Unit
PDS	Population and Development Strategies (UNFPA sub-programme)
PEs	Peer Educators
PLA	Participatory Learning for Action
POPFILE	Population and Family Life Education
PPU	Population Planning Unit
PROMEP	Programme Monitoring and Evaluation Plan
PRS	Poverty Reduction Strategy
PRSD	Programme Review and Strategy Development
PRSP	Poverty Reduction Strategy Paper
RCH	Reproductive and Child Health
RCHS	Reproductive and Child Health Section of the MOH
RFSU	Association for Sexuality Education of Sweden
RH	Reproductive Health
RHRU	Reproductive Health Research Unit
SDP	Service Delivery Point
SP	Strategic Plan
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
TACAIDS	Tanzania Commission on HIV/AIDS
TAPAC	Tanzania Parliamentarians' AIDS Coalition
TAS	Tanzania Assistance Strategy for HIV/AIDS
TGNP	Tanzania Gender Networking Programme
TOT	Training of Trainers
TRCHS	Tanzania Reproductive and Child Health Survey (1999)
TTC	Teacher Training College
UMATI	Chama Cha Uzazi Na Malezi Bora Tanzania (The Tanzania FPA)
UNDAF	United Nations Development Assistance Framework
UNFPA CO	United Nations Population Fund Country Office
UNICEF	United Nations Children's Fund
VCT	HIV Voluntary Counselling and Testing
VETA	Vocational and Education Training Authority
WHO	World Health Organisation
WPB	Work Programme Budget
YFS	Youth Friendly Services
YIP	Youth Involvement and Participation
YMEP	Young Men as Equal Partners

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We also wish to emphasise that the views expressed herein are ours alone, and not those of the evaluation sponsors.

## ANALYTICAL SUMMARY

### Introduction

The German Ministry for Economic Cooperation and Development (BMZ), the Danish Ministry of Foreign Affairs, the UK Department for International Development (DFID), the Netherlands Ministry of Foreign Affairs, and the Norwegian Ministry of Foreign Affairs have sponsored an evaluation of the contribution of the United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF) to addressing the reproductive rights and health needs of young people in the period since the finalisation of the Programme of Action (POA) developed at the International Conference on Population and Development (ICPD) in 1994. The goal of the evaluation is to contribute to a better understanding of the conditions necessary for achieving best practice, and to draw strategic lessons for the future; the purpose is to assess the performance of UNFPA country offices and FPAs in six selected countries in promoting the reproductive rights and health of adolescents and youth.

This analytical summary presents the main conclusions and lessons from the evaluation of the UNFPA Tanzania Country Office and UMATI (the Tanzania IPPF affiliate) against the five evaluation themes of strategic focus, institutional arrangements, policy and advocacy, service strengthening, and information and education. The summary highlights key findings against 10 key questions<sup>1</sup> set out in the original TORs for the evaluation under the following headings:

#### *Strategic Focus:*

The extent to which UNFPA and UMATI:

- recognise and articulate the country-specific socio-cultural factors that impact on the reproductive rights and health of young people;
- recognise and articulate the diversity of needs of young people;
- promote the concept and practice of reproductive rights; and
- are gender-sensitive in addressing RH needs and rights of young people.

#### *Institutional Arrangements:*

The extent to which UNFPA and UMATI:

- contribute to the response of government and civil society to the reproductive rights and health needs of young people;
- provide quality technical support and promote lesson learning and best practice in young people's reproductive rights and health;
- promote the participation and empowerment of young people;
- demonstrate complementarity, coherence and cooperation with each other; and
- demonstrate relevance, scope and effectiveness in coordination arrangements and partnerships with other actors in the field of reproductive rights and health.

#### *Policy and Advocacy:*

The extent to which UNFPA and UMATI are:

- Stimulating enabling environments for policy development in relation to young people's reproductive health and rights.

The above issues are explored in detail in the main report, and further elaborated in the discussions on service strengthening and IEC.

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<sup>1</sup> See section 2.2 of *Addressing Reproductive Rights and Health Needs of Young People After ICPD: The Contribution of UNFPA and IPPF. Description of the Evaluation/Substantive Requirements of the Bid/Description of Measures* (issued by BMZ 2002). Of the eleven key questions one has not been addressed (with agreement of the Steering Group): "The extent to which both organisations are effective in promoting behavioural change... in particular safe and healthy sexual behaviour".

## Strategic Focus

The strategic focus of both agencies has shifted significantly since ICPD 1994. However, resource and institutional constraints (and - in the case of UNFPA – persistent political and cultural sensitivities) have limited the extent to which they have been able to implement or support large-scale initiatives focused on meeting young people's reproductive health needs.

### UNFPA

UNFPA's first three country programmes (which ran consecutively from 1981 to 1996) made significant contributions to the integration of population variables into national planning (including support for the census), to the development of Tanzania's first National Population Policy in 1992, and to the strengthening of government capacity to deliver maternal and child health and family planning (MCH/FP) services (including the establishment of the National Family Planning Programme under the Family Planning Unit of the MOH). The Fourth Country Programme 1997-2001 (4CP) showed a significant reorientation - in discourse at least - from the family planning and demographic focus of previous CPs to a reproductive health approach. However, resource constraints and other limitations meant that 4CP had limited impact. Apart from support for the development of a draft national Adolescent Health and Development strategy and limited advocacy around Female Genital Cutting (FGC), there was little activity or strategic focus in 4CP specifically on young people's RH and rights. Following the recommendation of the Mid-Term Review of 4CP, a number of activities under the Population Advocacy Sub-Programme – including those which related to advocacy for adolescent reproductive health – were terminated, due to *inter alia* budgetary and institutional constraints.

The Fifth Country Programme (5CP) which runs from 2002-2006 also has limited specific focus on young people's RH and rights. The Gender and Advocacy sub-programme has one output focused on policies, programmes and laws related to reproductive rights (including some which affect young people). Under the RH sub-programme, UNFPA is fully funding a new Adolescent Reproductive Health (ARH) Training and Service Delivery Officer post in the Reproductive and Child Health Section of the MOH. UNFPA's contribution to policy and legislative reform related to young people's RH under 5CP will depend much upon its role in the five-year Africa Youth Alliance (AYA) project which started in 2001. As well as being the lead agency in AYA, UNFPA is responsible for the advocacy and policy component. AYA represents an opportunity for UNFPA to make a significant contribution to improving young people's RH and rights in Tanzania. To date implementation in AYA has been slow and there is a need to develop more effective linkages between AYA and UNFPA's 5CP to ensure synergies. A new National Programme Officer post in the UNFPA Country Office (CO) will be given responsibility for advocacy and gender, which will hopefully facilitate such linkages and synergies.

5CP articulates reproductive rights in terms of individuals' ability to make decisions that affect their personal and reproductive life, and as such focuses on educating and informing the public about individuals' rights to access services. There is very limited focus on empowering clients (including young people) to know their rights to demand quality services. Gender analysis within the country programme is also weak, but improving through an evolving framework for gender analysis (the mid-term evaluation of UNFPA's 4CP concluded that the programme had failed to develop a framework within which to address gender issues related to service delivery and IEC).

UNFPA's country programme articulates the priority RH and rights issues facing young people (notably harmful traditional practices such as early marriage for women and female genital cutting). It is also clear that the CO has a good appreciation of the socio-cultural and other factors which currently influence young people's RH and rights in Tanzania. To date,

financial resource constraints, lack of capacity within both the UNFPA CO and government implementing agencies, and political and cultural sensitivities mean that impact on addressing the priority issues has been limited.

### UMATI

From its inception in 1959 until 1992, UMATI's strategy and activities focused largely on family planning awareness and demand creation (through IEC), on training of family planning service providers for government, and on the procurement and distribution of family planning commodities. Despite its limited role in service provision, UMATI's advocacy and pioneering work during the 1970s and 1980s contributed to the launch of the National Family Planning Programme in 1989 and the 1992 Population Policy.

In 1992, with assistance from IPPF, UMATI developed its First Strategic Plan (1992-1996) which sought to redirect efforts towards bridging the gap between awareness and use of modern contraception, within what it termed "a broad reproductive health approach". Despite the strategic shift, a close examination of activities in the period 1993-2002, shows that the transition to a programme focus on reproductive health was slow and difficult.

UMATI's current Strategic Plan (2001-2005) represents a bold attempt to reorient and refocus its programme, through what it terms a "paradigm shift" (from family planning to integrated sexual and reproductive health) with an explicit and exclusive focus on young people. The strategic plan articulates the priority areas *inter alia* as STI/HIV/AIDS prevention, elimination of harmful practices, reduction of unsafe abortion, and prevention of unwanted pregnancies. However, capacity to implement the paradigm shift and to reorient staff and service delivery approaches is severely constrained by recent declines in human and financial resources.

UMATI staff have a clear understanding of the complexity and diversity of needs within the country context. Many projects seek to address site-specific priority issues, including rights-based issues through advocacy on FGC and the rights of young people to access education, information and services. Efforts have also been made to respond to the diversity of needs among young people, including the most marginal and vulnerable. Projects with refugees are reaching highly marginalised young people; contrasting strategies are implemented to reach in-school and out-of-school youth; CBD agents are trained to reach rural youth; and UMATI recognises the differing service delivery needs of married and unmarried youth. The main focus of UMATI's rights-based approach is on the rights of the client, and the rights of all young people to access SRH information and services. On a limited scale UMATI has tried to address the rights of pregnant girls to continue to access education. Small-scale location-specific projects are working to address issues related to gender, power and sexuality, and to reach young men with strategies to support behaviour change and to improve their access to services.

### **Institutional Arrangements**

The evaluation took cognisance of the differences and contrasts in the roles played by UNFPA and UMATI at country level. While UMATI is an implementing agency (guided by the policies and overall goals of IPPF), UNFPA does not implement its Country Programme (CP) directly, but through government partners. The UNFPA Country Programme is effectively "government owned", and its primary focus is to strengthen government capacity for direct execution of its population and RH programmes. UMATI by contrast is non-governmental, with all that such a status entails: from supporting government in geographical and thematic areas where government is unable or unwilling to work, to advocacy for policy and legislative changes. In terms of overall budgets, UNFPA's Fifth Country Programme is budgeted at US\$28.25m for the period 2002-2006 (US\$10.25m from UNFPA regular resources, and the

balance to be sought through co-financing modalities and other UNFPA sources). UMATI's annual budget spend for the year 2002 was around half that of UNFPA at US\$2.35m.

Both agencies are constrained institutionally, although in contrasting ways.

### UNFPA

The CO currently lacks expertise in adolescent sexual and reproductive health (ASRH), reproductive rights, and in advocacy. However, new staff appointments and an enhanced staff complement are expected to redress some of these gaps. Technical support from the UNFPA Country Support Team (CST) in Addis Ababa has over the past few years focused largely on the Population and Development Strategies (PDS) sub-programme, the design of 5CP, and on strengthening the CO's M&E capacity. The final evaluation of 4CP was critical of the lack of technical assistance (TA) from the CST in rights, ASRH, and advocacy. However, key partners acknowledge the role played by the CST in the development of the MOH's draft national Adolescent Health and Development strategy.

Despite overt statements in the 5CP of the importance of working with civil society institutions as full partners in programme implementation (in recognition of their comparative advantages in relation to service provision, advocacy, gender mainstreaming, research and training) funding to the only NGO implementing agency in 5CP is currently frozen, and there is limited strategic involvement of civil society in advocacy and IEC activities. This appears in part to be a consequence of government resistance.

UNFPA's effectiveness and impact is further constrained by the institutional weaknesses of its coordinating and implementing partners in government. It is unclear why UNFPA has not devoted more resources to institutional strengthening of these partners.

In relation to the health sector reforms, UNFPA is a full and active member of the Bilateral and Multilateral Health Forum (and its subcommittee on Reproductive Health), the health sector wide approach (SWAp) steering committee, and the annual Health Sector Review (undertaken to establish a common understanding of planned activities, budgeting and financing for the sector). These forums are seen by UNFPA as offering an opportunity to ensure RH and gender issues are considered within the health SWAp, particularly with regard to RH indicators, and strengthening health sector capability to respond to unmet RH needs. However, to date UNFPA's ability to exert such an influence has been limited, due in part to human resource constraints. In recognition of the importance of the SWAp process, the UNFPA CO has recently commissioned a consultant to draft a strategy for how best to integrate the CP more fully into the SWAp.

UNFPA is engaged in the Poverty Reduction Strategy process (PRS), but the CO recognises the need to strengthen its role. It is currently proposing technical support on incorporating population and reproductive health issues into the PRS, as well as greater advocacy on the relationship between RH/population and poverty reduction. However, as with the SWAp, UNFPA has made only a limited contribution to the PRS process to date, despite good intentions.

UNFPA monitoring and evaluation of its CP is weak, but improving. The CO, with CST support, has recently developed a programme monitoring and evaluation plan (PROMEP), which has a specific project budget line within 5CP. In addition to focusing on results and outcomes, PROMEP emphasises use of M&E findings for lesson learning and dissemination. PROMEP, along with the establishment of a detailed baseline for the 5CP LogFrame, and the appointment of a M&E officer in the Country Office, represent a promising start to a reform of the M&E system.

There are few mechanisms for young people's participation in the CP. The concept of young people's participation is not clearly understood within the UNFPA CO or its major government partners. However, youth involvement was central to the AMREF lifeskills project funded under 4CP; and youth involvement and participation (YIP) is a key strategy within AYA.

### UMATI

Declining core funding from IPPF has meant that key posts identified in the UMATI organogram developed as part of the current Strategic Plan have not been filled. UMATI has also experienced a high turnover of key programme staff in recent years, some of whom are central to implementation of the paradigm shift and have not been replaced. The reductions in IPPF core funds have increased UMATI's dependence on short-term donor-supported projects, leading to fragmented implementation of pilot approaches, which have not yet been effectively integrated into the overall UMATI programme. Technical assistance from the IPPF Africa Regional Office has been limited, due in large part to institutional problems within the Regional Office.

Project baseline surveys and evaluation reports are of varying quality and do not provide an adequate database from which to assess programme effectiveness. A major limitation of the existing MIS is that service utilisation data are not disaggregated by age and it is therefore not possible to analyse trends in utilisation of different UMATI services by young people. The limitations of the MIS are well recognised by UMATI and support is being provided by AYA to adapt the MIS, to reflect more adequately the needs of the programme in monitoring impact on young people's reproductive health and rights.

UMATI has long-standing partnerships with international NGOs, in particular the UK-based Population Concern and RFSU (the Association for Sexuality Education of Sweden), who have supported UMATI's pilot approaches to young people's sexual and reproductive health and rights. UMATI is collaborating with AYA across all three components of the AYA programme (advocacy, BCC and youth friendly services), which is entirely appropriate to UMATI's strategic objectives. UMATI is also collaborating with AMREF in integrating voluntary counselling and testing (VCT) services into some of its youth centres. However, coordination with AMREF on areas such as lifeskills has been limited, even though UMATI (through AYA) and AMREF (supported by UNFPA) have developed lifeskills curricula. UMATI has also formed effective, albeit small-scale, partnerships with government, who recognise UMATI's capacity in lifeskills, peer education and counselling training. UMATI has assisted in integrating lifeskills training into the technical training programmes of the Vocational Education Training Authority (VETA) in MLYDS, and has provided technical assistance to VETA in development of a lifeskills curriculum and in training of lifeskills trainers. Partnership with the MOH has been on a smaller-scale, through pilot project approaches (including linking rural outreach with government service delivery points). Collaboration with MEC has also been project-based, and integrated into school-link activities across several projects in which teachers have been trained by UMATI in lifeskills related to young people's sexual and reproductive health for out-of-curricula activities.

While mechanisms for young people's participation have been established at project level, they are not institutionalised throughout UMATI's policy-making volunteer structure. Youth centres have established youth committees (to represent the views of young people to centre staff), but these tend to be separate from the youth centre volunteer boards which are the formal UMATI policy-making bodies. There is currently limited participation of young people on the UMATI National Council which is the main policy-making body of UMATI and there is resistance among volunteers at Regional and District level to include young people in decision-making. There is a general perception among volunteers that young people lack the capacity to participate effectively in decision-making.

### Complementarity and coordination between UNFPA and UMATI

UMATI's approach to young people's sexual and reproductive health is largely complementary to that being of UNFPA. For example, UNFPA is supporting the MOH to improve the youth friendliness of services in the public sector, UMATI has been a lead organisation advocating for and piloting RH service delivery to young people. UNFPA is supporting FLE in-schools, UMATI has prioritised peer education and lifeskills approaches to reach out-of-school youth. UMATI is also complementing UNFPA's FLE programme through the development of school-link activities in selected project sites to increase teachers' competencies in working with young people on lifeskills. Both organisations are now prioritising development of protocols and guidelines to support implementation of a package of youth friendly services, training service providers to improve quality of service provision to young people, and integrating lifeskills and community based behaviour change approaches within service delivery.

Despite complementarity of approaches, coordination and lesson learning between UNFPA and UMATI have been limited. UMATI is an implementing partner in the AYA programme, and there are some clear areas of overlap between UMATI's efforts supported under AYA and those that UNFPA identified in its own country programme. In order to avoid duplication UNFPA has put on hold those 5CP activities which are supposed to be addressed by AYA partners (such as development of the package of youth friendly services). As AYA implementation has been slow, this has placed constraints on implementation of planned activities and coordination of efforts by both UMATI and UNFPA.

There is great potential for scaling-up best practice through improved coordination between UNFPA and UMATI and through including NGOs such as UMATI as implementing partners under UNFPA's 5CP. UMATI does not receive any core funding from UNFPA. During the evaluation UMATI expressed a willingness for much greater collaboration and coordination with UNFPA, and to play an active role in 5CP.

### **Policy and Advocacy**

There are numerous national policies and laws regarding and/or affecting the reproductive health and rights of young people in Tanzania. Some are contradictory, others ambiguous. Both UNFPA and UMATI recognise the need for clarification and reform of legislation and policies affecting young people's RH and rights. Although both national programmes have established advocacy and policy reform objectives, neither agency (and especially UNFPA) has made demonstrable contributions to policy and legislative reforms specifically in relation to young people.

### UNFPA

Historically, UNFPA's contribution to policy reform and advocacy in Tanzania has centred around its work on the national population policy, on family planning, and more recently on awareness-raising among senior policy-makers of the ICPD Programme of Action. UNFPA's contribution to stimulating an enabling environment for policy support to young people's reproductive health and rights has been limited. Inherent flaws in the design and implementation of 4CP, and weak capacity with key partners in 4CP, meant that the country programme made very little difference to the policy environment for young people.

5CP has a limited focus on policy and advocacy in general, and on young people's RH and rights in particular. One of the four outputs of the Population and Development Strategies (PDS) sub-programme seeks to improve the "environment for reproductive, population and gender programmes" through establishing parliamentary caucuses to lobby and sensitise government on population and RH rights, and increasing the number of political, religious

and local leaders supporting RH programmes. The 5CP Gender and Advocacy (GA) sub-programme sets out to promote a rights-based approach by focusing on a number of priority issues, which include promoting sexual and reproductive rights of adolescents, and addressing sexual offences and harmful traditional practices. Proposed activities include establishment and/or strengthening of networks and alliances of organisations at district level (including media coalitions), information campaigns on issues such as early marriage and childbearing, and the risks to adolescents of early unprotected sex, and on building advocacy skills community leaders, government partners and NGOs. UNFPA is also managing the Policy and Advocacy component of AYA, the objectives of which relate to revising and/or improving ASRH-related policies and laws, and increasing community participation and commitment for ASRH policies and programmes.

UNFPA support under 4CP for the review of laws and policies relating to or affecting young people's reproductive health and rights, the current AYA initiative in this area, and the review work undertaken as part of the development of the draft AHD strategy, have increased UNFPA CO and partners' awareness of policy and legal issues relating to young people's RH and rights. However, it remains to be seen how effective 5CP and AYA will be in terms of translating increasing awareness into reforms. Much will depend upon the extent to which new staff appointments and an enhanced staff complement in the CO will be able to redress the lack of capacity and expertise in ASRH, rights and advocacy within the CO.

While UNFPA is recognised by many bilateral and multilateral agencies as an effective lead agency in relation to the national population census and in other population sub-sectoral areas, there is a view held by some of these partners, that UNFPA lacks leadership in RH. Some bilateral partners expressed the view UNFPA's decision to remain outside the Health Sector Basket Fund (HSBF) set up under the health sector-wide approach (SWAp), hampers its policy role. UNFPA argues that its decision is the result of what it perceives as institutional weaknesses at district level. However, and in recognition of the importance of the SWAp process, the UNFPA CO has continued to be a full and active member of the Bilateral and Multilateral Health Forum (whose mandate includes health sector reform and SWAp).

### UMATI

UMATI's major contribution historically to policy reform and advocacy is recognised by partners as stemming from its role as a pioneer for family planning and more recently for services to young people. However, UMATI's advocacy activities are currently constrained by lack of funds and staff. The IEC and Advocacy Officer post is currently vacant.

The first goal of UMATI's current strategic plan is to advocate for community support, and change to laws, policies and practices to empower youths to exercise their SRH rights. Five strategies are set out to achieve this goal, only two of which been funded over the past three years because of resource constraints. These relate to raising community awareness on harmful practices, and to increasing young people's knowledge on SRH and rights. Under these strategies, just three projects were active in 2002: the "young men as equal partners" (YMPEP) project which has successfully sensitised education authorities, district leaders and community leaders; the "adolescent reproductive rights advocacy" (ARRA) project which works with advocacy "coalition partners" (media, NGOs, lawyers associations etc); and the "youth driven initiative" implemented in one district, which is sensitising local government leaders, community development officers, religious leaders and teachers and parents on SRH issues. To date all these projects have been small-scale.

## **Reproductive Health Services**

While UNFPA and UMATI are placing an emphasis in their national programmes on the development of youth friendly services, both have experienced significant constraints to implementation.

### UNFPA

The evaluation recognises that building political support for delivery of RH services to young people has necessarily been a slow process, and that implementation of services to young people has been constrained by the cultural sensitivity and stigma surrounding young people's sexual and reproductive behaviour.

However, there was a very limited focus on youth friendly services under 4CP, and because of resource constraints, activities relating to services to young people were not prioritised. Adolescent Reproductive Health was included in the training of service providers on integrated RCH skills implemented by the Reproductive and Child Health Section (RCHS) of the MOH, with a primary focus on family planning services.

The UNFPA CO has made efforts to ensure that 5CP increases emphasis on provision of RH services to young people. Proposed 5CP activities include socio-cultural research on barriers to information and services for out-of-school youth in project areas, development of a minimum package on Adolescent Friendly Health Services based on the National Package of Essential Reproductive and Child Interventions, and training of service providers using the National Adolescent SRH curriculum being developed by the MOH with support from AYA. However, there has been no implementation of planned activities relating to delivery of young people's RH services under 5CP, as a result of a number of constraining factors. The evaluation concludes, with supporting evidence, that young people in mainland Tanzania are not accessing public sector services, and do not perceive such services to be youth friendly.

A concerted effort was made by the evaluation team to understand (from UNFPA's perspective) the main constraining factors on implementation of the activities outlined in 5CP. The constraints identified by UNFPA staff can be summarised as lack of capacity within RCHS (the implementing partner) to prioritise and implement youth friendly services (which UNFPA is seeking to address by supporting a new post of ARH Training and Service Delivery Officer with the RCHS), an overlap of efforts with AYA which has led to UNFPA dropping key activities, weak coordination between UNFPA and AYA and slow implementation of AYA, and constraints on including NGOs as implementing partners under 5CP due in part to resistance within RCHS to collaborating with civil society partners.

### UMATI

UMATI is recognised by key stakeholders (government and NGOs) as having played a pioneering role in provision of reproductive health services to young people. UMATI's service delivery for young people consists of a range of small-scale, geographically dispersed approaches including the integration of youth friendly clinic services into multipurpose youth centres, peer education linked to youth centres, integration of an ARH component into community based services, and pilot approaches linking peer education to other service delivery points (eg government dispensaries through the YMEP project). In recent years UMATI has shifted its focus from family planning services to a more integrated reproductive health approach including STI diagnosis and treatment, counselling, and provision of VCT (which has been integrated in two UMATI youth centres).

UMATI is now facing the challenge of how to scale up its service delivery to young people and to reorient its 12 core clinics (which currently focus on adults) to reach young people as

their primary clients. Lack of financial and human resources have been major constraining factors to implementation of planned activities, such as renovation of existing clinics and the training of service providers in youth friendly services. Internal UMATI lesson learning on best practice – a basic necessity for any scaling-up approach - has been constrained by lack of data from which to analyse trends in service utilisation by young people and the relative costs and effectiveness of different service delivery approaches. Lack of documentation of lesson learning has further constrained the extent to which UMATI has been able to influence best practice as implemented by government and other NGOs. UMATI recognises this limitation and is addressing the need for improved documentation with support from AYA. Through its involvement in AYA, UMATI should be better placed to influence national best practice.

Consolidation of lessons learned on best practice will be crucial to UMATI's strategy to scale-up from fragmented pilot projects, and to integrate lesson learning on youth friendly services into its core programme.

### **Reproductive Health Information and Education**

While UNFPA and UMATI for some time relied upon rather conventional IEC approaches, both have in recent years supported innovative youth-focused BCC initiatives. However, and for contrasting reasons, in their current national programmes neither agency is able to scale-up this innovative work.

#### UNFPA

UNFPA has been supporting two main approaches to IEC/BCC: family life education (FLE) and life skills education.

The development of the Family Life Education (FLE) and Moral Ethics and Environmental Studies (MEES) curricula and materials was a major focus of 4CP. The curricula and teaching guides integrate issues related to population, sexual and reproductive health and gender into four host subjects (geography, biology, civics, and home economics), and the FLE/MEES component of these subjects is now examinable. 5CP continues to support development of learning materials for teachers and students; along with the training of trainers, teachers and peer educators. UNFPA to date has not undertaken a systematic assessment of the strategic value and effectiveness of FLE/MEES, and its impact on young people's RH, although KAP surveys undertaken in 1999 with support from UNFPA now provide a baseline from which effectiveness can be monitored.

Under 4CP, UNFPA supported a Life Skills Education project implemented by AMREF. The project has trained young people as peer counsellors, parents in parent-youth communication skills, and community members as para-professional counsellors. An external evaluation carried out in January 2003 indicates that community ownership has been a key strength of the project and that activities have led to changes in behaviour and attitudes among young people. Funding for this project has now come to an end, and AMREF's view is that they are no longer an implementing partner in 5CP<sup>2</sup>. However, the AMREF life skills approach has been integrated into 5CP to be implemented by the MOH at district level, although there may be insufficient capacity within RCHS to take the approach forward. AMREF is also not an implementing partner under the BCC component of AYA, and as a result an important opportunity for scaling up best practice supported under 4PC appears to have been lost.

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<sup>2</sup> The UNFPA Tanzania CO - subsequent to the evaluation - have indicated that further funds within 5CP might be made available to AMREF

## UMATI

UMATI has produced RH educational and information materials for young people to meet locally identified needs, on a project-by-project basis. These materials have been produced with young people's participation and address a range of priority issues identified by young people. However, materials have not yet been developed to address the differing age-specific needs of young people.

UMATI is currently making efforts to facilitate a transition from an IEC to a BCC approach. A BCC approach to address gender specific needs was developed under the YMEP project, and with support from AYA, UMATI is currently developing a lifeskills manual and has undertaken training of trainers. Peer education has been an important component of UMATI's RH education approach since the late 1980s. A recent evaluation of the peer education programme indicates that peer educators have been effective in making referral to services, but noted that peer educators focus more on information giving and need further training in counselling skills.

The challenge for UMATI is to scale-up and integrate these different project-based approaches into an IEC/BCC strategy for the overall programme. However, coordination and capacity to take this forward is currently constrained by the lack of an IEC/Advocacy Manager. UMATI is addressing the issue of sustainability of IEC materials through its partnership with AYA, and has formed a strong partnership with MLYDS to integrate peer education and lifeskills approaches into government supported education programmes.

## KEY FINDINGS AND RECOMMENDATIONS

### Key Findings

The strategic focus of both UNFPA and UMATI shifted considerably post-ICPD from a demographic rationale (population/family planning) to one based on reproductive health and rights. Both organisations demonstrate an appreciation of the complex socio-cultural context in which they are working, and the key reproductive health and rights issues facing young people in Tanzania. Both emphasise the need for the development of youth friendly services, and both have supported youth-focused IEC and more recently BCC activities. However, the evaluation concludes that resource and institutional constraints have seriously limited the extent to which both agencies have been able to implement or support large-scale initiatives focused on meeting young people's reproductive rights and health needs. Further, while both agencies recognise the need for policy and legislative reform, neither has made significant and demonstrable contributions to policy and legislative reforms specifically in relation to young people.

### **UNFPA**

- UNFPA's first three country programmes made significant contributions to population, MCH and family planning issues. The Fourth Country Programme (1997-2001) showed a significant reorientation in rhetoric and discourse from family planning to reproductive health, but had little impact, lacking activities and strategic focus on young people.
- The Fifth Country Programme (2002-2006) also has a limited focus on young people's reproductive health and rights, although it does clearly articulate the priority RH and rights issues facing young people, the socio-cultural context and other factors that influence young people's RH. Rights are articulated in terms of individuals' ability to make decisions that affect their personal and reproductive life, but there is a limited focus on empowering clients, and gender analysis is weak, though improving.
- UNFPA's contribution to improving young people's RH and rights in Tanzania under 5CP will depend much upon its role in the five-year Africa Youth Alliance (AYA) project. AYA represents an opportunity to make a significant contribution, but implementation has been slow to date, and synergies between 5CP and UNFPA have not been realised.
- The Country Office currently lacks expertise in adolescent RH, reproductive rights and in advocacy, although new appointments are expected to redress these weaknesses. Technical support from the UNFPA Country Support Team in Addis Ababa has been effective in certain areas (eg strategy development), but limited in adolescent RH, rights and advocacy. Monitoring and evaluation – and dissemination of best practice - are weak, but improving.
- UNFPA is recognised as the lead agency in population issues in Tanzania. It is involved in a variety of bi- and multilateral forums through which it aims to ensure the prominence of RH issues on the wider development agendas. However its ability to exert influence has been limited, and some partners expressed concern that UNFPA lacked leadership in RH.
- UNFPA currently has very few partnerships with civil society organisations, and the one 5CP project with an NGO implementing agency has recently terminated. This limits the potential impact and effectiveness of 5CP. Further, the capacity of government implementing partners is weak, and limited resources have been devoted to strengthening them.
- There are few mechanisms for young people's participation in the CP, and young people's participation is not clearly understood by UNFPA or its government partners. Youth empowerment and participation is a key strategy within AYA.

- Historically UNFPA's contribution to policy reform and advocacy has centred on population policy, family planning and awareness-raising in relation to the ICPD Programme of Action. 5CP has limited focus on policy and advocacy in relation to ARH and rights, and it remains to be seen how effective AYA will be in terms of translating increased awareness of policy and legislation into reforms. Much will depend on enhancing the capacity of the UNFPA country office.
- Despite the CO's efforts to increase its emphasis on provision of RH services to young people, there has been no implementation of planned activities relating to young people's RH service delivery to date. Constraining factors include a lack of capacity in implementing partners, and poor coordination with AYA. The evaluation concludes that young people in mainland Tanzania are not accessing public sector RH services, and do not perceive services to be youth friendly.
- UNFPA has supported innovative youth focused BCC activities including family life education and life skills education but missed opportunities to scale up this work due to lack of continuity with implementing partners and weak monitoring and evaluation. An increased emphasis on lesson learning and dissemination will address this to some extent.

### **UMATI**

- UMATI's First Strategic Plan (1992-96) sought to redirect efforts from family planning to a "broad reproductive health approach". However, the transition has been slow and difficult. The current Strategic Plan (2001-2005) represents a bold attempt to reorient and refocus the programme through a "paradigm shift" from family planning to integrated RH, with an exclusive focus on youth.
- UMATI staff have a clear understanding of the complexity and diversity of needs within the country context, reproductive health rights and gender, which can be recognised in the diversity of projects and services at the local level. Efforts have also been made to respond to the diversity of needs among young people, including the most marginal and vulnerable.
- The capacity to implement the "paradigm shift" and to reorient staff and service approaches is constrained by recent declines in human and financial resources. Reduced IPPF core funding has meant that staff posts key to implementing the new paradigm have not been filled, and there is high dependence on short-term donor funded projects, not integrated into the strategic plan. TA from IPPFARO has been limited, due to institutional problems in the regional office.
- Monitoring and evaluation activities do not provide an adequate baseline from which to assess programme effectiveness. Notably, service data are not disaggregated by age. These weaknesses are well-recognised by UMATI and being addressed with AYA support.
- UMATI has well developed partnerships with other NGOs, and has formed effective, albeit small-scale partnerships with government partners.
- Mechanisms for young people's participation have been established at project level, but are not institutionalised in UMATI's policy-making volunteer structure. There is a general perception among volunteers that young people lack the capacity to participate effectively in decision-making.
- UMATI's major contribution historically to policy reform and advocacy is recognised by partners as stemming from its role as a pioneer for family planning and now young people's reproductive health and rights. UMATI's advocacy activities are currently constrained by lack of funds and staff.
- UMATI has also played a pioneering role in provision of RH services to young people. Activities consist of a range of small-scale, geographically dispersed approaches, and lack of human and financial resources have been major constraining factors.

- Consolidation of lessons learnt on best practice will be crucial to UMATI's strategy to scale up and to integrate lesson learning on youth friendly services into its core programme.
- UMATI has supported innovative youth-focused IEC to meet locally identified needs on a project-by-project basis. Efforts are currently being made to facilitate a transition from an IEC to a BCC approach. The challenge will be to scale up and integrate different projects; recruitment of an IEC/Advocacy Manager will be key to taking this forward.

### **Complementarity of UNFPA and UMATI**

- UMATI's approach to young people's sexual and reproductive health is largely complementary to that of UNFPA.
- Despite complementarity of approaches, coordination and lesson learning between the two organisations have been limited. UMATI is an implementing partner in the AYA programme, but slow implementation has placed constraints on coordination efforts by both UMATI and UNFPA.
- There is great potential for scaling-up best practice through improved coordination between UNFPA and UMATI, and through including NGOs such as UMATI as implementing partners in UNFPA's Country Programme. However, government resistance appears to be a major constraint to UNFPA working with NGOs as CP implementing partners.

### Recommendations<sup>3</sup>

#### **UNFPA**

- The Country Office should increase and enhance its expertise in adolescent RH, reproductive rights and in advocacy (proposed new appointments are expected to redress some of these weaknesses). In addition to new appointments, training and awareness raising courses for existing staff and greater support from the CST (and/or international consultants) in adolescent RH, rights and advocacy should be considered as strategies for enhancing CO capacity and expertise.
- The Country Programme needs a strengthened and more strategic focus on empowering young people and on gender issues as they affect young people's reproductive health and rights.
- Greater effort needs to be devoted to realising synergies between the UNFPA Country Programme and AYA.
  
- Mechanisms should be developed to facilitate young people's participation in the CP. This requires *inter alia* greater understanding among the CO staff and government partners of issues around young people's participation. A closer and more strategic relationship with AYA would go some way to addressing the former (development of participatory mechanisms).
- In order for UNFPA to exert influence at national level (both within government and within the key donor forums such as the PRSP, Health SWAp Steering Committee, the Bilateral and Multilateral Health Forum), UNFPA's leadership role in RH needs to be more visible and strategic.
- More UNFPA resources need to be devoted to developing the capacity of government implementing partners.
- Despite current government resistance, UNFPA should seek to develop more interventions with NGOs as implementing partners.

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<sup>3</sup> These recommendations were not discussed in-country with UNFPA or UMATI. However, both agencies were subsequently sent them by their respective HQs ahead of finalising the report.

- UNFPA's limited focus on policy and advocacy in relation to ARH and rights should not be redressed exclusively through AYA. Much will depend on enhancing the capacity of the UNFPA country office.
- UNFPA should explore strategies to scale up some of its innovative youth focused BCC activities (including family life education and life skills education). Partnerships with NGOs and an increased emphasis on lesson learning and dissemination would address this to some extent.

### **UMATI**

In order to implement more effectively the paradigm shift (from family planning to integrated reproductive health with young people as the primary client group) UMATI should:

- Institute mechanisms for young people's full participation in policy and decision-making in line with the revised constitution, and ensure that these mechanisms are operational at all levels of UMATI's decision-making structure (ie at national, regional, branch and ward levels).
- Strengthen the internal capacity of UMATI staff to implement the paradigm shift and to provide youth-friendly services. In particular, focus on training of existing service providers on youth-friendly services in the core UMATI clinics.
- Strengthen the BCC programme through appointing a BCC and Advocacy Manager, and provide central coordination for BCC and advocacy activities carried out at local/project level.
- Strengthen Monitoring and Evaluation to allow for analysis of trends in service utilisation by young people and to enable UMATI to assess programme effectiveness in bringing about sustained behaviour change among their target population.
- Institutionalise the documentation and analysis of lessons learnt on best practice from pilot youth projects, as a basis for scaling-up and integrating pilot projects into a coherent programme approach.

In addition IPPF should:

- Provide ongoing and consistent technical support to UMATI to enable them to implement the paradigm shift, as approved by the IPPF Regional Office.
- Ensure that there are no bottle-necks in fund-flows to UMATI, to enable them to recruit the necessary staff and to implement their programme as set out in their strategic plan and work-programmes and budgets.

## INTRODUCTION

The Ministry for Economic Cooperation and Development (BMZ) of Germany, the Danish Ministry of Foreign Affairs, the UK Department for International Development (DFID), the Netherlands Ministry of Foreign Affairs, and the Norwegian Ministry of Foreign Affairs are jointly sponsoring an evaluation of the contribution of the United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF) to addressing the reproductive rights and health needs of young people<sup>4</sup> - and especially adolescents - in the period since the finalisation of the Programme of Action (POA) developed at the International Conference on Population and Development (ICPD) in 1994.

The evaluation focuses on six country case studies: Tanzania, Burkina Faso, Bangladesh, Egypt, Nicaragua and Vietnam undertaken between March and May 2003. The findings from these six country studies will be synthesised into a final report to be presented at an international workshop in December 2003.

### Overall Objectives of the Evaluation

The overall aim of the evaluation is to clarify how UNFPA and IPPF contribute to the implementation of key aspects of the ICPD Programme of Action, relating to the reproductive rights and health of young people. UNFPA and IPPF have affirmed their commitment to the ICPD framework; central to which are the notions of gender empowerment, equity, and a rights based approach. IPPF's commitment to a rights based approach is outlined in the IPPF Charter on Sexual and Reproductive Rights (1995), and in the objectives and strategies of Vision 2000.

The goal of the evaluation is to contribute to a better understanding of the conditions necessary for achieving best practice, and to draw strategic lessons for the future.

The purpose is to assess the performance of UNFPA country offices and FPAs in selected countries (see below) in promoting reproductive rights and health (with the aim of achieving behavioural change), with a particular emphasis on adolescents and youth.

### Composition, Timing and Schedule of the Tanzania Country Evaluation

The local partner for the Tanzania country evaluation was the Institute of Public Health at Muhimbili University College of Health Sciences (IPH/MUCHS), a College of the University of Dar es Salaam. MUCHS undertook preliminary studies ahead of and during the international team's visit to Tanzania. The international team for the Tanzania country evaluation was: Dr Neil Price (team leader), Dr Kirstan Hawkins (international team member) and Mr Mangi Ezekiel (national team member). The international team members arrived Tanzania on 9<sup>th</sup> March 2003, and departed on 28<sup>th</sup> March 2003. A list of key people met and site visits is at Annex 1. A list of the participants at the stakeholder workshop held at the beginning of the evaluation is at annex 2.

UNFPA and UMATI work with the governments of both Mainland Tanzania and Zanzibar, which together make up the United Republic of Tanzania. Because of the security situation we were unable to visit Zanzibar. However, a number of government representatives from Zanzibar attended the stakeholder workshop at the beginning of the evaluation and made significant contributions to discussions. We have also extensively consulted secondary source documents from Zanzibar as part of the evaluation.

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<sup>4</sup> The evaluation adopts UN definitions: adolescents are those aged 10-19 years, youths are aged 15-24 years; while young people includes both categories (10-24 years).

## **Report Format**

The report is in six sections, relating respectively to the country context, the strategic focus of the two agencies' national programmes, institutional arrangements; and the contribution of each agency to policy reform, strengthening services and provision of information and education. Each section is structured around the criteria of the evaluation, which include relevance, integration of rights, capacity, efficiency, effectiveness, and sustainability. With the exception of section 1, the remaining sections are divided into two separate sub-sections on UNFPA and UMATI respectively, with each sub-section concluding with a short summary of the main conclusions.

## SECTION 1: THE COUNTRY-SPECIFIC CONTEXT

This opening section considers a range of historical, economic, political, policy/legal, socio-cultural and behavioural factors influencing young people's reproductive health and rights. The analysis places the status, roles and rights of young people within the broader developmental context of Tanzania. Subsequent sections of the report are informed by and analysed in relation to this section.

### 1.1 Demographic and Socio-Economic Context

#### Poverty

Tanzania ranks as one of the poorest countries in the world (GDP per capita in 2000 was US\$478); and is ranked 140<sup>th</sup> out of 162 in the Human Development Index<sup>5</sup>. Estimates for 2000 suggest that over 50% of the population of mainland Tanzania are living below the poverty line<sup>6</sup>. Poverty is highest in rural areas, where 79% of the total population - and more than three out of every four young people - live. Lack of economic and social opportunities has led to growing despair among young people.

High infant and under-5 mortality rates and low life expectancy (see below) are important indicators of persistent poverty in Tanzania. One of the key challenges to achieving sustainable improvements in poverty indicators derives from the still rising numbers of HIV infections (see below). Estimates suggest that Tanzania's future GDP will be up to 20% lower in 2010 than it would have been without HIV/AIDS.

#### Demographic and health indicators

The population of Tanzania according to the Population and Housing Census 2002 is 34,569,232 (33,584,607 Mainland; 984,625 Zanzibar). The annual population growth rate is 2.9%. 65% of the population is under 25 years of age. Adolescents aged 10-19 comprise almost 25% of the population; young people aged 10-24 over 30%.

Tanzania has a high age dependency ratio which has increased from 0.89 in 1991 to 0.97 in 2000. The dependency ratio is higher in rural than urban areas (PRSP 2000).

The total fertility rate is 5.6, and declining slowly (TRCHS 1999<sup>7</sup>). TFR is higher in rural (6.5) than urban areas (3.2). Age-specific fertility for the 15-19 year cohort is 199 per 1000. The contraceptive prevalence rate has increased from 10% in 1992 to 22% in 1999 (16% for modern methods). Unmet need in 1999 was estimated at 40% (TRCHS 1999).

IMR and U5MR both worsened in the period between the 1996 DHS and 1999 TRCHS. IMR increased from 88 to 99 per 1000 live births; U5MR from 137 to 147. Neonatal mortality over the same period increased from 25 to 44. Life expectancy has decreased from 50 in 1988 to 47 in 1999. The maternal mortality ratio (MMR) is estimated at 529 per 1000 live births.

#### Gender relations and status of women

Recent deterioration in social capital and traditional security systems has increased the vulnerability of women, young people and children. 25% of households are female headed and one fifth of adolescents 10-19 years live in female-headed households (TRCHS 1999).

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<sup>5</sup> UNDP (2001) Human Development Report

<sup>6</sup> United Republic of Tanzania (2000) *Poverty Reduction Strategy Paper* (known henceforth as PRSP)

<sup>7</sup> National Bureau of Statistics Tanzania & Macro International (2000) *Tanzania Reproductive and Child Health Survey 1999* (known henceforth as TRCHS 1999)

In male-headed households women often lack access to household income and control over household budgets.

Women are generally poorer than men due to lack of access to land and ownership of assets such as livestock. Women in Zanzibar and large parts of the mainland face discriminatory restrictions on inheritance and ownership of property because of concessions by the Government and courts to customary and Islamic law.

According to UNICEF's Country Programme document, female literacy dropped from 88% in 1986 to 64% in 2000.

Under Zanzibari law, unmarried women under the age of 21 who become pregnant are subject to 2 years imprisonment.

Studies indicate increasing levels of violence against women and sexual abuse of girls (see 1.4 below).

## **1.2 The Policy and Legal Context**

There are numerous national policies and laws regarding and/or affecting the reproductive rights of young people. Some are contradictory, others ambiguous, as the following brief summary illustrates.

### **Policies and Strategies**

#### The National Population Policy

A national population policy was formulated in 1992, and revised (in draft form only) in 2001. The revised draft policy assumes a more explicit role for government, civil society, and private sector within a multi-sectoral approach to population and development, poverty reduction, elimination of discriminatory and harmful practices, and promotion of reproductive health and rights. The current draft does not place much emphasis on young people, but does call for the establishment of youth friendly reproductive health services. Discussions with the head of the government's national Planning and Privatisation Commission revealed that promulgation of the revised Population Policy has been delayed to allow for incorporation of data from the 2002 Census. Finalisation of the revised national Population Policy is expected later in 2003. The Planning and Privatisation Commission also confirmed that young people will be given greater prominence in the final version of the revised Population Policy, particularly in relation to unsafe abortion, HIV/AIDS and school education. Elements of the draft National Adolescent Health and Development Strategy (see below) will also be incorporated into the revised National Population Policy.

#### The National Health Policy

The National Health Policy, formulated in 1990, does not address young people directly, except in regard to family planning, wherein it denies services to adolescent girls who have no children. This directly contradicts the Family Planning Guidelines and Services Standards (1994) which state that "all males and females of reproductive age including adolescents, irrespective of their parity and marital status shall have the right of access to family planning information, education and services". A revised draft National Health Policy was produced in February 2002, which is yet to be approved. The reference to nulliparous adolescent girls being denied family planning services has been removed in the draft, which contains but one passing reference to adolescents/young people (as one of a number of vulnerable groups).

### National Reproductive and Child Health Strategy

In July 1997, the Strategy for Reproductive Health and Child Survival (1997-2001) was formulated by the then Family Planning Unit (FPU) of the MOH with support from UNFPA. FPU later that year became the Reproductive and Child Health Section (RCHS). The strategy had 11 objectives, the one relating to reproductive health specifically referring to advocacy (in partnership with UMATI) for a national youth reproductive health strategy (which later became the adolescent health and development strategy, see below).

The RCHS subsequently developed a National Package of Essential Reproductive and Child Health Interventions (NPERCHI) as a companion to the National Package of Essential Health Interventions developed by the MOH in 2000 in response to the health sector reforms. NPERCHI expands the RCH components of the National Package of Essential Health Interventions. The 13 categories of RCH interventions in the package do not address explicitly adolescent reproductive health, although mention is made regarding provision of IEC to adolescents on the dangers of unsafe abortion, safer sexual practices, birth spacing and delaying child-bearing, and modes of HIV transmission.

The RCHS has recently developed its Reproductive and Child Health Strategy (2003-2006) as a follow-on to the Strategy for Reproductive Health and Child Survival (1997-2001). Young people are identified as a priority for RH services within the new strategy, but interviews with the Head of RCHS in the MOH revealed that (until the National AHD strategy is finalised see below) – no clear vision on the provision of youth-friendly services or the appropriate target groups of young people can be agreed (see also section 5.1).

### National Adolescent Health and Development Strategy

This strategy – under the RCHS of the MOH - was drafted in 2000-2001 with assistance from UNFPA and WHO. It has remained in draft form for over two years. Institutional arrangements for the implementation of the strategy in the draft document remain vague, but mirror the decentralisation process within the health sector. The strategy has five objectives relating to enabling the policy environment, improving access (through youth friendly services), provision of behaviour change communication (to community, parents and young people), development of livelihood skills, and increased capacity for youth programmes.

### HIV/AIDS Policy and Strategy

The government has been slow in putting in place effective HIV/AIDS programmes and institutional arrangements for a national programme.

The National AIDS Control Programme (NACP) located in the MOH – whose goal is to reduce HIV transmission and minimise or mitigate the impact of HIV infection - was launched in 1988, and there have been three medium term plans. Implementation through the 1990s was hampered by lack of funds and lack of political will. Emphasis in the third medium term plan (NACP MTP III 1998-2002) was on decentralisation of implementation to district and lower levels. The *Health Sector HIV/AIDS Strategy for Tanzania 2003-2006* has recently been finalised, and is a successor to the MTP III which ended in 2002.

The Health Sector HIV/AIDS Strategy will shift HIV/AIDS from being a vertical programme to an integral component of the health services for which MOH has responsibility. NACP's role has been redefined so that it becomes a specialised agency of the MOH.

The Health Sector HIV/AIDS Strategy identifies young people as a priority vulnerable group. One of the core prevention strategies articulated in the Health Sector HIV/AIDS Strategy 2003-2006 is to reduce vulnerability to HIV/AIDS and STDs among in-school and

out-of-school young people. Strategies include youth-friendly health services and youth-focused health promotion, including the mass media, incorporating HIV/AIDS/STD education into the school curriculum, involving parents in prevention activities, incorporating HIV/AIDS education into extra-curricular activities, and using peer educators to promote behaviour change at post-secondary level and among out-of-school youths). The strategy also includes provision for advocacy and technical support to non-health sector partners (MEC, MLYDS, Ministry of Higher Education and NGOs) in health promotion and BCC, within the Multisectoral Strategic Framework (under TACAIDS). TACAIDS (The Tanzania Commission for AIDS) was established in 2001 for coordinating the multisectoral response.

The DAC Consultative Group Meeting in 2002 emphasised the need for more resources to support orphans and vulnerable children within the HIV/AIDS Multisectoral Strategic Framework.

Under NACP, behavioural surveillance of the 15-24 year age group started in 2002 in the catchment areas of the 24 sentinel clinic sites located in six Regions (from 2003 there will be 48 sentinel clinics in 12 Regions). Unlinked anonymous antenatal HIV screening takes place in the sentinel clinic sites.

#### The National Education Act and Policy

Sex education in schools is not compulsory, although the Education Act allows FLE and HIV/AIDS education in schools. Government school regulations under the Education Act encourage schools to interpret pregnancy by schoolgirls as misbehaviour, for which they are expelled.

#### The National Youth Policy

The National Youth Policy was formulated in 1996, under the Ministry of Labour, Youth Development and Sports. The policy identifies five problems facing young people: FGM and early childbearing, STDs/HIV, poor nutrition, and mental health. The policy is currently being reviewed – with UNFPA assistance.

#### Children Development Policy

Dating from 1996, this policy calls for the removal of legislative and policy barriers that deny access to RH information and services provided to young people. It also emphasises the need to educate and mobilise parents, guardians, communities and institutions for a better understanding and upholding of rights of children; to review and abandon outdated laws which allow violations of children's rights; and advocates strong punishment for all acts of defilement, rape and exploitation of children.

#### Other relevant policies

The Sport and Development Policy (1995) Community Development Policy (1996) and Cultural Policy (1997) all identify youth as meriting special attention in terms of: needing proper upbringing and guidance, urging communities to discard customs and traditions which have deleterious effects on the youth and children, discouraging gender discrimination, encouraging utilisation of good customs and traditions in preparing the youth for responsible parenthood while discouraging harmful practices.

### **Laws**

Under the Marriage Act (1971) the legal age of marriage for boys is 18, and for girls with parental or guardian consent it is 15 (without consent it is 18). Under special circumstances a

court can give consent for a girl to marry at 14, and under traditional law girls can marry at 12.

The Sexual Offences Act (1998) makes it an offence of rape for a male to have sex with a girl under 18 (unless he is married to her). The Act has also been used to prosecute those who perform female genital cutting (FGC) on young girls (see below).

## **Rights**

The Tanzania Constitution includes a bill of rights which guarantees a right to equality and to life. Tanzania has ratified international and regional rights conventions including: CEDAW, CRC, Goals of the World Summit for Children, Africa Charter on the Rights and Welfare of the Child, ICPD and Beijing Platform for Action.

In 2000, the government passed a Constitutional amendment to establish the Tanzania Commission of Human Rights and Good Governance. The commission is an independent organ, which replaced the former Permanent Commission of Inquiry. The first mission of the commission is centred on offering civic education, including human rights to the citizenry and how to take legal steps against violators of those rights. Some of the areas addressed in the work of the commission include:

- The right to life and liberty, including freedom of speech, freedom of peaceful assembly and association, freedom of religion, freedom of movement within the country, foreign travel, emigration and repatriation.
- Equal rights of women and men.
- The right to a standard of living adequate for health and well-being of the individual and his/her family.
- The right to social protection in times of need.
- The right to the highest attainable standard of physical and mental health.
- The right to participation in the political process, and the right of citizens to change their Government.

The Constitution prohibits discrimination based on nationality, tribe, origin, political affiliation, colour and religion. Discrimination based on sex, age or disability is not prohibited specifically by law, but is discouraged publicly in official statements<sup>8</sup>. Discrimination against women and religious and ethnic minorities persists. TAPAC established by the government in 2001 seeks to address discrimination against people infected with HIV.

## **Young People's Participation in National Policies and Programmes**

The Tanzania PRSP provides a supportive framework to promote young people's participation in the development process. However, children and young people are regularly denied the right to participation at household level, in school settings, and other public policy decision-making forums. In many cases government and community do not perceive participation as a right of young people. Girls, orphans and young people with disabilities are particularly discriminated against.

The Children Development Policy (see above) argues for children's right to participation in decisions affecting their lives.

A number of NGO programmes place a strong emphasis on involvement of young people in design, implementation, management and evaluation (eg those run by Kuleana and YCIC, who are also involved in advocacy efforts).

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<sup>8</sup> US State Department (2002) *Tanzania – Country Report on Human Rights Practices*.

The appointment of a young HIV/AIDS commissioner is an encouraging step towards young people beginning to exert influence in leadership positions.

### **1.3 Sexual and Reproductive Behaviour**

#### Social and cultural attitudes towards sex, marriage and fertility

Studies on age of first sexual encounter have been carried out in many regions of Tanzania. While there are variations between studies and between regions, generally they indicate a later onset of sexual activity among girls than boys<sup>9</sup>. For example, a study carried out in Lindi region<sup>10</sup> found mean age of sexual debut for boys to be 11 years and 14 years for girls.

Focus group discussions (FGDs) carried out with young people by IPH/MUCHS as part of the evaluation, indicate that attitudes regarding appropriate age of marriage and sexual debut also vary according to gender. Appropriate age of marriage was considered by young people in the FGDs to be between 20-25 years for young men, and between 14-20 years for young women. Young men identified mainly economic reasons for delaying marriage, including the need to find employment, complete schooling, secure a business or a farm, and have a home and a car. Conversely an economic rationale was given for early marriage among girls. In some FGDs young women talked about parents exerting pressure on them to marry and leave school after only completing primary education so as not to be an economic burden on the household. In these cases girls referred to parents abusing them and blaming them for being an economic drain if they did not marry. Girls also referred to pressure to accept economic support from men in exchange for sex, and being pressured to marry after puberty to avoid pregnancy out of wedlock. Young people also suggested that parents who had been sensitised through sexual and reproductive health and rights programmes were more considerate of young people's needs, and less likely to pressurise them into early marriage.

Attitudes and practices regarding appropriate age of marriage and sexual initiation vary considerably according to region and ethnicity. In FGDs, young people in Arusha referred to a practice among the Maasai of girls being "booked for marriage" through a dowry system, in which girls move to live in the future husband's homestead to tend cattle from as early an age as 5 years old.

Sexual behaviour studies have pointed to a variety of reasons given by young people as to why they are sexually active<sup>11</sup>. Reasons include sex being a natural desire and creating good feelings, lack of reproductive health knowledge and lack of access to services and condoms, peer pressure, increasing belief among older men that girls are free from HIV or that having sex with a virgin can cure AIDS, belief among older men that "having sex with girls might revitalise failing potency", economic pressure, increasing delay between puberty and marriage, breakdown of traditional support structures and of traditional mechanisms for sex

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<sup>9</sup> Goergen, R (2001) "Facts and burning issues on young people's sexuality and reproductive health in Tanzania" (GTZ Reproductive Health Project).

<sup>10</sup> MOH/GTZ (2000) "Survey on knowledge attitudes and practice of adolescents with regard to reproductive health and sexually transmitted infections, including HIV/AIDS, Lindi region".

<sup>11</sup> Matasha, E et al (1996) "Baseline questionnaire survey of sexual and reproductive health among primary and secondary school pupils in Mwanza region, Tanzania" (AMREF); Lugoe, W *et al* (1996) "Sexual debut and predictors of condom use among secondary school students in Arusha" (*AIDS Care* 8:4, 443-452); Lwihula G (1997) "Sexual and reproductive knowledge, perceptions and behaviour among school youths in Kinondoni District, Dar es Salaam"; Lwihula, G (1998) "Baseline survey on factors that may inhibit or facilitate behaviour change among out of school youth (10-18 years) with regard to HIV/AIDS in two rural districts (Musoma and Kisarawe), Tanzania" (UNICEF Report); MOH/GTZ (2000).

education, and rape and coercion<sup>12</sup>. Studies also indicate that girls often feel particularly vulnerable as they lack the power and social status to be able to resist harassment by older men<sup>13</sup>.

A 2001 KAP study carried out by the Ministry of Education and Culture<sup>14</sup> identifies teenage pregnancy as a serious problem. However, the focus group discussions carried by IPH/MUCHS indicate that young people perceive a high degree of disapproval by parents and community members regarding use of contraceptives by unmarried youth. Young people also expressed a need for sexual and reproductive health services, which recognise that many young people are sexually active before marriage. Girls in school, in particular, expressed a strong need to access contraceptives to avoid becoming pregnant and being expelled. Girls in the FGDs were much more concerned about the social consequences of pregnancy than they were about HIV and STIs. The baseline study for the UMATI Young Men as Equal Partners project in 2000 indicated that young men perceived that they had more rights on issues relating to sexuality than women, and that for young men fathering a baby before marriage was a source of pride. At the same time, young men stated that they would not be prepared to marry a woman who had a pregnancy before marriage.

#### Age disparities within sexual unions

Numerous studies indicate that boys are most likely to have sex with girls of their own or similar age. In Lindi Region three quarters of boys surveyed reported having had sex with girls of their age<sup>15</sup>. On the other hand girls are more likely to have sex with an older or much older partner<sup>16</sup>. Studies have also indicated that older sex partners are often family members, members of the community, and teachers<sup>17</sup>. In Mwanza, 20% of primary school girls said that their first sexual experience had been as the result of coercion by older men<sup>18</sup>.

The baseline KAP study carried out for the Family Life Education Programme by the MEC in 2001 highlights high levels of sexual harassment and abuse of students by teachers as a major issue. The study indicates that 35% of primary school pupils of both sexes had been asked by teachers and other adults to have sex. The MEC KAP study in Shinyanga Region indicated that 54% of school students had been asked to have sexual intercourse by adults. The study in Mwanza region<sup>19</sup> indicates a considerable number of girls (7.7%) and boys (4.2%) reported sex with a family member.

#### Risk behaviours

Small-scale studies carried in different parts of Tanzania indicate that very few young people use condoms to prevent HIV or pregnancy, and/or other contraceptives to prevent pregnancy. A recent study carried out in Dar es Salaam primary schools (Standard VI) showed that only 8% of sexually active boys ever used a condom. A study in primary schools in Lindi Region found only 11% of sexually active boys ever used a condom and only 8% used one during last sex<sup>20</sup>. In secondary schools the figure is higher. A study among secondary school students in Arusha aged 15-24 showed that 27% had ever used a condom

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<sup>12</sup> Goergen (2001)

<sup>13</sup> Leshabari, M (1988) "Factors influencing school adolescent fertility behaviour in Dar es Salaam".

<sup>14</sup> MEC (2001) "A Baseline Survey on Knowledge, Attitude and Practices (KAP) in Tanzania Mainland" (Ministry of Education and Culture).

<sup>15</sup> MOH/GTZ (2000)

<sup>16</sup> Leshabari (1988), Matasha et al (1996), Lugoe (1996), Lwihula (1997, 1998), MOH/GTZ (2000)

<sup>17</sup> MEC (2001)

<sup>18</sup> Matasha et al (1996)

<sup>19</sup> Matasha et al (1996)

<sup>20</sup> Goergen (2001)

and 22% used it during last sexual encounter<sup>21</sup>. Almost half of secondary school students also report having experienced some form of sexual abuse, which included female genital cutting, rape and sex for money. Many said they had not discussed these issues with anybody<sup>22</sup>.

The focus group discussions with young people carried out by IPH/MUCHS also indicate high levels of risk behaviour among young people. Specific risk behaviours and practices referred to by boys and girls in FGDs included sex with peers “accepting risky dating in the dark with the opposite sex”, sexual favours used as advances to get employment, sex for presents from older men and women, and substance abuse including drugs and alcohol. While the young people in the FGDs indicated that they had a good knowledge of STI/HIV prevention, in many of the above risky situations condoms are not used (especially under the influence of drugs and alcohol). Both boys and girls were able to name a range of contraceptives methods. Girls also referred to a range of traditional contraceptive methods that are often favoured by young people. These include *pigi* (sticks tied on a string and worn around the waste), the *ndula* plant which is dried and ingested after mixing with water, drinking a litre of water after intercourse, and immediate urination by the woman after intercourse to wash away the sperm.

## 1.4 Priority Sexual and Reproductive Health Issues Facing Young People

### Marriage and fertility

For women, marriage is early and almost universal. The median age of first marriage for women is approximately 19 years (TRCHS 1999), up from 18 in 1992 (DHS 1991/92). 25% of young women aged 15-19 are currently married or in a cohabiting union, compared with only 2% of young men in the same age group (TRCHS 1999).

Age of sexual initiation is also early. 15% of young women and 24% of young men aged 15-19 have had sexual intercourse by age 15. Almost one-third of young women aged 15-19 years are sexually active, of these 60% are married (TRCHS 1999).

Age of first childbearing is also early. One out of four young women aged 15-19 has ever been pregnant and one out of five have had a child. 56% of ever-married 15-19 year old women have had a child.

Contraceptive prevalence among young people is low, estimated in 1999 at 5.8% for young women aged 15-19 and 11% for men in the same age group (TRCHS 1999). 87% of married young women aged 15-19 have heard of a modern method of contraception compared to 70% of never-married young women in the same age group.

### Safe motherhood and unsafe abortion

The combined effects on young women of early sexual debut and marriage, early childbearing, poor access to services and low contraceptive prevalence results in high levels of unwanted pregnancies and unsafe abortion.

Data on the prevalence of unsafe abortion are difficult to obtain given the illegality of the practice (the Penal Code prohibits abortion services), and because of the shame associated with it. The UNFPA CPA (2001)<sup>23</sup> suggests that between 15% and 25% of maternal morbidity and mortality is caused by unsafe abortion, and notes that 38% of admissions with obstetric

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<sup>21</sup> Lugoe (1996)

<sup>22</sup> MEC (2001).

<sup>23</sup> UNFPA (2001) *Tanzania Country Population Assessment*.

complications to a hospital in Shinyanga were due to abortion. 1992 data from Muhimbili National Referral Hospital indicate that 47% of 965 obstetric admissions were abortion complications. Nationally it has been estimated that one-third of all hospitalised cases of incomplete abortions are to teenagers (TRCHS 1999). Although post-abortion care (PAC) is a component of the national RCH strategies (1997-2001, 2003-2006), access is severely limited, and there is a shortage of MVA kits.

According to the TRCHS 1999, only 36% of deliveries in Tanzania are by skilled attendant (a 20% decline over the previous decade). While antenatal coverage is high, the quality of service and care is poor. Less than 5% of women receive postnatal care. The low caesarean rate (2% of all births) indicates that most obstetric emergencies do not reach health facilities, undoubtedly contributing the very high maternal mortality ratio. A 1999 needs assessment in life saving skills showed that only 4% of service delivery points were offering basic level essential obstetric care.

Many women develop vesico-vaginal fistulae as a result of prolonged and complicated deliveries (exacerbated by those women who have been circumcised, see below). VVF repairs are performed in only a small number of consultant hospitals, and the cost of the surgery is prohibitive for most women. Ten mission hospitals also perform VVF repairs at the rate of about 10-20 per year<sup>24</sup>.

### Curable STIs and HIV/AIDS

Estimates of HIV prevalence in the adult population (15-49) vary significantly. NACP<sup>25</sup> estimates from antenatal sentinel surveillance that the national adult (15-49) prevalence is 9.6%, with prevalence among the 15-24 age group at 7.6%. 60% of new HIV infections are in the 15-24 age group.

The gender gap in HIV infections is widening. Current estimates – based on blood donor<sup>26</sup> surveillance – show 13.7% prevalence among women and 10.4% among men<sup>27</sup>. Young women are between four and six times more likely to be HIV infected than young men.

There are large regional differences in HIV prevalence. Sentinel surveillance data from antenatal clinics show HIV infection prevalence of 4.2% in Mwanza District and 32.1% in Iringa District<sup>28</sup>.

While nearly all 15-19 year olds have heard of HIV/AIDS, knowledge of prevention is limited. According to UNAIDS data, only 37.8% of females aged 15-19 years know of two ways of preventing HIV. While similar proportions of young men and women perceive themselves to be at moderate to high risk of contracting HIV, sexually active young men are three-times more likely than sexually active young women to use condoms (22% compared to 7%).

Stigmatisation of people living with HIV and AIDS is common in Tanzania.

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<sup>24</sup> UNFPA (2001) *Tanzania Country Population Assessment*

<sup>25</sup> NACP (2002) *HIV/AIDS/STI Surveillance Report 2002*, Dar es Salaam

<sup>26</sup> Blood donors may be a biased sample, but data from this group provide a useful indicator of trends in sex-based differences in HIV prevalence, as sentinel surveillance relies upon data from women only (antenatal attendees)

<sup>27</sup> NACP (2002)

<sup>28</sup> NACP (2002)

### Access to education

Gender equality in primary education enrolment has been achieved. Gross primary enrolment is estimated at 76.8% for boys and girls (PRSP Monitoring Report 2002). Three million children of primary school age are currently not in school. At upper secondary and tertiary levels of education, there is marked gender inequality, with much higher levels of male than female enrolment. The transition rate from primary to secondary school at 18.8% (Ministry of Education and Culture 2001) is among the lowest in the world. The PRSP 2002 monitoring report estimates the transition rate to have increased to 20%, and gross primary enrolment at 83%.

For both boys and girls, 10-14 year olds are twice as likely to be in-school than 10-19 year olds. Urban adolescents are more likely than rural adolescents to be in-school (TRCHS 1999).

According to the 1999 TRCHS, no 15-19 year old young women who are married and/or have a child are in school – a consequence of the interpretation by head teachers that a girl who becomes pregnant is guilty of “misbehaviour”, which - under the Education Act - allows schools to expel them.

### Gender-based violence

Domestic violence against women is widespread. Assault provisions against women - under the Criminal Code - are difficult to enforce in practice. The Marriage Act includes a declaration against spousal battery but does not prohibit it or provide for any punishment. Traditional customs that subordinate women remain strong in urban and rural areas. Local magistrates often uphold such practices. Women may be punished by their husbands for not bearing children. It is acceptable for a man to beat his wife, and wife beating occurs at all levels of society<sup>29</sup>. Sexual and gender-based violence continues to be a problem in refugee camps.

In 2000 Parliament amended the Constitution to prohibit sexual harassment of women in the workplace by a person in authority, but the practice remains widespread.

### Commercial and transactional sex among young people

A 1998 study by ILO reported a growth in child prostitution. Child labour remains a problem<sup>30</sup>. There are reports of forced and bonded labour of children. ILO and UNICEF report that children are trafficked away from their families to work in mines, commercial agriculture, as domestic labourers, and in other business entities. Children who are trafficked to work as domestic labourers are often subjected to commercial sexual exploitation (ILO, UNICEF). The Constitution does not specifically prohibit forced or bonded child labour.

### Alcohol and drug abuse

Alcohol and drug abuse are associated with other risk-taking behaviour, particularly in relation to sexual practices. The extent of drug abuse among young people is unclear, although all reports indicate that it is more common among young men than young women. A 1991 study in four regions, reported cannabis had been used by just 3.8% of young people, and 0.1% had ever used heroin. However, a 1992 study of 1100 secondary school students

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<sup>29</sup> US State Department (2002) *Tanzania – Country Report on Human Rights Practices* (Bureau of Democracy, Human Rights and Labour)

<sup>30</sup> US State Department (2002)

in Dar es Salaam, with a mean age of 17.6 years revealed that 63% reported use of non-medical drugs, notably stimulants, cannabis and heroin.

### Harmful practices

Cultural and gender identity and control of women's sexuality are the main reasons cited in studies for the continuation of female genital mutilation (FGM). Although government officially discourages FGM, it is still performed at a very early age among 20 of the country's 130 ethnic groups. Nationally, FGM is estimated to affect 18% of the female population. Median age of circumcision for never-married 15-19 year-old women is 10.9 years and for never-married 15-49 year-old women it is 14.3 years. In some districts, the practice is carried out on very young girls<sup>31</sup>.

Clitoridectomy and excision are the most common forms of female circumcision. In some ethnic groups FGM is mandatory; in those where it is nominally voluntary a woman who is not circumcised will be unable to marry. The most affected region is Arusha (81% prevalence), followed by Dodoma (68%), Mara (44%), Kilimanjaro (37%), Iringa (27%), Tanga/Singida (25%) and Morogoro (20%). FGM is virtually non-existent in the rest of the country. There is no law which specifically prohibits FGM, although the 1998 Sexual Offences Special Provisions Act – which prohibits cruelty against children – has been used as the basis of campaigns against FGM performed on girls. There have been a small number of prosecutions and imprisonments of persons who have performed FGM on young girls.

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<sup>31</sup> US State Department (2002)

## SECTION 2: THE COUNTRY PROGRAMMES' STRATEGIC PRIORITIES

### 2.1 THE UNFPA COUNTRY PROGRAMME

#### 2.1.1 Relevance

##### Strategic objectives and priorities: overview of UNFPA assistance to Tanzania (to 1997)

UNFPA's support to Tanzania dates back to 1971. Between 1971 and 1980 UNFPA provided support for the census, obstetrics and gynaecology training, and research on MCH and child spacing.

UNFPA's first three country programmes (which ran consecutively from 1981 to 1996) made significant contributions to the development of Tanzania's first National Population Policy, to the integration of population variables into national planning (including support to two censuses), and in strengthening government capacity to deliver MCH/FP services (including the establishment of the National Family Planning Programme under the Family Planning Unit of the MOH).

In 1980 UNFPA's Governing Council approved its first Country Programme (1CP) for Tanzania (1981-1985), with five components: population awareness creation, health personnel development, MCH, policy formulation, and integration of demographic variables into socio-economic planning. In 1987 UNFPA approved the second Country Programme (2CP), which ran to 1991, with a major focus on the development of a national population programme and policy. Operationally, it included projects in MCH/FP service delivery (including CBD), institution strengthening (particularly in MCH/FP), IEC, the 1988 census, integration of population variables into the planning process, and women and development. The third Country Programme (3CP) (1992-1996), which was operational by the time of the lead-up to ICPD, had multiple objectives on enhanced delivery of MCH/FP services to meet unmet demand, IEC, training and research capacity building, women and development, donor coordination, and increasing the profile of NGOs.

The 1996 UNFPA *Programme Review and Strategy Development* (PRSD) report was critical of the 3CP for paying insufficient attention to adolescent RH and recommended that the 4CP pay closer attention to the "reproductive rights ... of boys and girls than was the case in the Third Country Programme" (PRSD 1996: 11). 3CP remained firmly articulated within a demographic rationale, with the IEC objective being "to promote public awareness of the need to match population growth and national economic performance". Although its objectives included reference to improved MCH/FP service provision, explicit objectives relating to improvement in reproductive health status were largely missing from the overall goals of the programme (ODA Evaluation of UNFPA Tanzania 1994). Since 1997 however, with the launching of the fourth country programme (4CP), UNFPA in Tanzania has shifted its focus to RH in line with the ICPD Programme of Action.

##### Strategic objectives and priorities in the Fourth Country Programme (1997-2001)

The Fourth Country Programme (1997-2001) showed a significant reorientation away from the family planning and demographic focus of previous CPs to a more reproductive health-focused programme. However, financial and human resource constraints and other limitations (including lack of capacity in government partners and failure to develop effective partnerships with NGOs) meant that a number of activities had to be curtailed or cancelled and 4CP had limited impact. Apart from support for the draft AHD strategy (in 2001) and

limited advocacy around FGC, there was little activity or strategic focus in 4CP on young people's RH and rights. Following the recommendation of the Mid-Term Review of 4CP, a number of outputs under the Population Advocacy Sub-Programme – including those which related to advocacy for adolescent reproductive health – were dropped (see section 4).

4CP had numerous projects which were grouped into three sub-programmes:

- Population and development strategies (PDS), which contributed towards the revision of the 1992 national population policy and the development of the Zanzibar population policy. The sub-programme supported preparation for the 2002 census and collaborated in carrying out the 1999 TRCHS.
- Reproductive health (RH), which operated at both national and district levels. Interventions of national scope included distributing commodities (mostly condoms and contraceptives), carrying out mass media communication, and supporting population and family life education (FLE). Support was provided for the development of the MOH's Reproductive Health and Child Survival Strategy (1997-2001) and a draft of the MOH's National Adolescent Health and Development Strategy (ADH) in 2001. UNFPA CST assistance was fundamental to the development of the AHD Strategy in 2001 - from the participatory consultations for the baseline information through to the writing of the final draft document. The draft strategy (which is still to be finalised by RCHS) forms the framework for UNFPA programming related to adolescent reproductive health). RH service delivery strengthening focused on 26 districts on the mainland and 10 districts in Zanzibar. Essential reproductive health equipment was provided to these districts, including for emergency obstetric care and family planning. At the district level, support was provided for the training of service providers in integrated reproductive and child health clinical skills. A referral system was instituted on a pilot basis in five districts, which were given ambulances and radio communication systems. Six health facilities in the Shinyanga region and 15 facilities in Zanzibar were renovated. The sub-programme continued support for community-based distribution in the public sector, operating in 10 districts on the mainland and two in Zanzibar. 4CP supported the integration of population, sexual and reproductive health and gender concepts into the curricula of secondary schools and teacher training colleges. Two knowledge, attitudes and practices (KAP) surveys were conducted nationwide to identify factors to promote the teaching of family life education (FLE) in teacher training colleges and in primary and secondary schools. Findings of the surveys were used to update FLE content in school syllabuses. The African Medical and Research Foundation implemented a life skills education activity for in- and out-of-school youth in one district in Dar es Salaam (see sections 5.1 and 6.1).
- Population advocacy, under which a population advocacy unit was established in the Ministry of Community Development, Gender and Children (MCDGAC) to coordinate population advocacy activities. Caucuses were formed in Parliament and the Zanzibar House of Representatives in support of population issues. A media relationship was forged, resulting in support for a popular radio soap opera dealing with population issues (see section 4.1).

#### Objectives, priorities and strategic approach in the Fifth Country Programme (2002-06)

5CP was approved by the Executive Board for UNDP and UNFPA at its first regular session of 2002 (February). The design process of 5CP – which took well over a year – involved a number of established UNFPA processes. The Terminal Evaluation of 4CP, undertaken by three national consultants in conjunction with national UNFPA CP partners, took place in February 2001 (final report May 2001). The Tanzania Country Population Assessment (CPA), which replaced the Programme Review and Strategy Development (PRSD) system as UNFPA's key document for assessing progress with the previous country programme and providing a situational analysis within which to design the next country programme, was undertaken around the same time in 2001, and involved national and international consultants commissioned by UNFPA, a member of the Country Support Team (CST) from

Addis Ababa, as well as a DFID-sponsored consultant. Once the Terminal Evaluation and CPA were approved, programme design for 5CP commenced with the involvement of representatives from UNFPA's Executive Board and the Country CST. Four members of the CST (specialists in reproductive health, population and development, advocacy, and gender) each made two trips to Tanzania in 2001.

5CP is budgeted at US\$28.25 million for the period 2002-2006, of which \$10.25 million is to be programmed from UNFPA regular resources, and the balance of \$18 million sought through co-financing modalities and other UNFPA sources. 5CP has 17 projects grouped into these three sub-programmes.

In line with the United Nations Development Assistance Framework (UNDAF) for Tanzania (see section 3.1), 5CP focuses on building national capacity and increasing access to basic services. The goal is set as "to contribute to national efforts to improve the quality of life of the Tanzanian people, with an emphasis on reproductive health, gender equality, women's empowerment and sustainable development". 5CP has three purposes: to contribute to increased utilisation of quality sexual and reproductive health services and information by men, women and adolescents; to contribute to effective implementation of population and development policies and programmes; and to contribute to the enhancement of gender equity and equality and the empowerment of women. These three purposes correspond to the three 5CP sub-programmes in Reproductive Health, Population and Development Strategies, and Gender and Advocacy.

#### *The Reproductive Health (RH) Sub-programme*

In order to contribute to increased utilisation of quality sexual and reproductive health services and information by men, women and adolescents the RH sub-programme has two outputs: improved quality of sexual and reproductive health information, service and care; and increased availability and use of such information and services by men, women and adolescents.

Activities for realising the first output include: improving the skills and knowledge of health service providers, teachers, counsellors, peer educators, community-based resource persons, and programme managers; improving the referral system for emergency obstetric care; improving availability of commodities and essential supplies; reviewing and/or developing service protocols.

Under the second output, numerous strategies are to be employed, which include: strengthening and establishing user-friendly outlets providing SRH information and services; establishing outreach programmes for out-of-school youth; promoting community-based services and information; promoting reproductive health rights for men, women and adolescents; encouraging community participation; implementing IEC activities to promote behavioural change (mainly through the in-school FLE project); integrating management of STIs into service delivery at all service delivery points; promoting male involvement and participation in sexual and reproductive health programmes.

The mainland Ministry of Health and the Zanzibar Ministry of Health and Social Welfare are responsible for coordinating the RH sub-programme interventions. District-level activities are limited to the 26 districts in mainland Tanzania and 10 in Zanzibar. The Ministry of Education and Culture (MEC) on the mainland and the Ministry of Education and Sports in Zanzibar coordinate the FLE activities in schools and colleges throughout URT. In designing the RH sub-programme, UNFPA has taken into account the work of the African Youth Alliance, which focuses on advocacy, behaviour change communication and the provision of youth-friendly services (see below). Prevention of HIV/AIDS is treated as a crosscutting issue

in all reproductive health interventions, addressed mainly through training in IEC and behaviour change communication, condom promotion, and syndromic management of STIs.

#### *The Population and Development Strategies (PDS) Sub-programme*

The PDS sub-programme has four outputs relating respectively to: availability and accessibility of disaggregated data for planning, monitoring and evaluation of population-related programmes; action plans for the national and Zanzibar population policies; strengthened mechanisms for coordination, monitoring and evaluation of population programmes at national, regional and district levels; and increased commitment and support for reproductive health, population and gender policies and programmes by policy makers, legislators, programme managers and leaders. The latter includes activities to establish parliamentary caucuses, whose roles include lobbying and sensitisation of government on population and RH rights. The PDS sub-programme also plans to work with and through the other two sub-programmes, specifically in relation to promoting the education and value of the girl child, and male involvement in FP/RH.

#### *The Gender and Advocacy (GA) Sub-programme*

The GA sub-programme sets out to promote a rights-based approach by focusing on a number of priority issues, which – in relation to young people – include sexual and reproductive rights of adolescents (addressing institutional, cultural and social constraints for accessing SRH information, services and care) and gender-based violence (addressing sexual offences, harmful traditional practices such as early marriage and FGC, and women's rights to land and other resources). Proposed activities – through two projects with the Ministry of Community Development, Gender and Children (MCDGAC) on the mainland and the Zanzibar Ministry of Youth, Employment, Women and Children Development respectively include establishment and/or strengthening of networks and alliances of organisations at district level (including parliamentary caucuses, media coalitions); information campaigns to include lobbying on issues such as early marriage and childbearing, risks to adolescents of early unprotected sex; building the advocacy skills of officials, community leaders, government partners, and NGOs; and operations research to inform advocacy strategies. UNFPA's flagship project in this sub-programme is the "media partnership project" initiated under 4CP. This is a partnership with Radio Tanzania for production of its *Twende na Wakati* (Let's Walk with Times) soap opera, which highlights central issues of the Country Programme in "a socially accessible way". Under 5CP, other radio stations (including Radio Zanzibar) have begun airing the soap opera.

#### *The Africa Youth Alliance*

This five-year project – funded by the Bill and Melinda Gates Foundation – is working in Tanzania, Ghana, Botswana and Uganda. The Tanzania AYA project became operational in January 2001, with a five-year budget of US\$16.5 million. AYA is a partnership between UNFPA (who are the lead agency and command the bulk of the budget), Pathfinder International and PATH (who receive US\$4.86m and 4.26m respectively). The project aims to reduce the incidence and spread of HIV/AIDS and STIs among adolescents and youth (in the age bracket 10-24) and to improve overall sexual and reproductive health within this age group. Six strategies are used to implement the programme: policy and advocacy (UNFPA); behaviour change communication and education (PATH); livelihood skills (PATH); youth-friendly services (Pathfinder); building institutional capacity to plan, implement, evaluate and sustain youth programmes (Pathfinder); and information sharing and lesson learning (UNFPA). Much rests on AYA in regard to UNFPA's policy and advocacy strategy for young people under 5CP (see 4.1). AYA represents an opportunity for UNFPA to make a significant contribution to improving young people's RH and rights in Tanzania. To date implementation in AYA has been slow and there is a need to develop more effective linkages

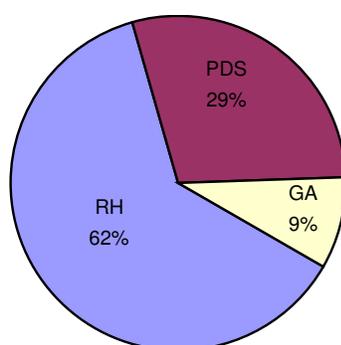
between AYA and UNFPA's 5CP to ensure synergies. A new National Programme Officer post in the UNFPA CO will be given responsibility for advocacy and gender, which should facilitate such linkages and synergies (see 3.1).

#### UNFPA recognition of the priority reproductive health issues facing young people

From the discussion so far it is clear that UNFPA under 5CP (and to a lesser extent under 4CP) recognises and articulates the priority RH issues facing young people (eg early marriage for women, poor access to information and services, harmful practices, etc). However, to date financial resource constraints, and lack of capacity both within UNFPA (see section 3.1) and within government (see eg 5.1) – along with political sensitivities - mean that UNFPA has been able to make only limited impact through its country programme on directly addressing these priority issues.

#### Proportion of the CP devoted to policy development, service strengthening and IEC

Using UNFPA's own sub-programming categorisation and budgets, around 62% of the current CP budget is devoted to RH service strengthening (albeit not specifically youth-focused). This increases to around 71% if the AYA project is included. Of the remainder of the CP, 29% of the budget is allocated to PDS (22% if AYA project included), and 9% to Gender and Advocacy (7% with AYA). However, elements of PDS include advocacy and policy reform, and large parts of the gender and advocacy sub-programme are not focused on policy, but on gender mainstreaming. AYA is categorised under the RH sub-programme (see Annex 5) but UNFPA is responsible for the policy and advocacy component. In short, a significant proportion of the country programme budget and resources is devoted to RH service strengthening; much less to policy reform and advocacy. Considerable resources are committed to PDS (which includes continued work on the 2002 census, and development of action plans for the revised National Population Policy). See section 4.1, 5.1 and 6.1 for further details on resource allocation and activities within these three sub-programmes.



#### UNFPA Fifth Country Programme: Funding by Sub-programme

##### UNFPA's strategic sectoral role

During the evaluation some bilateral partners expressed concern that - at a time when many development assistance agencies in Tanzania are moving to direct budget support, sector wide approaches (SWAp) and basket funding to the health sector – UNFPA's focus remains on its own projects and sub-programmes. These partners also expressed concern that

UNFPA could have played a more critical and strategic role in RH policy and programme debates in Tanzania (see section 3.1 which discusses sectoral and institutional issues in more detail).

### Addressing the diversity of needs of young people

A major constraint to addressing young people's diversity of needs is the lack of a coherent strategy within 5CP to form effective implementing partnerships with NGOs and CBOs, which have much greater potential to address diversity of needs at the local level than government. Despite the fact that the 5CP document states that creating a supportive environment for NGO participation in the implementation of the programme is important, there are currently no NGO implementing partners in 5CP (see sections 4.1, 5.1 and 6.1).

## **2.1.2 Integration of Rights**

According to the 5CP document, the fifth Country Programme was developed within the "framework of a human rights approach". 5CP claims to adopt a rights-based approach to programming in both formulating the programme and in its implementation:

- 5CP is based on international human rights standards, emphasising accountability, equality, empowerment and participation – "the operational expression of the inextricable link between development and human rights".
- 5CP "integrates the norms, standards, and principles of the international human rights system into the plans, strategies and processes of programming" (norms and standards are defined as those contained in the ICPD Programme of Action, and other international treaties and declarations). All activities under 5CP are to "be undertaken in accordance with the principles and objectives of the ICPD Programme of Action".

5CP articulates rights in terms of individuals' ability to make decisions that affect their personal and reproductive life, and as such 5CP seeks to:

- Promote the participation of individuals in policy-making in relation to population issues;
- provide education and information to the public about individuals' rights; and
- increase the rights of all individuals irrespective of age, marital status, ethnicity etc to access RH information and services.

The regional initiative "Improving the Quality of SRH Care" (see 5.1) has a more explicit focus on rights through empowering clients (including young people) to know their rights to demand quality RH services.

The mid-term evaluation of the 4CP indicated that gender analysis within the country programme was weak and that 4CP had failed to develop a framework within which to address gender issues related to service delivery and IEC (see 5.1 and 6.1). The evaluation also suggests that implementing partners had limited capacities to undertake systematic gender analysis. Resources channelled to gender related issues were focused mainly on women-oriented activities. Gender focus within 5CP remains weak, but is improving. See sections 5.1 and 6.1 below for further discussion of gender and rights-based issues.

## **2.1.3 Sustainability**

The evaluation TORs ask for an assessment of the extent to which the UNFPA Country Programme articulates a strategy for the incorporation of externally-funded young people's activities/projects into the regular programmes of its partner organisations (government and NGOs). As noted, there was very little specifically youth-focused activity in 4CP. The *Final Report of the Terminal Evaluation of the Fourth Country Programme (1997-2001)* concluded that: "Ownership remains a problem in some of the sub-programme activities as evidenced by the tendency to see them as 'special' and not an integral part of the day-to-day work of

the implementing agencies”, but noted that in Zanzibar, 4CP sub-programmes were better implemented because of “greater ownership and leadership by the involved staff”.

Within 5CP, there is no specifically youth-focused activity against which to assess prospects for sustainability. Within AYA - as noted - there is a specific programme objective relating to “strengthened institutional capacity to sustain ASRH outcomes” by strengthening technical, managerial and financial skills in public sector and civil society implementing agencies.

5CP, under its RH sub-programme support to the RCHS is fully funding a new Adolescent Reproductive Health Training and Service Delivery Officer. Although UNFPA did not make funding conditional upon MOH confirmation that the post would become part of the civil service complement after UNFPA funding, the Head of RCHS - in an interview with international team members - expressed optimism that it would be confirmed in light of the new emphasis on young people’s RH in the new RCH strategy (2003-2007).

#### **2.1.4 In Summary: UNFPA Attention to the Priority RH Issues Facing Young People**

While UNFPA recognises and articulates the priority RH issues facing young people (notably early marriage for women, female genital cutting, and poor access to information and services), lack of capacity and financial resource constraints – along with political sensitivities - mean that to date there have been few activities which directly address these priority issues.

## **2.2 UMATI’s NATIONAL PROGRAMME**

### **2.2.1 Relevance**

#### Priorities and strategic approach: overview of UMATI’s programmes (1959-1992)

UMATI was formed in 1959 and became an IPPF member in 1969. Until 1974 UMATI was the sole provider of family planning information and services in Tanzania. From 1974, when the MOH introduced family planning services as part of its MCH programme, until 1992 UMATI focused its activities largely upon IEC (awareness and demand creation), training of service providers for government, and procurement and distribution of commodities for MOH.

UMATI played an important role in the launch of the National Family Planning Programme in 1989, and in the promulgation of the national Population Policy in 1992, primarily through its early family planning advocacy and pioneering activities. Despite its lack of demonstrable effectiveness in the area of IEC, and its limited role in service provision, UMATI nonetheless was an important player within the population sector during the 1970s and 1980s.

In 1992 UMATI undertook, with external assistance, a strategic planning exercise, which concluded that UMATI “had spread itself over a wide area at very high cost and the returns were negligible in terms of acceptance rates for family planning”. UMATI’s First Strategic Plan (1992-1996) thus sought to redirect UMATI’s efforts towards bridging the gap between awareness and use of modern contraception, within what it termed at the time “a broad reproductive health approach”, which would significantly reduce IEC activities and focus more on service delivery.

Despite the apparent shift in focus and strategy, a close examination of activities and strategies since 1992, shows that the process of shifting to a programme focus on reproductive health has been slow and difficult.

Strategic objectives and priorities: UMATI's First Strategic Plan (1992-1996)

UMATI's 1SP highlighted its potential to play a pioneering role in the development *inter alia* of adolescent family planning services and counselling programmes, and "advocacy for family planning as a human right" - in line with its NGO status and willingness to tackle the more sensitive areas of family planning and reproductive health in Tanzania. In its advocacy role, UMATI set its stall out to improve the availability and accessibility of FP information and education for *teenagers* and underprivileged women "so that [they] can make free and informed choices about their reproductive rights".

1SP had three strategic objectives, under which UMATI's various projects and activities were clustered. From the strategic plan, it is evident that in the period to 1997, UMATI continued to focus on family planning and responsible parenthood, with an emphasis on service delivery (and an emerging focus on young people). The three strategic objectives were (emphases added to direct quotations):

- "To increase the Couple Years of Protection (CYP) in selected rural and marginal populations through the provision of high quality, comprehensive, accessible and client-responsive *family planning* services for individuals and couples"
- "In collaboration with other agencies, establish and implement an effective IEC system which will be able to generate and sustain a high level of *contraceptive usage*, be sensitive to adverse propaganda to *family planning*, and promote *responsible parenthood* ideas among the youth"
- "To strengthen the training capacity of UMATI in order to provide effective training to both UMATI staff and collaborating agencies in *family planning* service provision, communication skills and *responsible parenthood* education"

Strategic objectives and priorities: UMATI's Second Strategic Plan (1997-2001)

By the time 2SP started implementation, UMATI had articulated a shift away from family planning to reproductive health. Its three core programme strategies were expressed in the 1997 Annual Report (emphases added) as:

- "To consolidate and carefully expand *sexual and reproductive health* services in selected rural and urban areas through the provision of accessible, quality, cost-effective services and piloting new and innovative approaches to service delivery"
- "To promote *sexual and reproductive health* through establishing youth friendly demonstration pilot project, advocating for the services and developing youth policy and strategy"
- "To promote *sexual and reproductive health* through advocacy and developing client behaviour oriented IEC systems for underserved groups"

Despite the rhetoric, the emphasis in implementation remained firmly on family planning, as opposed to integrated SRH services. For instance under strategy 2 on youth friendly services and youth policy, only two projects were implemented in 1997: "Youth family planning services through peers" and "Emergency family planning services in selected higher learning and vocational training institutions".

By 1999, there had been further refinement of 2SP's strategies, which were reformulated as:

- "To provide integrated high quality comprehensive family planning, sexual and reproductive health information and services through innovative community-based service approaches and efficient and effective models for clinical services"
- "To establish and operate appropriate, accessible youth friendly services and information outlets for sexual and reproductive health in order to empower youth to understand and cope with their sexuality and reproductive health"

- “To institutionalise quality of care through establishment of quality control mechanisms, enhanced facilitative supervision and skills development for service providers”
- “To collaborate with other agencies in the promotion and safeguarding of sexual and reproductive health rights of individuals, especially women and young people, against negative practices and other legal barriers”

In 2000, UMATI used its 40<sup>th</sup> Anniversary celebrations to further its advocacy with government and other agencies for what it termed “FP/SRH rights”, and launched a new project entitled “Improvement of SRH services and rights among youth in Tanzania”. Funding for this project was not secured, and so it was replaced with a project entitled “Youth driven initiatives in sexual and reproductive health in Tanzania” (see section 4.2, 5.2 and 6.2) funded by the EU.

#### Strategic objectives and priorities: UMATI’s Third Strategic Plan (2001-2005)

The Third Strategic Plan (2001-05) marks an attempt by UMATI to reorient and refocus its entire programme. 3SP identifies the need to secure a viable niche, and for UMATI to be more client-responsive. It recognises the priority areas as STI/HIV/AIDS prevention, elimination of harmful practices (FGM), reduction of unsafe abortion, prevention of unwanted pregnancies and drug abuse. It lays the foundation for what it terms a paradigm shift (from family planning to integrated sexual and reproductive health), through a youth-oriented programme, and identifies the need for “fruitful partnering for effective sexual and reproductive health and rights, advocacy, service delivery, research/marketing, resource mobilisation, and institutional and management capacity” (p6).

The 2001-2005 Strategic Plan (pp7-8) states that UMATI’s mission is to: “Commit itself to the youth as the primary client for advocacy on SRH and the elimination of harmful practices to enable them to make free and informed choices about their sexuality and well-being”; and to “Provide leadership and play a catalytic role in the provision of quality model youth friendly services that are market oriented, gender sensitive and focus on the prevention and management of STIs, HIV/AIDS as well as unwanted pregnancies”.

Clients in the age range 10-25 thus become the primary market segment, including in- and out-of-school, urban and rural youth: “All proactive outreach work will be targeted to the youth and facility-based services will provide youth friendly services”.

#### How priorities were determined

The shift to a youth-focused programme began in 1998, when the IPPF Africa Region (IPPFAR) identified UMATI as one of nine FPAs in Africa to be “pioneers” of the post-ICPD paradigm shift. During 1998 IPPFAR also indicated that FPAs in the region needed to carefully re-position themselves in view of enduring “donor fatigue”. In 1999 and 2000 IPPFAR sent representatives and international consultants to UMATI to undertake stakeholder analyses and to facilitate consensus-building workshops. These activities and processes led UMATI to identify gaps in the provision of services, information and rights for youth people in Tanzania, and a potential niche for the organisation in addressing these needs. By 2001, UMATI was engaged in a detailed strategic planning process – highlighted above.

#### Coherence between UMATI’s youth programmes and its other programmes

On paper the UMATI programme is now entirely youth focused. In reality UMATI continues with activities which focus on client groups other than young people, recognising adults as secondary clients. The key problem facing UMATI has been the lack of resources (human and financial) to take forward its youth-focused national programme, along with lack of support from IPPFAR office. The IPPFAR draft Strategic Plan 2001-2005 identifies three

categories of African FPA by priority focus for technical assistance. UMATI is identified in the strategic plan as a priority FPA for receipt of TA in safe motherhood (the other two categories are on HIV/AIDS and FP). UMATI staff expressed confusion as to the rationale behind the focus of the proposed IPPFAR TA (see section 3.2 for more on these issues), and concern that they had received no technical assistance with implementing their strategic plan with its focus on young people.

Proportion of UMATI's activities with young people devoted to policy development, service strengthening, education and information

It is difficult to disaggregate resource allocation by policy, services and IEC. Within UMATI's planning and financing, policy development is part of advocacy, and IEC is included in both advocacy and service delivery. The tables show that over the past two years just under 85% of direct budget support to activities goes to services (including some IEC), with policy development (in the form of advocacy and some rights-based IEC) receiving between 11.2% and 15.4%. The tables show the declining share of the UMATI budget allocated to salaries and administration, a decline which preceded 2001 and has continued into 2003 - and reflects the shrinking human resource base within UMATI HQ and its field operations.

Table 1: Actual Spend 2001

Activity	(Millions Tz Sh)	% total spend	% spend (without sal/admin)
Advocacy	190.7	8.9	11.2
Service delivery	1438.0	67.1	84.6
Instl strengthening	69.5	3.2	4.2
Salaries/admin	444.8	20.8	
Total	2143	100	100

Table 2: Actual Spend 2002

Activity	(Millions Tz Sh)	% total spend	% spend (without sal/admin)
Advocacy	304	12.9	15.4
Service delivery	1664.6	70.8	84.5
Other	1.4	0.1	0.1
Salaries/admin	382.5	16.2	
Total	2352.5	100	100

The current Strategic Plan has five Goals, relating to advocacy (five strategic objectives), services (three strategic objectives), research and marketing (three strategic objectives), resource mobilisation (four strategic objectives), and institutional/management capacity (three strategic objectives). In reality – and because of reduced funding – UMATI in 2001 and 2002 was only able to commit funds to (ie implement activities under) the goals on advocacy and service delivery. Within the advocacy goal only the first two strategies were funded (on community awareness creation and youth knowledge of their rights respectively). All three of the strategies under the services delivery goal were supported.

Responding to the diversity of needs of young people

Efforts have been made at project level to respond to the diversity of needs among young people (see sections 5.2, 6.2): projects working with refugees are seeking to reach highly marginalised young people; contrasting strategies are implemented to reach in-school and out-of-school youth. UMATI also recognises the differing service delivery needs of married and un-married youth (youth centre-clinic services largely target unmarried youth, while

married youth are expected to access adult clinics for services). Efforts have also been made to train CBD agents to reach rural youth.

#### Involvement of young people

Mechanisms for young people's participation have been established at project level (see below and sections 5.2 and 6.2), but not institutionalised throughout the policy-making volunteer structure (see section 3.2). Despite UMATI's Constitution stating that 25% of the membership of its policy-making bodies should be young people, this has not been translated into practice. There is currently limited participation of young people on the National Council which is the main policy-making body and there is resistance among volunteers at Regional and District level to include young people in decision-making. There is a general perception among volunteers that young people lack the capacity to participate effectively in decision-making.

At project level, youth involvement is limited in terms of management, monitoring and evaluation, but relatively high in terms of implementation – largely through peer education and youth centre activities. Young people's views are sought in some project evaluations and peer educators' views are routinely fed into some projects. UMATI staff recognise that the level of young people's participation in project design, monitoring and decision-making needs to be improved and more clearly articulated throughout the UMATI programme.

### **2.2.2 Integration of rights**

The main focus of UMATI's rights-based approach is on the rights of the client, and the rights of all young people to access SRH information and services. On a limited scale UMATI has tried to address the rights of pregnant girls to continue to access education. The YMEP project (see section 5.2) seeks to address issues related gender, power and sexuality and to reach young men with strategies to support behaviour change and increase their access to services. The ARRA project (section 3.2, 4.2 and 6.2) directly addresses issues related to reproductive rights, using billboards and leaflets with reproductive rights messages.

### **2.2.3 Sustainability of UMATI's Youth Programmes**

#### Proportion of UMATI's youth programmes dependent on time-bound external funding

98% of UMATI's income is from donors (including IPPF). This level of dependency has been constant since UMATI was formed over forty years ago. While IPPF *core funding* has declined each year since 1997, the proportion of income that UMATI derives from IPPF has remained between 26% and 36% over the six years (due to successfully securing IPPF special funds). Since 2001 UMATI has been anticipating significant income from AYA, but AYA has been slow to disburse and many of the initiatives that UMATI had planned to undertake with UMATI support have been delayed. See section 3.2 below for further discussion of UMATI's institutional capacity and its attempts to develop partnerships as part of a sustainability strategy.

### **2.2.4 In Summary: Attention to Priority RH Issues Facing Young People**

UMATI's current Strategic Plan (2001-05) identifies the priority areas for work with young people as STI and HIV prevention, elimination of harmful practices (FGM), reduction of unsafe abortion, prevention of unwanted pregnancies and drug abuse. In this respect, the current programme articulates the main RH issues facing young people in Tanzania. Sections 4-6 which follow, document the extent to which UMATI has been able to translate this attention into action.

## SECTION 3: INSTITUTIONAL ARRANGEMENTS

### 3.1 The UNFPA Country Office

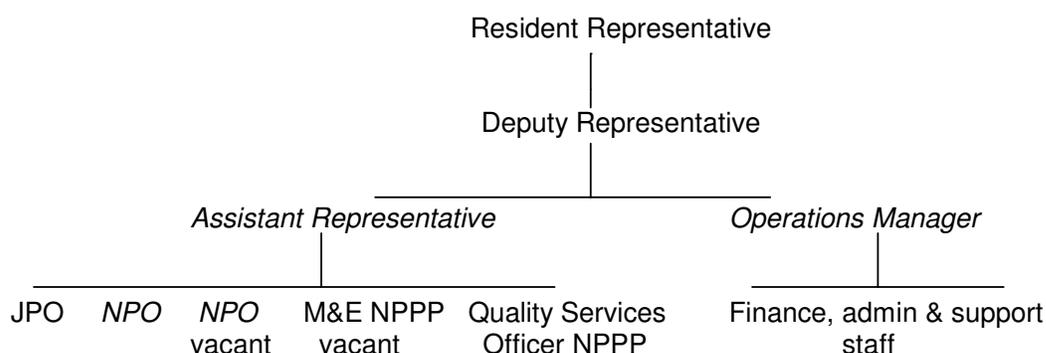
#### 3.1.1 Relevance

##### Organisational structure

The UNFPA Country Office is headed by a Resident Representative, a post which was upgraded from Country Director level in 1998. The Deputy Representative – an additional core post also agreed in 1998 - is also an international appointment. A third international post is filled by a Junior Professional Officer (JPO) – funded by the Swiss government – and responsible within the current CP for overseeing the FLE project. The core national staff in the CO comprise:

- an Assistant Representative;
- an Operations Manager, responsible for CO management, financing and administration (at a senior level equivalent to Assistant Rep);
- two National Programme Officers (NPOs) - the second NPO post was recently approved and is yet to be filled (he/she will be responsible for the Gender and Advocacy Sub Programme); and
- an administrative and finance assistant, a driver, and three secretaries.

##### UNFPA Country Office Organogram



This staffing level fits what UNFPA HQ terms a Type IV programme<sup>32</sup>. Type IV programmes are allowed up to four core national staff (aside from support staff) These core national staff are shown in italics in the above organogram. UNFPA New York's Office of Human Resources allows a Type IV staff complement if a convincing case can be made at the time of the design of new CPs. The Tanzania UNFPA Representative clearly made an effective case at the time of the evaluation of 4CP.

In addition to the core staff, UNFPA currently supports

- a short-term Policy and Advocacy Technical Officer in the AYA project (not shown in the organogram); and
- a Project Manager responsible for the Improvement of Quality Services Project: a District Medical Officer on a short-term National Professional Project Personnel (NPPP) special services contract.

<sup>32</sup> See the *UNFPA Country Office Typology: Implementation Guide* (issued by the UNFPA Office of Human Resources, March 2003).

A number of other NPPPs are to be employed using CP funds, including a M&E officer for the Country Programme (to be located in the Country Office), two M&E officers for Mainland and Zanzibar respectively, plus two Finance and Administrative Officers and a driver in the CO.

Within the current staffing structure, the CO lacks expertise in young people's reproductive health and rights, and in advocacy. This lack of capacity is confirmed by the Terminal Evaluation of 4CP, and in discussions that the international team held with key partners in Tanzania. UNAIDS for instance pointed out that under arrangements for the UN Joint Response to HIV/AIDS, UNFPA is mandated to coordinate and lead on advocacy initiatives (including chairing the monthly Advocacy Task Force meetings), and yet has no expertise in this field. The UNFPA CO is responsible for the policy and advocacy component of the AYA project, and as noted, funds a full-time staff member in AYA to head up this work. Despite attempts to develop operational linkages between the AYA policy and advocacy work and the 5CP, this has proved difficult (the UNFPA-funded Policy and Advocacy Technical Officer in AYA is physically located in the AYA office not the UNFPA CO<sup>33</sup>).

This enhanced staff complement and the additional NPPP posts indicated above are expected to redress these gaps in expertise in young people's reproductive health and rights, and in advocacy.

Despite these long-standing shortfalls in capacity and technical expertise in the CO, technical support from the CST in Addis Ababa (see below) has over the past three years focused largely on the PDS sub-programme (and especially support for the 2002 Census), on M&E capacity building, and on the design of 5CP. The Terminal Evaluation of 4CP was critical of the lack of TA provided to Tanzania by the CST in the fields of rights, adolescent RH, and advocacy. However, key partners have acknowledged the important role played by the CST in the development of the AHD draft strategy.

### Monitoring and Evaluation

UNFPA monitoring and evaluation of its CP is weak, but improving<sup>34</sup>. As part of the UN system's move towards demonstrating results from its country programmes, UNFPA's Division of Evaluation and Oversight in New York introduced "results-based monitoring" in 2001. The UNFPA Tanzania CO in response developed a programme monitoring and evaluation plan (PROMEP) at the onset of 5CP. PROMEP has a specific project budget line within 5CP (funded by 5% of each component project's budget), and in addition to focusing on results and outcomes, PROMEP emphasises use of M&E findings for lesson learning and dissemination. The CST provided support to PROMEP in 2001-2002 (culminating in a two-week workshop in Arusha in 2002 at which PROMEP was finalised).

The rationale behind PROMEP and results-based monitoring stems from the past emphasis within the CP on monitoring of activities and financial disbursement<sup>35</sup> at the expense of effectiveness and results/impact. The Terminal Evaluation of 4CP noted that there were no baselines or process monitoring data upon which to assess effectiveness or impact; and recommended strongly that the CO engage a M&E specialist. As noted above, this post has now been created with an appointment of a NPPP (interviews have taken place, and the post is scheduled to be filled by May 2003). The same evaluation of 4CP also criticised the lack of M&E tools and methods which could systematically monitor progress against objectives.

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<sup>33</sup> It should, however, be noted these two offices are within the same compound

<sup>34</sup> Also noted in section 3 of the UNFPA *Tanzania Country Office 2002 Annual Report*

<sup>35</sup> Financial monitoring by UNFPA has always been good - as previous evaluations, including those by ODA/DFID have confirmed

Under PROMEP, monitoring and evaluation takes place at the project, sub-programme and country programme level.

The specific arrangements under PROMEP for Country Programme monitoring and evaluation were agreed at the initiation the 5CP, at which stage Logical Frameworks were developed as the cornerstone of M&E. With support from CST advisors, UNFPA and government partners have developed an overall LogFrame for the 5CP plus LogFrames for each of the three sub-programmes. Goal and purpose-level indicators in the CP LogFrame are population-based and are obtained from the census and other major surveys, such as the DHS. Preliminary results from the recently-conducted Tanzania Population and Housing Census (25<sup>th</sup> August–9<sup>th</sup> September, 2002) are now available, and the next DHS will take place in 2004. Information not available through the census or DHS has been obtained from an extensive baseline study, which was conducted in November 2002. The results of the baseline study became available in February 2003.

The 5CP baseline survey was conducted by Mzumbe University, DataVision International Ltd, and Ifakara Health Research and Development Centre. The survey was overseen by the UNFPA M&E Steering Committee composed of managers of UNFPA-supported projects (see below). The extensive baseline survey – using sample survey questionnaires and FGDs – assessed the pre-programme status of each of the output indicators in the 5CP LogFrame. To this end the survey covered the 36 CP districts (26 Mainland, 10 Zanzibar).

As 5CP has limited direct focus on young people, there is little direct monitoring of 5CP's contribution to young people's RH and rights. However, the 5CP baseline data collection for the RH sub-programme involved *inter alia* school health surveys and health facility surveys (see section 5.1). Data collection for the GA sub-programme focused on policy, rights and legal issues at national, district, schools/colleges and community level (the latter focusing on FGM and early marriage), as well as data on issues of land ownership by sex, and on attitudes to gender violence.

In addition to the LogFrames, a number of other key UNFPA tools support CP evaluation. The Country Population Assessment or CPA (which replaced the PRSD) serves *inter alia* as an evaluation of the achievements towards the end of each Country Programme. An evaluative perspective at the Country Programme level is also supposed to be provided by the Annual Country Programme Review (see below), the Country Programme Mid-Term Review, and the Terminal Evaluation of the CP. Representatives from UNFPA HQ, together with CST, government and CO staff are meant to participate in these key evaluation processes. However, there has been little UNFPA HQ participation, and the CST office in Addis Ababa has been downsized recently, so their participation has also been limited (eg they were unable to send someone for the Terminal Evaluation of 4CP).

A further dimension of CP monitoring and evaluation is the Annual Country Programme Report (known as the Annual Report), which the Country Office submits to New York. This serves as a record of agreement between government, implementing agencies and UNFPA of achievements through the year. In Tanzania, the Annual Report is produced for discussion at the Annual Country Programme Review Meeting (ACPR), at which other donors are also present. The effectiveness of this meeting as a monitoring forum, and its capacity to inform programme changes, is handicapped by the ineffective coordinating role played by PPU (see below).

The Annual Report is informed by Quarterly Programme Review Meetings under the auspices of the recently constituted Country Programme M&E Technical Committee (which will be comprised of the CO M&E Officer, plus the M&E focal persons for each project) which reports to the quarterly Country Programme M&E Sub-Committee (constituted of the UNFPA CO and CP

Project Managers). To date under 5CP these two meetings have tended to be collapsed into a single one-day meeting.

There are also Quarterly Sub-programme Review Meetings for each of the three sub-programmes, at which the component project managers for each sub-programme meet with the UNFPA CO staff member(s) responsible for that sub-programme, plus the component project accountants. These quarterly meetings culminate annually in the Annual Sub-programme Review Meeting.

At project level, each project is required to produce workplans against which budgets for activities are set. Quarterly requests for advances are then assessed by UNFPA against the workplans. In Tanzania, with the large number of (government) projects, this system is too unwieldy to provide the basis for Country Office monitoring, beyond a financial accountability function. An annual Component Projects Review Meeting is supposed to be held in the first quarter of each year (although they are rarely held this often). Annual project reports are produced by the implementing agency based on progress against agreed annual workplans. Project reporting (including the Final Project Report) is supposed to provide government and UNFPA with recommendations for the effective management and utilisation of project results and experiences. There is no evidence that the reports play such a role.

The UNFPA CO recognises the shortcomings with the above M&E system, particularly the quarterly and annual project and sub-programme reporting (which continues to focus on activities and disbursement). Great efforts are being made to make the reports more meaningful by encouraging the reporting of failures and constraints as well as successes. It is too early to assess the likely improvements that PROMEP will bring to M&E. However, the establishment of a detailed baseline for the 5CP LogFrames, and the appointment of a M&E officer in the Country Office represent a promising start to a long-overdue reform of the M&E system.

#### Partnerships and collaboration

See section 3.2.1 for a discussion on UNFPA's collaboration with UMATI.

#### *Country Programme Implementation and Coordination*

National government institutions are responsible for coordinating and implementing projects under 5CP. The Planning and Privatisation Commission within the President's Office is responsible for the overall execution and coordination of 5CP, through the Population Planning Unit (PPU). In Zanzibar, the Ministry of Finance and Economic Affairs exercises equivalent functions. Major responsibility for the implementation of the three sub-programmes falls on relevant government ministries and departments: the Reproductive and Child Health Section of the MOH is responsible for the RH sub-programme; the PPU for the PDS sub-programme, and the Ministry of Community Development, Gender and Children (MCDGAC) for the GA sub-programme (and their equivalents in Zanzibar), see sections 4.1, 5.1 and 6.1. The PPU was established in 1987 by UNFPA, and successive evaluations of the UNFPA Country Programme have pointed to its institutional weaknesses and lack of capacity. Staff of the UNFPA CO expressed frustration with the difficulties of dealing with PPU. Many bilateral and multilateral donors expressed their concern that UNFPA continues with PPU as overall coordinating partner, as it has no mandate or experience in Reproductive Health. MCDGAC – as indicated elsewhere in the evaluation – is also recognised by UNFPA CO as an ineffective partner for its Gender and Advocacy sub-programme. RCHS has also proven to have institutional weaknesses and limitations (see sections 5.1 and 6.1).

While UNFPA's effectiveness and impact is clearly constrained by the institutional weaknesses of its coordinating and implementing partners in government, it is unclear why

UNFPA has not sought to work with other partners, or does not devote more effort to institutional strengthening<sup>36</sup> (see sections 5.1 and 6.1 on the implications of RCHS institutional weaknesses, and 4.1.1 on MCDGAC).

### *Civil Society*

The 5CP document states that “Civil society institutions – including NGOs, religious organizations, universities, the media, professional associations, the private sector, and training and research institutions – would be full partners in programme implementation. They would be involved based on their comparative advantages in relation to service provision, advocacy, gender mainstreaming, research and training”. However AMREF is the only NGO implementing agency in 5CP (and their funding is currently frozen), and there is only limited strategic involvement of civil society in IEC activities (section 6.1) and in the GA sub-programme (section 4.1). 4CP did work closely with a small number of NGOs; and although it is not clear why NGOs are not engaged as implementing partners in 5CP, it would appear that it is in part due to resistance within the MOH.

### *The UN System in Tanzania*

The United Nations Development Assistance Framework (UNDAF) for Tanzania established in 2001, is a planning framework designed to achieve greater integration among the individual programmes of all UN agencies in Tanzania. Its objective is to “increase the effectiveness and efficiency of the UN System”<sup>37</sup> and to provide the UN with “a framework for a joint response to the needs and priorities of the Tanzanian people”. Under UNDAF, greater cooperation between UN agencies is to be pursued through the establishment of inter-agency working groups. HIV/AIDS for instance involves all agencies; while primary health is a sectoral UNDAF approach involving selected agencies (WHO, UNICEF, UNFPA).

The UNDAF is based on two government national development strategies – the Tanzania Assistance Strategy and the PRSP (which subsumed the UN Common Country Assessment: CCA) for mainland Tanzania, and the CCA for Zanzibar, which together establish the priorities for UNDAF. UNDAF has four strategic objectives, the second of which is to “contribute to the improvement of the quality of, and universal and equitable access to services to meet the basic needs of Tanzania’s poor”. Under this strategic objective there are four operational objectives relating to education, food security, health and HIV/AIDS respectively. The strategy for meeting the operational objective on health is involves the development of district and community health services focusing on MCH and RH services, and communicable diseases (malaria, TB, HIV/AIDS, STDs). The strategy for the operational objective on HIV/AIDS is to develop a multisectoral programme (with a specific objective being to reduce HIV prevalence especially among youth).

There are serious implications for the UNFPA CO of joint programming proposed by UNDAF. The UNFPA CO expressed its concern about the potential loss of control over key UNFPA programming areas, and the risk of diluting its impact. The CO is also concerned about the demands placed by the process on CO staff time. In its Annual Report for 2002, the UNFPA CO states that “current human resource capacity within the CO is inadequate to cover the UNFPA CP and the increasing load of joint projects” (emphasis added). Approval procedures and timings differ between the multi-year country programmes of the various UN agencies, thus creating obstacles for joint preparation and planning. As a result, UNFPA (and other UN agencies) appear to be proceeding with their individual country programmes, in relative

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<sup>36</sup> Although the recent agreement to fund an ARH post in the MOH should go some way to strengthening the RCHS.

<sup>37</sup> UN Inter-Agency Technical Committee on Programme Coordination (2001) *United Nations Development Assistance Framework Tanzania 2002-2006*, p1

isolation from UNDAF partners. For instance, UNICEF's new Country Programme is working on HIV/AIDS life skills and BCC for out-of-school youth in seven districts, and on youth friendly health services with District Councils in four districts. However, there seems to have been little liaison/lesson sharing with UNFPA, whose current country programme also covers these activities.

#### *UNFPA and the United Nations Joint Response to HIV/AIDS*

The UN joint response is in three main areas:

- Policy and strategy (support to TACAIDS and to sectoral responses to HIV/AIDS);
- advocacy (including coordination of the UN HIV/AIDS advocacy initiatives); and
- district-based responses (through the District Response Initiative (DRI) which is also known as the District and Community Response Initiative against HIV/AIDS in Tanzania).

We have already noted that UNFPA – despite lack of advocacy specialists in the CO – chairs the UN monthly HIV/AIDS task force meetings on Advocacy. UNAIDS reported that because of UNFPA's lack of expertise in advocacy and BCC, USAID (through its partnership with Johns Hopkins University, JHU) have been dominant in this field. The JHU model is based on advocacy and communication for behaviour change which focuses on the individual. UNAIDS are keen to introduce a more social change communication approach, and have had to rely upon UNICEF for this strategic push (UNICEF's Regional Office in Nairobi – in association with the UNAIDS Inter-Country Team in Pretoria has recently developed an approach entitled *Communication from a Human Rights Approach* to respond the HIV/AIDS pandemic in east and southern Africa).

#### *Partnerships with Multilateral and Bilateral Agencies in Reproductive Health*

UNFPA is a full member of the Bilateral and Multilateral Health Forum, and the recently constituted Reproductive Health Sub-Committee of the Health Forum. The sub-committee was formed in part as a recognition of inadequate collaboration and coordination among donor agencies supporting RH. Its two main focuses at present are on documenting and discussing what all key bilateral and multilaterals are currently funding in RH, and on the SWAp process. At a sub-committee meeting held during the evaluation, the team leader was able to participate in an interesting session in which USAID described how (given that they and UNFPA are the main donors in RH) they have begun to attempt joint work planning (in relation to the RCHS section of the MOH). The climate for collaboration between UNFPA and the main donors in RH is undoubtedly improving (see section 4.1.3).

#### *Health Sector Reform/SWAp*

The health SWAp commenced in 1998, with a Memorandum of Understanding signed by all partners, including UNFPA. An important purpose of the SWAp is to increase government's sense of ownership over the process of accessing and managing donor assistance while avoiding fragmentation in disbursement. The health SWAp is coordinated by the Primary Health Care Secretariat of the MOH, and the Health Sector Basket Fund (HSBF, to which a number of bilateral donors contribute) is managed jointly by the MOH and the Ministry of Finance.

The Tanzania health SWAp has strengthened policy analysis and implementation capacities within the MOH, and has reduced the Ministry's uncertainties about year-on-year funding, improving its ability to plan. Through the HSBF, US\$0.50 per capita is allocated to districts, thus redressing the long-standing imbalance between spending on curative services and spending on preventive services. Guidelines on expenditure at community, primary, secondary and tertiary health facilities have been developed to ensure that preventive and promotive health services receive a balanced share of resources.

Since 1998 on an annual basis a comprehensive Health Sector Review is undertaken to establish a common understanding of planned activities, budgeting and financing for the sector, constraints and facilitating factors. Health Sector Reform has been implemented in phases, and is currently in its final stage whereby all districts are supposed to be implementing the health sector reform proposals in 2003.

UNFPA is a member of the SWAp steering committee, which meets biannually. UNFPA CO staff, as well as a CST adviser, participate in the annual Health Sector Review. As noted UNFPA is also a member of the Bilateral and Multilateral Health Forum, and its subcommittee on Reproductive Health. These forums are seen by UNFPA as offering an opportunity to ensure RH and gender issues are considered within the health SWAp, particularly with regard to RH indicators, and strengthening health sector capability to respond to unmet RH needs. However, to date UNFPA's ability to exert such an influence has been limited. The CO attributes lack of human resource capacity as the major constraining factor in UNFPA's ability to play an effective role (UNFPA Tanzania Annual Report 2000, Annex F). However, some bilateral partners articulated the constraints as stemming much more from UNFPA's persistence with projects and its resistance to channel funds through the HSBF. In recognition, UNFPA CO has recently commissioned a national consultant to draft a strategy for how best to integrate the CP into the SWAp process. A further constraint to UNFPA playing a critical role within RH policy and programme debates in Tanzania is seen by many as stemming from its choice of the PPU in Planning and Privatisation Commission as its main partner (see section 4.1 which also discusses sectoral and institutional issues in detail). UNFPA CO recognises many of these shortcomings and is aware that UNFPA HQ does not preclude Country Programmes from basket or pooled funding. The CO has explored how it might use the HSBF and still be within UN regulations. One possibility that it has considered is to earmark funds in the basket account for special activities and geographical areas. In recognition that this might undermine the basic concept of the HSBF, the CO is awaiting the outcome of the recently commissioned consultancy exploring how best to position itself in the context of the SWAp. The international evaluation team were shown a copy of the terms of reference for this consultancy, which has as an output "a plan of action that outlines a process on how UNFPA based on its comparative advantage can position itself as an effective partner in development in the context of the ongoing SWAp and PRSP processes in Tanzania".

#### *Poverty Reduction Strategy (PRS)*

UNFPA is making efforts to engage in the PRSP process in Tanzania. It participated in the formulation of the PRS M&E indicators, and supported national and sub-national evidence-based dialogue on population and poverty interactions, including reproductive health. However, the CO recognises (see discussion above on SWAp) that it needs to strengthen its role in the PRS process. It is currently proposing to support the PRSP through technical support on incorporating population and reproductive health issues into the PRSP, as well as to undertake greater advocacy on the relationship between RH/population and poverty reduction. However, as with the SWAp above, UNFPA has made only a limited contribution to the PRS process to date, despite good intentions.

### **3.1.2 Integration of rights**

#### The Country Office definition and conceptualisation of rights

UNFPA CO staff recognise that a rights based approach has not been internalised or operationalised within the UNFPA Country Programme (see also section 5.1).

### Young people's rights as reflected in CO employment practices/conditions of work

There are no young people working in the UNFPA CO, and the Office does not have an explicit employment rights policy for young people. The Country Representative confirms that – as recommended by UN rules – a member of his staff has been trained in HIV/AIDS counselling, and is available to provide confidential advice and counselling to any member of staff who becomes infected with or affected by HIV/AIDS. UNFPA, through UN employment regulations, adopts an equal opportunities approach to employment and conditions of work.

### **3.1.3 Capacity**

As noted in section 3.1.1 above, there is little expertise and capacity within the CO to manage, promote and support the concept and practice of young people's reproductive health and rights. Sections 4.1, 5.1 and 6.1 highlight the implications of this for the UNFPA three sub-programmes. In reality, given the paucity of activity in the field of young people's RH and rights, there has been little call upon CO staff to demonstrate such expertise.

### UNFPA CO staff's understanding of socio-cultural and economic factors influencing young people's RH and rights

As articulated in key Country Programme documents (eg the sub-programme and project documents), and through CO staff members' participation in key forums and committees, it is clear that the Country Office has a good appreciation of the factors which currently influence young people's RH and rights in Tanzania. However, to date there has been limited application of this understanding in the Country Programme (sections 4.1, 5.1 and 6.1 do, however, provide examples from specific component projects).

### Institutional mechanisms to enable young people to participate in planning, implementation, monitoring and evaluation of CP components

There are few mechanisms for young people's participation in the CP (see sections 4.1, 5.1, 6.1). The concept of young people's participation is not clearly understood within the UNFPA CO or its major partners in government. However, youth involvement was central to the AMREF lifeskills approach project funded under 4CP (see 6.1). Again much faith is being invested in AYA to facilitate youth involvement in project cycle management. Youth Involvement and Participation (YIP) is a key strategy within AYA. During 2002, under UNFPA coordination, youth from AYA districts developed a draft YIP framework, which is meant to "guide the implementing partners in developing plans for meaningful youth involvement and participation". Other areas in which AYA has facilitated youth involvement include supporting two youths to attend the Barcelona HIV/AIDS Conference in 2002; and ten youth from implementing partners based in Dar, Arusha and Zanzibar have been trained in using video to document AYA project activities.

### Capacity of staff to use evidence-based planning, and to promote lesson learning and best practice in planning, implementation, monitoring and evaluation

To date there has been very little evidence-based planning or lesson learning in the Country Programme. See sections 5.1 and 6.1, and the discussion of monitoring and evaluation in 3.1.1 above.

### Capacity-building and support provided by the CST

The wider goal of the CST system is defined by UNFPA as "to build national capacity, sustainability of national programmes, and promotion of self-reliance to achieve ICPD goals". Support to COs is supposed to focus through technical assistance on sectoral context

(SWAp, UNDAF etc), design of CP and sub-programmes, capacity building/implementation of CPs, and M&E. Support to UNFPA HQ is to synthesise lessons learnt.

References have already been made to the shortcomings with and constraints faced by CST support to the CP (these are further discussed in section 4.1). The head of the Planning and Privatisation Commission confirmed that inputs from CST advisors are of good quality, but that they are constrained by their busy schedules.

The CST Addis Ababa has recently been scaled down from 17 Advisers (four PDS specialists, seven RH specialists, two Gender and Advocacy specialists, plus expertise in HIV/AIDS, socio-cultural research, MIS and monitoring) to just 10 (four PDS specialists, two in each of IEC and RH, and one each in GA and FLE). This is part of a wider UNFPA initiative to encourage Country Office's to develop and access a Register of International Consultants for technical support.

The Tanzania CO over the past three years has received the bulk of its CST support for the 2002 census (eight visits from advisers during 2002 alone), for monitoring and evaluation (including the development of the PROMEP and 5CP LogFrames and baseline survey), and for the design of 5CP (including the 2002 CPA, and design of the three sub-programmes). TA to specific youth-focused initiatives has been limited to two visits to AYA in 2002 (but focused on tools for M&E rather than direct TA for advocacy or services). In 2003, because of the restructuring of the CST office, no CST support had been received by the time of our evaluation, but requests have been confirmed for support in FLE and in AYA advocacy.

### **3.1.4 In Summary**

On CO capacity: the CO currently lacks expertise in young people's reproductive health and rights, and in advocacy, although an enhanced staff complement is expected to redress these gaps in expertise. Despite this long-standing shortage of key technical expertise, there has been little support from the CST during 4CP and 5CP in the fields of rights, adolescent RH, and advocacy. The CO's monitoring and evaluation system and capacity are improving under the new PROMEP approach, although it is too early to assess the likely impacts that PROMEP will make to M&E. However, the establishment of a detailed baseline for the 5CP LogFrames, and the appointment of a M&E officer in the Country Office represent a promising start to a long-overdue reform of the M&E system.

On partnerships: UNFPA's effectiveness and impact is constrained by the institutional weaknesses of its coordinating and implementing partners in government. However, it is unclear why UNFPA has not devoted more resources to institutional strengthening of these partners. Despite the recognised comparative advantages of NGOs in relation to advocacy, gender mainstreaming, research and training, there are no NGO implementing agencies in 5CP and only limited strategic involvement of civil society in IEC activities and in the GA sub-programme (which appears in part to be a consequence of government resistance).

On health sector reforms, UNFPA is a full and active member of the Bilateral and Multilateral Health Forum, and its subcommittee on Reproductive Health, the SWAp steering committee, and the annual Health Sector Review. These forums are seen by UNFPA as offering an opportunity to ensure RH and gender issues are considered within the health SWAp, particularly with regard to RH indicators, and strengthening health sector capability to respond to unmet RH needs. However, to date UNFPA's ability to exert such an influence has been limited, due to human resource constraints.

UNFPA is engaged in the PRS process, but the CO recognises the need to strengthen its role. It is currently proposing technical support on incorporating population and reproductive health issues into the PRS, as well as to undertake greater advocacy on the relationship

between RH/population and poverty reduction. However, as with the SWAp, UNFPA has made only a limited contribution to the PRS process to date, despite good intentions.

## **3.2 UMATI**

### **3.2.1 Relevance**

#### Constitution

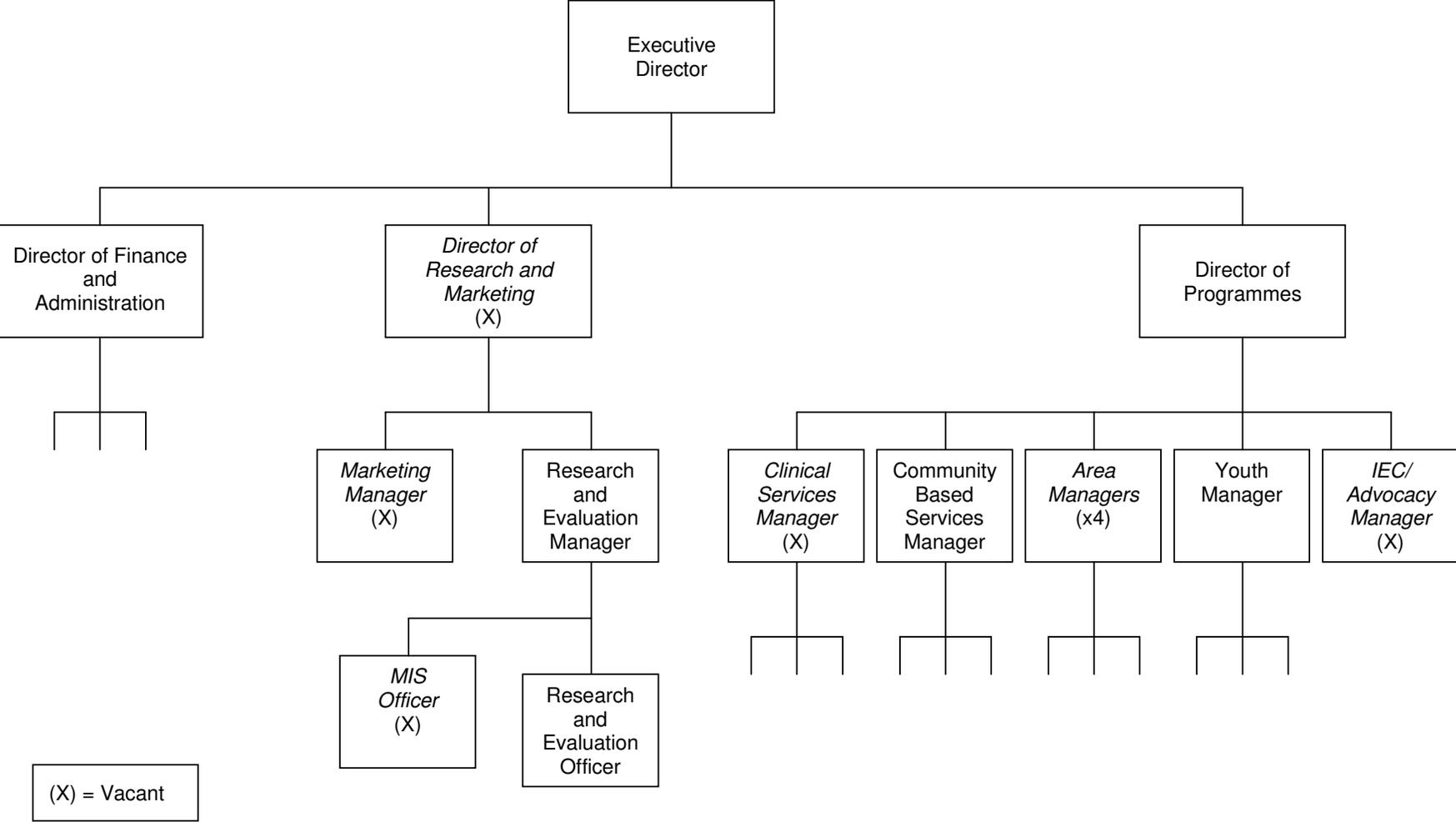
A revised constitution was produced in December 2000, to reflect the changing strategic vision of UMATI. The constitution is currently undergoing further revision, with assistance from IPPFAR. As yet, the aims and objectives as stated in the 2000 Constitution do not entirely reflect the major paradigm shift outlined in UMATI's Strategic Plan (2001-2005). The first two aims focus on UMATI's role as the leading NGO in family planning in the country, and its aim to advance the basic human right of all women, men and young people to make free and informed choices regarding their SRH and advocate for the means to exercise this right. Objective three relates specifically to young people, "to strive in particular to advance the SRH movement among the youth by addressing, through information, advocacy and services, their unmet need and demand for sexual and reproductive health". The 2000 Constitution states that main duties of Branches established at Regional, District and Ward level shall be to: advance the basic human right of all people particularly youth within its boundaries to make free and informed choices regarding their SRH including family planning and advocate that the means be provided to enable them to exercise this right.

The Constitution classifies those eligible for membership to the association into three age groups: adults (26 years and above); young adults (18-25 years); and teenagers (10-17 years). The Constitution also makes explicit provision for young people's participation in UMATI policy-making stating that "at least one quarter of members elected to any one UMATI policy-making body must be young people of both sexes" and that the Secretary of all policy-making bodies should be a young person. Gender equity is not explicitly addressed, but the constitution states that at least one-third of members elected to any UMATI policy-making body must be of the opposite sex.

#### Organisational structure

A revised organogram has been drawn up, with assistance from Mzumbe University in Morogoro, in an effort to match UMATI's human resources to achieving the objectives of the current Strategic Plan. UMATI was undergoing a skills audit by the consultancy firm Price-Waterhouse-Coopers at the time of the evaluation, and the results will be used to review the organisational structure.

**UMATI Organogram**



The new organogram has three core departments under the Executive Director: Finance and Administration, Research and Marketing, and Programmes. The Research and Marketing Department is considered by UMATI to be a core department for achieving the objectives of the new Strategic Plan both for sustainability through resource generation and for awareness raising and promotion of UMATI's focus on young people's sexual and reproductive health and rights. Due to shortfalls in funding from IPPF, the only post within this department that is currently filled is the existing post of Research and Evaluation Officer.

Within the new structure the key posts under the Director of Programmes include four Area Managers, a Community Based Services Manager, a Clinic Services Manager, and a Youth Manager. The Clinic Services Manager post is currently unfilled, and following the recent departure of the IEC and Advocacy Manager it is unclear where this post will be placed within the new organogram. Currently coordination of IEC/BCC activities is being undertaken by the Community Based Services Manager. Under the new organisational structure, the Youth Manager is the only management post exclusively focussed on young people. The Youth Manager currently coordinates all activities of the different youth projects with support from the Youth Officer. The role of the Youth Manager is clearly expanding significantly in the light of the paradigm shift to integrated SRH services for young people.

In recent years UMATI has suffered a high turnover of senior management and programme staff, including several changes in the Director of Programmes and the Youth Manager, and the loss of the IEC and Advocacy Manager. An indication of the high calibre of staff lost is that they have all moved on to large international agencies programmes (including ILO, CIDA and AYA). Staff attrition is largely due to improved employment packages offered elsewhere and a perception of a lack of potential for career development within UMATI due to its declining resource base.

There is no training department within UMATI. Staff from the former UMATI training department have been absorbed into the Clinical and Programme departments. Within the current structure, the Youth Manager and Director of Programmes are responsible for overseeing the process of training of service providers in youth friendly services, although the capacity of both these staff members to plan and manage a training programme is limited.

Capacity at Area Offices is also limited. Project managers (eg Youth Centre Managers, CBD/Peer Educator Coordinators and Clinic Managers) are supervised by the Area Manager and an Area Medical Officer. Due to loss of funding from USAID as a result of the "gag rule", it seems likely that the posts of Area Medical Officer will be lost, as these posts were financed under the USAID funded Engender Health project working on long-term and permanent contraceptives (see 5.2).

### Resource Allocation to Young People's RH

See section 2.2 above for details on the proportionate allocation of funds to advocacy and service delivery (currently around 15% and 85% respectively of UMATI's budget). Programme resources focused exclusively on young people have increased since the mid-1990s.

In the period 1995-1997 UMATI had only two projects aimed at young people, both with a predominantly family planning focus. The "Youth family planning services through peers" project implemented in nine sites, was aimed specifically at increasing accessibility and acceptability of family planning information and services to young people through trained peer educators and through the UMATI Youth Centre based in Dar es Salaam. The "Emergency contraception family planning services" project targeted young adults in national service camps and higher education institutes.

Between 1999 and 2001, additional Youth Centres were established on a pilot basis in Morogoro and Iringa Municipalities (both of which provide clinical RH services to young people); and two new projects were started: “Young men as equal partners” (YMEP) and the “Youth-driven initiative” (aimed at increasing accessibility and utilisation of STI/HIV/AIDS information and services by young people in Mbeya).

However, financial and human resource constraints have meant that since 2000, the level of activity focused on young people has been much lower than anticipated in the UMATI Strategic Plan (2001-2005). During 2002 only four projects (out of a total of nine) were aimed exclusively at young people: YMEP, Adolescent Reproductive Rights Advocacy (ARRA), the Youth-driven initiative, and the Youth SRH health services through peers project. Reach to young people therefore remains limited through small projects implemented in selected sites: the youth-driven initiative is being implemented in just one site in Mbeya; ARRA’s local level activities are focused on one district in Iringa (see section 4.2); and the SRH services project for youth includes peer education and community based interventions in 14 sites (with peer education, school-link and strengthening youth friendly services in four pilot centres). A UMATI-AYA BCC project will be implemented in seven districts.

Efforts have been made in the 2002 and 2003 Work Programme Budgets (WPBs) to integrate youth components into existing core projects. The provision of clinic services through UMATI’s 12 static clinics which currently serve adults has been reformulated under the project title “Integrated Model Youth Friendly Services”. The project envisaged renovating clinics to make them more youth friendly, but human and financial resource constraints prevented any activities being implemented under this project apart from provision of core clinic services to adults. Youth components have been incorporated into the “Integrated Community Based Services” project, through training CBD agents in ASRH, and recruitment of an additional 60 youth peer educators. The “Permanent and Long-Term Contraceptives Methods” project which will be handed over to government, includes a component on post-abortion care which includes young people; and the SRH projects for refugees and the new “Innovative Approaches to Maternal and Child Health Services” include components to reach young people.

### Monitoring and Evaluation

The Research and Evaluation Unit consists of one staff member who is responsible for overseeing all monitoring and evaluation activities. The Research and Evaluation Officer is well qualified and experienced. However, given the size of the UMATI programme, capacity for effective monitoring and evaluation is over-stretched.

Monitoring and evaluation of advocacy, IEC/BCC and services for young people has been carried out on a project-by-project basis. Baseline surveys have been carried out for a range of projects (see section 5.2.1). There have been evaluations of the Iringa Youth Centre, YMEP, Vision 2000 Family Planning and Reproductive Health Services Project, and of the peer education programme nationally.

Due to resource constraints some baseline surveys have been contracted out to consultants. The Research and Evaluation Officer recognises that they are of variable quality. For example, the ARRA and Youth Driven Initiative baselines, which used a range of participatory learning for action (PLA) techniques do not provide very usable data from which to measure project effectiveness against indicators identified in the LogFrames. More thorough baselines were carried out for the Iringa Youth Centre Project (supported by Population Concern) and for YMEP project and the recent Population Concern funded Innovative Approaches to Maternal and Child Health Project, which used both quantitative and qualitative methods and provided data to measure against indicators. Quality of

indicators for measuring effectiveness is also variable across projects. For example, the ARRA project includes a set of behaviour change indicators at purpose level, whereas the Youth Driven Initiative does not identify clear or appropriate indicators through which to monitor effectiveness. The comparability of indicators used in evaluation reports and those identified in baselines is also variable. As a result of the variable quality of both the baseline data and evaluation reports (which is recognised by UMATI), these studies alone do not provide an adequate or appropriate database from which to monitor and report impact.

A further constraint on effective monitoring and evaluation is that a range of different logical framework formats is being used to meet different donor monitoring and evaluation requirements. As a result, reporting formats also differ across project sites. Yet another reporting format will be introduced in AYA-supported sites (see sections 4.2, 5.2 and 6.2 for elaboration on UMATI's role in AYA). The Youth Manager anticipates that the AYA format will become the template for reporting across the programme. Currently data are reported by Youth Centre Managers and Peer Education/FLE site managers to the Youth Manager on a quarterly basis. These data collate numbers of IEC/BCC sessions provided and utilisation of SRH services by young people accessing the youth centres, but do not disaggregate by age group or socio-economic status. These data are not used to analyse trends, and no trend data was available from UMATI central office or youth centre sites.

The management information system (MIS) for reporting to IPPF has not been revised to reflect the strategic focus on young people or on reproductive rights.

Data collected at the 12 UMATI static clinics are not disaggregated by age (although they are disaggregated by sex), and therefore there is no means of monitoring utilisation of services by young people. Reporting to IPPF is focused on family planning data, reporting on contraceptive services provided through FPA clinics (disaggregated by new acceptors and total number of acceptors), supply of clinical contraceptive to MOH and other providers, number of outlets supplied with FPA contraceptives (which includes CBD and youth centres), and non-contraceptive services provided by FPA clinics and referral. These data provide no means of monitoring and reporting impact on young people's reproductive health and rights to IPPF. Narrative reporting on activities completed under each of the projects is included in the annual reports. However, again it is difficult to extract trend data from these reports. The Youth Manager and the Research and Evaluation Officer are both very aware of the shortcomings of the MIS and are in the process of accessing technical assistance from AYA to strengthen the system to reflect the new monitoring and evaluation requirements of the programme.

#### Partnerships and collaboration

UMATI has some long-standing partnerships with international NGOs, in particular the UK-based Population Concern and RFSU (Association for Sexuality Education of Sweden, originally the Swedish FPA), which have been instrumental in assisting UMATI to develop their resource base and technical capacity to pilot approaches to address young people's sexual and reproductive and rights.

UMATI is collaborating with AYA across all three components of the programme (advocacy, BCC and youth friendly services), which is entirely appropriate to UMATI's strategic objectives. UMATI is also collaborating with AMREF in integrating voluntary counselling and testing (VCT) services into some of its youth centres (Iringa, Mbeya, Temeke). However, coordination with AMREF on areas such as lifeskills has been limited, even though both UMATI (through AYA) and AMREF (supported by UNFPA) have developed lifeskills curricula.

UMATI is recognised by government partners for its capacity to provide training in lifeskills, peer education and counselling. An example of an effective partnership with government is through the Vocational Education Training Authority (VETA) in the MLYDS. UMATI has assisted in integrating lifeskills training into VETA's technical training programmes, and has provided technical assistance to VETA in development of a lifeskills curriculum and in training of lifeskills trainers. Partnership with the MOH has been on a smaller-scale, through pilot project approaches. A component of YMEP has been linking rural outreach with non-UMATI service delivery sites (including government service delivery points). Collaboration with MEC has also been project based, and integrated into school-link activities across several projects in which teachers have been trained by UMATI in lifeskills related to young people's sexual and reproductive health for out-of-curricula activities.

#### *UMATI-UNFPA complementarity and collaboration*

The overall approach of UMATI to young people's sexual and reproductive health is largely complementary to that being supported by UNFPA. While UNFPA is supporting the MOH to improve the youth friendliness of services in the public sector, UMATI has been one of the lead organisations in Tanzania in piloting RH service delivery to young people. Both organisations are now prioritising the development of protocols and guidelines to support the implementation of a package of youth friendly services; training of service providers to improve quality of service provision to young people; and the integration of lifeskills and community based behaviour change approaches with service delivery approaches. While UNFPA is supporting FLE in-schools, UMATI has prioritised peer education and lifeskills approaches to reach out-of-school youth. UMATI is also complementing UNFPA's FLE programme through the development of school-link activities in selected project sites to increase teachers' competencies in working with young people on lifeskills. UMATI's in-school activities are linked to Youth Centres as referral sites to increase young people's access to services and counselling. The support provided to school-link activities by Youth Centres is also crucial given the apparently high level of sexual abuse of students by teachers revealed in the knowledge, attitudes and practice (KAP) study carried out by UNFPA (2001).

Despite complementarity of approaches, coordination and lesson learning between UNFPA and UMATI have been limited. UMATI is an implementing partner in the AYA programme, and there are some clear areas of overlap between UMATI's efforts supported under AYA and those of UNFPA identified in its own country programme. In order to avoid duplication of efforts UNFPA has put on hold those activities in 5CP which are now being addressed by AYA partners (such as development of the package of youth friendly services). As implementation of the AYA programme has been slow, this has placed constraints on implementation of planned activities and coordination of efforts by both UMATI and UNFPA. There would be much greater potential for scaling-up best practice through improved coordination between UNFPA and UMATI and through including NGOs such as UMATI as implementing partners under UNFPA's 5CP. UMATI does not receive any core funding from UNFPA. However, during the evaluation UMATI expressed willingness for much greater collaboration and coordination with UNFPA, and to embrace opportunities to play an active role in the 5CP.

### **3.2.2 Integration of Rights**

The concept of young people's reproductive health and rights has not as yet been integrated into UMATI's employment policies. There are no explicit employment policies relating to young people or to sexual and reproductive health and rights, and no formal equal opportunities or gender policy. For example UMATI has no explicit policy relating to the rights of employees with HIV/AIDS. UMATI operates on a none discrimination policy based upon the general provisions stated in the constitution that "The Association shall not unfairly

discriminate on grounds of race, creed, ethnic origin, political belief, gender, disability or age in: admitting members, providing information and/or services, and recruiting staff”.

### **3.2.3 Capacity**

#### *Capacity to conceptualise reproductive health and rights and diversity of needs*

The concepts of young people’s reproductive health and rights are clearly understood and articulated by senior management and programme staff. In particular the partnership with RFSU has assisted UMATI in building institutional capacity at management level to understand and internalise the concepts of sexuality, gender and reproductive health as they relate to young people. Programme staff have a clear understanding of the complexity and diversity of needs within the country context, and baseline studies have collected data which reflect this diversity across the national programme. Project approaches include components to address a range of priority issues identified in different sites including gender related needs (eg through YMEP), needs of in and out-of school youth, reach to married and unmarried youth, and rights-based issues through advocacy on FGC and the rights of young people to access education, information and services.

Clear efforts have been made in the recent Work Programme and Budgets to integrate the concept of young people’s reproductive health and rights into the current portfolio of projects, and to fit projects within an overall strategic framework which prioritises young people. Under the YMEP project the four Area Managers and Youth Manager undertook a study tour to Sweden to be oriented on issues related to sexuality and gender. Senior programme staff have also received an orientation training from the Reproductive Health Research Unit in South Africa on the concept of Youth Friendly Services. However, UMATI management and senior programme staff recognise that clinic staff have not been sufficiently sensitised to issues relating to young people’s reproductive health and rights. Significant training needs to be undertaken to increase capacity of clinic staff to reorient their services to meet the needs of young people. It is also recognised that sensitisation of volunteers at national and branch level is essential to ensure that the paradigm shift is supported in policy and decision-making at all levels of the organisation. However, resource constraints have so far prevented activities aimed at sensitising volunteers from being implemented.

#### Institutional mechanisms for young people’s participation

Mechanisms for young people’s participation have been established at project level, but not institutionalised throughout UMATI’s policy-making volunteer structure. Young people’s participation is relatively high in project implementation but still relatively low in terms of decision-making structures. Youth centres have established youth committees to represent the views of young people to centre staff. However, in most cases these youth committees are separate from the youth centre volunteer boards which are the formal UMATI policy-making bodies. Peer educators are included in the Project Advisory Committee of Iringa Youth Centre.

Despite the constitution stating that 25% of the membership of UMATI policy-making bodies at all levels should be young people, UMATI staff are aware that this has not been translated into practice. There is currently limited participation of young people on the National Council which is the main policy-making body of UMATI and there is resistance among volunteers at Regional and District level to include young people in decision-making. There is a general perception among volunteers that young people lack the capacity to participate effectively in decision-making.

### Capacity to reach marginalised groups

UMATI's programmes prioritise reaching marginalised young people. A particular emphasis has been placed on reaching the poorest including out-of-school and unmarried youth. Youth components have also been integrated into projects reaching refugees in Dar es Salaam, and UMATI manages three refugee camps in Kigoma Region and in two other three border areas of Karagwe and Ngara (see section 5.2). The main constraint for UMATI in reaching marginalised young people is that coverage is currently restricted to geographically localised project interventions.

### Capacity to use evidence based planning and promote best practice

Evidence base for planning has been developed on a project-by-project basis. Discussion of the evidence base for project planning is covered in numerous other sections of this report and is not repeated here (see 3.2.1, 5.2.1 and 5.2.2).

Lesson learning on best practice – which is a basic necessity for scaling-up pilot projects – has been constrained by lack of systematic data through which to analyse trends and effectiveness of different approaches. Lack of documentation of lessons learned is also recognised by UMATI as a weakness in the development of a sound evidence base for future programme planning. Through the partnership with AYA UMATI is addressing this constraint and has the potential to feed into national lesson learning on best practice.

### Financing

UMATI has limited capacity at present to acquire financial resources. The proposed Research and Marketing Department is key to UMATI's strategy for sustainability and income generation. However, due to lack of funds received from the IPPF Africa Region (IPPFAR) Office, none of the essential posts in this department have been recruited. UMATI has made significant efforts to diversify its funding base through a wide range of donor-supported projects. However, this strategy has also affected the overall coherence and coordination of the programme. UMATI's main strategy for financial sustainability is cost-recovery from clinic services. However, this policy is not applied to young people. With the paradigm shift UMATI will need to develop an alternative strategy to ensure that they can generate income, for example, through marketing their training services. The Research and Marketing Department will be key to this approach.

### Capacity support from IPPF

Technical assistance from the IPPF Africa Regional Office (IPPFARO) has been limited. Between 2001 and 2003 only four visits have been made to UMATI by Regional Office staff. The IPPFARO has subsequently explained that this was due to what it describes as a "transitional period" for the Regional Office. One of the visits was to assist UMATI in planning the paradigm shift and in developing their current strategic plan. UMATI expressed frustration at the lack of strategic focus and support provided by the Regional Office, along with confusion about the IPPFAR Strategy (2002-2005) which is currently in draft. In the draft IPPFAR Strategy, Tanzania is identified among those countries to receive IPPF technical assistance in safe motherhood; UMATI noted the absence of reference to UMATI's need for strategic guidance on young people's SRH<sup>38</sup>.

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<sup>38</sup> The IPPFAR Strategy 2002-2005 identifies three programme areas for support to FPAs as HIV/AIDS, Family Planning and Safe Motherhood/Safe Abortion. Youth SRH is considered by IPPFAR to be a cross-cutting issue in all the main programme areas. IPPFAR state in correspondence with the evaluation team that "locating UMATI in the Safe Motherhood/Safe Abortion cluster "will not prevent IPPF to assist UMATI technically in other areas of UMATI's focus, which are Youth SRH".

The external evaluation of the IPPF Vision 2000 project<sup>39</sup> implemented by UMATI concluded that institutional problems within IPPFAR Office prevented appropriate technical assistance being provided. The evaluation states that “the region acted as a bottle neck” and failed to provide technical support. In addition the evaluation suggests that competition between London and IPPFAR led to fragmented management and technical backstopping. As a result of these institutional problems within IPPF and between IPPF and UMATI the evaluation suggests that “all partners are at serious risk of losing their combined investment because of this lack of coordinated transition planning which is already undermining achievements which will not be sustained in the short or long term unless collaborative effort is undertaken immediately to minimise losses and connect project stakeholders to other partners”.

### 3.2.4 In Summary

UMATI’s capacity to implement its current strategic plan has been severely constrained by a declining financial resource base and limited human resources. UMATI has experienced some serious staff losses in recent years with key members of senior management leaving to join international agencies. Some of these posts have not yet been refilled and key positions identified in the new organisational structure have not been confirmed. The absence of a Research and Marketing Department and the loss of the Training Department severely constrain UMATI’s capacity to implement long-term strategies for financial sustainability. While technical support was received from the IPPF Africa Regional Office (IPPFARO) in the strategic planning process, the paradigm shift does not appear to have manifested itself in the technical support provided by IPPFAR at the national level.

The extent to which UMATI has been able to assess the effectiveness and impact of its programme on improving young people’s reproductive health and rights has been constrained by the lack of an effective MIS. UMATI has made concerted efforts to ensure that baseline studies and evaluations are carried out on a project-by-project basis. However the variable quality of these studies and the inconsistency in indicators used, limits the extent to which they provide a database from which to measure effectiveness and impact. The current MIS does not disaggregate service data by age of users, and it is not possible to analyse trends in utilisation of services by young people. The limitations in the current MIS are recognised by programme staff and will be addressed through support from AYA.

The concepts of young people’s reproductive health and rights are clearly understood and articulated by senior management and programme staff. Clear efforts have been made in the recent Work Programme Budgets to integrate the concept of young people’s reproductive health and rights into the current portfolio of projects, and to fit projects within an overall strategic framework which prioritises young people. While senior programme staff have received orientation training, clinic staff have not been sufficiently sensitised to issues relating to young people’s reproductive health and rights. Improving skills and competencies of clinic staff to provide youth friendly services will require significant efforts to ensure that UMATI’s paradigm shift can be implemented effectively throughout its core programme.

The overall approach of UMATI to young people’s sexual and reproductive health is largely complementary to that being supported by UNFPA. Despite complementarity, coordination between UNFPA and UMATI has been limited, and has been blurred by the initiation of the AYA programme. UMATI is an implementing partner of AYA, and there are some clear areas of overlap between activities identified by the AYA programme and those identified in

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<sup>39</sup> The “Family Planning and Reproductive Health Services” project funded by the IPPF Central Office Vision 2000 fund was set up to pilot service delivery approaches to reach marginalised groups, including young people. The project does not appear in UMATI’s WPBs or Annual Reports, and thus we have little information on project activities

UNFPA's 5CP. The slow implementation of key AYA components has therefore had implications for the implementation of both the UMATI and UNFPA programmes.

## SECTION 4: ENABLING POLICY DEVELOPMENT AND REFORM

### 4.1 UNFPA Country Programme

#### 4.1.1 Relevance

##### Focus on policies and legislation relating to young people's RH and rights

Historically, UNFPA's contribution to policy reform and advocacy in Tanzania has centred around its work on the national population censuses, the national population policy, legitimation for family planning, and more recently on awareness raising among senior policy-makers of the ICPD Programme of Action.

Under 4CP, UNFPA supported a small initiative entitled Advocacy for Adolescent Reproductive Health within the MOH, as a result of which Members of Parliament in the Mainland and Members of the House of Representatives in Zanzibar were sensitised (leading to the formation of population caucuses, described elsewhere in this report). Under the initiative, advocacy against FGM and other harmful traditional practices (HTPs) was undertaken among leaders at regional, district and community levels in Arusha, Dodoma and Kilimanjaro, resulting in statements against HTPs and the formation of committees to fight the practices. UNFPA estimate that in working with these three regions they covered around 30% of the population practising FGM. Under 4CP, UNFPA also funded a review of laws and policies affecting young people's reproductive health<sup>40</sup>.

However, the 4CP advocacy performance was poor, due in part to budgetary constraints, but largely because of problems associated with the Population Advocacy Unit (PAU) established by UNFPA within the MCDGAC. The Mid-Term Review of 4CP noted (on pp 13-14) a number of shortcomings with and constraints faced by the PAU:

- "The unit is misplaced" within the MCDGAC (4CP Mid-Term Review, p13). Given the focus on gender within 4CP, it was felt that the PAU should be in the Gender Department of MCDGAC, and not the Community Development Department.
- Lack of capacity and expertise within the PAU in advocacy and in monitoring and evaluation.
- "The most significant obstacle, however, is having the unit positioned within the government, functioning as an advocate", which created difficulties working with NGOs (The 4CP Terminal Evaluation and a number of other commentators argue for an "Advocacy and Gender Coalition of NGOs" housed within an existing NGO, which then acts as its secretariat).

As a result of the criticism of the 4CP Advocacy sub-programme by the Mid-Term Review, all projects (except the radio soap opera programme) were closed down. The Terminal Evaluation of 4CP and the 2001 Country Population Assessment (CPA) therefore unsurprisingly note that most of the planned advocacy activities in 4CP were not implemented, and overall performance was poor. Reasons for this – in addition to the failings of the PAU - include:

- Weak partnerships with key stakeholders, especially NGOs. The 2001 UNFPA Annual Report notes that effective advocacy needs coalitions of NGOs. This was clearly not achieved under 4CP; 5CP has no significant NGO component, apart from AYA.
- Lack of technical assistance from the CST office and lack of expertise on advocacy within the CO (see 3.1 above).

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<sup>40</sup> *Consultancy Report on Laws and Policies Affecting Adolescents Reproductive Health* by A Mallya (Ministry of Justice and Constitutional Affairs) and M Otaru (Tanzania Women Lawyers Association) for the Ministry of Health Family Planning Unit 1998/1999

- Approaches to legislative reform under 4CP (especially in relation to FGM and sexual violence, including wife beating) were not grounded in work at the grassroots. Lack of community participation – especially of community leaders – and of a strategic alliance with activist organisations with members of the legal profession – were considered by the 4CP evaluation to be the main reasons for lack of progress with legislative reforms.

The lessons learnt from and recommendations articulated following 4CP, include the need for more dedicated resources (staff, funds and technical assistance) for advocacy, a more strategic and concerted effort at networking and information sharing (including alliances with NGOs), and the location of rights-based advocacy within the context of addressing socio-economic and cultural issues.

5CP has a number of small projects and activities related to advocacy and policy reform.

One of the four outputs within the Population and Development Strategies sub-programme relates to improving the “environment for reproductive, population and gender programmes” through:

- The establishment and functioning of parliamentary caucuses to lobby and sensitise government on population and RH rights. The main achievements to date seem to have been related to the census, while on the Mainland the caucus also developed links with Tanzanian Parliamentarians AIDS Coalition (TAPAC).
- Increasing the number of political, religious and local leaders supporting reproductive, population and gender (R/P/G) programmes. The UNFPA baseline survey 2002 shows that respondents in 17 out of the 26 Mainland, and 3 out of 10 of the Zanzibar UNFPA-supported districts report having heard political, religious and local leaders actively and publicly supporting R/P/G issues. A further indicator for success will be the number of councils (district and ward) allocating funds for population.

The PDS sub-programme under 5CP continues to be coordinated through the PPU (whose limitations have been highlighted). Under 5CP, the PDS sub-programme intends to work with and through the other two sub-programmes, specifically in relation to promoting the education and value of the girl child (with the G/A sub-programme), and male involvement in FP/RH (with the RH sub-programme).

The 5CP Gender and Advocacy sub-programme has two outputs: “enhancement of gender mainstreaming into policies and programmes” and “implementation and enforcement of gender-sensitive policies, programmes and laws related to female genital cutting (FGC) and other harmful practices, sexual offences, and land ownership, education and sexual and reproductive rights”. In relation to the second output, success will be measured by the number of sexual offences cases prosecuted (and the outcomes), court applications for transfer of land ownership by men and women (and the success rates), access to education for girls and boys, and changes to the incidence of and attitudes towards FGM. The strategies for achieving this output include<sup>41</sup>:

- Establishment and/or strengthening of networks and alliances of organisations at district level (including parliamentary caucuses, media coalitions);
- information campaigns to include lobbying on issues such as early marriage and childbearing, risks to adolescents of early unprotected sex;
- building the advocacy skills of officials, community leaders, government partners, and NGOs; and
- operations research to inform advocacy strategies.

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<sup>41</sup> This is taken from the Gender and Advocacy Sub-programme submission to the UNFPA Executive Board, approved Feb 2002: p7-8

5CP continues its support – through a component project – for the radio soap opera *Twende na Wakati* which has received financial and technical support from UNFPA since 1993. Although the radio programme is not specifically targeted at a youth audience, its story lines address issues related to traditional practices (eg FGC), early pregnancy, and sexual and reproductive rights, which are clearly pertinent to the priority issues facing young people. However, young people who participated in the FGDs conducted by IPH/MUCHS indicated that they and their friends did not listen to the programme.

The GA sub-programme under 5CP continues to be coordinated by MCDGAC, despite the criticisms of and shortcomings with this partner, which were identified during 4CP.

#### *The Africa Youth Alliance Project (AYA)*

UNFPA is managing the Policy and Advocacy component of AYA. The programme objective of the policy and advocacy component is stated in the AYA Results Framework as “Enabling and Supportive Environment Improved”. The four intermediate results, which shape the policy and advocacy activities and strategies are:

- ASRH-related policies and laws formulated, revised and/or implemented;
- improved harmonisation of ASRH-related laws and policies;
- increased community participation and commitment for ASRH policies and programmes (with a specific focus on early marriage and FGM); and
- Increased support for sustainability of ASRH programmes.

In relation to the work on laws and policies affecting young people’s SRH rights, AYA has engaged a law firm to undertake a detailed review, which is scheduled to be finished later in 2003. It is a follow-up to the MOH/FPU review from 1998/1999 (funded by UNFPA) entitled *Consultancy Report on Laws and Policies Affecting ARH*. The current review is expected to be more advocacy focused – highlighting inconsistencies in the laws and policies and providing “sound-bite” messages for lobbying and informing policy makers and the legislature. The immediate focus of the legislative and policy advocacy work will be the pursuit of reforms to the Marriage Act of 1971, and the implementation of the 1994 *Family Planning Guidelines and Services Standards*.

The UNFPA-funded staff member in AYA with overall responsibility for the Policy and Advocacy Component is a trained journalist. She understandably sees one the most effective ways to take forward the rights-based advocacy work as through media programmes and initiatives. An AYA Journalist Network has been established, with a view to *inter alia* covering court cases on rape, sodomy and other forms of sexual abuse of young people. A newsletter containing accounts from young people of their sexual and reproductive experiences is widely distributed (including to remote districts), and is targeted not only at young people but also at parliamentarians. AYA is also currently engaged in the development of a radio soap opera for an adolescent audience: a proposal is currently under review to formulate a youth version of *Twende na Wakati*.

#### Understanding of policy and laws which affect young people’s RH and rights among UNFPA staff and agencies supported by UNFPA

As noted there is considerable ambiguity surrounding, and contradiction and confusion within and between laws and policies relating to or affecting young people’s reproductive health and rights. For instance, the National Health Policy (1990) denies services to adolescent girls who have no children, in direct contradiction to the MOH’s *Family Planning Guidelines and Services Standards* (1994) which state that “all males and females of reproductive age including adolescents, irrespective of their parity and marital status shall have the right of access to family planning information, education and services”. The expelling from schools of girls who become pregnant is seen by many (and clearly by all head teachers, given that

the TRCHS 1999 reported not a single case of a pregnant girl or mother being in school) as based on law (as stated in the National Education Act). Advocates argue that pregnancy is only interpreted as misbehaviour and that there should therefore be discretion as regards its punishment.

UNFPA CO staff – and most of their key partners in government – are aware of these confusions and contradictions. UNFPA support for the review of laws and policies under 4CP, the current AYA initiative in this area, and the review work undertaken as part of the development of the draft AHD strategy, have undoubtedly increased UNFPA CO and partners' awareness of policy and legal issues. However, it remains to be seen how effective 5CP and AYA will be in terms of translating increasing awareness into reforms.

#### **4.1.2 Efficiency**

##### UNFPA's contribution to stimulating an enabling environment for policy support to young people's reproductive health and rights

UNFPA's contribution to stimulating an enabling environment for policy support to young people's reproductive health and rights has clearly been limited to date. Inherent flaws in the design and implementation of 4CP, and weak capacity with key partners in 4CP, meant that the country programme made very little difference to the policy environment for young people. As also noted, the CO currently lacks expertise in ASRH and advocacy. However new staff appointments and an enhanced staff complement are expected to redress the lack of capacity and expertise within the CO. Technical support from the CST in Addis Ababa has over the past few years focused heavily on the PDS sub-programme, and the final evaluation of 4CP was critical of the lack of TA in the areas of rights, adolescent RH, and advocacy. However, key partners have acknowledged the important role played by the CST in the development of the draft AHD strategy (from the participatory consultations for the baseline information through to the writing of the final draft document).

#### **4.1.3 Effectiveness**

##### Perception by key partners of UNFPA's impact on national policies, protocols and standards/norms for reproductive health

Interviews with representatives of UNFPA's main government partners indicated a high level of appreciation of UNFPA support. The RCHS (UNFPA's main partner with regards to young people's RH), however, explained that to date service providers in government facilities have received only minimal training on ARH under a UNFPA project specifically designed to provide such training (see section 5.1). Under 5CP, UNFPA is to support the development of a minimum package of adolescent friendly health services (AFHS), which will form the framework for the implementation of the RCHS' Package of Essential Reproductive and Child Health Interventions. However, at the time of the evaluation, RCHS indicated that these planned activities had not started (see 5.1). The MOH on both mainland and Zanzibar recognise the value of the technical support from UNFPA for the CBD component of the national reproductive health programme, which has included developing guidelines for service provision, training materials and tools for assisting districts to plan for CBD related activities.

Some bilateral partners expressed the view that UNFPA is not sufficiently engaged in the RH policy debate, and that it is too focused on its own projects and sub-programmes (partly the result of bilateral donors continuing to provide funds through multi-bi sources for such small-scale activities, but also because of the results-based management approach which forces UNFPA CO to seek to demonstrate attribution).

While UNFPA is recognised by many bilateral and multilateral agencies as an effective lead agency in relation to the national population census, there is a view held by some of these partners, that UNFPA lacks leadership in RH. One donor representative expressed the view that this shortcoming is exacerbated by UNFPA continuing to disburse funds and coordinate its Country Programme through the PPU<sup>42</sup>. Examples cited by partners of lack of leadership in key areas in which UNFPA would be expected to lead include:

- USAID taking the lead donor role on contraceptive and condom security, and on the HIV/AIDS health strategy; and
- UNICEF pushing strategically for a social change communication approach within the Joint Response to HIV/AIDS (see 3.1.1).

#### **4.1.4 In Summary**

UNFPA's contribution to stimulating an enabling environment for policy support to young people's reproductive health and rights has been limited over the period since ICPD. Inherent flaws in design and implementation, and weak capacity with key partners, meant that 4CP made little impact in the policy environment for young people. The final evaluation of 4CP was critical of the lack of TA from the CST in the areas of rights, adolescent RH, and advocacy. However, key partners have acknowledged the important role played by the CST in the development of the draft AHD strategy. 5CP has a number of projects and activities related to advocacy and policy reform under the PDS and GA sub-programmes. UNFPA is also managing the Policy and Advocacy component of AYA, the objectives of which relate to revising and/or improving ASRH-related policies and laws, and increasing community participation and commitment for ASRH policies and programmes. UNFPA support under 4CP for the review of laws and policies relating to or affecting young people's reproductive health and rights, the current AYA initiative in this area, and the review work undertaken as part of the development of the draft AHD strategy, have increased UNFPA CO and partners' awareness of policy and legal issues relating to young people's RH and rights. However, it remains to be seen how effective 5CP and AYA will be in terms of translating increasing awareness into reforms. Much will depend upon the extent to which new staff appointments and an enhanced staff complement in the CO will be able to redress the lack of capacity and expertise in ASRH and advocacy within the CO.

## **4.2 UMATI**

### **4.2.1 Relevance**

#### Components of UMATI's programme focusing on influencing reform of policies and legislation which relate to young people's RH and rights

Goal 1 of UMATI's current strategic plan for the period 2001-2005 is devoted to advocacy, expressed as "To advocate for community support, change of laws, policies and practices to empower the youths to exercise their SRH rights". Within the plan there are five strategies to achieve this goal, see box below:

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<sup>42</sup> However, it is important to note that in relation to reproductive health, the government-mandated lead agencies are the MOH and MEC

Strategies to Support Goal 1 of UMATI's Strategic Plan 2001-2005

Strategy 1: "To create community awareness on gender equality and socio-cultural practices that have negative effects on youth SRH and rights"

Strategy 2: "To increase knowledge on SRH and rights among youths that will empower them to access services"

Strategy 3: "To increase the level of understanding among policy and law makers on the magnitude of SRH related problems affecting youth and provide for a conducive environment for their eradication"

Strategy 4: "To create community awareness on cultural practices that have negative effects on youth SRH"

Strategy 5: "To spearhead the effective integration of SRH education in school curricula"

Over the past three years (including 2003) UMATI has only implemented strategies 1 and 2 because of funding cuts and budget shortfalls (see section 2.2 and 3.2). Under strategy 1 just two projects were active in 2002, one of which terminated that year:

*Young Men as Equal Partners (YMEP)*

This project, which commenced in 1999 worked in two urban and two rural sites (with very small catchment populations – sub-district/ward level). It used peer educators to reach out of school young men and teachers to reach in-school. Although termed an advocacy activity, in effect this project is more about services and IEC (its objectives relate to increasing the number of men seeking SRH services and information, increasing knowledge, and increasing number of men who discuss SRH with partners). Despite these objectives, the project was successfully involved in community sensitisation (to education authorities, district leaders and community leaders). The project terminated at the end of 2002 due to lack of funds, although UMATI has made a commitment to work with District Councils in the four sites to "make them provide financial support" for continuation of some activities. A total of just under 163m Tz shillings (approx \$170,000) was spent on the project over its 4 years of implementation. In January 2003 UMATI held a large workshop to disseminate the lessons learned from this project (participants included representatives from other African countries, RFSU, Population Concern, as well as senior Tanzanian officials from MOH, MEC). According to UMATI, at the workshop the MOH expressed great interest in the approach and indicated that it would commit district basket funds to the four UMATI sites so that the advocacy and rights issues could continue. MOH also apparently indicated a desire to scale up to other districts. However, a field visit during the evaluation to YMEP sites indicated that peer educators were facing the prospect of losing their jobs (see 5.2).

*Adolescent Reproductive Rights Advocacy (ARRA)*

This project is implemented at both the national level (working with 20 key policy makers) and at local level (working in Iringa Municipality). Local level started in 2001 and national in 2002. The Iringa ARRA activities include peer educators, teachers and community motivators (engaged in similar activities to the YMEP project – IEC and services), establishing a library focused on young people, VCT, and youth centre activities. This is funded by the UK NGO Population Concern. The national level activities in 2002 – funded by AYA - were limited to two 2-day consultative meetings with 20 advocacy "coalition partners" (media, advocacy NGOs such as TGNP, lawyers associations), which identified issues for advocacy as: youth

friendly services, review of policies and laws which negatively affect young people's SRH (eg Marriage Act), and integration of SRH in primary school curriculum. UMATI was mandated to formulate a task force for coordination at national level. In 2003 UMATI – in partnership with TGNP – and with AYA funds (from the AYA policy and advocacy programme managed by UNFPA) is expected to start building local coalitions of NGOs, media, lawyers etc in the AYA sites. The objective of these activities is to “promote ASRH rights issues to coalition members” who in turn will then lobby district authorities. The district level advocacy through coalitions work has been slow to get started. AYA have expressed frustration at the difficulties in getting UMATI to enter into partnership with TGNP, and suggested that recent staff losses in UMATI have left AYA without a focal person in UMATI with which to negotiate contracts and workplans. UMATI, however, explained that the AYA project design did not clearly delineate the roles of UMATI and TGNP (which led to confusion and delay), and that their Youth Officer was appointed as the AYA focal person immediately after the previous focal person left UMATI. According to UMATI, national level ARRA activities are now funded in full by Population Concern.

A project entitled “Working with heads of media and religious leaders in sex postponement and STI/HIV/AIDS prevention” planned to start in 2002 was not implemented, due to shortage of funds.

Under strategy 2, one project was being implemented in 2002, the “Youth Driven Initiative”. This is an IPPF funded project through the EC, being implemented in one district in Mbeya Region, on the highway to Zambia. Again, although labelled an advocacy project it is essentially IEC-focused in its strategy, using puppetry and other IEC/BCC strategies with the aim of reducing HIV and other STI rates among the youth. Its advocacy focus comes from sensitising and involving local government leaders, community development officers, religious leaders and teachers and parents.

#### Understanding of policy and laws affecting young people's RH and rights

As noted in section 1 and in 4.2.1 above, there is confusion and contradiction within and between policies and laws affecting young people's RH & rights. UMATI staff and volunteers are aware of these contradictions. UMATI is an active partner in the AYA project, which is seeking to address these (see 3.2 and other relevant sections).

#### **4.2.2 Efficiency**

##### UMATI's contribution to stimulating an enabling environment for policy support to young people's RH and rights

The above discussions (see also 5.2 and 6.2) have indicated that UMATI – despite recent declines in capacity - remains on many of the key policy and advisory forums in which young people's RH and rights are discussed. However, at present the IEC and Advocacy post in UMATI's organogram is vacant (the previous incumbent left to join ILO) and UMATI does not have funds to replace him. Section 2.2 indicated that between 11.2% and 15.6% of annual project spending is on advocacy activities. See section 3.2 for further discussion.

#### **4.2.3 Effectiveness**

##### UMATI's influence on development of national policies to promote the reproductive health and rights of young people

It is difficult to trace direct national policy influences. However, by being one of the few agencies in Tanzania to take on board the sensitive issue of young people's RH and rights, UMATI is clearly recognised by key stakeholders (donors, government and NGOs) as having

played a pioneering role in advocating for the provision of reproductive health services for young people in Tanzania.

One potential area for policy and legislative influence in the current programme is the work of the UMATI Youth Centres, which are reaching pregnant schoolgirls expelled from school. One of UMATI's objectives in working with these girls is to demonstrate to Tanzanian policy makers, planners and parents that "the girls have the capability and desire to continue and complete their education after childbirth". In addition to providing school curriculum-based education at the centres, UMATI also provides vocational training. However, as yet UMATI has not developed a strong evidence base to support its advocacy objectives within this approach, although as a member of a number of national policy forums, it is clear that policy makers in government are increasingly aware of the injustice of the discrimination against young girls who become pregnant before completing their schooling.

As already indicated (see section 3.2 and also 6.2) some UMATI pilot projects are able to demonstrate effective advocacy. Under the ARRA project for example, UMATI is directly addressing issues related to reproductive rights through its use of billboards and leaflets.

#### UMATI's impact on development of professional standards and best practice for young people's reproductive health

UMATI has been collaborating with the RCHS of the MOH in the implementation of the permanent and long-term contraceptives (PLTC) project. While this project is clearly focused on adults it has included a component of post-abortion care which addresses the needs of young people. The aim has been to assist the MOH to develop best practice in service provision, and the project is in the process of being handed over to MOH. UMATI has collaborated with the MOH on service delivery best practice in some UMATI project sites (see section 5.2.5 for examples). With support from IPPFARO and AYA, UMATI is developing a minimum package of Youth Friendly Services (YFS) to help guide clinic staff on best practice (see 5.2.3). The package is based on "Going for Gold" produced by the South African Reproductive Health Research Unit (RHRU), who were commissioned by IPPFARO to develop the manual "Standards for Youth Care". Through its involvement in AYA, UMATI should be able to contribute further to influencing national best practice on services for young people.

UMATI appears to have received few best practice guidelines from IPPF. Most youth centre clinic staff have little knowledge of IPPF best practice guidelines produced.

UMATI is also recognised by government partners for its capacity in providing training related to lifeskills, peer education and counselling. Section 3.2 cited the effective partnership that UMATI has developed with the Vocational Education Training Authority (VETA) in the Ministry of Labour and Youth Development, and training of teachers in lifeskills related to young people's sexual and reproductive health for out-of-curricula activities.

#### **4.2.4 In Summary**

UMATI's advocacy activities are currently constrained by lack of funds and staff. UMATI's current strategic plan sets as one of its goals to advocate for community support, and change of laws, policies and practices, to empower youths to exercise their SRH rights. Of the five strategies set out to achieve this goal, only two have been funded over the past three years: raising community awareness on harmful practices, and increasing young people's knowledge on SRH and rights. Under these strategies, just three projects were active in 2002: YMEP which has successfully sensitised education authorities, district leaders and community leaders, ARRA project which works with advocacy coalition partners (media, NGOs, lawyers associations etc), and the youth driven initiative implemented in one district, which is sensitising local government leaders, community development officers, religious

leaders and teachers and parents on SRH issues. To date all these projects have been small-scale. UMATI is also engaged in advocacy within its service delivery projects. Through its Youth Centre work with out-of-school young women, UMATI has contributed to the increasing awareness among policy-makers in government of the injustice of discrimination against young girls who become pregnant before completing their schooling. UMATI is also recognised by government for its capacity in providing training related to lifeskills, peer education and counselling. UMATI's collaboration with the MOH on post-abortion care aims to assist the MOH to develop best practice in service provision. UMATI is also developing a minimum package of YFS to help guide clinic staff on best practice.

Thus, despite resource constraints, UMATI is recognised by donors, government and NGOs as having played a pioneering role in advocating for the provision of RH services for young people in Tanzania.

## SECTION 5: STRENGTHENING REPRODUCTIVE HEALTH SERVICES

### 5.1 UNFPA Country Programme

#### 5.1.1 Relevance

##### Support to RH services for young people

Minimal support was provided to strengthening reproductive health services for young people under 3CP (1992-1996) and 4CP (1997-2001). 3CP supported provision of maternal and child health and family planning services, as opposed to a broad reproductive health approach. Within this framework no specific attention was given to service delivery to young people. Under 4CP priority was given to supporting the development of the national Adolescent Health and Development Strategy, which is intended to provide the framework for implementation of adolescent reproductive health services. The 4CP Reproductive Health sub-programme, which was aimed at diversifying the availability and accessibility of reproductive health services, included adolescent health as a component to be incorporated into the Package of Essential Reproductive and Child Health Interventions. However, due to budgetary constraints the adolescent health component was not prioritised in implementation of the package.

Significant efforts have been made by staff within the UNFPA CO to increase the focus on delivery of reproductive health services to young people within 5CP. Two component projects of the RH sub-programme include activities to strengthen RH services for young people, these are “Support for Improving Quality of Reproductive Health including Adolescent Sexual and Reproductive Health Services” (URT 02/P01-mainland) and “Reproductive Health, Family Planning and Safe Motherhood Programme” (URT 02/P02-Zanzibar). The two main outputs of these projects are:

- Improved quality of sexual and reproductive information, education and services to men, women and adolescents; and
- increased availability and use of sexual and reproductive health information and services.

The implementing partner is the Reproductive and Child Health Section of the Ministry of Health (mainland) and the Directorate of Preventive Services in the Ministry of Health and Social Welfare (Zanzibar). Under component project URT 02/P01 for mainland Tanzania planned activities include capacity building of programme managers in the RCHS on adolescent reproductive health (ARH), and strengthening the capacity of districts and communities to provide services to adolescents. The component project document (mainland) indicates that strengthening of adolescent friendly services will be implemented in phases, beginning with eight districts. Lessons learned from these districts will form the basis for expansion of services to young people in other districts. In addition the project document refers to development of a minimum package of adolescent friendly health services (AFHS), which will form the framework for the implementation of the Package of Essential Reproductive and Child Health Interventions. Training of service providers is also planned using a curriculum currently being developed by the RCHS with support from AYA. However, at the time of the evaluation none of these planned activities had begun to be implemented for reasons discussed in subsequent sections.

In addition to the proposed activities under the RH sub-programme, the regional project “Improving the Quality of Sexual and Reproductive Health (SRH) Care” which is supported by ILO, UNICEF and WHO, includes a component on services for young people. The project focuses on demand creation through empowering communities to know their rights to access quality RH services. The project will be implemented in four districts. Activities in Temeke

District in Dar es Salaam will include a focus on youth. Temeke is also an AYA District and is served by a UMATI youth centre.

Pathfinder International is the agency responsible for implementing the Youth Friendly Services Component of AYA. Despite the fact that UNFPA is the lead agency in the AYA partnership, no institutional linkages have been formed between UNFPA and Pathfinder, making coordination of activities difficult.

### Evidence base

A baseline knowledge, attitudes and practice (KAP) survey was recently completed in the 36 districts covered by 5CP (26 in mainland Tanzania, and 10 in Zanzibar). This is the first baseline study conducted for the UNFPA Country Programme. Data collected in the baseline indicate that quality and accessibility of services to young people are poor and “has been neglected for some time”. According to the baseline data only 10% of service delivery points (SDPs) offered some SRH, IEC and counselling services to young people and only 16% of providers knew of community outlets offering SRH information and counselling services to out-of-school youth. The baseline provides some key indicators for measuring effectiveness of 5CP. These include: % of SDPs offering SRH information, education, communication and counselling services to adolescents; % of community outlets offering SRH information, education, communication and counselling services to out-of-school youth; women, men and adolescent’s knowledge on SRH issues, and school and colleges providing SRH information, education and counselling. A baseline needs assessment has also been undertaken for the Improving Quality of SRH Care Project, and focus group discussions were undertaken with young people in Temeke and Mwanza Districts.

The URT02/PO1 component project includes socio-cultural studies on barriers to RH information, education and services for out-of-school youth. The terms of reference for the studies (according to the project document) are assessment of the adolescent friendliness of existing SDPs, community-owned means of communication, training needs of service providers, health seeking behaviour of adolescents, service needs of young people, and knowledge and attitudes of parents/guardians and significant others in the community towards provision of ASRH services. In the design of 5CP it was intended that these studies would form the baseline for strengthening ARH services in the eight pilot districts. However, largely due to severe capacity constraints within RCHS, none of these planned research activities has taken place. It is intended that baseline studies conducted by AYA in three project areas which overlap with UNFPA will be used to complement research needs for strengthening ARH services.

### Responsiveness to diverse needs

The proposed research studies are intended to consider the diversity of needs among young people. However, the extent to which services supported under 5CP will be able to address diverse needs of young people is severely constrained by the limited capacity of the implementing partner (RCHS). Efforts have been made in the design of 5CP to integrate lessons learned from the AMREF Lifeskills Education Project (discussed in section 6.1) into activities implemented by the MOH at district level. These include demand creation and awareness raising activities on ARH problems and needs in eight pilot districts. However, UNFPA CO staff recognise that there is very limited capacity within the RCHS to implement community based and participatory approaches which address a diversity of needs at district level.

A major constraint on addressing diversity of needs through different service delivery approaches is the lack of a strategy to form effective implementing partnerships with NGOs and CBOs, which have much greater potential to address diversity of needs at the local level

than the MOH. Despite the fact that the 5CP document states that creating a supportive environment for NGO participation in the implementation of the programme is important, there are no NGO implementing partners for the RH and adolescent services component project.

A key tool for addressing diversity of needs in the design of services for young people is the development of the minimum package of AFHS. The component project document states that the package would be distributed to the public sector, NGOs and CBOs serving young people, in order to consolidate adolescent friendly services in the project areas to address a diversity of needs. However, the development of the minimum package is also included in the planned activities of AYA. UNFPA is now looking to AYA to take a lead on this initiative (to avoid duplication of efforts). However, AYA has also been delayed in developing the package largely due to lack of capacity within the RCHS to move the process forward. This has led to somewhat of an impasse, with neither UNFPA nor AYA taking a lead on the initiative.

Despite the fact that the 5CP document states that there is a need to institute and support clear mechanisms for coordination of the overall Country Programme, the lack of effective institutional mechanisms for coordination with AYA partners is a major constraining factor on 5CP contributing to a coordinated effort to support service delivery approaches which are responsive to the diverse needs of young people. Given that AYA and UNFPA are supporting implementation of youth friendly services in different districts and through different implementing partners, effective coordination is crucial to ensure that lesson learning from projects informs a national response which recognises a diversity of needs among young people.

### **5.1.2 Integration of Rights**

#### Incorporation of concept of rights

The 5CP approach is aimed at increasing the rights of all individuals (including young people) irrespective of age, marital status, and ethnicity to access RH information and services (provided through the public sector). While this is a relatively narrow definition of rights, it is not inconsistent with the ICPD definition of reproductive rights. The regional initiative “Improving the Quality of SRH Care” has a more explicit focus on rights through empowering clients (including young people) to know their rights to demand quality RH services. Under its support to community-based distribution (CBD), UNFPA has also been promoting RH rights through community sensitisation, with particular success noted in Zanzibar.

As an outcome of UNDAF, UNICEF has now moved to a rights based approach. However, technical staff within the UNFPA CO recognise that a rights based approach has not been internalised or operationalised within the UNFPA Country Programme.

#### Gender and equity

The mid-term evaluation of 4CP suggested that gender analysis was weak and the strategic development process of 4CP did not produce a framework within which to address gender issues related to service delivery. The evaluation also suggests that implementing partners had limited capacities to undertake systematic gender analysis. Resources channelled to gender related issues were focused mainly on women oriented activities. Gender focus within 5CP is also weak, and there are no explicit strategies for addressing the specific service delivery needs of young men. The main focus of the National Package of Essential Reproductive Health and Child Health Interventions is on reaching women and adolescents

with contraceptives, free antenatal and maternity services, STI diagnosis and management and HIV prevention.

### **5.1.3 Capacity Building**

#### Competencies and skills of service providers

To date service providers in government facilities have received minimal training on ARH. Under 4CP a component of ARH was included in the integrated RCH skills training implemented by the RCHS. According to the RCHS the focus of this training was on family planning skills. However, the evaluation of the training found that skills development had not been effective. As a result a new curriculum is being developed, with support from AYA for the development of the ARH component. The UNFPA component project does not include curricula development, but does include support to training of trainers at district level using the curricula developed by the RCHS/AYA. As with the minimum package of AFHS there have been delays in the development of the curriculum and as yet no training activities have taken place.

Focus group discussion carried out with young people by the IPH/MUCHS indicate that young people perceive public sector providers as being unskilled in providing services to adolescents, and reported unfriendliness and rudeness of providers as a major impediment to them accessing public sector services.

### **5.1.4 Efficiency**

#### Provision of accessible, acceptable, and quality services

UNFPA support to services is targeted exclusively at public health facilities. As noted in previous sections, implementation has been severely constrained by limited capacity of the RCHS. No direct service provision to young people was supported under 3CP, and limited and ineffective training of providers was supported under 4CP. While 5CP outlines activities to improve quality of services through training providers, no implementation has yet taken place.

UNFPA has provided technical support to the MOH for the CBD component within the national reproductive health programme. UNFPA support has included developing guidelines for service provision, training materials and tools for assisting districts to plan for CBD related activities. CBD agents have access to young people although no data exist on accessibility of services provided to young people by CBD agents.

#### Young people's participation

RCHS recognises that there are few mechanisms for young people's participation in service delivery, and that the concept of young people's participation is not clearly understood within MOH. RCHS also recognises that there are significant resource and institutional constraints to involving young people in service delivery.

Under 5CP, the main approach to young people's involvement is through training of peer educators at district level, although implementation has not taken place. Focus group discussions and consultations with young people were also undertaken as part of the process of developing the draft National AHD Strategy.

## Monitoring

RCHS recognises the limitations of its current monitoring system. SDPs only collect routine data on children under 5 years of age and service users above 5 years of age. There is no system for collecting other age specific data. Tools for monitoring quality of services to young people will form part of the proposed minimum package of AFHS to be developed by AYA.

The main sources of monitoring data for the UNFPA Country Programme are discussed in section 3.1. Until the recent baseline study there were no population-based data against which to monitor impact.

## Cost-effectiveness

No costing studies have been carried out. UNFPA's approach to cost-effectiveness has been to provide support within the existing institutional framework of the MOH. While this approach may have proven to reduce costs, there is as yet little to show in terms of effectiveness in strengthening service delivery to young people.

### **5.1.5 Effectiveness**

#### Effectiveness of support to government

The evaluation recognises that building political support for delivery of RH services to young people has necessarily been a slow process, and that implementation of services to young people has been constrained by the cultural sensitivity and stigma surrounding issues relating to young people's sexual and reproductive health (see Section 1). Despite the apparent cultural constraints to providing services to young people (which have been identified by UNFPA) there are some important examples of approaches which have increased young people's access to services, notably through the UMATI youth centre and clinic approach (see section 5.2) and through the Infectious Diseases Control clinic of Muhimbili University in Dar es Salaam which has established a youth clinic, partly as a result of AYA advocacy efforts. Through the MEES project implemented in Zanzibar UNFPA has been reaching out to some strategically situated health service delivery points to refer students from neighbouring schools. There is anecdotal evidence that this approach has had an impact in reducing the number of STI cases among in-school youth.

However, the above examples are limited in their scope and reach and as yet there is little evidence of implementation of youth friendly services through the public sector. Focus group discussions (see annex 4) indicate that young people do not identify public sector outlets as preferred sources of reproductive health services. Some of the identified barriers to access to public sector services being cost of services provided at Regional and District hospitals, lack of privacy and poor attitudes of service providers towards young people.

Within the political and cultural constraints noted, UNFPA has achieved significant advances in the formulation of 5CP, in which provision of services to young people is now identified as a key component of the Reproductive Health sub-programme. However, the extent to which UNFPA has to date been effective in supporting government to increase young people's access to services has been constrained by a number of factors. A major constraining factor to implementation of activities planned under the 5CP, which has been identified by a number of key stakeholders, has been the limited capacity within the RCHS. UNFPA is partly addressing this through fully-funding a new post of ARH Training and Service Delivery Officer. The Officer will be responsible for supporting planning, implementation and evaluation of UNFPA supported activities. A further constraint has been lack of a clear leadership role taken by UNFPA to advocate for RCHS to prioritise and implement planned activities. UNFPA is looking to AYA to take the lead in several initiatives, including some

initially designed to fall under UNFPA's remit (eg the minimum package of AFHS). Both UNFPA and RCHS view AYA as the flagship programme to provide best practice examples for youth friendly services. However, much stronger institutional mechanisms for coordination between AYA, UNFPA and RCHS are needed if best practice is to be supported and built upon.

As no implementation of activities to improve service delivery to young people has taken place through the RCHS, it is not possible to make an assessment of effectiveness of service delivery approaches and strategies as stipulated in the evaluation TORs. UNFPA CP staff recognise that some of the constraints on effectiveness could be addressed by broadening the range of implementing partners in 5CP to include NGOs (as indicated in the country programme document). However, according to UNFPA CP staff, forming effective partnerships with NGOs has been constrained by resistance from key individuals with the RCHS to working in partnership with civil society organisations.

### **5.1.6 Sustainability**

UNFPA's approach to sustainability is to support service delivery exclusively through the public sector. While supporting service delivery exclusively through the public sector is an important approach to ensuring long-term financial and institutional sustainability of services, this approach to sustainability appears to have constrained effectiveness in the short-term as implementation through the public sector has as yet been minimal. It is therefore, extremely difficult to discuss sustainability of approaches and services which have not as yet been implemented.

Staff in the UNFPA CO have voiced concerns over the potential sustainability of regional initiatives which are not integral to the CP. For example, there are concerns over the extent to which pilot approaches such as the Quality of Care project will raise expectations that cannot be met and sustained by the Country Programme.

### **5.1.7 In Summary**

Concerted efforts have been made by the UNFPA CO staff to ensure that 5CP emphasises the provision of reproductive health services to young people. The evaluation recognises that building political support for delivery of RH services to young people has necessarily been a slow process, and that implementation of services to young people has been constrained by the cultural sensitivity and stigma surrounding issues relating to young people's sexual and reproductive health. Within the Tanzanian context, UNFPA has made advances in the formulation of 5CP, in which provision of services to young people is now identified as a key component of the Reproductive Health sub-programme.

However, as yet there has been no implementation of planned activities relating to delivery of services to young people under 5CP, as a result of a number of constraining factors. The findings of the MUCHS FGDs as well as the baseline KAP surveys carried out by UNFPA support the conclusion that young people in mainland Tanzania are not accessing public sector services, and do not perceive public sector services to be youth friendly.

A concerted effort has therefore been made by the evaluation team to understand (from UNFPA's perspective) the main constraining factors on implementation of the activities outlined in 5CP. In-depth discussions were held with UNFPA CO staff, during which staff identified the main factors militating against implementation of key activities outlined in the component project documents. The constraints identified by UNFPA staff can be summarised as follows: lack of capacity of the implementing partner (the RCHS) to prioritise and implement youth friendly services; an overlap of efforts with AYA which has led to UNFPA dropping key activities (eg development of the minimum package of AFHS) to avoid

duplication of efforts; weak coordination between UNFPA and AYA and slow implementation of the AYA programme resulting in key activities, such as the development of the minimum package of AFHS not being taken forward by key stakeholders; constraints on including NGOs as implementing partners under 5CP due to personality issues within the RCHS and a resistance within the RCHS to collaborating with civil society partners.

## **5.2 UMATI**

### **5.2.1 Relevance**

#### Support to RH services for young people

UMATI is recognised by key stakeholders (government and NGOs) as having played a pioneering role in initiating provision of reproductive health services to young people in Tanzania. UMATI's service delivery to young people consists of a range of small-scale and geographically dispersed interventions, including multi-purpose youth centres with integrated clinical services (Temeke, Morogoro, Iringa, Mbeya and Arusha), peer education linked to youth centres, peer education linked to community based services through community based distribution (CBD) agents, pilot approaches which have linked peer education to schools and to public and private sector health facilities (through the YMEP project), and peer education linked to a UMATI adult clinic (Mwanza). UMATI projects are making important efforts to address priority issues related to young people's sexual and reproductive health, in particular to increasing young people's access to RH services (including family planning), gender issues related to condom use, access to STI treatment, empowering young people to reduce risk behaviours for HIV prevention, increasing access to condoms through peer educators, and advocacy and community sensitisation for reduction of harmful practices, such as FGC in relevant project areas.

#### Evidence base for programme design

The evidence base for design of interventions has largely been developed on a project-by-project basis. Detailed baselines were carried out for the Iringa Youth Centre (initially funded by Population Concern), the YMEP project (using questionnaires and focus group discussions); the ARRA project, the Youth Driven Initiative and the Innovative Approaches to Maternal and Child Health Services in the HIV/AIDS Climate in Tanzania project (funded by Population Concern). However, these baselines have been developed largely as tools for project monitoring as opposed to forming an evidence base for reviewing and refining design of service delivery approaches.

There are two main service delivery approaches to young people supported by UMATI: clinical services integrated into youth centres, and peer education. The modality of these approaches varies across project sites. The youth centre model was favoured by many Family Planning Associations (FPAs) in Africa and Latin America in the late 1980s and early 1990s. However evaluations of many of these approaches have indicated that centres are often under-utilised for reproductive health services<sup>43</sup>. The UMATI youth centre approach (which has been replicated in six sites) is largely modelled on the Temeke Youth Centre which has been operational since 1988. The Temeke centre was initiated as a pilot project aimed at reaching pregnant schoolgirls who had been excluded from school. The initial aim was to "prove to Tanzanian policy makers, planners and parents that the girls have the capability and desire to continue and complete their education after childbirth". The initial focus of the centre was on providing vocational training to girls expelled from school. While the centre has now expanded to reach young men through peer education and has in recent

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<sup>43</sup> Price, N and K Hawkins (2001) "Young people's sexual and reproductive health: towards a framework for action" in Tremayne(ed) *Managing Reproductive Life* Berghahn Books, pp194-221

years integrated clinical RH services (including VCT) into the facility, vocational training continues to be a core part of the programme. The vocational training approach has also been integrated into a youth centre in Mbeya. The other youth centres include recreational activities, peer education, clinical services and income generating activities. As yet UMATI has not developed a strong evidence base to support the replication of the approach, or to demonstrate its effectiveness in reaching a diverse range of young people with services. The peer education programme has also been supported by UMATI since 1993. The first evidence base to demonstrate the strengths and weaknesses of the approach was developed in 2001 when an internal evaluation of the programme was carried out. As the evaluation notes, generally very little evidence base exists to demonstrate the effectiveness of the peer education approach. Some of the key findings of the evaluation are discussed in section 6.2.3 of this report.

### Responsiveness to diverse needs

Efforts have been made at project level to respond to the diversity of needs among young people. For example, youth components have been integrated into the projects reaching refugees (Karago, Kanemba, Mkugwa) in order to reach highly marginalised groups of young people. Different strategies are being implemented to reach in-school and out-of school youth, for example through school-linked interventions in some sites and peer education to reach out-of-school youth. UMATI also recognises the differing service delivery needs of married and un-married youth. The integrated youth centre-clinic services largely target unmarried youth, while it is anticipated that married youth will access the 12 adult clinics for services. Efforts have also been made to train CBD agents in ARH and to incorporate peer educators into the CBD programme in order to reach rural youth. In recent years UMATI has shifted its approach from family planning services to an integrated reproductive health approach. Services provided at youth centres include STI diagnosis and management, psychosocial counselling, HIV prevention and VCT services have been integrated into several youth centres (eg Temeke, Mbeya and Iringa).

### Technical support from IPPF

Despite the important efforts made by UMATI to shift its strategic focus to serving young people, limited technical support has been provided by IPPF Regional or Central Offices to help guide UMATI's service delivery strategies (for instance in relation to introducing the Youth Friendly Services Initiative, and in improving providers' capacity to provide quality of care). The bulk of technical support related to service delivery to young people has been accessed through project partners. RFSU, who have been a partner in the YMEP project, has provided technical assistance in developing materials to address issues related to young people's sexuality. Technical assistance was also provided by Population Concern for the Iringa Youth Centre. IPPFAR has supported UMATI with technical assistance on Youth Friendly Initiatives from the South African Reproductive Health Research Centre, through a study tour by key programme staff. However, UMATI has very limited access to best-practice documents from IPPF Central or Regional Office. The main source of information received from IPPF referred to by programme staff was *Africa Link*, although UMATI does not appear to have been in receipt of *Africa Link* for some time.

## **5.2.2 Integration of Rights**

The main focus of UMATI's approach is on the rights of the client, and the rights of all young people to access SRH information and services. On a limited scale UMATI has tried to address the rights of pregnant girls to continue to access education. Gender specific strategies have been piloted through the YMEP project, which was designed in order to address issues related gender, power and sexuality and to reach young men with strategies to support behaviour change and increase their access to services.

### **5.2.3 Capacity Building**

#### Provider skills and competencies

UMATI is now facing the challenge of how to scale up the pilot and project-based approaches described above to ensure that the national programme reaches young people as the primary clients. A major constraining factor on reaching young people through the 12 static (adult) UMATI clinics which form the core of the UMATI programme, is the current capacity of service delivery staff to provide youth friendly services. With initial support from IPPFARO, and ongoing support from AYA, UMATI is in the process of developing a minimum package of Youth Friendly Services (YFS) to help guide clinic staff on best practice related to provision of services to young people. The package will cover 10 standards for youth friendly services: effective management, physical environment, availability and accessibility of services, existence of effective policies, adequate supplies and equipment, competence of service providers, adequate and correct IEC, client-centred services, adequate assessment of youth, and continuity of care. The package is based on “Going for Gold” produced by the South African Reproductive Health Research Unit, who were commissioned by IPPFARO to develop the manual “Standards for Youth Care”.

One of the projects in the 2003 WPB aims to renovate existing clinics and to train providers, to make clinics youth friendly. However, due to budgetary constraints and lack of human resources, training of clinic staff has not taken place. Some UMATI senior management/programme staff fear that it will be difficult to change attitudes of some service providers within the clinics (many of whom have been with UMATI for over 20 years), and that some may prove untrainable to provide YFS. According to programme staff the concept of YFS is not familiar to many clinic staff, and only limited orientation has taken place. A further constraint is the lack of a training department.

UMATI clinic and programme management staff are well trained and well qualified in the provision of general reproductive health services, although few staff have received training in the provision of youth friendly services. UMATI has identified staff shortages both in clinics and community based programmes (eg CBD and peer education) as a constraining factor on service delivery. The internal evaluation of the peer education programme<sup>44</sup> indicated that there is a need to strengthen supervisory systems to support peer education. Most youth centres include a trained nurse, counsellor and sessional doctor all of whom have been trained in ARH. Site visits and FGDs with young people indicated that staff in UMATI youth centres are skilled and competent in providing SRH services to young people (see next section on efficiency). However, youth centre staff mentioned shortage of personnel as a barrier to providing quality services to meet the demands of youth. For instance in Iringa a sessional doctor visits the youth centre three times a week, although demand for services is high. Due to the introduction of VCT in Iringa, the doctor and lab technician share equipment, which staff considered may compromise quality of services.

### **5.2.4 Efficiency**

#### Acceptability, accessibility and quality of services

A large number of young people in the FGDs carried out by IPH/MUCHS in Temeke, Morogoro, Arusha and Iringa indicated that young people are confident in the skills and capabilities of UMATI youth clinic staff in providing quality services. Young people in FGDs referred to UMATI youth centres, “Angaza” (AMREF’s VCT services provided in UMATI clinics), and peer educators as their main source of RH information and services.

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<sup>44</sup> Internal Evaluation of Youth SRH Services Through Peers Project (2001)

UMATI youth centres were perceived to offer services in a friendly and conducive environment, which observed confidentiality, privacy and were responsive to young people's needs and problems. Services provided at UMATI youth centres are free and therefore cost is not a barrier to access, which young people in FGDs identified as an important factor in utilising services. Gender, age, ethnicity and marital status were not identified by young people in FGDs as important factors influencing access to UMATI youth centres and peer educators. Key factors influencing utilisation were that the services are youth friendly, affordable, cater for young people without an adult influence in service provision and are flexible in accommodating youth problems and concerns.

An independent assessment of the Temeke Youth Centre carried out under the Quality of Sexual and Reproductive Health Care Project supported by UNFPA also indicated that youth centre staff were well aware of the concept of quality of services as indicated by good history-taking, proper examination of clients and confirmation of diagnosis of STIs through laboratory testing. The assessment also indicated that clients felt that the information exchange with providers was good and that providers were approachable, non-judgemental and addressed them as friends. Clients also considered that confidentiality was well maintained and that they are able to ask questions of providers, and that they would be happy to refer friends to the centre.

UMATI staff in Arusha expressed some concerns that the location of the youth centre is not appropriate and not easily accessible to young people. Staff also voiced concerns over the drug procurement procedures of the district authorities which have led to shortages in drugs, reducing the number of clients. In addition the Arusha centre is experiencing severe staff shortages.

### Youth involvement

Youth involvement in design and implementation of services has been developed on a project-by-project basis. Youth involvement is still limited in terms of management, monitoring and evaluation, but relatively high in terms of implementation. Young people are involved in implementation in most project sites through the peer education component. Youth centres have also formed youth committees (although in most cases these are separate from the volunteer advisory boards). A greater level of participation among young people in decision-making processes was observed in Temeke and Iringa youth centres that in Arusha and Morogoro. Young people's views have been sought in the evaluation of the Iringa youth centre and the YMEP project. Peer educators views are also routinely fed into programmes through supervisory meetings, although the regularity of such meetings varies according to project site and staffing capacity. Programme staff recognise that the level of young people's participation in project design, monitoring and decision-making needs to be institutionalised and more strongly articulated throughout the UMATI programme.

### Monitoring

Monitoring of services to young people takes place on a project-by-project basis. However, the MIS does not systematically collect or analyse data from the youth centres and peer education programme (see section 3.2.1). Monitoring of quality has not been systematically introduced. Some youth centres (eg Temeke) have instituted their own system of collecting client opinions through a comment box, and through feedback sessions with peer educators. UMATI programme staff recognise the weaknesses in the current approach and the need to systematise monitoring of quality. The minimum package of YFS being developed with support from AYA will include monitoring tools to address quality.

### Cost-effectiveness

As yet no cost-effectiveness studies have been carried out: the MIS does not produce data to enable an analysis of the effectiveness of different service delivery strategies in reaching young people. At a programme level it is not possible to track services provided to young people by youth centres, UMATI clinics, CBD agents and peer educators. As mentioned above, evaluations of youth centres in Latin America and other FPAs in Africa have indicated that this approach is very resource intensive relative to the number of young people reached by the approach. Given the paradigm shift within UMATI and the resource constraints to implementing the shift, it may be timely for UMATI to undertake some analysis of the relative cost-effectiveness of different interventions. For example, the vocational training provided by the Temeke Centre is very resource intensive and the most difficult component of the programme to sustain. The training is also very limited in reach – enrolling a maximum of 40 girls per year – and of questionable relevance to improving the sexual and reproductive health of young people.

## **5.2.5 Effectiveness**

### Utilisation of services

As noted, UMATI's MIS does not capture age-related data and no analysis has been conducted of trends in utilisation of services by young people. It is not therefore possible to make an assessment from the MIS of trends in utilisation of UMATI services by young people<sup>45</sup>. UMATI is now planning to address this weakness in the MIS with support from AYA. Given the paradigm shift it would now be timely for UMATI (with assistance from IPPF) to carry out an analysis of utilisation of services as one proxy for measuring programme effectiveness.

However, final project evaluations and MUCHS FGDs indicate that UMATI's approach to providing clinical and counselling services to young people integrated into youth centres has been effective in increasing utilisation of services by young people. FGDs indicate that important factors contributing to the acceptability and effectiveness of the approach have been that services are provided in a non-judgemental manner by staff trained in youth friendly approaches, and that services are provided in locations separate from adult clinics, thereby maintaining privacy and confidentiality. One participant in the MUCHS FGDs expressed young people's satisfaction with UMATI youth centre services:

“UMATI is a real friend in need if you have a problem you just walk in the centre / clinic and you are cordially welcomed, attended in privacy without grinning faces – you walk away and no gossiping over users” (see annexes 4 and 6)

While the youth clinic approach has clearly been effective in increasing young people's access to services, the approach is still constrained in terms of its overall reach. Data from the final evaluation of the Iringa youth centre<sup>46</sup> and routine service data collected at the Temeke youth centre suggest that client base of the centres is still relatively low, given the size of the potential youth population they are serving. Site visits to the Arusha centre also indicated that reach and utilisation has been constrained by a number of factors including,

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<sup>45</sup> Indeed UMATI annual reports provide little insight into whether or not UMATI's overall service delivery is growing. The 2000 AR states that clinics serviced a total of 18,718 clients for RH services and that clinics “...performed a lot better than in previous years”. The 1999 annual report states that performance of clinics in 1999 was however 8% lower than in 1998, with a total of 3,311 continuing acceptors attended and 4,339 revisits.

<sup>46</sup> (2001) *Final Evaluation of Iringa Youth Centre Project*. Population Concern.

location of the centre, staff shortages and shortfalls in supply of drugs from the district authorities.

The youth clinic approach has clearly demonstrated that there is a demand for services by young people and that those young people who are able to access the clinics value the quality of services being provided. Utilisation of services at the Temeke and Iringa youth centres also appear to have increased significantly since the introduction of VCT services.

One of the constraining factors on effectiveness is that by locating clinic services within multi-purpose youth centres the approach is very costly to replicate. In order to address this constraint UMATI has identified the need to transform its existing adult clinics into youth friendly services. As implementation of this approach has not yet started it is not possible to comment on the relative effectiveness of providing services through youth centres or through services integrated into existing adult clinics. However, lessons learned from the youth centre programme indicate that attitudes of providers to young people and maintaining privacy and confidentiality are key to the effectiveness of the approach. Significant efforts will therefore be required to reorient existing clinical staff and service delivery facilities to meet the needs of young people.

UMATI Peer educators are also trained to supply condoms, pills and spermicides. However, there are no data on the trends in condom and other contraceptive distribution by peer educators. An internal evaluation of the peer education programme indicated that peer educators are more effective in passing on information to their peers and referring them to services than they are in counselling and BCC. The YMEP project piloted a range of different referral strategies by peer educators. The final evaluation<sup>47</sup> indicated that referral by peer educators was more effective when linked to UMATI youth centres than when referral was made to public sector dispensaries, as quality and acceptability of UMATI youth services was perceived by young people to be much higher than in the public sector.

### Best practice

UMATI has been collaborating with RCHS in the implementation of the permanent and long-term contraceptives project. While this project is clearly focused mainly on adults it has included a component of post-abortion care which also addresses young people. The aim of the project has been to assist the MOH to develop best practice in service provision, and the project is in the process of being handed over to the MOH. Collaboration with the MOH in best practice in service delivery has also been carried out on a small-scale in some project sites. For example, the YMEP project formed linkages with government dispensaries in one project site to increase young people's access to services. Through its involvement in AYA, UMATI should be able to contribute to influencing national best practice. However, lack of documentation of lesson learning has been a constraining factor on the extent to which UMATI has been able to influence best practice by government and other NGOs. UMATI recognise this limitation and are addressing the need for improved documentation with support from AYA.

UMATI appears to have received few best practice guidelines from IPPF, and has accessed few materials on best practice for youth friendly services produced by IPPF. UMATI has been accessing materials and guidelines on best practice for youth friendly services through AYA and from the South African Reproductive Health Research Centre as well as through its project partnerships with RFSU. Interestingly, the field visits revealed that most youth centre staff had little knowledge of IPPF or that UMATI is an IPPF affiliate, and none had seen any best practice guidelines produced by IPPF.

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<sup>47</sup> (2003) *Young Men as Equal Partners in SRH Including HIV/AIDS Prevention* (YMEP) Project. Final Evaluation

## 5.2.6 Sustainability

### Externally funded projects

As discussed in previous sections, UMATI's programme is highly dependent upon external funding. While UMATI has made a concerted effort to integrate project activities into its core programme at the end of each funding period, UMATI is facing severe constraints in sustaining elements of its programme. For example, field visits indicated that peer educators financed under the YMEP project were concerned that they would no longer be supported by UMATI. UMATI is also potentially going to lose a whole cadre of middle management staff (the Area Medical Coordinators) who are based in the UMATI regional offices and have been supported with money from a USAID funded project, funding for which has now ceased as a result of the US administration's "gag rule"<sup>48</sup>.

### Cost-recovery

UMATI implements a cost-recovery policy in its adult clinics through charging fees for services. Fees are not charged in youth centres, in recognition that the majority of youth clients do not have the ability to pay for services. Hence the strategy shift to focus on young people as the primary client will have an impact on the financial sustainability of services.

### Local financing and management

UMATI is making important efforts to ensure that their projects are included in district plans in order to access district health sector basket funds (HSBF). Partnerships have also been formed with municipal councils to ensure sustainability, as a result of which the municipality provides sessional medical staff for the Temeke youth centre clinic.

## 5.2.7 In Summary

UMATI is recognised by key stakeholders (government and NGOs) as having played a pioneering role in initiating provision of RH services to young people in Tanzania. UMATI projects are making important efforts to address priority issues related to young people's sexual and reproductive health as identified in section 1 of this report. UMATI's service delivery to young people consists of a range of small-scale and geographically dispersed interventions, based on two main service delivery approaches: clinical services integrated into youth centres, and peer education. The modality of these approaches varies across project sites.

The evidence base for design of interventions has largely been developed on a project-by-project basis, and a number of detailed baseline studies have been carried out. However, these baselines have been developed largely as tools for project monitoring as opposed to forming an evidence base for reviewing and refining design of service delivery approaches.

As UMATI's MIS does not collect age specific data it is not possible to assess trends in utilisation of UMATI's services by young people. No trend analysis has been undertaken on data reported by the youth centres. Final project evaluations and MUCHS-conducted FGDs indicate that clinic services integrated into youth centres have been effective in increasing

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<sup>48</sup> The "Long-Term and Permanent Contraceptives Project" was funded by USAID through Engender Health. Activities implemented under this project are being handed over to RCHS, due to USAID funding coming to an end as result of the "Gag Rule" (by which USAID does not allow its funds to be used by agencies which support abortion). Core staff located in UMATI regional offices were supported under this project and hence these posts are now likely to be lost.

utilisation of services by young people. FGDs indicate that important factors contributing to the acceptability and effectiveness of the approach have been that services are provided in a non-judgemental manner by staff trained in youth friendly approaches, and that services to young people are provided in locations separate from adult clinics, thereby maintaining privacy and confidentiality. An internal evaluation of the peer education programme indicated that peer educators are more effective in passing on information to their peers and referring them to services than they are in counselling and BCC. UMATI staff recognise the need for further training of peer educators in counselling skills.

While the youth clinic approach has clearly been effective in increasing young people's access to services, the approach is still constrained in terms of overall reach and client base. By locating clinic services within multi-purpose youth centres the approach is very costly to replicate. UMATI is now facing the challenge of how to scale up pilot and project-based approaches to ensure that the national programme reaches young people as the primary clients. UMATI has identified the need to transform its existing adult clinics into youth friendly services. Significant resources will be required for staff training to ensure that lessons learned from the youth centres can be integrated into the core UMATI programme. Implementation has been constrained by lack of financial resources for staff training and for renovation of facilities.

## SECTION 6: PROMOTING REPRODUCTIVE HEALTH INFORMATION AND EDUCATION

### 6.1 UNFPA Country Programme

#### 6.1.1 Relevance

##### Evidence base for approaches

UNFPA has been supporting three main approaches to IEC/BCC.

(i) The first has focused on reaching in-school youth through *Family Life Education* (FLE) on mainland Tanzania, and Moral Ethics and Environmental Studies (MEES) on Zanzibar. Implementing partners are the Ministry of Education and Culture (MEC); and the Ministry of Education, Culture and Sport (respectively). Support to FLE/MEES has been a core UNFPA activity since the early 1990s. The first phase, which was a pilot project to introduce FLE into curricula of schools and teacher training colleges, was supported under 3CP (1992-1996). Under 4CP (1997-2001), UNFPA supported curricula development, development of teacher guides and source books for secondary schools, and training of trainers in teacher training colleges. 5CP will continue to support production of materials including student books and training of teachers, counsellors and peer educators.

Two KAP studies were carried out in 1999 on mainland Tanzania and Zanzibar, which form the first baseline from which to measure effectiveness of the FLE/MEES approach. However, curriculum and materials development (which has been the focus of the programme for the past 10 years) has had a limited evidence base to inform design. Technical support was provided by the CST in curriculum development. However, as yet there is no evidence base from which to assess whether FLE/MEES is an effective approach for bringing about behaviour change among young people.

(ii) The second approach is *Lifeskills*, which under 4CP involved the AMREF Lifeskills Education Project in Kinondoni District (the only project implemented by a civil society partner under 5CP). The project built upon a similar approach developed by UNICEF, whereby Participatory Learning and Action (PLA) tools were used to gain information on problems faced by young people in the community, and to provide an evidence base for intervention design. However, the external evaluation of the project (conducted in 2003) indicates that as no baseline data were collected before implementation within Kinondoni District, assessment of programme impact could not be measured against pre-programme implementation data.

Under 5CP, UNFPA's support for young people's lifeskills is limited to the forthcoming ERASE-AIDS initiative aimed at equipping out-of-school youth with competency skills to foster positive behaviour change for HIV prevention. The ERASE-AIDS project has been designed at regional level, and is not a local level initiative. UNFPA anticipated that AMREF would be the implementing partner, enabling lessons learned from its Kinondoni project to be taken forward and to provide a local evidence base for scaling up lessons learned from the Kinondoni District intervention. However, for reasons that were unclear to the evaluation, the Centre For African Family Studies (CAFS) based in Nairobi has been identified as implementing partner<sup>49</sup>, and AMREF currently receive no funding under 5CP.

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<sup>49</sup> CAFS was selected at regional level not locally, as a result of which UNFPA has less influence on how the project will be implemented, and limited influence on building on local best practice.

(iii) A third approach – through UNFPA’s media partnership project – has involved technical and financial support since 1993 to the soap opera *Twende na Wakati* which is produced by Radio Tanzania. The focus of the project under 5CP is to support the outputs of the GA sub-programme. The radio programme is targeted at a general audience (especially in rural areas), using story lines which address issues related to traditional practices (eg FGC), early pregnancy, gender issues, and sexual and reproductive rights. The programme is not specifically targeted at a youth audience, and focus group discussions conducted by IPH/MUCHS indicated that few young people listen to the programme.

#### Appropriateness and relevance of information

FLE/MEES are integrated into the national curriculum and are now taught in secondary schools as examinable subjects. The FLE/MEES curriculum has been integrated into four host subjects: biology, geography, civics and home economics. Efforts have been made to integrate ICPD definitions and concepts of gender equity, women’s empowerment and reproductive health into the subjects. The teacher guides include some discussion on issues related to sexuality and sexual health. However, the approach is quite theoretical and at times uses moralistic language, covering issues such as: “psychological effects that can be caused by irresponsible sexual behaviour to both culprit and victim”; and technical discussions on the meaning of sexuality, sexual health and socio-cultural practices. Nonetheless, the teacher guides do discuss issues related to sexuality and discuss condom use as an option for safer sex as well as abstinence. However, many of the FLE sessions appear to have little relevance to the reality of young people’s sexual and reproductive behaviour. For example, the first FLE session in the teacher guides for geography teachers is on “the sun”, and includes a discussion on the gender impact of solar energy. The home economic syllabus combines moral discussions on issues such as good manners, age of courtship, and marriage with more technical discussions on issues related to HIV/AIDS, STIs, and population growth. One of the main constraining factors on developing a curriculum and materials that are contextually relevant and appropriate to the needs of young people, is that UNFPA’s implementing partner is the Ministry of Education and Culture (MEC) and as such is one of the more conservative partners for addressing issues related to sexuality and reproductive health. In addition, the focus of support has been on developing an examinable curriculum which links discussions related to young people’s sexual and reproductive health with population dynamics and moral debates on family life, as opposed to out-of-curricula activities.

Within UNFPA’s support to training teachers in the FLE curriculum, there is limited focus on addressing teachers’ attitudes. UNFPA have identified the need to train counsellors in schools under 5CP – but as yet little seems to have been done regarding addressing issues related to teachers’ attitudes and sexual behaviour by UNFPA. This is an important issue given that the findings of the KAP studies referred to above indicated high levels of sexual exploitation of pupils/students by teachers.

The AMREF Lifeskills Education project supported under 4CP, and for the first year of 5CP, used a participatory and learner-centred approach, aimed at empowering young people and community members to reduce risk behaviours among young people through skills to enable them to adopt positive behaviours. The lifeskills education tools were developed through community-centred participatory techniques to ensure their relevance to the issues facing young people in the District. The educational component of the lifeskills approach is based upon ten lifeskills for “psychosocial competence” identified and developed by WHO. These are self-awareness, interpersonal relationships, effective communication, problem-solving, decision-making, coping with emotions, coping with stress, creative thinking, critical thinking and empathy. IEC materials have been developed through participatory approaches to address specific issues/problems identified by young people in the community, such as HIV/AIDS, drug abuse, STIs and early pregnancy. An indicator of the contextual relevance of

the approach is that some groups of peer educators have now established their own CBOs, and have set up small community booths in which IEC/BCC materials are available for young people to access. While the IEC materials are only accessible to literate youth through the CBOs, trained peers also provide lifeskills sessions and community theatre to reach both literate and non-literate young people.

#### Contribution to coherent IEC/BCC policies and programmes

The main contribution of UNFPA to IEC policies since 1994 has been through the integration of FLE into the national curriculum, the development of national teacher and student guides and the training of FLE trainers in teacher training colleges. The Ministries of Education on mainland Tanzania and Zanzibar are committed to expanding the FLE/MEES programme to all secondary schools. During 4CP the IEC/BCC activities implemented were limited in scope and coverage, and 5CP is focusing on increasing national coverage of training and materials. GTZ and Family Care International (FCI) have also been involved in developing FLE/IEC materials, which have also been distributed to schools in districts covered by their respective projects. However, integration of these different project approaches has not occurred at national level.

UNFPA has attempted to integrate lessons learned from the AMREF project into 5CP through the reproductive health and adolescent services component project implemented by the RCHS. Activities to be implemented include training of peer educators, parents and community members (para-professional counsellors) in lifeskills, and awareness raising through community theatre. However, linkages between the Ministry FLE/MEES programmes and the proposed integration of the lifeskills approach into the IEC/BCC activities implemented by the MOH, remain weak. Training of peer educators and counsellors is included in the FLE/MEES component projects in 5CP. Due to limited resources, training of school counsellors is planned in seven UNFPA RH sub-programme regions, although implementation of these activities has not as yet taken place. Few linkages have been formed between schools and service delivery points on mainland Tanzania, although there is anecdotal evidence of informal linkages between schools and health facilities in Zanzibar. Most of the efforts to train counsellors and peer educators in schools and to link in-school programmes with services has been undertaken by NGOs (eg UMATI, AMREF) and have been small-scale.

The AYA programme should be an important mechanism through which to scale-up NGO initiatives and provide coordination of IEC/BCC approaches. However, UNFPA has not been yet been able to take a proactive role in facilitating effective coordination with AYA, and ensuring that best practice supported by UNFPA is integrated into the AYA programme. An indicator of the lack of coordination between UNFPA and AYA is that AMREF is not an implementing partner of the AYA programme, and further UNFPA support to AMREF under 5CP is currently uncertain, despite a positive evaluation of the project.

#### **6.1.2 Integration of Rights**

As mentioned, a concerted effort has been made to integrate the ICPD concepts of gender equity, women's empowerment and reproductive health into the host subjects of the FLE curricula. Within this context there is limited reference to broad socio-economic rights of young people. Some efforts have been made to integrate an understanding of rights into the civics curriculum. However, this has been done largely through theoretical discussions on issues relating to human rights (as defined in international charters), international cooperation and reproductive laws and rights. Teacher's guides also include the ICPD definitions of reproductive health and rights.

The lifeskills approach developed by AMREF has more of a focus on sexual health and individual behaviours than on rights. The main approach to rights is to empower young people to reduce risk behaviours and to increase support to young people from parents and community members.

### **6.1.3 Capacity**

#### Skills and competencies

To date, the training of teachers in FLE has been minimal. Training has been a very slow process given that the curriculum has been in place since 1997. Discussions with the MEC indicated that teachers who have not received training feel unskilled in teaching the FLE curriculum. The evaluation of 4CP also indicated that major problems and constraints in implementing the MEES project were due to lack of adequately trained personnel, and that the project suffered from inadequate curriculum and resource materials for both teachers and students. Local assessments of teacher capacity to teach FLE carried out by NGOs such as UMATI also indicate that many teachers feel ill-equipped to address issues related to sexual and reproductive health with students. The 5CP component project document for FLE also recognises the current limited capacity of teachers to teach FLE stating that: “most of the teachers and tutors in schools and teachers training colleges respectively have not been exposed to POPFLE in terms of its content, scope, and methods of teaching FLE concepts, as it is a relatively new subject, which is geared at influencing change in attitudes, behaviour and practices. These elements have their roots in socio-cultural values and beliefs and take time to be influenced”. UNFPA is addressing this problem in the design of 5CP through expanding the coverage of training of secondary school teachers through training a national cadre of FLE trainers based in teacher training colleges. Guidance and counselling services are still generally lacking in schools and teacher training colleges, and training of teacher counsellors has not yet taken place on mainland Tanzania, although teacher counsellors have been trained in Zanzibar.

#### Peer educators

While the RH sub-programme includes training of peer educators both in-school and out-of-school, this training has not yet been implemented either by the RCHS or the MEC. Training of 73 peer educators/lifeskills trainers was carried out under the AMREF Lifeskills Education Project. The evaluation of the Lifeskills Project indicates that many peer educators have acquired skills in communication and that increased self-confidence as a result of the lifeskills training has enhanced their ability to communicate with family and peers. However, the evaluation also indicates that some young people felt that the lifeskills programme alienated them from young people who had not been involved in the project, and that they tended to socialise only with those young people who had been exposed to the same ideas.

### **6.1.4 Efficiency**

#### Development and distribution of IEC materials

Development of FLE/MEES materials has been a lengthy process, which has been supported under 4CP and continues under 5CP. Teacher’s guides and source books have now been printed and are being distributed. Distribution is problematic as the MEC does not have a logistics system for distribution of materials. The distribution process relies on teachers being given materials when they attend the teacher training colleges for training, or materials being taken to schools by inspectors. As a result distribution has not been consistent, has not achieved national coverage and is difficult to monitor. Student books have been developed but are still in the process of being printed.

Materials have been developed with TA from the CST. Pre-testing has been limited, based on receiving comments on drafts of teachers guides at TOT workshops and the pre-testing of students books and posters in selected schools in Dar es Salaam. Hence pre-testing has not been carried out in areas with differing socio-cultural contexts.

### Monitoring

According to the MEC, school inspectors are responsible for the monitoring of FLE/MEES in schools, and have been trained in the FLE/MEES curriculum. During monitoring visits inspectors are supposed to check whether teachers are using appropriate teaching methods (including participatory approaches) and that they are not missing out core elements of the curriculum. Monitoring of effectiveness has not been undertaken up to this point in the FLE/MEES programme. However, the KAP surveys undertaken in 1999 now provide a baseline from which effectiveness can be monitored.

AMREF undertook routine monitoring of the lifeskills programme through regular collection of demographic data on lifeskills trainers, youth participants and attendance at training sessions. Weekly supervision was also provided for each group through community supervisors, with additional technical support provided by AMREF programme staff. Impact has also been monitored by AMREF, through use of pre and post-training skills assessments including multiple-choice questionnaires. However, the external evaluation suggests that additional methods are required to adequately assess skills acquired through training.

### Youth involvement

There is very limited youth involvement in the design and implementation of the FLE/MEES curricula. The incorporation of FLE/MEES into host examinable subjects inevitably leads to a top-down teacher-led approach. The main approach to youth involvement is through the proposed training of peer educators under 5CP. It is intended that peer educators and teacher-counsellors will be involved in developing out-of-curricula activities, although as yet implementation has not taken place.

Youth involvement has been central to the AMREF lifeskills approach. IEC materials have been developed through an extensive process of message identification, pre-testing and implementation involving young people in the district. Young people have also participated extensively in the evaluation of the project. However, the extent to which this level of youth involvement in IEC/BCC approaches will be supported by the RCHS programme is questionable given the limited capacity of the RCHS in this area.

### Cost-effectiveness

As yet no attempts have been made to measure the cost-effectiveness of support to FLE/MEES. An analysis of cost-effectiveness will need to take into account the resources that UNFPA has allocated to supporting a national FLE/MEES programme over the past three country programmes, as against the current outputs which are still very limited. While the external evaluation of the AMREF Lifeskills Education project considered impact on behaviour change, no analysis has been carried out of the cost-effectiveness of the approach.

## **6.1.5 Effectiveness**

### Effectiveness and acceptability of IEC/BCC approaches

UNFPA support has focused on FLE/MEES to support behaviour change among in-school youth, and the AMREF Lifeskills Education project to support behaviour change among

out-of-school youth. In many respects FLE and lifeskills are contrasting approaches. While FLE is learning and teacher centred, the lifeskills approach is centred on developing communication and negotiation skills. Central to the lifeskills approach is building community ownership through training young people as lifeskills trainers, parents as trainers in parent-youth communication and community members as para-professional counsellors to provide regular support to young people in their communities.

UNFPA support to the FLE/MEES programme has been ongoing for over ten years. As yet there are no data to indicate that FLE/MEES has had an impact on behaviours among in-school youth. While a number of studies have been carried out to monitor performance (eg School Inspectorate Reports), as yet no systematic assessment has been undertaken of the effectiveness of the approach on behaviour change. As mentioned in section 6.1.1 KAP studies have now been finalised which will form a baseline for assessment of programme effectiveness. Given the amount of human and financial resources that UNFPA has invested in this approach, it would therefore seem timely for UNFPA to undertake an assessment of the effectiveness of the approach to help guide their strategic support to behaviour change communication for young people. In the IPH FGDs with young people in Iringa, Morogoro, Arusha and Dar es Salaam few young people cited FLE as a preferred source of information on reproductive health. Most cited local theatre, entertainment and participatory dialogue with peer educators. Only 10% of young people involved in the focus groups indicated that knowledge on issues related to reproductive health had been acquired in school.

The external evaluation<sup>50</sup> of the AMREF Lifeskills project points to some significant impact on attitudes and behaviours among young people. Positive benefits identified by young people and community members include reduction in visible groups of youth taking drugs, increased school attendances, increased visits for VCT, improved communication between parents and children, and increased self-confidence and communication skills among young people trained in life skills. However, para-professional counselling has been subject to constraints, as community members often do not feel that counsellors have sufficient skills. The evaluation also indicates that there is an increasing divide in attitudes and behaviour between those who have been exposed to lifeskills and those who have not. Implementation strategies have not been successful in involving all members of the community and the spread of knowledge is limited to those directly involved in the programme. Involvement of youth is estimated at only 20% of the total population, while parental involvement is much lower.

### **6.1.6 Sustainability**

#### Integration of best practice

Support to FLE/MEES is sustained through partnership with the MEC. FLE/MEES is therefore an ongoing programme although as yet no lesson learning on best practice for behaviour change has been produced by this approach.

Significant lessons for best practice have been produced by the Lifeskills Education Project. While there is a budget line to AMREF identified under the 5CP (URT/02/P07), UNFPA support to the project has been limited to US\$100,000 in the first year of 5CP, with further funding uncertain. AMREF perceive that they are no longer a UNFPA implementing partner. The main constraining factor on continuing project support to AMREF appears to be the resistance from a key staff member with the RCHS to collaborating with civil society organisations in the implementation of the 5CP. UNFPA CP staff have therefore made

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<sup>50</sup> (2003) Draft. *Community-centred Lifeskills Education Programme to promote sexual and reproductive health among out-of-school youth. Programme Evaluation Report.* AMREF, Dar es Salaam.

concerted efforts to ensure that lessons learned from the Lifeskills project will be sustained through integrating lifeskills activities into district level ARH plans. However UNFPA CP staff expressed concerns that the sustainability of the Lifeskills approach will be severely constrained by lack of capacity within the RCHS and the districts to implement participatory and community based approaches. UNFPA has been unable to influence AYA to adopt the approach under its BCC component, and have also been unable to influence the RCHS in collaborating with AMREF as an implementing partner in 5CP. As a result important potentials for scaling-up and sustaining the approach appear to have been lost.

### **6.1.7 In Summary**

UNFPA has been supporting three main approaches to IEC/BCC: FLE/ MEES to reach in-school youth; lifeskills education to reach out-of-school youth; advocacy to the general population through the soap opera *Twende na Wakati*. In many respects FLE and lifeskills are contrasting approaches. While FLE is learning-centred and teacher-centred, the lifeskills approach is centred on developing communication and negotiation skills. UNFPA support to the FLE/MEES programme has been ongoing for nearly fifteen years. As yet no systematic assessment has been undertaken of the effectiveness of the approach on behaviour change. The FLE project has been slow to implement due to the cultural sensitivity of the issues and the conservative nature of the implementing partner (MEC). Integrated curricula and teaching materials have been produced, and some teacher training has taken place. Student materials are currently under production.

The AMREF Lifeskills Education Project which has now come to an end was implemented over three years. The external evaluation<sup>51</sup> points to some significant impact on attitudes and behaviours among young people and some important lessons for best practice have been produced by the project. UNFPA support to the project recently ended. While UNFPA CP staff have made concerted efforts to ensure that lessons learned from the lifeskills project will be sustained through integrating lifeskills activities into district level ARH activities, UNFPA CP staff perceive that sustainability of the approach may be severely constrained by lack of capacity within the RCHS and the districts to implement participatory and community based approaches. AMREF is also not an implementing partner of AYA. As a consequence the potential for scaling up some important lesson learning on best practice supported under the 4CP appears to have been lost under 5CP.

## **6.2 UMATI**

### **6.2.1 Relevance**

#### Evidence base, priority issues and appropriateness and contextual relevance

IEC materials for young people have been developed on a project-by-project basis. Baseline studies (referred to in 5.2.1) have provided an evidence base for identifying young people's information needs. Local level needs assessment conducted at project sites have formed the basis for identification of priority issues to be addressed by IEC messages. IEC materials have been designed to cover a range of priority issues including early pregnancy, condom use, HIV/AIDS, family planning, reproductive rights, responsible parenthood, gender relations, drug abuse, and harmful traditional practices.

A wide variety of IEC materials have been produced through a range of projects. These include billboards, posters, leaflets, booklets and radio and TV slots. Young people in the

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<sup>51</sup> (2003) Draft. *Community-centred lifeskills education programme to promote sexual and reproductive health among out-of-school youth. Programme evaluation report*. AMREF, Dar es Salaam.

IPH FGDs indicated that the radio programme “Be Sexwise” which is produced by UMATI and broadcast on Radio Free Africa is very popular among young people. UMATI is also collaborating with schools under the ARRA project, to complement the FLE approach being implemented by the MEC (supported by UNFPA). Through this project teachers are being trained in reproductive rights in order to deliver information to young people. ARRA has been designed to address early pregnancies, unsafe abortion, STIs and HIV/AIDS, sexual harassment, and harmful sexual practices (including FGC) and drug abuse. In Iringa, ARRA is using the youth-to-youth approach in 14 wards. Young people have been involved in producing messages to ensure their contextual relevance. In Iringa, youth have produced materials related to widow inheritance, which they consider as being crucial to understanding issues related to gender, sexuality, marriage and divorce. In Temeke, youth have been able to design and develop leaflets and booklets which reflect the realities of young people in urban areas. In Arusha some IEC methods such as puppetry have been adopted to suit the local context of young people’s culture. The YMEP project produced a training guide on gender and sexuality which has been widely distributed, and IEC materials to address young men’s role in HIV/AIDS prevention and SRH have been produced and distributed.

UMATI is making the transition from an IEC to a BCC approach. A BCC approach to address gender-specific needs was developed under YMEP, and with support from AYA UMATI is currently developing a lifeskills manual, and a training-of-trainers workshop in life skills has been carried out. UMATI have also provided technical assistance to the Vocational Education Training Authority (VETA) within the Ministry of Labour and Youth Development to integrate lifeskills and peer education into the vocational training programmes in technical colleges.

### **6.2.2 Integration of Rights**

As mentioned in the previous section, the ARRA project is directly addressing issues related to reproductive rights. Billboards and leaflets with reproductive rights messages have been produced and distributed. The main aim of the YMEP project was “to change young men’s attitudes related to sexuality” through IEC and BCC. Gender integration has been one of the important aspects of the project, and training of trainers on gender issues was provided by the Tanzania Gender Networking Programme (TGNP).

### **6.2.3 Capacity building**

#### Staff capacity

Staff capacity at youth centres and in UMATI central and area offices to produce IEC materials is limited, and most staff do not have specialised skills in this area. At project sites, UMATI collaborates with local NGOs with expertise in materials development, or relies on the creativity of young people to design the materials. The capacity to produce materials is also constrained by the current lack of an IEC specialist in UMATI.

UMATI has produced a training manual for peer educators, which addresses sexual and reproductive health, family planning, STI/HIV/AIDS, body changes, teenage pregnancy and responsible parenthood. The training period for peer educators is not homogenous from site to site, and refresher training has been limited. UMATI staff appear to be skilled in training peer educators, and UMATI is noted by partners (such as VETA) for its skills and competencies in training in peer education.

#### Peer educators (PEs)

A thorough internal evaluation of the peer education programme was carried out in 2001. The evaluation makes sound recommendations for strengthening the approach, and shows

that peer educators have been effective in making referral to services, and that referral is most effective if it is to a UMATI youth centre (as peers have more trust in these services). However, the evaluation noted that peer educators focus more on information giving and feel less skilled in providing counselling. The evaluation also noted that continual refresher training is needed as the absorptive capacity of peer educators is relatively low, and PEs have difficulty in providing correct information in response to SRH issues raised by their peers. Issues related to rumours surrounding condom use, menstruation and side-effects of contraceptives were examples of issues that PEs felt unskilled in providing information. At the time of the evaluation only PEs at Temeke had been introduced to lifeskills training. Site visits to Temeke indicated that peers were comfortable and skilled in using the lifeskills approach.

#### **6.2.4 Efficiency**

##### Monitoring

Monitoring and supervision have been integral to the peer education approach. Monitoring activities include regular meetings organised by project managers with peer educators. Report forms for peer counsellors and teachers involved in the school-link interventions are used to record and report activities of peer educators and counsellors.

While data are collected at project level they have not been systematically collated and analysed at central level. As yet there has been no means of monitoring the effectiveness of different IEC/BCC approaches, apart from through project evaluations, such as that carried out by YMEP.

##### Youth involvement

As it is not possible to discuss the contextual relevance of IEC materials without referring to youth involvement, this has been discussed in section 6.2.1. Youth involvement has been variable across project sites. Field visits noted that youth involvement in IEC production had been high in Iringa and Temeke, but limited in Arusha and Morogoro.

##### IEC production and distribution

UMATI staff and youth have generally been satisfied with the distribution of materials. Materials produced at specific sites (eg Temeke and YMEP project sites) have been distributed to – and are readily available at - all UMATI youth centres nationwide.

#### **6.2.5 Effectiveness**

##### Behaviour change

The main approaches to behaviour change currently being supported by UMATI are IEC, peer education and lifeskills. UMATI staff recognise that it is difficult to assess behaviour change, and monitoring of behaviour change has been limited. Indicators of behaviour change have been produced on a project basis. For example the evaluation of the YMEP project indicates that the project was effective in increasing utilisation of services in YMEP sites and noted positive changes in attitudes of young men and in condom uptake and use of STI diagnosis and treatment services. However pre and post intervention data were not available from all the project sites.

### Acceptability to young people

Young people in FGDs conducted by IPH/MUCHS showed a high level of message recall and indicated IEC materials produced by UMATI were generally considered to be acceptable. As many as 70% of young people in FGDs (boys and girls) reported having accessed SRH and gender educational messages through UMATI youth centres. Young people were of the opinion that more effort needs to be made to direct SRH messages in school settings where unsafe sexual practices were considered to be high. In some youth centres (eg Morogoro) girls voiced the opinion that the programme was more responsive to boys as a result of activities implemented under the YMEP project. Preferred sources of information mentioned by young people in FGDs were theatre groups, entertainment (eg radio) and discussions with peer educators. The reasons for these preferences were: these media are more accessible to non-literate youth, young people are attracted to entertainment and messages delivered with humour, these approaches give young people the opportunity to ask questions and voice their opinions. Main concerns of young people were the inability of non-literate youth to read IEC materials and that some messages were produced in English which is not locally appropriate (eg an IPPF poster on reproductive rights).

### **6.2.6 Sustainability**

Issues related to sustainability of IEC/BCC approaches are similar to those discussed under services (see section 6.1.6). UMATI has made efforts to integrate materials produced by externally funded projects into its overall programme (eg YMEP). However, as noted previously there are resource constraints on sustaining peer educators supported under this project, and the perception of young people at project sites is that peer educators are attached to projects as opposed to the UMATI programme. The lack of an IEC and Advocacy Manager has also affected the sustainability of approaches and materials developed. Youth centres also have a limited budget with which to produce and distribute IEC materials. UMATI is addressing the issues of sustainability through its partnership with AYA and seeking a diversified external funding base. UMATI has also formed some a strong partnership with The Ministry of Labour, Youth Development and Sport to integrate peer education and life skills approaches into government supported education programmes. At the local level UMATI is also collaborating with NGOs and CBOs in the production and distribution of IEC materials. The challenge facing UMATI is to pull the lessons learned from project-based activities into a coherent IEC/BCC programme.

### **6.2.7 In Summary**

UMATI has produced a wide range of reproductive health education material on a project-by-project basis, and design of materials has been informed by local level needs assessment conducted at project sites. Materials have been designed to cover a range of priority issues identified in section 1, and reflect key concerns of young people regarding reproductive health and rights.

Young people in MUCHS-conducted FGDs showed a high level of message recall and indicated that materials produced by UMATI were generally considered to be acceptable. Nearly three-quarters of young people in FGDs (boys and girls) reported having accessed RH and gender educational messages through UMATI youth centres. Young people were of the opinion that more effort needs to be made to direct RH messages to school settings where unsafe sexual practices were considered to be high.

UMATI is in the process of making the transition from an IEC to a BCC approach. A BCC approach to address gender-specific needs was developed under YMEP, and with support from AYA, UMATI is currently developing a lifeskills manual. Peer education is a key component of UMATI's BCC approach. However, the internal evaluation of the peer

education programme carried out in 2001 indicates that peer educators are more effective in information giving than in providing counselling and behaviour change communication.

The lack of an IEC and Advocacy Manager has affected the sustainability of approaches and materials developed, and the integration of project specific approaches into the core UMATI programme. UMATI is addressing the issue of sustainability of IEC materials through its partnership with AYA. UMATI has also formed a strong partnership with MLYDS to integrate peer education and life skills approaches into government supported education programmes.